PUBLIC

THE LEGISLATIVE COUNCIL GOVERNMENT ADMINISTRATION COMMITTEE A MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART, ON THURSDAY 2 FEBRUARY 2012

COST REDUCTION STRATEGIES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

CHAIR - Thanks for coming. Just to remind you of how the committee works, everything you say is recorded on *Hansard* for the purpose of preparing a report at some stage into the future. What you say here is protected by parliamentary privilege. If you say anything outside it may not be - outside of the Parliament, outside of the hearing. If you do want to give any evidence at all that you consider to be of confidential nature, you can make that request and the committee can consider it and then determine whether we hear that in camera or not.

We have your submission and I know that you have had a long history of commenting on public health policy and that is great. If you would like to give an overview or summary of your submission and then members will have some questions for you. I know there has been a bit of passage of time since your submission and the cuts are probably starting to show more direct effect that you may be able to describe as well since you put that submission in. Anything up-to-date would be helpful as well.

Dr ALEXANDER - Ruth, you mentioned that I did present, I think it was in 2009, to another upper House committee. My description of the health system at that time was the same as the then Prime Minister, Kevin Rudd, and the Opposition Leader, Tony Abbott, that health in this country was a dog's breakfast. Since that day it has gone from bad to worse. The health cuts had come at a time when we were all struggling in health care.

I have been a doctor for 30 years and a GP for 25 years. As my submission says, I have run two large general practices during that time. The struggle to implement good primary health care is now almost impossible and we are working in the dark in most areas. We are going over problems that should have been fixed a long time ago.

The sad thing from my point of view, and it is in my submission, is that in August last year every senior government and Health minister in this country met in Canberra for numerous photo opportunities and delivered what they said was the greatest change in health care in this country since Medicare. They promised there would be no blame game. They promised there would be adequate funding for our public hospitals. They promised that there would be more doctors. They promised there would be greater and earlier access to elective surgery. That was in August of last year. I did not make up those promises, they were promises made by Julia Gillard, Nicola Roxon, Lara Giddings and Michelle O'Byrne, the four senior players in dealing with what we are doing at the moment. They made those promises. Within less than two months they had gone back on all those promises. They could no longer guarantee any of those things. So in less

than two months they have done a complete U-turn. They are either incompetent or they deliberately set out to deceive. It has to be one of those two. You cannot make such a turnaround in two months to deliver these cuts to health care. That is part of my submission.

My submission also, I think, looks at from a GP's perspective. I think there is no better person than a GP, not me specifically, but a GP to look at these cuts and how they affect the public. We are closer to the public than any other group. We have ongoing care which many who will sit here today do not have. We look after these people right through the health system, right through their lives. We interact with every other section of the healthcare system. So whether it be A&E, public, private hospitals, physios, ambulance officers, we interact with the lot. No other group does that and so I think we are in a good group.

I do not claim to represent anyone. I run a large practice that has roughly 10 000 patients or more so I probably claim to represent those 10 000 patients as someone who has had more than a quarter of century working in the health system. I would like questions.

CHAIR - At this stage there have not been any significant cuts to primary health directly. We have the list of saving strategies that were released in October last year that target the acute health service, elective surgery, agency-wide cuts, and things like that. Are you aware of any discussion around cuts to the primary health area, the rural hospitals, that sort of thing, that have all been the elephant in the room?

The second question is what direct patient impacts are you seeing from the cuts at the acute service level?

Dr ALEXANDER - There have been huge cuts into primary health care - I will use Mental Health as an example. When the State Government slashes Mental Health money, you have to realise that at the same time the Federal Government slashed general practitioners' Mental Health money. So Mental Health is a very precarious position at the moment in this State. The Federal Government only yesterday did a U-turn again on some of those changes to the Better Access to Health Care, and some of those systems.

General practice, for example, is being continually starved of what I consider funding to practise good-quality health care. There is certainly always funding where maybe the larger, and especially on the mainland, corporatised clinics are able to churn through and make huge incomes. That is a certainty. Tasmania is not really in that situation that we see on the mainland but overall there has been a starving of funding. The best example of that is the rebate that GPs work on. I see a patient for from five to 20 minutes, so up to 20 minutes the rebate for that sits at about $35. That has sat for such a long time while the Government implements and fiddles with other programs that they introduce and then removes, for example, the Mental Health money. Many of those programs have been introduced, and the reason for introducing them is that it will be offset against the rise in the rebate.

The reason I am mentioning that - and I am not here crying poor - is that the problem that we are all facing in Tasmania is complex, elderly patients with multiple problems. They are not five-minute consultations, they are not in and out, they are complex, they are difficult and they are pushing much more to the 20 minutes than the five minutes. That is

where the problem lies for Tasmania. The dispersed population in Tasmania also has an effect because there are many regional areas trying to cover more than maybe in the inner suburbs of Sydney, for example.

CHAIR - GPs are funded from the Federal Government currently.

Dr ALEXANDER - Yes.

CHAIR - That is a Federal Government issue. I don't expect you rely on rural hospitals that much in your practice, do you?

Dr ALEXANDER - No.

CHAIR - Maybe it would be good to comment on those.

Dr ALEXANDER - My practice has a wide range of population sectors and relies heavily on the public hospital, much more than other areas of the State might. So we rely heavily on that public hospital.

CHAIR - The Royal?

Dr ALEXANDER - The Royal. It is the same situation right across the board. When you mentioned that I am mainly federally funded, that is virtually true, but now we see this mixed way of funding our public hospitals. I think Neroli Ellis was talking yesterday about the increased presentations from ED with patients who have been discharged too early or patients who have presented to ED who immediately need surgery because they have been so long on the waiting list. That patient who does that may well have presented to our surgery 20, 30 or 40 times over that time. I do not specifically look at my funding as being federally alone. If the State Government ever gets interested in health care and can then streamline that system, then our work becomes much easier and therefore we can run a far better cost-effective practice. But we have to interact with those hospitals all the time. I am sure we will come to communication later, or lack of communication.

I will give you an example. This is what the public hospital gives to patients from our point of view. It has nothing on it, it just says, 'Next time you contact or visit your GP, could you ask for an indefinite referral', and there is not enough being talked about with this. A patient either comes to me where an item number can be charged or rings our surgery and says, 'I need an indefinite referral'.

CHAIR - To a specialist?

Dr ALEXANDER - To a specialist within the hospital. This is simply a consultation with this little piece of paper that the State Government can then bill the Federal Government for.

CHAIR - So the cost-shifting is the issue here, with the two funders?

Dr ALEXANDER - Yes. Again, it's just a mishmash of Federal and State. We, probably more than any other group, get stuck in between because, as you point out, we are

federally funded basically for rebates et cetera. Well, we're not federally funded at all, patients are. Patients have the rebate; I don't have the rebate. It's a patient rebate and I think that is forgotten. It is State and Federal and to us it means very little. What we try to do is sort out the problem we have in the seat next to us. I just do the job as I'm trained and very rarely would I think that this is a State or Federal issue. You just try to sort the problem. But when you sit back after work or we get together as a group as GPs we talk about what a mess it is.

CHAIR - What impacts are you seeing for the elective surgery cuts and the other cuts that have been made?

Dr ALEXANDER - The impact hasn't really hit full on yet and the reason is that over the holiday period rarely in any year is there a lot of elective surgery. For example, I doubt if very much neurosurgery was done over the two or three weeks of Christmas and early January - routine, elective neurosurgery. The neurosurgery ward would be full of general medical patients and every patient who needs a bed. Now, the neurosurgeons start up work again and those beds are taken up by neurosurgical patients. There will still come the pressure from the patients you can't avoid admitting - I shouldn't say it in that way but I think that's the way the Government looks at it. There are patients who will need admission and they will be taking up elective surgery beds. I think we got a warning sign recently from the Health minister, Michelle O'Byrne, that our figures are disastrous and they're going to get worse and we'd all better get used to it.

CHAIR - The dollars you mean?

Dr ALEXANDER - Yes. Tasmania wins the wooden spoon in nearly every category of health care before the cuts. I think that is the thing we're not grasping enough. This was in decline before the cuts. These cuts are so silly it doesn't bear thinking about. It is decimating every aspect of our workforce. It's decimating health care and we're now spending a little less money for massively worse outcomes. I heard someone from the Chamber of Commerce discussing it recently and they were saying, 'Isn't it great we're saving a few dollars?' without ever thinking if we're getting good benefit from these dollars we are saving or are we simply shackling our health system so we get no outcomes at all? No-one put a brain cell to what happens in simply winding back *x* number of dollars and what the effect will be on the output. We're probably going to run a very expensive and very inefficient health system from now on.

CHAIR - Let's accept for the moment that we have a budget that is in a bad way. The reason we got there is irrelevant; we are where we are, so what would you do? If you were given the job of recognising the budget challenges and recognising that every area of government probably should have some savings, what do you think could be done in health that could save money but not impact on patient care and direct delivery of service?

Dr ALEXANDER - It's a bit like saying, 'What would you do if you were on the *Titanic* and it's sinking?'. You would grab a lifeboat. The lifeboat this State has at the moment is a Federal Government takeover. I have been saying that for a lot of years. The reason I say it is that with our State Government I would challenge anyone to raise one aspect where they've shown any interest, desire or ability to run a health system. They haven't, ever. In 2009 I talked about leadership and a health policy. That committee hearing was

held because the health system in this State was collapsing. Again, I challenge anyone to show me a decent health policy and any leadership from any politician since 2009 in health care? It is not leadership to cut money and run around saying there is no more hay in the barn. The reason that the health dollar is under pressure is that the system is run so badly. It is not that we are spending too much money. In answer to your question, I would say we need Federal Government takeover with considerable local input into how our hospitals are run.

CHAIR - You are talking about one funder.

Dr ALEXANDER - It has to be a single funder. The *Titanic* is sinking and we have to do something.

CHAIR - Let's say there was agreement to have a single funder. What would you then do to ensure that the money was best spent? We keep hearing here that before the cuts were made that the system was broke and a lot of that was the cost-shifting. We have had that discussion in the past and I agree it is a major problem. But how do you run a health system which is a very money-hungry beast. Health inflation costs, we all recognise, far outstrip other inflation costs. How do we manage it?

Dr ALEXANDER - The most important thing is to integrate the primary health care system with the hospital system. I used the word chasm -

Mr WILKINSON - Try canyon.

Dr ALEXANDER - Yes, canyon. All these people come in with all these highfalutin futuristic ideas but we could solve the problem with a phone and a fax machine provided someone is prepared to pick it up or do it. Yes, it has been thrown up all the time that eHealth will fix this; eHealth will not fix anything. It still requires someone to download that information. That information isn't being downloaded now; it's not the speed of transmission that's causing us problems. The problem at the moment is our pubic hospital systems. It would be less - I am sure - in a smaller community like the north-west coast, for example, or up north. The two major public hospitals, LGH and Royal Hobart Hospital, almost sit in isolation with a moat around them. The patients are pushed out the door at the end and no-one thinks twice about what happens to that patient. Again, there are various plans and things set up but someone has to continue the healthcare once they leave that hospital.

We see discharge summaries and, yes, we are starting to see some improvement in some of these areas but we have 12 experienced GPs in our surgery with probably in excess of 250 years experience in general practice. We sit and cheer in our staffroom when we get rung about a patient of ours who is in hospital. We laugh about it that, yes, it's happening and isn't it great but it's so a rare an occurrence for us to talk about it. So for a patient I might send in whom I have a long history on - I might have done numerous tests on; they might be expensive tests such as CAT scans, MRIs and they might have seen numerous private specialists - that information is never ever gathered during that admission or never accessed.

CHAIR - And often repeated.

Dr ALEXANDER - Yes, sometimes repeated within 24 hours.

CHAIR - That's where the cost-shifting is an issue.

Dr ALEXANDER - Yes.

CHAIR - Because if it's done by you, the Commonwealth pays, but if it's done in the hospital, the State pays.

Dr ALEXANDER - Then there's the reverse thing where our patients might get an early discharge because the hospital needs the bed, but they're still not worked out properly so they might need a CAT scan or blood test. They will get sent to us so we do them and then bill the Federal Government.

I might have a patient who repeatedly goes to an outpatient clinic with a complex problem; I might have no idea they even go there. That's how bad the correspondence and communication is. I might have no idea that they go there and yet the patient might come and say to me, 'I need *x* blood tests done before I go back to the clinic'. I'm sitting there thinking what clinic, what tests? We have to get on the phone and find out what tests. One of our permanent staff is almost permanently trying to access information out of our public hospitals.

CHAIR - Don't you even get pathology sent through?

Dr ALEXANDER - Rarely. That also requires someone to write our name on the form. I have some forms here. Even though I have written two letters, I and the patients need copies of these. Worse still, we might get faxed to us a result of one of our patients and we have no idea why they are in hospital. I got one on Christmas Eve, a grossly abnormal result which means it is my responsibility to chase this result. I have no idea why the test has been ordered, no idea actually where the patient is - they were at home. Then we have to go and chase the result up because it's my legal responsibility -

CHAIR - Once you've got the result.

Dr ALEXANDER - Once I've got it. Communication is where a lot of these problems lie. So how would I fix it? I would fix the communication, I would get primary health care working better, I would start to develop a decent workforce. The workforce issues in this State and country have been abysmal for a long time. We raised medical students numbers, we then might raise some training position numbers. We have a bottleneck of internship numbers and the State Government's only interest in interns is not to produce better doctors but to staff their hospitals. All of us would say, medical students - let us increase them; same for nurses as well, same for everything, then training positions, then placement positions. None of that happens. I despair a bit with our university. I do not know how many medical students we are putting out at the moment but I would love to know how many are Tasmanians? The reason I say that is that it is a proven fact that Tasmanian graduates stay in Tasmania, much more than other graduates. I know that we have other doctors coming from elsewhere, but it is a statistic whether they be nurses or whatever. I would love to know what percentage is that. I would love to know what percentage the university gets from funding for their training. I would love to know what training people think these medical students entering our public hospitals at the

moment are going to get with public hospitals that are working at about a quarter pace. Twice the number of medical students of a few years ago and probably half or less the number of patients to learn on.

CHAIR - There is also a glut, I think it is this year, when they have fifth and sixth years graduating together for that one year when they reduced the medical training from six to five years. So there are two years graduating at once.

Dr ALEXANDER - Yes. The workforce is depleted, demoralised and aging - fast. And yet what we have done here is virtually take a baseball bat to all our young workforce. I am sure that everyone here has family members who have done nursing training, family members who have are going to medical school, and all they can think of at the moment is how am I going to get out of here. How can I get a job on the mainland where I will have a future. That is all they think about, all they talk about. That will take us decades. Even if the Government reversed their decision tomorrow and said that they were going to adequately fund, they have done irreparable damage to our future workforce and you cannot run a health system without a workforce.

Mr HALL - I take on board what you are saying that there has not been any leadership by politicians.

Dr ALEXANDER - I am generalising.

Mr HALL - That is okay. Members of this committee do not have any direct input into policy matters; we do the best we can. Could I talk about the health bureaucracy per se and the fact that leadership starts with, perhaps, the secretary of Health and then going down through the health bureaucracy. In your view how has that served Tasmania?

Dr ALEXANDER - Abysmally. It throttles everything we do. There seems to be this preoccupation, if you think about eHealth and every other project that is underway, that we seem to be following the UK NHS slowly, in a catastrophe, some four or five years behind them. I do not know whether the bureaucracy here has become like an out-branch of the failing UK NHS, which is having huge problems. E-health for example, cost billions of dollars and it has proved to be a failure. Why? Because they did not get out and ask those people on the ground who actually have to do the work what is needed to be done.

The CEOs of our public hospitals are simply political puppets. To get them to make a sensible comment about the pressures their hospitals are under just does not happen. They are political puppets. We would not have had, a decade or so ago, what the CEOs of our hospitals are saying, head in the sand, at the moment. I would take what they say with a grain of salt because their job is to make the whole image to look better. That is their main focus.

Mr HALL - Do you see better models in the bureaucratic system in other States, that other States can perform better?

Dr ALEXANDER - I think that now we have the Medicare Locals, and sadly we have three Medicare Locals in the State -

CHAIR - No, we have only one Medicare local. We have three Tasmanian Health Organisations.

Dr ALEXANDER - Yes, Tasmanian Health Organisations. It is split; I do not think the other States have to put up with that as much as we do. It needs to be streamlined from the top down. The leadership still comes with the leadership of our State and Federal governments and it is just not there. Again, I will challenge anyone to show me anywhere where they have shown leadership in health care. Here is the challenge; I will pick Bob Brown, Tony Abbott, Julia Gillard. I know this has had a State government cutback focus but we cannot fix this without Federal Government involvement and they are heavily involved in every section of this, whether it be building our public hospitals or whatever. Their tentacles are everywhere but they are not interested. I challenge everyone to see where do those three politicians I named put health care in their list of priorities. I challenged Nick McKim after a rally in Hobart and he agreed with me that for Bob Brown it is not in his top 20. I am just staggered at that. When has it been mentioned in Parliament? Our health system is collapsing around our ears and we cannot get a mention. It just beggars belief.

CHAIR - That is why we are doing this

Dr ALEXANDER - Yes. In every single poll people say health and education are the top two. They are but health is the number one, it beats education hands down. In every poll, health care is the number one concern for the public, but it is not in the top 20 for a vast number of our politicians. I am excluding people here and I appreciate that. But for the main political leaders, the main game players who have left us in this dog's breakfast, it is not in their top 10 at least, if not top 20.

Dr GOODWIN - You have mentioned some of the issues, and the communication problem obviously is a big one, but these are things that seem to have been around for a while. In terms of these cuts to elective surgery I think you said that you have not really had time to see the full impact because of the summer period. What are you expecting the impact to be over and above the problems you have already experienced?

Dr ALEXANDER - I said I have not seen the impact of the recent cuts. I have seen impact of cuts and poor health policy for a long time. Probably people saw me on the *7.30 Report* discussing various cases. I have a patient whom I know has diagnosed gallstones. They have gallstones, they need the gall bladder out, they are having pain recurringly. I now look at them and know they will probably never be operated on electively, ever. Equally, a patient with a hernia will probably never be operated on. The only way they will get operated on is if they get a serious complication. That is now, today, before these health cuts are really hitting hard. So I have to look at them and I have to manage them, assuming they will never be operated on. So I have to assume that they will present to casualty, to A&E, goodness knows how many times. I have to assume they will be ringing our surgery early Monday; they need to be seen because they waited eight hours in casualty and could not be seen. They need more medication, they need more pain relief and the gall bladder is now infected. Then eventually they will have a much more complex, difficult and longer hospital stay. There are a vast number of patients I know will not be operated on.

Our practice would have a vast number of patients who can no longer work but who could work if they had their surgery. So I would be writing Centrelink certificates for people in order to keep them financially viable while they are sitting waiting for their surgery. The moment they had their surgery, within weeks they would be back at work. For every aspect we look at, we waited. For some patients with life-threatening conditions, we just wait. In nearly every aspect the wait gets forgotten. Everyone looks at the waiting list and it is artificially low and the reason it is artificially low is that a vast number of patients are not there yet. They have not been able to get the clinic to get onto the waiting - a huge number. That number is going to go up massively.

CHAIR - It would take longer to get on the waiting list too because the specialist -

Dr ALEXANDER - Yes. So it will be longer to get on the waiting list and therefore longer to get to surgery, and more complex stays. We are all led to believe that the health dollar is going to consume the State budget. Simply, if you run a health system as badly and as uncaringly as we run it, it will, and it doesn't matter if you have cut back $120 million, it is still going to do it because patients will still demand far more costly and difficult surgery. Earlier I touched on the chasm between us and the public hospital system. The private hospital system is struggling too but no-one talks about it. We frequently would have an elderly patient who might have a complex illness needing a complex stay in hospital clutching their private health insurance that they have paid religiously year-in, year-out, yet their chances of getting in a private hospital are slim if not nil.

CHAIR - Because of the comorbidities?

Dr ALEXANDER - Yes, comorbidities - we don't have general physicians anymore; they have gone by the wayside, sadly. I read a newspaper article recently where someone thought what a good idea it would be to have a general physician. Well, when I started out -

CHAIR - That was all you had.

Dr ALEXANDER - Yes. It was a big newspaper article saying it was groundbreaking that we were going to have general physicians and again, for Tasmania, with a complex elderly population, general physicians are just what we need. They are not in our private hospitals. Our private hospitals are frequently on bypass, which leaves all these complex problems in our public hospital system, so to separate out this as a public hospital problem, I can't do that. This is going to make the system we will all probably rely on sometime in our lives massively worse.

Parents often say to me, 'I have private health insurance for my children'. For some things that is useful but nearly all paediatrics is done in our public hospital system and many a frustrated parent is saying to me, 'Why do I have to go there?' or, 'Why do I have to wait those eight hours in A&E?' The answer is that is where paediatrics is done and your private hospital insurance is no use to you. There are huge areas where we all rely on it, no matter how affluent and how well connected we are, and people find that out. It is interesting to me that a lot of people say to me, 'What's all the fuss about?' Once they or one of their family has to access the Tasmanian health system they learn pretty quickly how bad it is and they come back and say, 'Now I know what it's all about'.

Mr HARRISS - Graeme, that coalface interaction which you opened by talking about, are you seeing yet or do you think it may occur because of the re-presents which you see, somebody who has been diagnosed with a life-threatening condition - it could be a cancer - and is ready for surgery, but is bumped off the list because at that moment they can postpone the surgery on the cancer, so then they re-present to you at some later stage not too far down the track? Are we going to have incidences of avoidable deaths?

Dr ALEXANDER - I think we already have. I think we have to have. I am sure our surgery would have already seen avoidable deaths if we had been able to get at them earlier. But the problem is again how this system is all intertwined. In that situation you probably rely heavily on your GP to whinge and moan and ring and fax and ring and fax and re-present the patient and re-present the patient. I am singing the praises of GPs now but if you roll your sleeves up and work you can usually can get them in but, again, how time-consuming it is. I reckon I spend two hours a day inefficiently struggling through these things and we have a receptionist whose job is almost entirely to extract results and ring, 'Where is this patient?', but I think since the cuts came the whole information from us, from the public hospital, has got darker still in that I now have no idea. When you ring and say, 'Do you have any idea when this patient may actually get to a clinic or may get their surgery?', often the answer is, 'We have no idea', whereas previously they may have given me a stab-in-the-dark estimate, which is important to me because it tells me how I am going to manage that patient. The whole system - and I am probably exuding frustration - is frustrating. It is a dog's breakfast at the moment and, again, this is like the killer blow coming at the end, and it is done to everything. As I said, our workforce, the way we manage our patients - we have no idea what is happening now.

In general practice patients often look at me and think I must know when they are up. We have no idea, and we are deliberately told 'no idea', I am sure. But patients ring all the time. Patients present all the time. There is a bit of a myth that A&E is full of general practice patients. It is an absolute myth. Every survey that is ever done from A&E shows that it is not the case at all. In fact, the reverse is true. Our surgeries are full of patients who should have been treated in our public hospitals, and I am sure some of the A&E people - and Neroli referred to it yesterday - are actually patients who should have been dealt with by the public hospital system. But from every survey I have ever seen it is not general practice patients clogging up A&E and, with all due respect to my A&E colleagues, there is too much of a focus on A&E in all this. From my point of view it is a very, very important part of our health system but it is literally only a small part. The surgical wards and the general medical wards are important. General practice is important. Aged care involves complex elderly patients. I actually said in 2009 that I would like someone sometime to come with me after hours to a nursing home. It should be the duty of all of us to go to a nursing home and see some very ageing, depleted staff managing huge numbers of patients in difficult conditions. So it is the whole system that is struggling, and I know the focus of this is about government cuts, and it should be, but it is only part of the whole system. It is a dog's breakfast and this is the worst thing that could have happened to the system, and how anyone could have come up with an idea that this was somehow fiscally responsible is mind-boggling.

Mr HARRISS - So following that, then, what would be your observation about the state of our statewide Clinical Services Plan?

Dr ALEXANDER - I have had a look at a few clinical services plans and I do not think I am that stupid, but I struggled to understand any of them. I struggled to understand the information that we have been sent about Medicare Local, you name it. We pass it around amongst ourselves and we just shake our heads in disbelief. To me - and I have said it before - the statewide Clinical Services Plan is not worth the paper it is printed on.

Mr HARRISS - I was asking that a bit tongue-in-cheek; my personal observation or assessment is that it is deficient.

Dr ALEXANDER - Yes, I was trying to be polite, but it is not worth the paper it is printed on, and they have big words like Medicare Local and integrated healthcare centres. What do they mean?

Mr HARRISS - No crisis.

Dr ALEXANDER - No, and I talked about the State and Federal chasm. We have also an independent in this State and, yes, he may have a certain amount of money to build a hospital, but I will say again that we could probably run a better health system with a good quality workforce in a row of tents. The building is important, because that also gives you opportunities to improve things like communication. But here we have, as I said, this so-called groundbreaking health and hospital reform, and here we have our State Premier telling the Federal member for Denison to 'get back to Canberra and mind his own business'. Imagine what people like us and people who work in the hospital, the nursing staff, think when we hear that sort of nonsense going on. It is mind-boggling.

CHAIR - We have actually run out of time, Graeme. I am sure we could ask you about a whole range of other aspects of this issue.

Mr HALL - We might at a later time.

CHAIR - Yes. Thank you for your time. I think one of the issues we didn't really cover was the whole rationalisation of health services and those difficult discussions I think we need to have as a community, as well as political leaders, I guess, but also the health professions.

Dr ALEXANDER - Can I just touch on that briefly? Before the health cuts came there was *x* amount of dollars that had to be cut, and the Government said, 'You will cut that money', but they were not specific about it at all. In other words, they said, 'You've got to cut that money but we are going to wash our hands of it'. Decisions like that, unfortunately, where we rationalise our health system, will have to be made, I think, by levels of government.

CHAIR - It is a discussion for another day, obviously, but I think some of those difficult discussions about who we treat where and what we do treat need to be considered perhaps in some other discussion, and the commissions definitely need to be involved in that. Thanks for your time.

THE WITNESS WITHDREW.

PUBLIC

Mr DAVID WATSON, AMBULANCE PRIVATE, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - David, have you given evidence to a parliamentary committee before?

Mr WATSON - I have. I heard your comments before.

CHAIR - We have your submission here. We would like you to speak to it and then members will ask you questions. We are trying to focus on the savings strategy that has been put out by the Government. Whilst it's not directly aimed at your particular area we appreciate that you have some comments to make that relate to the cuts.

Mr WATSON - There are three main parts to the letter I sent to you, Chair. I was concerned that a letter I had sent to the Minister for Health had not been responded to appropriately. There is also material back from the minister on the same matter.

The main issue - and this has been a sticking point for us for some time - is the advent of the almost $10 million Federal grant to the Mersey Community Hospital, which reappeared in Hobart as a $9.8 million grant which was used by the Ambulance Service to ramp up the very small patient transport service. That service is now the dominant player in the State. There is no point in going back over that material, whether or not people agree or disagree with it. I am concerned about the running expenses of that service and how much money is being lost by it. That is why I wrote the letter to the minister in the first place. When I sent the letter off to the minister I suggested at the time that there was well in excess of $2 million to be saved immediately by closing down the patient transfer service, but that money did not include the money required for that work to go back to the private sector again.

CHAIR - This is the non-urgent patient transport?

Mr WATSON - Yes. This is a subsection of the Ambulance Service that has been put together, which is costing them a lot of money. Since writing these letters I believe it has blown out by another $1 million, so it will be interesting to see some figures when they are circulated. I proposed that they close down the patient transport service and outsource its work. At that stage I believe it was costing in excess of $3 million. I have since been given some unconfirmed reports that it is in excess of $4 million being spent by the service to do what amounts to $1 million worth of work.

CHAIR - Just to pick up on that point, I think there was some suggestion from the minister in the letter -

Mr WATSON - That they didn't agree with my figures?

CHAIR - Yes, but they also suggested that one of the reasons for not agreeing with the figures is that you can't completely separate the non-urgent patient transport from the other work they are doing as part of the Ambulance Service.

Mr WATSON - Well, they have done that by running two separate organisations - seven different vehicles, different names, different staffing. The only area where it all comes

together is that they operate out of the same building so far as the communication centre goes. It is quite easy to look at ambulances and say that the primary function is emergency services. The primary function of patient transport is non-emergency transport, which is inherently hospital-based transport. It is quite easy to look at them and it has been for the 12 years that we have been in operation.

I suggested closing it down immediately and putting the work back into the private sector again. At that stage I believed that there was approximately a $2 million saving and I believe it has probably blown out even further now. I have been saying this message for so long that it is embarrassing but we have an ambulance service that loses money every time it sends out an ambulance to a public contract. Racing Tasmania should have a sign up saying the ambulance service is one of its biggest donors because the money they take from racing to have an ambulance at the race track does not cover the cost of the wages. If they send an ambulance to the Falls Concert, they do not cover the cost of the wages.

Dr GOODWIN - So they are not charging enough for the service?

Mr WATSON - No. We have this rather silly situation where the market is being artificially suppressed by one of the players operating at below cost. It is time to stop and I have been saying this now all the way through.

CHAIR - You are saying it is not even cost-recovery; it is running at a loss.

Mr WATSON - Yes. For V8 Supercars, for every contract they go to they use overtime wages and unless they put two students together, or something like that, they run at a loss for the wages. It doesn't even cover the cost of the vehicle going out.

Dr GOODWIN - Have they always done that or is it something that the private sector used to do?

Mr WATSON - We are involved in those sporting contracts but you have to be extremely careful with your dollars to come under a Tas Ambulance quote.

Dr GOODWIN - So you have to compete with them and they always undercut?

Mr WATSON - Yes. They are not making the prices up as they go along. They come from legislation but inherently, and what I have been saying for years, is that the fundamental pricing structure is faulty and needs to be addressed.

The other area I am also concerned about is the revenue-raising side of the ambulance service. The minister said I was wrong in this but I am certainly not wrong. We have a situation where the head of the ambulance service is supposed to produce a forward estimate of his expenditure and revenue and the Treasurer will make up the gap between the two. That is part of the act and it is written quite clearly; there is no question about it.

CHAIR - Where there is a gap, you mean?

Mr WATSON - Yes, expenditure in the ambulance service, revenue in the ambulance service and the Treasurer is going to cover the two between. What it basically means is that money earned by the ambulance service is inherently neutral. If the ambulance service

earns $100 000 from revenue, its budget allocation will be reduced by $100 000. It does not take into account the cost of actually earning the $100 000 in the first place, whether it be another vehicle or a couple of extra spare vehicles, increase in wages and consumables at the same time. So in actual fact the ambulance service loses money by being involved in revenue collection.

CHAIR - They only contribute the cost to the revenue, only the straight revenue?

Mr WATSON - Yes.

CHAIR - They don't take the costs out of that?

Mr WATSON - The 1982 Ambulance Service Act shows quite clearly that the gap between revenue and expenditure is to be covered by the Treasurer, but it doesn't allow for the cost of revenue collection or generation. I found that to be an anomaly for many years. If anything it is a nonsensical way of doing business. There should be an incentive to earn money, to operate at a profit.

CHAIR - You could read this as the difference between expenditure and the revenue specified in the estimate approved by the minister under section 27. The expenditure could include the expenditure of raising the revenue, but you are saying it doesn't.

Mr WATSON - I can't argue with that; that's a fair point.

CHAIR - You would need to see the breakdown of it.

Mr WATSON - In saying that, what I did look at were the areas that Ambulance Tas looked at as a revenue base. Veterans' Affairs, Motor Accident Insurance Board work and insurance cases should inherently be passed back to the private sector immediately. It would be in their interests to do so, but they haven't done it.

They were the main points I put to the minister and what I got back was an unusual response that didn't really answer very much of what I talked about. The policy approved by Cabinet, which talks about not outsourcing ambulance work, came from about 2000, I believe, and it has been wheeled out every time we write a letter to the Government; they use the same response. 'My understanding of the budget allocation for Ambulance Tas non-emergency patient transport is substantially higher than provided.' My figures were quite accurate and I can quite happily boost them up with something that fell off the back of a truck, which is a business unit report from February for the transport division which quite clearly shows that the budget allocation I talked about of $2.017 million is correct.

CHAIR - Are you happy to table that?

Mr WATSON - I am more than happy to table it. I don't think it's forged. It does show that the budget allocation was correct. It also shows that there is a massive overspend already in that budget of February of last year, which would have gone on to be approximately a $4 million overrun. I don't normally table things like that but I do get a bit annoyed when I'm told that my figures are wrong or it is suggested that they're not correct. In this case they most certainly are correct.

I did not propose that we withdraw from attending public contracts in that sense and I suggested there is no legal mechanism. What I suggested was that if they are going to do it then do it at a profit. If they're not going to it at a profit then don't do it at all. There is no requirement for them to be there.

CHAIR - So it's a tender process?

Mr WATSON - It's an open process. If you were with Racing Tas you could call anybody you want who complies with the requirements for jockeys.

CHAIR - So how does Tasracing determine who they are going to contract to provide the services on each race day?

Mr WATSON - I would imagine that it would be on a percentage basis and 60 per cent would be to do with price; the remainder would be to do with the skill level.

CHAIR - They must obviously go out seeking tenders -

Mr WATSON - No; they've been traditionally Tas Ambulance all the way down the line. There is an interplay there where the jockey association is always very keen to have paramedics there as well. We would have to go and prove ourselves on merit if we were to win that sort of work, the same as any other organisation that was capable of doing the work. But first off let's get the pricing structure fair so we don't have the situation where a government unit is operating under what is actually a fair market price.

CHAIR - You did say that one of the reasons they perhaps keep their costs down is that they use two students, but obviously two students aren't paramedics.

Mr WATSON - You can't do that. You could put a paramedic with another student, a first-year student; you pay the first-year student a very small percentage and you pay your paramedic quite a lot. Even then, your wages bill is very close to what you're collecting from the racing people.

This says I raised the view that the ambulance service is unable to recover fees for compensable cases and Veterans' Affairs. I didn't say that. What I am saying is that the money raised is immediately taken off them anyway. I take on board your comment as to whether the expenses were already added into that. It certainly would suggest so but you really wonder why they're doing it if there's no need to do it. Certainly the end result is that you've got an ambulance service doing more work, doing non-urgent cases that could be done by the private sector, but at the same time they're telling us that we need more resources for the ambulance service because we're doing too much work. So what the hell are they doing in doing compensable when they don't need to?

The main point has already been made that whilst health is suffering cuts across the board, it's not completely across the board. The ambulance service has been excluded dramatically from an area of cuts and yet it is a service that has expanded in a huge way in the last few years. It's gone from a management structure of approximately five or six people to, I believe, in excess of 30 now. Yet it's been excluded from the savagery of some of the cuts that other organisations have had to put up with.

Mr HARRISS - Do I conclude from what you've put in your submission that the expansion of management staff, if you like, and the expansion of the non-urgent patient transfer service of the Tasmanian Ambulance Service, arises from Federal funding somewhere along the line?

Mr WATSON - Yes, absolutely. During the issues with the Mersey hospital - and Greg probably knows more about it than I do - at one stage there was a $10 million Federal grant to assist with transport along the north-west coast. That money reappeared in Hobart, minus a bit. I don't know how that happened but it came back as $9.8 million and funded a new building for the Ambulance Service, a communication centre, a new communication service and patient transport expansion of a service that was doing about 40 jobs a month and is now doing in excess of 800. A large number of those cases were being done by the private sector immediately beforehand. Am I crook on the Federal Government? I guess I am a bit; I think it was very carelessly done.

Dr GOODWIN - That's not recurrent funding?

Mr WATSON - I would assume it was a one-off. We now have the situation where the patient transport service was set up with a budget of $2.1 million and I believed at the time that it had blown out to $3 million. I believe it is probably closer to $4 million now. The work being done by the patient transport service is approximately $1 million worth of work a year, by the private sector. We have a situation where for $1 million worth of work we are putting probably $4 million on the line and have caused a considerable amount of angst in the private sector.

Dr GOODWIN - How does it work in other States?

Mr WATSON - Differently. Victoria is probably a role model that has had some ups and downs but does run an ambulance service and a quite elaborate non-emergency patient transport service in the private sector.

Mr HARRISS - Only from the private sector in Victoria?

Mr WATSON - I think some of the hospitals have their own transport units but inherently the ambulance service concentrates on ambulance high-level work. That is a good model to look at. I sit on the Non-Emergency Patient Transport Association Committee in Melbourne to keep tabs on what's happening over there. New South Wales has kept it in-house altogether and I believe there are changes there. Queensland has done the same. They have had some ups and downs and I believe it is changing again now. Western Australia is a St John-based operation, the same as South Australia, but there are some moves in those areas. Western Australia has made a few moves. South Australia hasn't moved very much yet. It is completely different in each State.

Mr HARRISS - With regard to this document that fell off the back of a truck, have you drawn to the attention of the minister or the bureaucrats that you are aware of their own figures?

Mr WATSON - No. I guess there's a point where you get a little bit frustrated and it is rather nice when you stop banging your head against the wall because it stops hurting. You tend to get used to standard replies.

Mr HARRISS - In the mix of things there is another player, and I refer to St John Ambulance Service. Do they receive funding from the State, which then might ramp these figures up in any way?

Mr WATSON - It is hard to say. There are three players in patient transport in the State at the moment. This has caused some grief because there is barely enough work to sustain one player. We now have added competition from within the sector as well. The end result of that is that it will have an impact across the board. Where's the work coming from? Through our 12- to 13-year history we have been pretty well the single player for the private hospital sector and we've picked up overflow work from the government sector. When they came in St John Ambulance was picking up some work from St John's Hospital for a while. I believe that has filtered out to almost nil, so the only work they are getting at the moment is coming from the Royal. How it is coming from the Royal, whether it's wards ringing directly or being directed to them from the Ambulance Service, I have no idea and I haven't tried to explore it. They are operating on a fairly low caseload and it is interesting that it is a caseload that we don't seem to be able to tap into. Having said that, we do do some work for a couple of sections of the Royal as far as after-hours work is concerned, mainly because of the quality of work that we can do and the appropriateness of our timing.

Dr GOODWIN - Could there be any benefits from doing it in-house? Why do you think they went down this path? Was it just that the money was available or did they think there would be a benefit in having an in-house, non-urgent patient transfer?

Mr WATSON - There has been a number of inquiries into the ambulance service and Paul has been at a lot of them. Bangkok Shirley (?), a more recent one of about three or four years ago, highlighted the fact that patient transport in the government sector was a very hodge-podge affair and it was nothing unusual to see one ambulance driving down to Hobart with a patient and going back empty and one going from Hobart back to their base with a patient on board. There was no coordination. A central point, a single point, was recommended. With a lot of the ambulance inquiries that have been held none of the points have been taken up and worked with but for some reason or another Bangkok Shirley got a massive response and Federal money was poured into it. I do not believe that the issues that Bangkok Shirley wrote of were insurmountable issues. We already had a situation where we provide backload patients for hospitals at half price so we were more than aware of dead legs. That was the main point. Patient transport does not require a massive administration structure to look over the top of it.

CHAIR - I noticed whilst the major hospitals have the biggest brunt of the health cuts announced last year, Ambulance Tasmania did have a couple here; I am just refer to the comments that you made - savings measures of $300 000 a year for the next three years, along with increased revenue by billing doctors on compensable medical retrievals and increased revenue budget by taking into account billing for compensable non-emergency patient transports.

Mr WATSON - Yes. It is not explained.

CHAIR - What you are saying, though, is that if they increase their revenue then their appropriation is less.

Mr WATSON - Yes. It makes a mockery of the figures.

CHAIR - It just makes you wonder.

Mr WATSON - I am not quite sure where they would find money for non-emergency patient transport. The hospitals do not pay for the transports. They get it free from the Ambulance Service.

CHAIR - It says 'compensable non-emergency patient transport', so where are they?

Mr WATSON - They are the private hospitals. But they are not working within the private hospital sector. There would be a scream a mile long if they did. If they were set up with federal money and were operating -

CHAIR - Patient transport do transport patients from the North-West Private Hospital to Launceston and places like that, though?

Mr WATSON - That is unusual. We are supposed to be doing their transports.

CHAIR - I have been out of the system for a little while. It used to happen. Maybe it does not anymore.

Mr WATSON - You know the proximity of the two hospitals as well as I do and a number of patients are transferred across and then have their transport from the public hospital.

CHAIR - These were patients who were private patients in the private hospital going to Launceston.

Mr WATSON - I do not believe that there is a chargeable base for patient transport to charge a private hospital. It is a very messy area. Under competition laws I think that they probably would have stretched the friendship a little bit if they were set up with a Federal grant to do that work in opposition to the private sector.

Dr GOODWIN - You mentioned, David, that the non-urgent patient transport and the other side are separate effectively. Is there any crossover?

Mr WATSON - Not really. You do occasionally get the situation where in total desperation they might send a patient transport service to, say, a collapse in the city because there is no-one else around. That is fine. The end of the other spectrum as well is that when the patient transport guys have gone home at night it is not unusual to see a full ambulance being used to do a patient transport case. There are crossovers in that area, there is no question about it.

Dr GOODWIN - Is that something that you are worried about, particularly at night?

Mr WATSON - I am aware of it. I think that we have the situation now where a lot of the after-hours work in Burnie is done by Mersey hospital staff, the Mersey hospital patient transport. There is certainly some confusion about how the funding of that one works as well, following on from what was in the paper about a month ago. There has been a

blurring of the lines for years with non-emergency patient transport as to whether emergency ambulances which run at a bare minimum at night-time should be utilised for that sort of work or not. The minister has suggested that it is done during downtime but as a practising ambulance officer for many years I could never predict my downtime. I think that they have done very well if they can do that now.

CHAIR - Thank you very much, David, we appreciate that.

Mr WATSON - In closing, I will say that I came to the committee with something that did not fit fully the terms of reference and I appreciate the fact the I have been given an opportunity to release my bit on the data.

CHAIR - That is all right. Thanks for taking the time to make a submission.

THE WITNESS WITHDREW.

Mr MARTYN GODDARD, CONSULTANT, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Have you given evidence to a parliamentary committee before?

Mr GODDARD - Only the Senate.

CHAIR - We are a little more relaxed. Everything you say is being recorded on *Hansard*, what you say is protected by parliamentary privilege during the proceedings but if you speak outside the proceedings that may not be the case. You can speak to the media if you choose to but you need to keep that in mind.

Would you like to give us a general overview and any additional points you want to make and members might have questions for you.

Mr GODDARD - What I thought I would do, rather than going over what you already have, is try to put this into broader policy context, more of a philosophical context if you like, because what concerns me is not just what is happening at the moment, it is what the future holds and it is what it means for the kind of society we are.

I think with the Health policy, always, you end up with a fundament moral question and that is: should a person's life and health depend on how wealthy they are? I think there is good evidence to show that the vast majority of the Australian population believes that politics shouldn't come with a death sentence, that the fundamental right to health and life is something which is indivisible, which we cannot give to some people and not to others. Once you believe that then you therefore believe in a universal health system which is paid for by the whole community, not paid for simply at the time of treatment, paid by the whole community on the basis of their capacity to pay, and is accessed according to need.

The ideals include efficiency - that is, the best use of whatever human resources and money we have. We do not have universal health care at the moment, we never really have had it but we are further from it now than we have been at any time since Malcolm Fraser demolished Medibank. There are a number of reasons for saying that. One is PBS co-payments - $35 per script for a month's supply. Medicare gap fees - the fact that unless you are lucky or you have a healthcare card, you are probably going to pay an extra $30 or so to go to a GP. Then there are the costs of specialist care resources. There is virtually no public dental cover. What we are concerned with here is that public hospitals around the country are in a state of constant crisis.

The question goes well beyond these current cuts, however bad they are. This is not a new story for us in this State. Every 10 years we have had a fiscal crisis. We had it at the beginning of the 1990s when the Field Government was elected and put the State into receivership. We had it 10 years or so ago and we have it again now.

If you look at the figures on capital expenditure on page 15, that table right at the top of the page shows up in capital depreciation because every 10 years or so capital spending goes down the tube because that is the first one - you can do without capital spending

most easily in health and then we try to catch up again and we never do catch up. That is just indicative of what is happening across the board.

This episode that we are having here is going to be extended, it is not going to be over next year or the year after. We are seeing lower GST receipts because of low consumer spending. You would have to be a real optimist to think that that was going to change very soon. There is a poor recovery in the United States. Europe is already in recession. I think that you would have to say that the possibility of another global financial crisis is maybe 50 per cent - .

Mr WILKINSON - And the dollar is $1.06 now or -

Mr GODDARD - That is right and even if our economy goes down, everybody else's economy is going down further and so the exchange rate is going to stay the same or get worse. China's growth is slowing. All of that affects GST receipts, all of that affects how much we can spend on health. The underlying long-term reality is more important than what is happening at the moment. Hospital costs have been outstripping the State's ability to pay for a very long time. There are two ways out of it: one is that we wait for the Commonwealth to properly fund the States to fund their services and that has never happened, not only to fund them but to go on funding them into the future, no matter what. The other solution - the only other solution I can think of - is that the Commonwealth takes over responsibility for public hospital funding because that is the growth area, the real growth area in State expenditure and the fact that hospital costs are going up so much faster almost twice as fast as receipts.

CHAIR - Martyn, could I put it to you on that point that one way of containing costs in public hospitals is to stop people going there and the only way you can stop people going there is dealing with their health issues before they get there - preventative health, early interventions that often can have conservative management that avoids the need for surgery or acute medical admissions - you say Commonwealth funding to public hospitals, yes, but isn't there an imperative that the Commonwealth adequately fund primary health and that area as well?

Mr GODDARD - Yes, there is - of course there is. They already have the fundamental responsibility for that and they could do a lot better than they are and there is a whole lot of reasons for that as you know. I am actually doing a paper at the moment on the question of whether disease prevention is under-funded and I think that when you actually look at the evidence across the board it probably isn't compared with everything else. The other thing is that we tend to think that spending money on prevention is necessarily more cost effective than spending money later on and it isn't necessarily the case. Projects which require the screening of huge numbers of people of the whole population tend very often not to be very cost effective at all in terms of the long-term health outcome. That is a really complicated question.

CHAIR - We have had the discussion in the public arena just recently about prostate examinations and PCRs and mammography.

Mr GODDARD - Yes. The answer is that we need to do everything properly. Everybody is going to need a hospital at some point and if you avoid this list there will be another one waiting for you. Hospitals are by no means the beginning and the end of medical care.

They are what is going up at the moment. I do not think I have seen any evidence which would say we are going to be so successful so quickly in prevention, no matter what we do to save our hospital budgets. I would be very wary of believing that we can make major cuts in hospital expenditure by improving prevention. I am not at all sure it follows. There are so many things, for instance, involved in disease prevention which have given us a massive improvement in life expectancy over the past 150 years that are no longer even in the Health portfolio, things like sewerage. Most of the things which have given us that improvement in life expectancy are no longer counted as health measures. It is a very complicated issue.

CHAIR - I accept that.

Mr HALL - Following on from that, under your heading, 'Can we afford health care?', it has always been my assumption and the public perception that health care costs on an annual basis exceeds CPI. You are saying that is not the case in your submission.

Mr GODDARD - If you did the same things year after year after year, then the increase in the price of those same things is pretty benign. It is doing new things to new people, increased demand, new technology, new things, that is forcing costs up. Health price inflation is benign. New technologies are darned expensive.

CHAIR - The public expectations are the issue here. I have been a nurse for over 30 years and when I used to work in A&E as a student nurse in the early years, a patient would come in with abdominal pain and you would have to poke around their belly first and then if you or the doctor thought they needed to get an x-ray that is all they would get. Now they want an MRI and a CAT scan and the whole bit and there is an expectation that unless you have all that you have not been adequately assessed. So this is the whole thing. If you do the same as what you have done, yes, the cost will not increase, but the public do not accept that any more.

Mr GODDARD - I think there are a few reasons for that. One is the courts. Doctors are concerned that they are going to get sued if they do not do the whole thing. Every health system in the world rations health. There is never enough money to go around. There are two ways of doing it. One is through shortages, which is the way America chooses and they way, increasingly, we choose. The other one is to do it more rationally on the basis of evidence, working out the cost-effectiveness, working out whether we are better off buying this than that. That was the way I became used to when I was on the PBS committee. It seems to me that we're never going to have enough money to do everything, we're never going to have enough people to do everything, therefore let's choose on the basis of how we get the best health outcome for our money. It may well be that giving MRI scans to people who have a stomach ache isn't the best way. If we have the evidence that that's not the best way of treating that symptom -

CHAIR - You have to convince the court.

Mr GODDARD - The individual doctor is going to be off the hook to some extent at least if that is the way the system is required to operate; if they are required under standards of care.

Mr WILKINSON - And he has to do what is reasonably appropriate in the circumstances and accept it as reasonably appropriate within the medical era of the time.

Mr GODDARD - That's right.

CHAIR - That's true, but CTG machines were introduced with no evidence to prove their value in saving babies' lives and once they were in there you could not get rid of them. There has been many a baby born by caesarean unnecessarily as a result of the CTG machine. Anyway, we are getting off the track a little bit.

Mr GODDARD - No, we're talking about efficiency, which is pretty important. One of the problems is that we don't have the evidence. We have reasonable evidence, not great, for drugs. A lot of procedures and tests we don't have great evidence for, but that's not to say we don't have any evidence. I think we can do a better job than we do in working out whether we should spend money on *x* or whether we would get better outcomes through spending it on *y*. We have to make the decisions and we have to ration health; that is the reality. We are rationing health, we are rationing it right at the moment - that's what this committee is all about. We either do it brutally on the basis of no evidence, simply on the basis of shortages and book-keeping, or we do it on the basis of what is the best thing for the patient.

CHAIR - Can you see a better way of achieving the savings that the Government states need to be made? I think we all accept that the Budget is in a bit of a mess, so is there a way that you can see these savings could be effected in Health as across other areas they need to be, that could achieve similar savings without this slash-and-burn approach of elective surgery and the frontline attack?

Mr GODDARD - I don't think you can in the short term. If you got rid of 1 000 public servants - even if you could and it would cost you a lot of money to do that - you would save a block of money and maybe you would say that those people's salaries and on-costs et cetera would be going up at a rate of, say, 3 per cent a year. Hospital costs are going up at 11 per cent a year, so saving that money would buy you some time but wouldn't change the basic reality. We could knock off these cuts at the moment, borrow money or take money from somewhere else, maybe, but what happens next year or the year after or the year after that? It doesn't solve the problem.

CHAIR - So what do we need to do to solve the problem? You're right, it is not just this year, it is next year and the year after.

Mr GODDARD - As I said, if you look at government expenditure and the category that is increasing, it is hospitals. It is that that is putting the pressure on the Budget. That is the reason we are reducing schools. That is the reason police are losing their mobile phones, all of that. Unless we change structurally and the Commonwealth comes to the party, which is the only level of government that is capable of paying - the States are not capable of paying for health - we cannot afford to pay for health. The Commonwealth can and the Commonwealth has to.

CHAIR - The Commonwealth says they are not interested.

Mr GODDARD - The Commonwealth says they are not interested, that's right. The present Commonwealth Government isn't interested. Kevin Rudd had been interested in doing it his way. Tony Abbott has told the AMA that he is interested in the idea, although I don't think it goes any further than that. One of the problems is that the pain is happening here, not in Canberra.

Dr GOODWIN - So what is plan B if we don't get the Commonwealth to take over, because we are going to need a plan B?

Mr GODDARD - Old people dying - people dying.

Dr GOODWIN - So in your view there is another way of doing it? Commonwealth take-over or -

Mr GODDARD - What else is there? We fund the States from the Commonwealth because that is where, particularly since the income tax power went across during the Second World War -

CHAIR - And never came back.

Mr GODDARD - and never came back, the Commonwealth has been rich comparatively and the States have been poor. It is not just us. Now either for the first time in history we change that, and we change it not just for this year but even when things are a little bit tough for the Commonwealth, and the Commonwealth puts in a formula by which we get the money to do our job, or we change the job. It would be much simpler if we had the money to perform the task. We haven't. The Commonwealth has had powers to make laws on health since 1946 and they haven't done it yet. How much longer do we have to wait? I don't see any alternative. I have never met anybody who has come up with an alternative.

Dr GOODWIN - Martyn, you talked a bit about an evidence-based approach to the delivery of health services, and whether we are making the best use of the resources we have available, so does there need to be some rationalisation regardless of whether or not the Commonwealth takes over funding?

Mr GODDARD - One of the problems we face is that cutting budgets has left us without the money to do things more cheaply. A good example is closing down the Hospital in the Home program in Launceston. We all know that treating people in Hospital in the Home with cystic fibrosis or whatever is a darn sight cheaper than putting them into an acute bed in hospital.

CHAIR - Plus it has better patient outcomes.

Mr GODDARD - Patients prefer it, it has better outcomes, all of those. Now what we should be doing is not having 24 patients in Hospital in the Home, which seems to me to be pretty low, but we should be looking at expanding that and keeping those people out of hospital. There are all sorts of things that are alternatives to hospital care, acute inpatient care, which aren't there because they take a bit of money to set up. We need more money to do things more cheaply, but the demand is still going to be there. I think there's a pretty substantial amount of unmet demand out there. If and when things start

getting better, those people are going to start coming forward. It's like a participation rate for employment figures. So improving the system is going to bring those people out of the woodwork as well and then we're going to get a further surprise. I can't see an alternative.

CHAIR - In Tasmania we have this tendency to want be all things to all people everywhere.

Mr GODDARD - Yes.

CHAIR - We have a couple of exceptions to that; one is neurosurgery and one is neonatal intensive care. On the north-west coast we know that if you have a head injury that requires surgery or you've got some neuro lesion or similar, you have to go to Hobart or Melbourne; the same with neonatal intensive care. You know that.

Mr GODDARD - Yes.

CHAIR - Do we need to look at further rationalising services so that we're not trying to provide everything everywhere? This is a very difficult political debate to have because people don't like to think they are not going to get everything right down the road, five minutes drive, and if you can't park outside then you don't go in. This is a bit of the approach we have here.

Dr GOODWIN - That's what I was getting at because of the earlier discussion around that.

Mr GODDARD - I think there are a few issues and you've been through these many times. Do you have a building with 'hospital' written on it -

CHAIR - And you don't get the care inside that a hospital warrants.

Mr GODDARD - That's right - and that hasn't got the case load, hasn't got the practice. Those institutions can be quite unsafe. There is a lot of evidence on that but you try taking them away. Yes, of course there is. If you do that, you save a block amount of money but then you have still got to treat those people. You might treat them more cost effectively or cheaply or effectively but the basic reality of health costs is that hospital costs are going up 11 per cent and government receipts are going up at about 6 per cent. That's not going to change. That is the fundamental problem.

Mr HALL - Still on the myth-busters concept, one was on the CPI business I talked about before and the second one you talked about in your submission is the ageing population. Would you care to expand on that a little bit because that's something we've always understood is going to cause us undue stress.

Mr GODDARD - Yes. Jeff Richardson did a lot of work on that. I was astonished, as you are, when I did this research and started reading these papers. There are simple linear models which is what commonsense would tell you is going to happen. Somebody gets older and as they get older they are going to cost increasingly more in health. That's in fact not what happens. Much of the age-related increase in costs happens in the process of dying, in the last two years. Some 25 to 40 per cent of lifetime health costs are incurred there. Once you take that into account, the models which are being used by the health economists here and around the world are coming to the same conclusions. On

complex models I am not a health economist but in the results they come up with the death effect, the Fooks effect I was talking about, is one of the important things. It is a surprise to me but if they are right, and I think they probably are, then there is a bit of hope, isn't there.

Mr HALL - You also commented that our national productivity will be able to cope with -

Mr GODDARD - Those increases, yes. When you look at the broad evidence, I don't think that increased health costs are going to bankrupt the nation; nowhere near it. In 2000-01, which is the last year I was on the committee that puts drugs on the PBS, we had an increase in the cost to government of the PBS of 19.2 per cent. Everybody was getting very upset and worried about that and that was when Peter Costello decided to introduce these very, very large co-payments and bump the PBS co-payment up to $30. Since then we have had a fraction of that. There has not been a major blockbuster drug going on the PBS since then. The international drug development pipelines in these big companies are impoverished. There was much ballyhoo a few years ago about a new means of designing drugs. Somebody would design a molecule to fit in with a therapeutic target to disrupt some sort of molecular process. Design the molecular and then somebody would go down the corridor and build a drug. They haven't been able to do that very often so it hasn't worked. We are still producing drugs through screening thousands and thousands of things and the boom in pharmaceuticals, I think, is over. What we are going to be doing now is more and more individual therapies. Those are very expensive but they are going to become cheaper because with new technology it always does. Most of those are one-offs, they are not things that you keep on doing.

CHAIR - What do you mean by individual therapies?

Mr GODDARD - A lot of the cell-based therapies or even spare parts, all that stem cell stuff. If that is the way we are going, and not through this huge increase in drug costs, then from the Commonwealth's point of view that is probably going to be more manageable financially. I don't think we need to panic. I don't think we need to assume that a universal healthcare system is something we can't afford. We can't afford to do everything for everybody and it has to be paid for but we can afford to run a decent society.

CHAIR - The Commonwealth takeover appears to be, certainly in your mind and in the minds of a number of others, the solution here but the Commonwealth say they are not interested at the moment because they haven't got any money either. We currently pay a Medicare levy which is 1.5 per cent at the moment.

Mr GODDARD - It only pays for about a quarter.

CHAIR - Yes, but we pay a levy and it is paid on a capacity-to-pay basis pretty much.

Mr GODDARD - Well, yes, a flat tax.

CHAIR - If that was to be increased. I have a view that the general public will probably accept it because they are paying extra for the flood levy this year anyway. If it was being paid directly to improve access to health services and health service provision then I would expect that there would a reasonable level of support for that, has that even been

discussed at the Commonwealth level do you know? The Commonwealth say that they have not got enough money to fund it and it is your problem anyway, go away.

Mr GODDARD - Kevin Rudd had his idea which required everybody to come to the party.

CHAIR - And he was going to claw back the GST to get it.

Mr GODDARD - I think you have to do that. I think a State which had the funding of its hospitals taken over would have to surrender the amount of money it is spending at the moment. I do not think that any Commonwealth Government is going to come at just giving -

CHAIR - Are you talking about spending the recurrent service spending as opposed to the capital expenditure?

Mr GODDARD - Yes, we are talking about that.

CHAIR - Most of the capital expenditure is specific purpose grants.

Mr GODDARD - A fair bit of it is.

CHAIR - Which are not excluded from the Commonwealth Grants Commission.

Mr GODDARD - The model that I came up with suggests that as soon as you lose responsibility for funding hospitals then the SPPs go automatically. You would also have to surrender part of GST which would have to be equal to what you are spending on health. The total would have to be what you are spending on health at the moment. The Commonwealth would have to take over responsibility for growth in the system. The other important thing is that the Grants Commission would not have to penalise us for no longer having responsibility for health. Otherwise there would be no point.

CHAIR - The Commonwealth Grants Commission is in the process of being reviewed at the moment and no doubt there will be a recommendation that will come out of that that will change the way that things are done - possibly to Tasmania's detriment even further.

Mr GODDARD - Yes.

CHAIR - That does not happen every year generally, a review of that nature, it is every three or four years, I think

Mr GODDARD - About every five years.

CHAIR - Is now the time to have that discussion?

Mr GODDARD - If, as some people in Western Australia, for instance, want the Tasmanian share of GST to go from 3.6 per cent to 2.3 per cent, which is a population share, I think we could just turn out the lights and go home. No State left - no hospitals, no police, no schools, no parliament, do not need that.

Mr WILKINSON - So in short, Martyn, after all your workings in relation to this, you believe that the best way out of this problem is that it should be for the Commonwealth to take over hospitals and health all over Australia.

Mr GODDARD - Yes, if the Commonwealth made this offer to one State it would have to make it to the rest.

Mr WILKINSON - Sure.

Mr GODDARD - One of the things which some of the interstate people are interested in, particularly Stephen Leeder from the University of Sydney, is what it would mean as an example. To point to Tasmania as having look at what you can do when you have a properly funded, properly run system. Look how much better off things are in Tasmania than they are anywhere else and that would be the best way of convincing the rest of the country that this is the future for them as well.

Mr WILKINSON - Some might argue, aren't you only transferring then the problems that the States have now to the Federals, so you would therefore have to show that there would be quite a cost savings in order for the Federal Government to do it as opposed to the States. There would have to be that evidence to show that if the Federals did it, we would have huge savings, we would have savings because we are going the maybe reduce bureaucracy and do whatever. You would have to show that, wouldn't you, otherwise it would just be a transfer of responsibility?

Mr GODDARD - It is just a transfer of responsibilities but, no, I do not think we can promise cheaper. We may be able to promise more efficient, not necessarily the same thing as cheaper.

Mr WILKINSON - More importantly, would you be able to promise better health outcomes?

Mr GODDARD - Yes, if people can get health care they are probably going to have better health outcomes.

CHAIR - In a timely manner.

Mr GODDARD - That is right.

Mr WILKINSON - But will that occur if all the States are under Federal control?

Mr GODDARD - Yes because the problem is one of fiscal imbalance. The problem is that all the States are poor compared with the Commonwealth. The Commonwealth has itself into a situation where it has a structural budget deficit - over the cycle their spending is greater than their income. They have been too busy with the budget cuts. They are not doing their job as efficiently as they could but that can be fixed. Our capacity to raise more money as a State is almost near zero. What do you do, do you put more pokies in, do you bung up payroll tax and squash the economy, what do you do? The Commonwealth has the capacity to raise the money. I do not personally favour a flat tax like the Medicare levy. I do not think flat taxes are a good idea. I think a progressive tax

is much better. I would prefer to see that money paid through the broad tax system which includes all of the taxation options open to the Commonwealth.

Mr WILKINSON - Therefore, if I might, you are saying that the reason the Federals are better able to deal with the pluses because they have a better ability to raise the money.

Mr GODDARD - They can raise the money, that is right.

Mr WILKINSON - So therefore by increasing let us say your GST by whatever percent, that would give them a significant amount more money and then they would be able to fund the system better than -

Mr GODDARD - There are all sorts of options open and it is not just income tax and it is not just Medicare levy and it is not just GST that are open to the Commonwealth.

Mr WILKINSON - I was just using that as an example.

Mr GODDARD - The other thing is that they can start looking a bit harder at their own expenditure. Having had something to do for a number of years with the Commonwealth Department of Health, I do not think I could promise you decreased bureaucracy. But one of the important things is that the administration has to stay within the State.

CHAIR - But we are talking about saving money and I tend to agree with you that I do not think we will see a reduction in bureaucracy. So it just defeats the whole purpose in a way when we are looking at one the biggest criticisms is cuts to health services at the front line, not the backroom bureaucracy. There are certain levels of bureaucracy you have to have to run any system and particularly a health system, you cannot get rid of it all. But if we are ending up with another layer, where you have a Federal takeover with a bureaucracy that would involve providing the funding - you need to have the local input so you would need to have a bureaucracy there to manage that.

Mr GODDARD - We already have the bureaucracy under the new health reform arrangement, you don't need any more.

CHAIR - Can we do with less?

Mr GODDARD - Yes.

CHAIR - You just said you didn't think there would be a reduction.

Mr GODDARD - As far as the Commonwealth Department of Health is concerned. If we maintain an administrative agency - the model I am putting forward is that you have a purchasing authority buying services from the hospitals, the THOs, ambulance and so on, from the NGOs. It also buys administrative services from the health part of DHHS which is hived off as is currently being planned anyway.

CHAIR - That's right.

Mr GODDARD - So none of that needs to change. The only new thing would be the central purchasing authority, which would not have its own staff. It would purchase all of its administrative services from what is about to become a ministry.

CHAIR - Isn't that the way we are heading?

Mr GODDARD - It is very similar, it is not reinventing the wheel.

CHAIR - What we are getting now is very much as you describe it, with rather than being 40 per cent funded by the Commonwealth and 60 per cent by the State for the ongoing provision of health services, it will be 60:40 with the Commonwealth taking up the slack with the inflationary costs. What is different from what is being proposed, that will start 1 July, to what you are saying?

Mr GODDARD - First of all it does not cover capital expenditure. The most recent reforms that have come out of Canberra are not gain changes, they are not really going to change the system. They do not properly cover the increase in expenditure, they do not cover primary care, they do not cover capital investment. This is not going to get us out of our problem, unless we have the Commonwealth taking over the responsibility for all growth in the system including capital we are just not going to be able to pay. From memory - and I don't have it in front of me - I think the most recent health reforms disappointed everyone in terms of what they are going to be capable of doing.

CHAIR - In the country or just the State?

Mr GODDARD - Around the country.

CHAIR - It's hardly revolutionary but there you go. Martyn, any other comments you wanted to make?

Mr GODDARD - I had a look at the website of the Grants Commission, just on the Royal Hobart Hospital stuff. The terms of reference from the Treasurer for this year's review aren't up yet. There might still be time, theoretically, to get that Royal Hobart Hospital money exempted, but I don't think that is going to happen.

CHAIR - Do you think Wilkie is out of favour?

Mr GODDARD - I think he has more power than he had before but with the State Government saying it doesn't really matter -

CHAIR - We've already received some of this money, though.

Mr GODDARD - That's right, we have already received something like $100 million, but we haven't started paying it back yet. There is a period before which you have to start losing your GST money. From this financial year we start losing money as a result.

CHAIR - It would be up to the Premier to make that application then, wouldn't it.

Mr GODDARD - She said she is not going to; she's not interested. Why the State signed up to that dud deal, I have no idea. Why do we have to say yes to every specific purpose

payment coming from Canberra under any sort of conditions without looking at whether this is in the State's interest? We just sign on the dotted line.

CHAIR - You have to admit that Andrew Wilkie was naive in not realising that it wasn't excluded from the Commonwealth Grants Commission assessment?

Mr GODDARD - Yes, of course he was. I can understand that and I can understand why he was naive, and I think most people are; most people don't know this stuff. What I find it very hard to understand is once he found out why didn't he try to do something about it?

CHAIR - I raised this back in June last year when I saw it in the budget papers, that this was an issue we were going to suffer for.

Mr GODDARD - Yes. I'm told by people who were involved in it that the suggestion that the forestry deal should be exempted came from the Commonwealth. The State hadn't even thought about it.

CHAIR - They will have learnt after this.

Mr GODDARD - If we didn't have to spend this money, $322 million I think, down the tube simply for want of negotiating it properly. We could do with $322 million; it would come in handy.

CHAIR - We would have got it anyway. Thank you very much for coming along today.

THE WITNESS WITHDREW.

Dr JOHN DAVIS, Dr CHRIS MIDDLETON, Dr TIMOTHY GREENAWAY AND **Mr ANTHONY STEVENS**, CEO, AUSTRALIAN MEDICAL ASSOCIATION, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - I will just explain to you, Tim, how these committees work. Everything is recorded. It will be transcribed by Hansard and become part of the public record. Everything you say is protected by parliamentary privilege during the proceedings, but if you do speak to the media outside that may not be the case so you need to keep that in mind. If there is information you wanted to give in confidence to the committee, you can make that request and explain to us why it needs to be in confidence and the committee can then consider that. Otherwise it will form part of record and may well be used in our report.

We didn't receive a submission as such from the AMA. Chris, are you taking the lead?

Dr MIDDLETON - Yes.

CHAIR - If you would like to start off with your comments and then we will probably have some questions from members.

Dr MIDDLETON - Thank you for the opportunity to speak to the committee. I am a board member, branch councillor and area federal councillor for AMA Tasmania. I am also employed at the Royal Hobart Hospital as Director of Gastroenterology and acting Head of Endoscopy. For several years the AMA has produced a public hospital report card which some of you may be familiar with - those with computers can Google 'AMA report card' and this will come up. It compares the national situation with each of the States and Tasmania usually comes out towards the back of the field every year, often only beating the Northern Territory on numerous health parameters. For instance, in this public hospital report card which came out in 2011, I printed out the relevant bits for Tasmania and we can see that for patients who present to emergency departments as category 3 - to be seen within 30 minutes - about 49 per cent of those are seen within 30 minutes as compared to 64 per cent of the national average. We can see that for elective surgery waiting times the national average for category 2 - to be seen within 90 days - is 77 per cent, whereas Tasmania manages 55 per cent, albeit during the collection period, and that was before the most recent cuts were introduced.

In Tasmania, we have a more elderly, more socially and economically disadvantaged population with very high rates of chronic disease, so we are already behind the eight-ball, and these recent cuts can only exacerbate that situation. We know that the Department of Health and Human Services have been asked to save $100.2 million for the 2011-12 period and we know that $30 million of this will come from cuts in elective surgery. I understand that about 23 operating sessions have been cut each week at the Royal Hobart Hospital and about 21 surgical beds have been closed in an attempt to save $17.3 million from the Southern Tasmania Area Health Service budget and, not surprisingly, this has led to a reduction in services.

One of our members, Dr Andrew Hunn, a neurosurgeon, wrote to us, and I will just read some extracts from his correspondence. He says that there have been three major cost-saving strategies imposed and they are reduction in resident staff, reduction in bed

numbers and reduction in theatre allocation from 35 to 28 sessions per month. The cuts are imposed in an environment of increasing case numbers consequent on ageing of the population and as a result of the cuts the following consequences will follow: loss of skilled nursing staff who have not been offered contracts because of reduced bed numbers; decreased numbers of elective patients on the waiting list has an increasing proportion of reduced theatre time because it is taken up with urgent cases; and increased interstate transfer of patients with complex conditions. That is largely because the two most experienced neurosurgeons who are both visiting medical officers have had their sessions halved and now both officially have 0.1 full-time equivalents each with operating sessions every fortnight.

CHAIR - One session a fortnight?

Dr MIDDLETON - That is my understanding.

Some patients will not be able to be delayed until the next schedule list which results in increased costs as interstate hospitals bill for services, and there is also a slow attrition of hard-won skills. He goes on to talk about the increased stresses on resident staff trying to cope with the increased load with reduced manpower. He says that the neurosurgery unit is very busy, even at a national level. The unit is busier than Royal North Shore, St Vincents in Sydney and Prince of Wales, and is successful in terms of placing registrars in training units and documented outcomes at least as good as the international benchmarks.

Dr Hunn goes on to say that, in short, there is a downward spiral just when demand for services is increasing and that he is completely at a loss to see how this can work. He is frustrated and angry that those responsible for government can allow it to happen. I am happy to table that letter if you wish.

CHAIR - You may not be able to answer this question, Chris, but Dr Hunn makes comments about the business of the unit - I assume that is comparative to the population size and the number of neurosurgeons and neurologists we would have there.

Dr MIDDLETON - He doesn't actually qualify it but suggests that the amount of work done at the Royal Hobart Hospital Neurosurgical Unit is at least as busy if not busier than those major units I mentioned before.

Dr GREENAWAY - I can certainly add to that in at least the endocrine aspects of neurosurgery - that is dealing with pituitary tumours and complications - I can guarantee that the Royal Hobart Hospital is at least as busy if not busier in that aspect than those hospitals that were mentioned. I am from Sydney and am on the SAC in endocrinology for the College of Physicians, so I can tell you that the Royal Hobart Hospital is busy. Before all the cuts that Dr Middleton has been talking about the cuts that we are discussing today, one the major issues is that there is no St Vincent's, Prince of Wales or Royal Melbourne Hospital in Tasmania. If you are in Hobart it is the Royal Hobart Hospital and it is the only one.

CHAIR - It is all there. Everything is done there.

Dr GREENAWAY - When there is deadlock and the beds are completely full, there is nowhere else for people to go. The neurosurgery unit that Mr Hunn is talking about is the tertiary referral centre for the whole State, so all of the neurosurgery comes to Hobart and 500 000 is the population here.

CHAIR - Yes, there is nowhere else for them to go except interstate.

Dr GREENAWAY - Yes, and that is going to cost and that is something people need to be well aware of. If we cannot look after our own population they will have to go interstate.

CHAIR - How many neurosurgeons do you have at the Royal? Four, aren't there?

Dr GREENAWAY - It is a question of the cuts. You would have to speak to the lists in terms of if you cut down to a 0.1 FTE, that is one session. That means, as Dr Middleton suggests, there is only one operating session a fortnight because the other session is chasing results and reviewing scans, as you would know.

CHAIR - This is one elective list, so they have to do the emergency cases.

Dr GREENAWAY - Their emergency is separate but the problem is with the cuts to elective surgery being so dramatic, the patients can progress and what was elective can become semi-urgent or in fact urgent and people present to the Emergency Department.

CHAIR - As far as you are aware, there was no consideration given to neurosurgery being the only unit in the State for the whole State?

Dr GREENAWAY - No. I think hospital administration is well aware of the tertiary roles of various departments within the hospital. That is not it, it is the question of the impact of the cuts that have been forced upon it.

CHAIR - Thank you.

Dr MIDDLETON - Such disquiet is not limited to neurosurgery. In fact, if you talk to any of the other surgical disciplines - colorectal surgery, general surgery or orthopaedic surgery - they all have similar anxieties and frustrations. But surgical constraints do not only impact on the surgical units, other units are utterly dependent on surgery for their smooth running. I have a letter here from a staff specialist paediatrician who says she is concerned about the effects of surgery cuts on the throughput of their team of three surgeons. These paediatric surgeons were about to set up statewide services. Loss of the newer surgeons would lead to a collapse of neonatal surgery which affects the viability of neonatal intensive care in the State.

She goes on to say that cuts to mental health also impact on them, the child and adolescent teams are already significantly understaffed and the workload and poor resourcing make attracting new psychiatrists and allied health very hard indeed. There are no mental health beds for under-18s statewide or adolescent wards in the State and any loss of community positions places a load on the four paediatric units in the State as acute admissions come to the children's ward. Not filling empty positions is a dangerous strategy in children and adult mental health services.

Just continuing on the concerns from the psychiatric side of things, here is a letter written to us from a concerned staff specialist in adult mental health services and an AMA members. He says:

> 'A local staff specialist met regularly with local management in late 2011 to discuss the new plan for services as proposed by the local management in the context of budget cuts. Management outlined their belief that the current 42 acute beds, 10 step-down beds and 27 medium- and long-term beds could all be managed by three staff specialists employed to work at the Royal Hobart Hospital. They outlined their additional belief that backfill for positions for leave would be by the community psychiatrists who would then cover all their colleagues and all their clinical responsibilities while continuing to manage their outpatient clinics. Staff specialists who have met regularly with management are in unanimous agreement that not only are the backfill arrangements unworkable, unsustainable and unsafe, but that the total number of specialists employed to manage the inpatient services is manifestly inadequate and that this arrangement will undoubtedly lead to an increase in serious and sentinel events.'

When you talk to all disciplines they have similar sorts of concerns and I think Dr Greenaway is going to continue with that theme.

Dr GREENAWAY - I know that you have received a number of submissions and I have spoken to people in my role as a member of the AMA. I am secretary of the Tasmanian Salaried Medical Practitioners Society, I am also the Director of Clinical Endocrinology at the Royal and I have an academic position at the university and I have spoken to members from a number of areas including intensive care, neurosurgery, paediatrics and women's and children's health. In neurology I have been impressed, as I am sure you would have been, by the unanimity and consistency of the arguments and concerns of the impact of the cuts, which are basically over service delivery, the standards of care and teaching and training to maintain accreditation within each of the disciplines.

If you go back through the history of Tasmanian health you can look at the Wellington report, the Richardson report or in 2004 at the Royal because of major problems in the department of Medicine where the College of Physicians externally reviewed the number of senior positions and the training that was offered and found major deficiencies which were then addressed. The situation currently is much worse than it was in 2004. The potential harm, as I know some of the submissions have pointed out, is that long term trying to rebuild the standard of health care of the Tasmanian public may take a decade or more if things deteriorate to the extent that we are worried they will. The cuts, as Dr Middleton has pointed out, in elective surgery and the difficulties that our surgical colleagues are facing, affect everybody. They affect physicians - affect all aspects of health care.

People do not present just with one problem. We treat them holistically and they have a number of different problems. If patients cannot be operated on routinely and accreditation is lost, because a certain number of routine procedures are necessary to maintain competency, as was alluded to by Mr Hunn, people start to leave and that will affect everybody. It will affect both the public and private sectors. Just because people

have private health insurance does not mean that they are protected from what is going to happen because if senior staff leave there will not be the people to replace them.

CHAIR - Just on that point, Tim, we have to be careful that we do not scaremonger by saying we will lose our accreditation and we will lose this and that sort of thing -

Dr GREENAWAY - But that is a possibility.

CHAIR - I know it is. You say that there are certain numbers of procedures and levels of supervision and that sort of thing that need to be met to maintain your accreditation, and obviously there is that benchmark, but do you have information about what the benchmarks are in each area and where we are with them?

Dr GREENAWAY - We could get it. I was talking about each of the surgical areas. I am a physician, not a surgeon. You just need to go back to 2004 to see the report that was made in the area of medicine, my area, at the Royal Hobart Hospital, and in particular in endocrinology which is what I do, but that is only one area.

CHAIR - Can the AMA provide that information? Is it something that is readily accessible? The colleges set the standard.

Dr GREENAWAY - Yes. The standards are independent of everything. They are certainly independent of hospital administration and various departments of health. For example, you could ask Mr Hunn specifically about the standards for neurosurgery, and someone else about standards for gastroenterology and colorectal surgery. Each of the areas within surgery and medicine have their own requirements for the maintenance of standards because they are discrete.

CHAIR - I understand that. If you are getting really close to that point then it becomes even more imperative that action is taken. I am not saying ease up because there is a bit of a gap there, but we are hearing this, and I accept that this is an issue and I think everyone does.

Dr GREENAWAY - I don't like talking in terms of anecdotes but I'm going to because I was on last weekend at the Royal and the hospital was full, and this is the quietest time of the year. I can tell you - I won't name the physician involved - that patients are starting to be transferred out of the intensive care unit into the private system which is going to cost us because there are no beds available. This is in the quietest time of the year. The hospital is completely full; there is no elective surgery. What's going to happen when the flu season hits in a couple of months?

CHAIR - Or when elective surgery ramps back up.

Dr GREENAWAY - Well, it can't ramp back up if there aren't any beds.

CHAIR - That's right but tries to ramp back up.

Dr GREENAWAY - The situation is dire. Not only are patients from the Critical Care Unit being transferred to other hospitals, they are being transferred from the critical care section of the hospital to wards after hours simply because somebody is sick or is coming

in and we know that it leads to adverse outcomes so that you don't want to transfer unstable patients in the middle of the night when staffing levels are low but if you have to do it, you have to do it. I know because I have spoken to the critical care physicians that they have made a submission and the concerns are listed in it. I'm sure that submission speaks for itself but what I know they are worried about, because they've spoken to me about it, is already happening. That is, patients having to be transferred out of the unit and the consequences for the community are potentially dire.

CHAIR - I think it would be fair to say that even before the cuts it would happen on occasions when there was really high demand.

Dr GREENAWAY - Sure, but this is the quietest time. I've been here for 20 years and in summer when people are away, with school holidays and no elective surgery it is supposed to be quiet. I can tell you it was diabolical on the weekend. The assessment and planning unit was full; the emergency department was full. It is not a good thing for patients to be waiting in the emergency department in ambulances because they can't be seen. The concern that everybody has is what's going to happen in the next couple of months when the weather changes and the flu season hits. We don't know what the flu season is going to be like.

CHAIR - You need to have some slack in the system, don't you.

Dr GREENAWAY - You do and the concern is that the Royal Hobart Hospital was running at above national standards in terms of occupancy rate before the cuts.

CHAIR - Do you know what the occupancy rate was before?

Dr GREENAWAY - Yes, about 97 per cent, I understand it to be - very high.

Mr STEVENS - The AMA recommendation is 85 per cent.

CHAIR - And the LGH is the same; it's well over.

Dr GREENAWAY - It is.

Mr HALL - So in essence we have a system which, without the cuts, was under pressure anyway.

Dr GREENAWAY - That's exactly right.

Mr HALL - So we're just exacerbating the whole situation.

Dr GREENAWAY - That's exactly the point.

Mr WILKINSON - The real question is, what's the solution? You've just become Minister for Health.

Dr MIDDLETON - I think you have to go back to Treasury because it's Treasury that controls the purse strings and demands that the cuts are made and the Government takes advice from Treasury on these matters. Clearly, the State Government is determined to

try to come in on some sort of budget rather than running a deficit. The problem with doing that, of course, is that if you run a public hospital down what happens is you actually destroy a lot of systems that have taken years to build up and just because in a couple of year's time Treasury decides that in fact they can free up some more funds, you may well have already lost sufficient staff and you can't easily rebuild services that took ages to build up. You've lost your trainees and then you've got medical students leaving and so you damage a whole lot of systems that are quite fragile and will not recover immediately just because funding is restored. So it's important to maintain a level of funding that doesn't result in that sort of damage and we're heading in that direction now.

Mr WILKINSON - Is it also a false economy in some way because you might say that by not spending now, we're saving money but in fact that's not the case because you've got to transfer these people into, say, Hobart Private, or you've got to transfer them interstate and you've got to pay for them for that to occur and therefore the so-called savings are not really the case?

Dr GREENAWAY - I think that's absolutely true, and I think it is also true that if elective surgery is deferred then problems that were chronic can become acute and it is much more expensive to treat somebody who is acutely unwell than somebody who has a chronic problem. The other thing is that we have no problems with demand for efficiency or review of expenditure. There are no qualms with any of that, but I guess just as an individual my concerns for some time have been that the previous reports, such as the Wellington and the Richardson Report which looked at these issues in detail, do not appear to have been heard or at least some of the concerns addressed, so we seem to be reinventing the wheel a little bit.

Mr HALL - Following on from what Jim said, and with a little bit of generalisation I suppose, does the AMA basically agree with Dr Hunn's assessment at the end where he gets a bit pithy, could I say: 'With a $5 million a day budget for health, Tasmanians deserve better than 1.5 administrators per clinician, a bloated bureaucracy of about $3 million a day, and no long-term planning or vision.'? Do you essentially agree with that premise?

Dr GREENAWAY - I can't talk about the accuracy of the figures that he quotes but the point that has been made - and I know that Neroli Ellis made the same point, or at least it was reported online in the *Examiner* so I read that - about the need to maintain frontline positions at the expense of the number of health bureaucrats and the primacy of people actually working in primary care, and certainly the point about a long-term vision and planning for health care in Tasmania is absolutely true, and I would agree with that. And that is the point I was making about the Wellington Report, the Richardson Report, the reports that have been done by the AMA, by others, that do not appear to have been heard and for whatever reason, whether it be political will - and I can't comment on that - we are suffering the consequences of that inaction now.

Dr GOODWIN - I ask you to elaborate on the costs involved with transferring patients to private hospitals or interstate because it is hard to know how much cost is involved in that and whether we are going to be able to track it to see what the impact of these cuts has been.

Dr DAVIS - There's the absolute cost in terms of dollars, but there is the human cost in terms of there are doctors in Tasmania not treating these patients and keeping their skills up and desiring to stay here. There is the cost to the patient and their family in human suffering and being moved, and there is the clinical risk in moving a patient between a hospital in Hobart and another hospital and, more importantly, across Bass Strait to a hospital on the mainland, so we can't just quantify this in terms of pure dollars. We have to look at the entire impact on our system, and it is very significant.

Mr WILKINSON - But not only that, John, if I might, I have been with a fellow whose son was suffering from cancer. He was at the children's hospital in Melbourne and Tasmania was paying for his accommodation, for the parents' accommodation, for the trip across as well, so I hear what you say that the major argument is the individual themselves and the cost it is on that individual, but the financial cost as well is significant if there isn't the ability to do it here.

Mr STEVENS - This information should be available through the Royal Hobart Hospital or any of the other area health services, the cost of ambulances, aircraft, accommodation, all of those types of things.

CHAIR - And there is a charge back for the service that other facility provides.

Dr GREENAWAY - Yes, bed-day fees plus the costs of the care involved by doctors and nurses et cetera.

CHAIR - I think we all understand the problems with making cuts where they have been made. If you had a clean slate and said, 'We accept that this money needs to be saved. Whether we like it or not the Budget is in a bad State so savings need to be made and everyone should take some of the pain', if there are to be cuts in Health where could they be made? Are you aware of other areas within Health where cuts could be made without having this direct impact on frontline services and thus the flow-on effects of attraction and staff retention, accreditation and all those other things?

Dr MIDDLETON - At the clinical level everything is pretty marginal at best, even before the cuts, for all services in Tasmania. I don't believe there are any clinical services that can effectively be cut without leading to a risk for patients.

CHAIR - I know you are not working in the bureaucracy yourselves, but you talk to people and see what is going on around the place, don't you?

Mr STEVENS - There is a magnificent saving coming with the evolution of e-health administration. There are many areas in the department that are currently working towards introducing new electronic means of communication, record keeping and that type of thing. If that was to be pushed forward and more money put into developing it and coordinating it between every part of the Health sector, private and public, there would be magnificent savings there. The problem is that is all being held up because of the cuts being implemented now, so the possible savings are being held up by the current savings. Also, I think a lot of this has come from a revenue point of view. We're all talking about the expenditure and where we can cut the expenditure but what nobody seems to be taking on board is the fact that GST revenue is down. What is the State Government doing about that when they are talking to the Federal Government? Who in

the department is looking at the possibility of involving the private sector, which is not necessarily operating at 85 per cent occupancy? There are other avenues out there but you have to think wider than just the department.

Dr DAVIS - It really goes to the point that we mentioned mid-late last year that we need to redesign the health system in Tasmania. The system is broken and has been broken for a very long time. We had Save the Royal in 1981-82. The system is broken at a State level and a Federal level. There is no integration; no-one talks to each other. We just all expend in our own silos and we expend and expend.

CHAIR - What is your vision for the future then?

Dr DAVIS - We have to sit down and redesign the Tasmanian health system with one funder, one group responsible for funding health in this State and making decisions about how we integrate health care for the benefit of Tasmanians across the spectrum - the people of Tasmania and the government. If you read papers and watch television we all know that there is a financial crisis in the world and it's right down to Tasmania. We don't have enough money coming in to meet the expenses going out and we double up on a lot of those expenses. Now is the time to get it right, and if we do not we will be back next year and the year after and in five years and in 10 years. The trouble is that next year and in two years and in five years we will have less competent clinicians providing the care that Tasmanians need now, let alone in 10 years. That is something that the Government and the public has to take on board and there has to be a very serious debate about what health the public sector should provide in this State and how it can provide that to the highest level. Tasmanians deserve the same level of health care as any other Australian and we're not getting it at the moment.

CHAIR - What does that mean on a statewide basis, John? This sort of approach has been suggested and we have discussed it in the past but we try to be all things to all people in this State. We have a dispersed population and we seem to shy away very quickly from those difficult discussions about what we treat.

Dr DAVIS - I'm not sure that we've ever shied away from the difficult stuff.

CHAIR - No, we as a State.

Dr DAVIS - Governments certainly do. The closer you get to an election the more difficult it is to address the difficult stuff. Do we have too many community hospitals, too many large hospitals. We do have a small population and we need to manage the health very carefully because the pit is not bottomless, even in the good times. We have stupidity in really simple stuff. I'm a GP in general practice. I do a full blood count on a patient today who comes in for a particular problem. The problem gets worse overnight and the patient goes to the Royal Hobart Hospital and what do they get? The exact same blood test.

Dr GREENAWAY - And the reason you do it is that you can't find out what the result is.

Dr DAVIS - Yes. Or a patient goes to the RHH or LGH tonight and has a full blood count, comes to see me tomorrow and invariably doesn't tell me that sort of thing and we reprocess the whole thing.

CHAIR - And we have cost-shifting this because when they do it with you it's charged to Medicare; when they do it in the hospital it's charged to the State.

Dr GREENAWAY - The diseconomies of scale, the fact that we've only got 500 000 people, the duplication and triplication of services, all of that has to be addressed. All of these points were made. I know I sound like a broken record but this was all discussed; it's in the Richardson Report and so on. It's all laid out and the points that we're discussing now were all taken up in those reports and have been ignored. We can't keep funding a health system for 500 000 people as though everybody can have a teaching hospital down the road; it's just not going to work.

Mr HALL - Dr Davis, you have already categorically said that we need one funder. It would seem to me that the only one that has the capacity to provide the wherewithal is the Federal Government. The States may not have the capacity. Is that your view?

Dr DAVIS - Most of the funding for the State comes from the Federal Government so it's logical that the Federal Government have more capacity to fund than the State. We've certainly said during 2011 that it is our view that the one funder should be the Commonwealth Government. How you actually achieve the infrastructure to make that happen doesn't necessarily mean that health in Tasmania is run out of Woden in the ACT. It should be run out of Tasmania but there should be one funder and there should be a board that looks after health in this State and makes sure we cut the duplication, we improve service delivery, that people get the care they desire and we retain the clinicians and, in fact, encourage more clinicians to come here to deliver the high quality healthcare we need. If we don't do that, as I said, next year we'll be back and in five years we'll be back. It's not going to be easy to fix the problem. The hole is so deep but we have an opportunity to make an effort.

Mr WILKINSON - We know the Richardson Report got plaudits from many people. I don't know anybody who said that what was said in that report was contrary to what should be said. I know the Wellington report as well. It's all there and nothing has really been done to enact what's there, so what's got to be done to enact it? It might seem simple to say that members of parliament and governments have to enact it but it hasn't happened. That should have been done back when the reports were handed down. What you are saying now is what was said in the Richardson Report. What should be done for it to be enacted? What needs to be done?

Dr DAVIS - The Parliament needs to get on and make it happen. You are part of the elected membership of Government in this State. It's beholden on you to make it happen. We can make noise, we can talk to the television, we can talk to the press, we can try to educate the public but at the end of the day it's the Government and the politicians of this State that need to lead the charge.

CHAIR - It's the Government which makes the policy decisions.

Dr DAVIS - Well, you're the upper House, you're the house of review, there are things that you can do to persuade and, I suspect, even force Government to do something.

Mr WILKINSON - Which, of course, is what's happening now.

Dr DAVIS - Yes, so we call on you to force Government in this State to look at the one-funder model for health and redesign the Tasmanian healthcare system, not simply by looking inside the same series of boxes and silos that currently exist but by getting a plain piece of paper out, seeking advice and starting to develop the system that, at the end of the day, every State in this country is going to need to adopt. Most of the other smaller States, for want of a better term, are not very far behind us in having the same problems.

Mr WILKINSON - Do you believe that the one funder can commence in Tasmania as opposed to other States?

CHAIR - Like a pilot?

Mr WILKINSON - Yes, like a pilot. They say Tasmania is a good State to have those pilots tested, so my argument would be, yes, it can. I am looking for some support to say why it can.

Dr DAVIS - I think there's no question it can. As Tony alluded to earlier, at the moment the system is in such a state that all the players are ready to sit down and talk. The private sector, the private hospitals, are ready to sit down and talk about how we can do health better in Tasmania. The public sector needs to. Private practitioners have been waiting for years to do this. Staff specialists and visiting medical officers in all our hospitals are waiting to lead the way in the development of a health care system that is worth working in because it delivers the results that the patients deserve.

Dr MIDDLETON - Tasmania is already a pilot case in that we are the first State that is heading into a health care crisis of this magnitude. The other States look to us because they know that down the track they're going to be in the same situation. Tasmania is about 10 years ahead of the larger States usually in these deteriorating circumstances.

Mr HALL - Is your view consistent with that of the AMA in other States?

Dr DAVIS - The AMA in other jurisdictions, because their State governments have not got this far into the mire as we have, haven't articulated their views quite as clearly. The Federal AMA two or three years ago talked of one funder.

Dr MIDDLETON - Certainly single funding and local accountability was Kevin Rudd's mantra as he was going around and raising with many of you the situation of health in Tasmania. He sat down with many of us and he was all for a single funder with local accountability. Just continuing on John's theme of history repeating itself, one year, five years, 10 years later, the AMA has presented to this council before. We had a Legislative Council inquiry into the Tasmanian public hospital system and we came along in 2008 and spoke about all these things.

CHAIR - For your information, that committee was discontinued because of this national Rudd reform that was going on. It had the potential to completely turn the whole system around so it was felt that that inquiry should be suspended at that time.

Dr MIDDLETON - This is certainly not the first time we've sat before you making exactly these points and giving a list of recommendations, and I assume you still have a copy of the report - sufficient resourcing to 85 per cent bed occupancy, accretion of statewide mental services, a planning committee with authority to develop, implement and monitor clinical services in public hospitals et cetera. We had a vision, a well-thought-out plan, back in 2008.

CHAIR - It is fair to say that the Wellington Report was acted on to a degree with the Tasmanian Health Plan?

Dr DAVIS - Yes, but the Tasmanian Health Plan has not followed through. The initial implementation of some of the recommendations was, in terms of statewide delivery of care, started but many of those statewide committees have fallen into disarray.

CHAIR - John Howard intervened in the Mersey in the middle of that as well.

Dr DAVIS - The Mersey is a great example. We already have a unique model of care in Tasmania in that the Australian Government provides the funds for the Mersey. We have already set the benchmark; we have changed the rules. We just have to keep changing them until we get the health system that works. Both sides of the Federal Parliament supported the Mersey model. John Howard introduced it and the current Labor Government has continued to fund it, so we are an advantage there.

Mr HARRISS - Whether we need the Mersey or not is another question.

Laughter.

Dr DAVIS - That wasn't part of the debate. The State cannot sustain four public hospitals of the size they are because you don't have sufficient clinicians to provide the quality of care in those hospitals.

CHAIR - If the health plan had been implemented, as it was suggested, including the Mersey, we would have been looking at a different picture now.

Dr DAVIS - We would still have two funders. We would still have the fundamental problem of complete lack of integration of health care because there are two funders. In aged care you have the Federal Government funding aged care and if you get a sick person in an aged-care home, what do you want to do? Get them out into a public hospital because the State funds that. So you're not talking about quality care and wise use of money and resource, you are just saying, 'I can move $300 a day to the State'.

CHAIR - John, what consultation was held with the AMA by the government minister, bureaucrats or whatever in relation to the budget cuts proposed?

Dr DAVIS - Tony, help me, we had a meeting where we were told -

Mr STEVENS - We have regular meetings with the minister and I at my level see different bureaucrats but there was no warning or consultation from the Government about the actual structure or the implementation process of these cuts. The budget was released then the department started work on it.

CHAIR - You were not asked for input as to where cuts could be made?

Mr STEVENS - No, not at the AMA level.

Dr GREENAWAY - I am also the chair of the Medical Advisory Committee at the Royal, and what we were told was that the hospital administration argued quite strongly about the effects of the cuts but were told basically this is the budget you must meet. There was no direction as to how those cuts were to be made. It is my understanding that the hospital administration made it very clear to the Department of Health and to the minister that the cuts would have significant adverse effects on health delivery. But they were told that they must meet those cuts anyway. If I take one step back, efficiencies in health systems do not actually save money. By that I mean that if you discharge patients promptly another patient will come in and consumables increase. There is a lot of evidence showing that good care, which we all need to provide and receive, does not necessarily save money in a health system. What does save money is, and this is what happens, is bed cuts, job cuts, so you save money by cutting jobs and by cutting beds and by restricting operating sessions. That saves money and that is the only way that they could do it.

CHAIR - It reduces the expenditure as opposed to saving.

Dr GOODWIN - In the short term though.

Dr GREENAWAY - That is exactly the point. It reduces it short term as the point was being made, but longer term you are going to have adverse effects, people are going to be transferred, chronic problems are going to be become acute. My own personal view working in the Royal is that I do not blame hospital administration for this, they had no choice in what was done.

Dr MIDDLETON - And they were told to do it very quickly.

Dr GREENAWAY - That is the other point.

CHAIR - The savings to be made in the is current financial year.

Dr GREENAWAY - Immediately. So they had no choice.

CHAIR - As far as consideration given to cuts in the payroll of the Department of Health or the IT department of health or any other department as opposed to the acute services -

Dr GREENAWAY - I can speak for the Medical Advisory Committee and we made the same point that you are hearing and you have heard from others that frontline positions have to be maintained and that other positions in the bureaucracy or in non frontline delivery of care were, not that anything is expendable, or the effects of cuts in those areas would be less than in the cuts to frontline positions. That point was made but I believe that the hospital administration had no choice in any of this.

CHAIR - It comes back to who makes the decision about where the cuts are made. If we are looking at an area health service then south has some small hospitals, the north and

north-west certainly have a number of smaller regional hospitals but they seem to have escaped unscathed almost at this point. Maybe they are round two for the budget that is coming up. Is this likely to then create further problems if they are the next in the gun?

Dr MIDDLETON - They probably have not been cut in the first round because to cut them would cause political uproar and problems down the track that would end up costing money. It is the same as not doing elective surgery. Eventually you have to do it. So you might make a very short term saving at the cost of -

CHAIR - Is it not the same argument for elective surgery, you are making a quick cut?

Dr GREENAWAY - Yes, of course, but hospital administration knew it and told the department that this is what the effects would be but had no choice - and I do not know that the department had a choice because the minister and Treasury have said this is what must happen.

If they are hiding behind the illusion that because they have private health insurance it does not matter to them or their family they have another think coming. Because the systems are inter-related and there is one group of doctors who service all the patients and the systems need to work together as John has already pointed out.

Dr DAVIS - I think the issue with the community hospitals is that I am not sure that anyone has seriously looked at the ongoing medical care that they will be able to provide to those hospitals into the future. It is very difficult to get general practitioners to work in Hobart and Launceston, and the further you get from those two centres the more difficult it is, and some doctors do not like working in hospitals. Some do. Regarding GPs in community hospitals, it is a matter of what services should those hospitals provide, what does the community expect them to provide, and what doctors are there available to provide those services, and we need to look at all those aspects.

CHAIR - These are the discussions that need to be had, aren't they.

Dr DAVIS - Yes. Fewer and fewer general practitioners are interested in rural medicine and remote medicine, and that is what we are talking about. We are talking about what services can you reasonably and safely provide in these hospitals, and do the doctors exist to provide them?

Dr GREENAWAY - Elaborating on that theme, the other issue is peer support and collegiality. It is not a fun thing being on call 24 hours a day, day in, day out, and if you have an isolated doctor or isolated health practitioner of any discipline, that is the potential problem.

CHAIR - Then there becomes a real issue.

Dr GREENAWAY - Indeed.

Mr HARRISS - Just following on from where Ruth left off with the consultation or lack of with the AMA, regarding the Premier's comments of recent days that the department is unlikely to meet its savings targets, have you been given any indication by the Government as to the impact of that in the event that it doesn't meet those savings?

Dr DAVIS - We've had no communication from the Government, Premier or minister for some months. I don't think it is a surprise to anyone that the system is not going to meet the targets. The targets are unmeetable.

CHAIR - We were told before Christmas by the department, the CEO, that there was $9 million at risk at least.

Dr DAVIS - I think the numbers are probably much, much bigger than that in the next year - much, much bigger than that.

Mr STEVENS - A lot of the costs that they aimed for this year haven't been introduced early. They have been introduced from November onwards, so they do not have the full 12 months' effect of the cuts. Anything that they don't meet is then put over to the next year, which already has an extra 50 per cent on it on what has been cut this year.

Dr GREENAWAY - Yes, so there will be cuts on top of cuts.

CHAIR - That's right. That was made fairly clear, yes.

Dr GREENAWAY - We are aware of that, certainly. At the hospital level we are aware of the consequences of this, but we are worried about what is happening right now. As I have already said, my real concern is what is going to happen in the next few months. I have worked in this place for 20 years, and I have worked over Christmas and the New Year period lots and lots of times, and I have never ever seen the place full - this is the Royal Hobart Hospital - at this time of the year, and basically there are alarm bells going off everywhere.

CHAIR - So what is it going to take then before -

Dr GREENAWAY - It will take public outcry, I think, and that is going to happen very quickly because people's relatives are stuck in an ambulance and can't even get into the emergency department because the hospital is full, the Assessment Planning Unit is full, ICU is full, and we know there is a lot of evidence that adverse outcomes occur if people aren't seen. They are not in wards, they are not assessed in the emergency department. Nasty things happen, and it will take somebody to die in an ambulance in Argyle Street or in Liverpool Street on a ramp and then something might happen.

Mr HALL - Can you comment on that scenario that you just painted of the RHH? Has that been replicated during that period at the LGH and the north-western hospital?

Dr GREENAWAY - Except in terms of patients referred to see me, I cannot talk directly about the LGH, but historically the LGH's occupancy rate is the same as or even worse, 97 or 98 per cent, so it is a statewide thing.

Mr HALL - That is what I was trying to establish.

Dr GOODWIN - Can you clarify what you think is at the heart of that, though? Can it be a product of the cuts this early for it to have occurred in January?

Mr GREEN - That's an interesting question. Yes, because certainly we are down an extraordinary number of beds, but you see the cuts are both to surgical beds and medical beds, and we have no elective surgery happening at the minute, so the place is full after the cuts because we have lost the beds. We are coming into the flu season which starts in late March/April, that kind of stuff, and I had a chat to a colleague - I had better not name him - about the infectious diseases with respect to what sort of flu season we might be expecting, and there is a chance it is going to be a bad flu season and the consequences of that may be diabolical if the hospital is full in January.

Dr GOODWIN - Yes, but even just an average flu season presumably will still be problematic if you have lost your beds and you are full in January.

Dr GREENAWAY - Yes, it will be.

Dr MIDDLETON - If there is no slack in the system you can't cope with any special activity at all.

Dr GREENAWAY - Exactly, and the pressure is going to come back onto the general practitioners because people are not going to be able to get into hospital and they are going to be seeing sicker and sicker patients.

Dr DAVIS - If they can get to see us. We are at crisis point in Launceston regarding GPs. Certainly there are GPs whose books are full up to a month in advance.

Dr MIDDLETON - The general practitioners are dealing with hospital cases, as John said. If you are not getting your hip fixed then you are back and forth getting your analgesia and if you are not getting your gall bladder fixed, the same thing.

CHAIR - John, we did ask another GP and he said it was a bit early to tell because the cuts really haven't hit that hard because of the lack of elective surgery over the break as usual. Are you seeing patients re-presenting a number of times?

Dr DAVIS - Absolutely.

CHAIR - An increase? That happens anyway.

Dr DAVIS - The system has been broken for years. The problem at the moment as I see it from a GP's point of view and it has just become circuitous is that there are patients who have been referred to public hospitals for definitive diagnosis and treatment who are on waiting lists to get into clinics to have a diagnosis made and a plan for their care put in place. They are waiting months and years sometimes for that process so they are coming back to you getting sicker as time goes by and we now have the situation where those patients who have had a diagnosis made and a treatment plan put in place in the public hospital system have had the time frame for their care blown out and again you get back to this thing where there is the human toll on their life and their family's life by being unwell -

Dr MIDDLETON - And loss of productivity - they are not working.

Dr DAVIS - And so then it becomes a Centrelink issue but that is okay because that is a Commonwealth Government issue.

CHAIR - It is not only Centrelink; it is a productivity issue in the private sector if they are working in the private sector.

Dr DAVIS - You also get the issue, as we were saying, they come back monthly, two-monthly or three-monthly for analgesics, they are having physiotherapy attendances, you end up having ramps and orthotic aids put into homes that are unnecessary if only the surgery had been done so the overall cost before they now even get to their operation is probably greater than doing the operation in the first place.

Dr MIDDLETON - And the problem is by the time they have been waiting two or three years for their total hip they are so deconditioned and frail that they are going to get into dreadful trouble when they get into hospital.

Dr GREENAWAY - And they need extended periods of rehabilitation that might otherwise not have been necessary.

Dr DAVIS - I had a grandmother this morning come in with her granddaughter who is now on the list for tonsillectomy. She saw a surgeon in private on the list at the Royal for tonsillectomy and was told two, three or four years so this child is constantly on antibiotics but this grandmother had the insight to say, 'All I hope is that when she finally gets her operation we have retained in Tasmania sufficient skill to actually do it'. That is really insightful when a grandmother comes in and says, 'But granddaughter is not getting the care and I wonder if we'll actually have someone to do it'.

CHAIR - If she has to go to Melbourne anyway maybe they should just go now.

Dr DAVIS - They can't afford to.

Dr GREENAWAY - Some people do.

CHAIR - I think you have painted the picture fairly well. I know you have said it before but we also need it on the record for this committee. Chris, if you would not mind tabling that document that had the recommendations from the last time.

Dr MIDDLETON - I have about the first 10 pages, it is a 30-page document, and you are welcome to have the summary. I can e-mail the -

CHAIR - I can certainly get it from the other committee anyway. Is it possible for the AMA to provide that information about the accreditation standards?

Dr MIDDLETON - For each discipline?

CHAIR - Yes.

Dr GREENAWAY - Through the colleges. You go College of Surgeons, College of Physicians - for each of them.

Dr DAVIS - The Feds should be able to.

CHAIR - I guess it would be a matter of going to the different hospitals to see what numbers we are undertaking and how close we are to the margins.

Dr GREENAWAY - You should easily be able to do that. I can tell you firstly because I am in a SAC endocrinology college position and, secondly, my department has just been accredited - at the end of last year - and this is an independent thing that the colleges do. They don't even tell the hospitals. They will tell the department. I told the Royal that we were being accredited and these are the people coming down, some completely independently. But each of the departments within the hospital would be able tell you when they were last accredited and what the result of that was, and the real kicker is that if the Department of O&G at the Royal, for example, lost accreditation, that affects all of the things we have been talking about - people working there, you cannot have trainees which affects the quality of the junior doctors, and the midwives will go because the department is losing accreditation. So the knock-on effect is enormous.

Dr MIDDLETON - The colleges do discredit and O&G is a great example of that.

CHAIR - Yes, that has been threatened a couple of times.

Dr DAVIS - I am have sure you have mentioned it, but it is not just that they are accredited or not. Even if they are accredited, the signals that are coming out of Tasmania, with respect -

Dr GREENAWAY - Why would you come down here to train if the department was threatened with loss of accreditation? Your training will not count and you will have to do it again and that will affect the midwives and NICU and will have a knock-on effect.

Dr DAVIS - And eventually it will flow back to medical school.

Dr GREENAWAY - Absolutely.

CHAIR - All we are wanting is the number of cases you have to conduct. This is the sort of information they assess, don't they? Their accreditation standards.

Dr GREENAWAY - Yes. How many operations you do, how many senior doctors are there, how many registrars, how many clinics you do and how many patients you see.

CHAIR - You will seek to provide that?

Dr GREENAWAY - Yes. It is for all of the departments.

Mr STEVENS - I will talk to you and to AMA Federal.

CHAIR - If we have to go somewhere else to get information you could let us know but it would be good if you can get what you can.

Dr GREENAWAY - Sure. All I can speak of is my own department because that is all I am responsible for. I will talk to John Burgess who is the head of endocrinology.

CHAIR - Thanks, I appreciate that. Thanks for your time.

Dr DAVIS - Thank you for listening.

CHAIR - In due course we will prepare a report. We will obviously speak to other witnesses and get the department back and possibly the minister and have a few more questions.

Dr MIDDLETON - I am sure.

CHAIR - I has been helpful hearing your point of view and getting it on the record.

Dr DAVIS - Thank you.

THE WITNESSES WITHDREW.

Mr PHIL EDMONDSON, CEO, TASMANIA MEDICARE LOCAL, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Thanks, Mr Edmondson. I will just explain to you how the process works. Everything that you say is recorded on *Hansard* and there will be a transcript of that which will be placed on the public website once we have all those up. What you say here during the committee is protected by parliamentary privilege. If you repeat things outside afterwards they may not be. If you want to give any evidence you consider of a confidential nature, you can make that request to the committee and the committee can consider it, otherwise it is public evidence. We have some members of the public here and we have had a couple during the day and the media have been in and out.

We are focused on this term of reference you have a copy of and whilst you come from a slightly different area obviously there are some links there. Perhaps you could give us an overview of your views on this topic. We did not get a submission from you as such.

Mr EDMONDSON - No, I will do a bit of grandstanding or just have a chat with you, if that is okay.

CHAIR - That fine. If you want to leave your notes at the end that is fine as well. I am happy for you to give us some comments and then we will have some questions no doubt.

Mr EDMONDSON - Okay, thanks for the opportunity. I want to speak to you from a primary health care perspective. As you have stated, it does not directly relate to the cuts made by the Health minister and the Government in respect to government spending but the primary care sector certainly is very strongly impacted, as I have no doubt you have already heard in regard to a number of different areas.

From that primary health care perspective, the organisation I work for, Tasmania Medicare Local, is a relatively new organisation and I thought I would just give you a bit of an understanding of where it has come from. I am not speaking to you from the perspective of two months' worth of experience of the Tasmanian system. I have been working as CEO of one of the forebear organisations to Medicare Local, which was General Practice North in the north of the State for 16 years. I have a long and fairly torrid and detailed history of the Tasmanian health system and I can speak to you from a reasonable degree of experience, both in respect of my own role but also in terms of the impacts of health changes and health service delivery policy on general practice and the broader primary care sector.

TML itself, Tasmania Medicare Local, represents the interests of the primary health care provider community in the State. Its role and function as part of and underneath the Federal and the broader national health reform policy process is to focus on really looking at systemic reforms in health care service delivery to enhance and support sound primary health care service delivery and the health outcomes of communities. That is the spiel, if you like. As such, we see ourselves intimately involved and interested in the vital processes of health reform and I guess, in some very broad and vague sense, what you might term a slash-and-burn strategy in relation to cost cutting in health reform. We

do not generally see it as that but it has major and significant impacts on the process and what needs to occur as a result of that.

I should add that a stronger focus on primary care has absolutely been recognised nationally as the future direction in sustainable primary health care system evolution and it is something that needs to be and, I understand, under the COAG agreement is required of States to increasingly focus on the differentiation, if you like, but also the interlinkage between the primary care system and the tertiary or secondary system. I will make some comments on that in a moment.

I guess it is probably fair in the context of Tasmania Medicare Local to predicate the comments I am about to make with another comment, and that is that in the context of a set of saving strategies, as published by the department at the start of the process, it has been very difficult to have a firm and fixed position on this because, as you would know and as you would see from that list, many of them are built around review and investigation as a result of which the actual saving strategy itself is implemented. So in many respects this document itself does not really detail what the actual outcome of most of those review process are. So I have to say that the process of responding, in some regards, to a lot of these expenditure savings measures has been a bit of a work in progress and an evolutionary work of thinking.

It is probably fair to say that TML acknowledges and understands to present need for cost containment within the public service system. Any sound-thinking Tasmanian would see that we are on an unsustainable growth train in respect to public service spending and that that cannot continue. We recognise that something has to be done. Having said that, this has been a freight train - and I will use a few analogies here that you have probably heard already - that everyone has seen coming for the last five or 10 years. Nobody has the right to sit here and say we did not know we were on an unsustainable expenditure pathway. It is convenient that people have forgotten or omitted to or chosen to defer action prior to now. I think that in some respects this is a situation of the system's own making. The expenditure overrun that has crept up on us has been evident widely to everybody within the health system. Everybody has known about it, everybody has spoken about it. It is not something that is new or unknown.

I believe that if we approach dealing with it in the same way that we are choosing to deal with it at the moment, and that is by a slashing and burning the budget, it is just going to be a cyclical recurrence on a reasonably regular pattern from here onwards. The unfortunate choice to deal with it as a crisis has allowed certain things that would not normally be done. It has allowed for a relatively unconsultative and haphazardly designed decision-making process to be implemented. Decisions are taken behind closed doors; they are released through media or otherwise and that is the first that you hear about them. That is a great concern for an organisation like ours which has sought to build very responsive and integrative frameworks with State government with a view to looking at long-term planning for health and long-term restructuring of the system in order to prevent this sort of thing happening in the future. The corollary of this process is that it is not going to produce a sustainable benefit and we are going to revisit this stuff time and time again. By any measure annual cuts in the order of $200 for every man, woman and child in the State are not insubstantial. It is a major cut to expenditure and will have a major impact on the community for a long time to come. This order of magnitude of cost saving ordinarily, outside of an emergency strategy or an emergency

process, would involve significant planning, significant management of risk and significant management of potential impact. Unfortunately that has not occurred, nor has, I believe, an effective program of stakeholder engagement.

Tasmanian Medicare Local believes that the current resource pathway for service delivery in health is unsustainable and something has to be done. So we are certainly not putting our heads in the sand and pretending that we can continue on this pathway. Unrestrained spending and expenditure containment is absolutely necessary. TML does not believe that the savings strategies proposed will result in sustainable or long-term beneficial changes to the system. They will be temporary, they will create an artificial reduction in spending growth and merely delay the inevitable reform questions and decisions that are clearly necessarily if we are to see meaningful and sustainable reorientation of spending within the system. Having said that, many of the savings measures proposed are reasonably logical and some may argue that they are quite overdue. Others clearly are measures that any progressive system that is worth its salt and is managing itself properly should be continually applying in order to preserve a well-trimmed ship. If you look through this list there are some things there that any reasonably functioning organisation would periodically go through anyway, regardless of whether it was an emergency savings measure or not.

TML is absolutely of the belief that major systemic reorientation and change planning is the only sustainable and viable option if we are to create longer term suitability within the system. That is major systemic reorientation and change planning and that is not evident in this current process. We believe that should necessarily involve an actual redirection of investment. Whilst sitting around the table talking about cost cutting and cost saving, any of the developed nations who have adopted a primary care focus system and are now in the business of containing cost have gone through a process of reinvestment, of redirection of investment in that system. So changed management and changed planning shouldn't just be about cost cutting; it should be about where can we better invest to derive longer-term savings in health care cost increases.

Mr HALL - Could you give us an example of any of those?

Mr EDMONDSON - Canada is an excellent example. They had major primary care investment that they put in upfront. That included investment in electronic communication between providers and management of data, sharing of records. We are talking of multibillions of dollars that as a result of that investment are now deriving huge longer term savings to the system. They have completely reorientated their thinking away from a hospital-centric system to a primary care-centric system.

CHAIR - When did they start that process?

Mr EDMONDSON - That happened probably eight or nine years ago.

Mr EDMONDSON - I guess you have to see a lot of this as being evolutionary in nature. The UK system has done exactly the same thing, albeit through different measures in terms of budget holding, fund holding and that type of arrangement. We are not advocating that that is necessarily the right way to go but certainly consideration of cost saving as the way to bring systems back into line, or cost cutting, has to be associated with planning for what you need to do to generate savings 10 years down the track, not

unfortunately, as our system tends to continually perpetuate, the three-year political cycle. Unfortunately, through 45 years of looking at and experiencing the Tasmanian system that is how we work; we work on political cycles. It is unfortunate in some respects that the national reform program that Rudd originally proposed was watered down through the COAG process to remove the opportunity to look at a national health commission that would have successively advised governments of both persuasions from that point forward. That would have removed some of the susceptibility that systems have to influencing good sound decision-making for the long term.

Mr HALL - Any other models apart from Canada?

Mr EDMONDSON - New Zealand has successfully done it. Those are probably the better known primary care-oriented systems.

CHAIR - You are focusing on the primary care side of it, aren't you?

Mr EDMONDSON - No, I am focusing on the fact that a system has to be seen as a system. It is both primary and secondary and tertiary rolled together. You have to understand that if you do something like cut 100 000 elective surgeries or whatever it is, that has a ripple effect down through the system so by the time it gets to the other end it is more of a tidal wave than a ripple. Cost cutting in health does not make the problem go away. It often exacerbates it, so it prolongs the treatment and therefore exacerbates the effects of illness. It transfers the problem to another sector. Conveniently in the case of primary and tertiary care in this country we have a State-run, tertiary-care system. We have, generally, a federally run primary-care system so there is a bit of blame shifting, if you like, in respect to that. If people aren't allowed into the hospital system, they are conveniently not seen as responsibilities of that system. I am arguing that the changes in relation to systemic reform need to be considered and planned for as a whole system and not as we think of it as two separate elements.

CHAIR - You mentioned the UK, Phil, but we have had evidence from some other witnesses that the UK system is stuffed and that integration, focus on primary care and the electronic records and data management and all that sort of thing are not working.

Mr EDMONDSON - Sure. I am not saying to you that the entire system should be taken and transplanted. What I am addressing is the thinking in relation to the health system being seen as one and the same thing rather than our predominant thinking on hospitals versus primary care, which is completely unhelpful.

CHAIR - It is more a philosophy as opposed to -

Mr EDMONDSON - It is not the philosophy; it is also the elements that underpin good quality and continuity of care, and that is the sharing of information across sectors, investment in things like electronic health records et cetera. They are absolutely essential components to being able to have a well-articulated and smoothly flowing movement of patients between healthcare providers and components within the system. We make these changes and, in respect of the changes here, we cut costs at that end thinking it is all right and the rest of the system will deal with it, without telling them what they are actually going to cut, without actually asking them how they think it is going to affect them and patients within the community. And I am referring primarily to general

practice and other primary care providers who are left carrying the can, not to mention the patient who has gone through three or four delays to their surgery anyway, and then is told it is going to be another six months. So there is a whole lot of progressive and interactive build-up of stress, concern and issue in relation to decisions simply to cut $10 million off elective surgery or whatever it was.

CHAIR - So was there any consultation with what would have been the division back then?

Mr EDMONDSON - No.

CHAIR - None at all?

Mr EDMONDSON - No. As with everybody else, these strategies were announced as being absolutely essential. The system was going through the process of working out what it could save. We found out the same way as everybody else, and that has 90 per cent of the time been through media or through back-door means. There has not been any consultation or engagement. I understand entirely the immediacy of the process, but if you are going to go through that process you at least need to be honest about the fact that it is not going to long-term solve the problems, and associated with that has to be a more structured and appropriately implemented and consultative process of reform, engagement and planning.

I will make a couple of other observations here that we think are quite pertinent. I think we are heavily industrialised in our system, and I think it has created a significant inertia that has prevented us from being able to look at some other areas of cost containment and cutting. I am talking about entrenched industrial sort of protectiveness within the bureaucracy which has not really permitted in the short-term sense the cutting of non-frontline positions in Health. I think by any sort of measure we have a fairly well inflated bureaucratic system that sits behind the clinical delivery system that we have on the front line. I think it behoves a sound process to be looking at expenditures in both areas, and I don't believe that has happened to any real extent. There has been a really unfortunate coincidence in timing of the National Health Reform implementation. Some of the investment the Federal Government has made has, rightly or wrongly, been seen as an opportune possibility for the State to actually take with one hand and use that as part of the reform strategy in another, and I think that is a concern because we all recognise that significant investment in the system is required longer term, not disinvestment.

The other thing I think is the absence of any policy background to this. Our view is that the primary care needs a substantial shift in policy thinking at government level. It needs supportive investment to go with that, and that will enable longer-term realisation of savings, and that is the only way you are going to get it. It will not happen if we just give it a severe haircut. We certainly see ourselves as part of the process, and we are happy to be part of the process, but we can only be part of the process if we are engaged in implementation, and we don't believe that has happened to a great extent. Tasmania I think has long-found difficulty, and I talked about the fact that there seems to be an inordinate and predominant focus on hospitals. Cynically the Tasmanian Department of Health and Human Services has long been referred to as the Department of Human and Hospital Services outside the system, because it has only ever really truly focused on hospitals, and obviously there are issues in terms of costs et cetera within the system that

drive some of that thinking, but a hospital does not a health system make, unfortunately. And if we focus on hospitals we are just going to knowingly accept the queue for them is going to get longer, it is going to get more acute and the pressures felt further down within the system are going to be more progressively compressed and piled up, and we simply do not have the capability or capacity within either general practice or community-based care to do that. This has gone in Tasmania to the extent where the majority of our community-based services outside of Hobart, it is my understanding, have been provided out of the hospitals themselves, so in many respects community-based service outside of Hobart is essentially accessed through the hospital system.

CHAIR - Through the Area Health Service.

Mr EDMONDSON - Through the Area Health Service, yes, and they are ostensibly running large hospital centres. Call them whatever you like, at the end of the day the majority of service from within those areas goes into hospital-based inpatient service. Very little actually gets out to referrable community-based care from general practice. So we focus our system on tertiary intervention, not on primary prevention.

CHAIR - Phil, I tend to agree with your position that we need to have this great approach and I think it's been long debated. Report after report has said the same thing but the reports sit on the shelf and tend to gather dust. Can a system like this work when it's a fully integrated system here where it's part of the health system, not a hospital system, as you say, if we continue to have this dual funding arrangement where you've got primary health predominantly funded by the Commonwealth and now the hospital's going to be funded 60:40 as opposed to 40:60.

Mr EDMONDSON - If you're asking me the question, would we advocate that a single funder for health is the best option, absolutely. Unfortunately that opportunity was lost through the COAG process. We would absolutely support that, longer term. I believe that you're only ever going to get that system-wide thinking if there is an imperative like that there.

Mr WILKINSON - Do you believe Tasmania would be a good State for there to be a pilot in deciding whether there should only be the one provider? Somebody argued a short time ago that they paid the money for the Mersey; whether that's a good decision or not is obviously -

Mr EDMONDSON - We won't go there.

CHAIR - Why don't we go there; everyone runs away from that?

Mr EDMONDSON - Clearly, playing around the edges and doing haphazard things like that is poor policy. It's reactive and it was very politically driven. We absolutely believe that it is the wrong way to motivate or reform decision-making.

Mr WILKINSON - Since they've got in charge of the hospital, the Mersey -

CHAIR - No, they're not in charge of it; we're in charge.

Mr WILKINSON - Well, not in charge, but since they're the funder -

CHAIR - They're paying, yes.

Mr EDMONDSON - I believe Tasmania would make a very good ground to test a single funded system. You could argue that, in some respects, that may be what the Federal Government is planning in setting up hospital networks and primary care organisations, to give themselves the capacity to actually think along those lines or enact that sort of policy at some stage in the future.

Mr WILKINSON - Why do you think Tassie would be a good place to start?

Mr EDMONDSON - Well, Tassie obviously has all the hallmarks of having a contained population easily identifiable, not withstanding the geographical barriers between regions that I think are more in people's minds than they are in pragmatic reality, we do have a very confined and contained environment in which to work. We don't have the problems of people tripping across State lines or sharing towns or cities that sit on State boundaries; none of those things exist so in some respects we do have an ideal potential opportunity. I think that, as long as we have a system in crisis, there is going to be reluctance from one or other party to take that responsibility. We would certainly hope that at some stage that may well become a reality.

Mr WILKINSON - A number of people have given us the same type of evidence that there needs to be a single provider and that the single provider should be the Federal Government.

Mr EDMONDSON - Thirty years of history will tell you that we are kidding ourselves if we think we can continue to run this duopoly. It doesn't work.

Getting back to the specific effects of some of these savings on primary care in particular, we have a major concern that there seems to have been this conveniently misguided belief that if things like elective surgery are cut it's not going to impact or affect anybody else. That is clearly wrong. General practice at the present stage suffers from a significant shortfall in terms of numbers across the State. Anyone who has tried to get into a GP would know that you often have to wait a number of weeks to be able to access them unless you are significantly acutely unwell, in which case they'll often put you in sooner. It is further compounding that issue. General practice is not well equipped to deal with the type of patient who is refused elective surgery. In many cases they are -

CHAIR - Refused or delayed?

Mr EDMONDSON - Delayed or refused access based on whatever decision is made at the time. It could be a whole range of things but at the end of the day the delay, if you want to call it that, associated with the cost cutting results in GPs seeing more acutely unwell patients and more acutely unwell patients being left in the care of their families, putting additional burden and pressure on them, often resulting in increased propensity for mental health impacts, such as stress and strain within families and for those individual patients.

The impact of co-morbidities - and they are associated health conditions - is often further exacerbated by delays in access to surgery. It is just not a good strategy. It is an easy one because it saves a lot of money but it is not a good strategy.

CHAIR - Saves a lot of money in the short term.

Mr EDMONDSON - Yes, and often when you do get to see those patients they require *x* amount more interventions so the costs are going to be that much greater, their length of stay in hospital is greater, therefore the impact on their quality of life, on their families et cetera is exacerbated.

CHAIR - And the risk of post operative complications increases.

Mr EDMONDSON - Exactly right. It is not a good strategy but, in the absence of others you can see why sometimes these decisions are taken. There is a fairly strong sense of denuded workforce across primary care providers in the State - not only GPs. Access to physios, access to occupational therapists et cetera is very limited outside of an inpatient referred environment. Often we are talking about patients in the community who do not have the means to pay for private services themselves, they are often not privately insured and even if they are, in the majority of areas outside of the major population centres these services are just not accessible.

To push this burden back onto primary care I believe is inappropriate, ill thought out and, in some respects, just convenient buck shifting.

CHAIR - Are you hearing from any of your members evidence of that re-presentation of patients on waiting lists and that sort of thing?

Mr EDMONDSON - Not re-presentation specifically, I think that is something that we would find very difficult within the short period of time that some of this has been happening to get that evidence. But certainly in terms of higher acuity patients seeking ongoing GP support in an environment where waiting lists are already full for a long time and over a period where many people are on holidays et cetera, makes access that much more difficult.

So, yes, we are certainly hearing more evidence of that from general practice. That is only going to get worse as this process continues because it is not going to get better in the next two or three years.

CHAIR - We heard from the AMA earlier about GP numbers and they suggested that in the north, in the Launceston area, GP numbers are at a bare minimum. Would you confirm that?

Mr EDMONDSON - Across the State I think there is a significant shortage of GPs. On the basis of your average which is one GP to 1 000 standard whole patients - whatever the terminology they use is - we are significantly denuded across the State. There is a significant shortage.

CHAIR - So when we think about that as a flow-on effect, if patients cannot get into the DEM because there is a bed block, the beds are closed, it is like a push back from every

point, they cannot get into a GP, there is not enough GPs and they are booked out anyway -

Mr EDMONDSON - That is correct.

CHAIR - So they end up back to the DEM

Mr EDMONDSON - It is a vicious cycle. I absolutely agree with that.

CHAIR - Outcomes will be impacted do you think?

Mr EDMONDSON - I have no doubt whatsoever that outcomes will be impacted. You would be mad to say otherwise. But in exactly what way and to what level it is very difficult to say. Our concern is with the processes used to make changes. At this particular stage, I believe, that there is a significant lack of process involved in this that could, in many respects, have helped alleviate some of the problems and issues by more effective pre-planning for particular patient types and support of other providers if they were available to help manage some of that increased burden.

CHAIR - If you were the senior policy advisor for the Minister for Health or you were given the ministry for the next two years, what would you do?

Mr EDMONDSON - I would be running.

Laughter.

Mr EDMONDSON - No, it is a difficult one. I would be arguing that as the biggest expenditure of public money in the system health demands a much more rigorous and structured long-term planning process than it has ever been given credit for, that decisions need to be made in the context of that plan and impacts need to be assessed in the context of that plan.

CHAIR - With a view to the future rather than right now?

Mr EDMONDSON - We have wasted three years of the Tasmanian Health Plan. Let us refer to them as the halcyon years of milk and honey when there was plenty of resource in the system. We have wasted the opportunity to undertake some of this planning in a way that could have helped us now. So there is always this, 'Let's put it off until later', and then we deal with it as a crisis and that is what we are doing at the moment.

CHAIR - It is crisis management.

Mr EDMONDSON - Yes, and that, unfortunately, is a reasonably repetitive cycle.

CHAIR - So, yes, we need a long-term strategic vision.

Mr EDMONDSON - Yes.

CHAIR - We need better planning.

Mr EDMONDSON - We need a change in policy that clearly directs that in any health care decision-making or resource allocation process we focus on preventing hospital admissions rather than managing them.

CHAIR - We acknowledge there is a budget issue and you were upfront acknowledging that. So you are still the policy adviser, if not the minister!

Mr EDMONDSON - Thank you.

Mr WILKINSON - Prime minister by now.

Laughter.

Mr EDMONDSON - Either that or a patient in an institution!

Laughter.

CHAIR - Or it could be both. But obviously we need some short-term strategies here as well as long-term vision and strategy. What can we do in the short term?

Mr EDMONDSON - You are asking me to do something I would never have got into in the first place. In the short term, there needs to be a serious look at how we invest in health care in this State - the proportions that we apply to project officers in Health department back rooms versus what we apply to direct patient care. Until we grab hold of the real elephant in the room, which is the entrenched and I would have to say, across the country, quite unique stranglehold that the industrial system has on our system here, preventing us from making decisions about who we employ, when we get rid of them, when we employ them et cetera, we are going to be facing this continued problem forever and a day, because we spend too much money on people not delivering health care and too little money on people who do deliver it.

CHAIR - If you did not have the industrial relations issues, the Fair Work problems we have, you would go with a new broom, is that what you are saying?

Mr EDMONDSON - Absolutely. I think we need to go back to the drawing board on how we structure, plan and deliver health in this State.

CHAIR - So we need a completely fresh look at this?

Mr EDMONDSON - We do, absolutely, and I do not think there would be too many people who would disagree with that, to be quite honest.

CHAIR - If we cannot move some of these people on, is there any -

Mr EDMONDSON - It is unfair to characterise the blame as sitting at their feet. This is our failure to take action with it or our willingness to accept that that is a necessary and acceptable part of our system. It is not their fault that they are sitting on jobs that are not doing an awful lot.

CHAIR - How do we change that? These people are there because they obviously have some capacity, so how do we get them thinking in a different way? You are saying we need to rethink -

Mr EDMONDSON - Yes. I would be being trite if I contained a process of long-term planning and systemic reorientation to a couple of sentences for you. The process of doing that needs to engage clinicians, policy makers and the community in making decisions about how we restructure our system for the future. To distil it into a couple of lines to answer a question like that I do not think is doing it justice. I have told you what I believe needs to happen. Nothing is going to fix the problem we have here and now and if cutting money is the only way to do that, we just have to live with the consequences of it. At the end of the day, though, if we just cut money, sit back and say, 'Haven't we done a wonderful job? We've saved the budget, we've got the budget back into surplus', or whatever it is that politicians do, then we have failed at the first hurdle. We have failed to accept and acknowledge that this is going to be a cyclical recurrence if we do not change the way in which we do business.

CHAIR - This is the thing. We are seeing these cuts that will make an impact on the budget bottom line. I'm not saying it will fix it; I don't believe it will, but there is no doubt it will have an impact. Can you see any evidence of this rethinking about how we're delivering services -

Mr EDMONDSON - Not in this, no. There's no evidence in that.

CHAIR - Not in that but even more broadly.

Mr EDMONDSON - There are a number of things happening at the moment, particularly around the COAG agreement with the Commonwealth that sees government working with us in particular at the moment with a lot of things underway that lead me to be vaguely positive about the future. I don't want to sound negative or overly pessimistic. There is stuff underway. I think there is significant opportunity to expand the current parameters that are being put around that and to think more broadly about how we change business models in healthcare. But -

CHAIR - Have you nailed down yet what Tasmania Medicare Local's role actually is or is that still a work in progress?

Mr EDMONDSON - That's a work in progress. We are only two months old. It's part of the Federal health reform. We're being fed iteratively through this sort of process. We have fairly good ideas about what we want to do and in the context of our work with the State, we see our remit as being everything outside hospital and helping to structure thinking around that. So Medicare Locals are a work in progress. It will depend on Federal Government funding what our eventual capacity is, but in the context of our engagement with the primary care sector, we certainly believe we are a key point of engagement in that process of planning, reorientation and rethinking. The only reason I'm in this job is because I believe there is a hell of a lot to do and a significant opportunity to do things better.

Dr GOODWIN - I want to go back, Phil, to some of the comments you were making about the bureaucracy and the industrial issues.

Mr EDMONDSON - Sure.

Dr GOODWIN - I think what you were getting at is that there are probably several positions within the bureaucracy that are perhaps what you might class as non-essential.

Mr EDMONDSON - I think what I'm getting at - and you'd have the numbers, I don't - is that we spend an awful lot of money on non-service delivery in our system. I'd be asking to what benefit at the present time. There is significant opportunity to focus some of that on doing the type of work I think we're talking about, and that is building something that eventually results in redundancy, if you like, and I use 'redundancy' to mean no longer needed. That, to me, would be a mechanism to redirect some of the spending within the current system to an end that has a much longer-term outlook and significant potential longer term to save the system itself.

Dr GOODWIN - With the new THO structure, regardless of whether it's three or one or whatever, what we're meant to end up with at the end of the day is a department or a ministry or whatever that is fairly streamlined and lean. That's my understanding. So some of these positions that you're talking about hopefully might disappear.

Mr EDMONDSON - I would hope that that would be one of the outcomes of the process. I'm not overly confident that it would be but I would hope it might be.

Dr GOODWIN - Right.

Mr EDMONDSON - I think we've missed some opportunities along the way. I think one of those is that we perpetuated this sense of regional competitiveness by going down the three THOs path. I understand the rationale and the reasons but I don't necessarily agree with it because I think there's significant opportunity really to look at making consistent statewide decisions that are not going to be easy when you've got three independent boards and regions fighting for a limited bucket of resources. In some respects, I think we've missed a bit of an opportunity but we've got what we've got and our responsibility and obligation now -

CHAIR - Can we change?

Mr EDMONDSON - Over to you guys. Our responsibility and obligation now is to make it work within the contextual limitations we are given.

Dr GOODWIN - Is a lot of this historical, though? Have these positions just kept being added along the years and -

Mr EDMONDSON - That's the appearance it has from outside. There's been a gradual build-up over time and you get used to it, I suppose. It's only when times like this happen that you really look at it and say, 'What is the problem here?' and it -

Dr GOODWIN - How did we get here?

Mr EDMONDSON - Exactly, and then how do we get out of this situation, which is the much more difficult question to answer, obviously.

CHAIR - Because no breadcrumbs have been left.

Mr EDMONDSON - That's right.

CHAIR - You only end up back where you started if you follow the breadcrumbs anyway, so you are no better off.

Mr EDMONDSON - Unless you have been following the sparrows.

Mr WILKINSON - He was in charge of the hospital.

CHAIR - Jack Sparrow, that is going back a few years.

Mr EDMONDSON - We have some great people within the system. I think given the opportunity to actually apply some free thinking without the constraints that are traditionally applied to the public service there would be some really good potential opportunity to look at reform and change but we are chasing our tails all the time and we are doing that now. We are chasing our tails. We are saying what should have happened six, 12, 18, 24 months ago instead of what is happening now and we are spending our time doing this and we will do it again in a couple of years' time.

CHAIR - Phil, we hear from the Commonwealth they are not interested in taking over the 100 per cent funding of health in spite of the fact that everyone else pretty much says that is the only way we are really going to get a consistent approach and avoid this costing that goes on and hope to lead to better communication within the systems between primary and acute health services. Is there any way, aside from convincing the Federal Government to reconsider that and perhaps look at a pilot model or whatever in Tasmania, you can see it working at all?

Mr EDMONDSON - Do I have any faith in the system framework?

CHAIR - Yes.

Mr EDMONDSON - I would have to resign if I didn't have any faith that the system could work. I believe it can work. It will be despite the limitations that the system offers rather than because of them. It will be because people have finally come to the realisation that we can't continually go through this boom-bust cycle of thinking. It will be because of that and not because there is a political will or otherwise to do it. I think there is a great sense of frustration within the system at the moment, reflected by all quarters, that we are constrained by traditional thinking and we are constrained by a whole range of things that make this type of process much more difficult but, by the same token, we are also afraid to admit that we are not doing things well at the moment and there is a real reluctance to do that. If we were prepared to admit that then I think we would find the path a heck of a lot easier in front of us.

CHAIR - Who then needs to lead this discussion? I think there are a number of discussions that need to be had about what we provide where, what we actually treat and what we don't. If you look at very elderly patients in nursing homes who develop pneumonia and they end up in ICU and things like that, the micro prems, the 23-weekers and things like

that particularly when they are born outside the NICU down here, that is a range of situations and I think Jim raised one earlier about patients with morbid obesity or smokers who -

Mr WILKINSON - Should you carry out vascular surgery on people who continue to smoke? They are difficult decisions.

Mr EDMONDSON - They are very difficult decisions but the people who need to lead that discussion are the clinicians themselves. Clinicians need to be involved in the decision-making process and if we are not engaging with clinicians in the decision-making process we will end up with bad outcomes. Having said that, the question that you are asking in respect of who should make decisions about whether a particular type of patient is treated or not is an extremely challenging ethical question and it is not one that you are going to draw me on now to answer in respect of any of those particular types.

CHAIR - No, I was asking who should lead the discussion.

Mr EDMONDSON - Clinicians themselves have to lead that discussion. They have to be involved and given a stake in the decision-making process about use of resourcing and allocation of resourcing.

CHAIR - Where I sit, I don't tend to see that. I know that clinicians are under a range of pressures at the moment and are facing all sorts of pressures that they weren't perhaps six or 12 months ago but this has to be part of a discussion as well as to what we provide where. Do we provide orthopaedic surgery in every hospital in this State?

Mr EDMONDSON - And these were the things that were bitten off four years ago in the Tasmanian Health Plan. These were the decisions that have sat in the too-hard basket for four years. These are the decisions that would have made some significant philosophical and systemic change if they had been taken at the time. The reality is that we have done the easy ones. We have ticked off the easy ones out of the Tasmanian Health Plan. We built a whole heap of buildings with Federal Government money and we have done a couple of fiddle-around-the-edges sort of things but we have failed really to act on the bigger-ticket items.

CHAIR - Structural things?

Mr EDMONDSON - Yes, structural things; really significant questions around who gets access to care when and how. In failing to do that we have, I guess, put ourselves into a situation where we say everybody is entitled to everything all of the time. Hence you have the expenditure requirements on the system that we have at the current time.

CHAIR - You could argue that they are entitled to it, it is where and how they access it that needs to be the other side of that debate.

Mr EDMONDSON - Yes, some of that regionalisation. I say we have made the task of moving on that much more difficult by perpetuating regionalisation in the sense of the THO decision.

Anyway, that is what it is.

CHAIR - We are where we are.

Mr WILKINSON - Getting back to talking about obesity and primary health care, stop the obesity, stop the diabetes later on et cetera, that is a process which is going to take some time.

Mr EDMONDSON - Yes, but you have to start somewhere and that is the problem.

Mr WILKINSON - I agree with that. If the Federal Government take it on they would like to see some type of return in order that they can come out and say, 'We have used Tasmania as a pilot, we have really focused on obesity, we have focused on smoking, we have focused on this and that. As a result of that we can see in the past three years that this has helped' - whatever. It is going to be longer than that, though, isn't it?

Mr EDMONDSON - Yes. It is a 10-year cycle. That is the way it has to go. Countries such as Canada that have really bitten off a strong primary care focus system do an inordinate amount of work in prevention and risk factor management and they are getting the benefits now. They are starting to see those benefits now.

Mr WILKINSON - Like physical fitness back in schools.

Mr EDMONDSON - It is the hump that you have to get over first because everybody wants to see something here and now within a three-year political cycle.

Mr WILKINSON - What have you got for this committee to -

CHAIR - Go to Canada?

Laughter.

Mr WILKINSON - Yes, with the budget constraints. Would it be good to get some information in relation to the Canadian system and, if so, where do you get it from, do you know who to speak to, or who is a contact over there that could show what they have done in the past?

Mr EDMONDSON - There are a lot of people within the Health department who have done a lot of work looking at those sorts of things. There are people you already employ who have that information at their fingertips and could give you a very good understanding of what the nuts and bolts of it are and how it works. It is not simply as easy as that. You cannot simply transplant something that works in a country that has a completely different healthcare and political system into somewhere like this. Government works on money. How much are you going to save after 10 years therefore what can you afford to put in 10 years earlier in order to generate that down the track? That is how government works. Really it has to come down to that kind of thinking. Those countries have now got enough history to show that that type of thinking is legitimate and it is probably the only documented way that I have read or seen that can really impact significantly on exponential growth in healthcare costs.

It has to be systematic, it has to be structured, it has to be an integral and accessible part of the system. You cannot fiddle around the edges with it. You cannot just throw a few hundred thousand dollars at it and hope that it will do something for you. It has to become part of the expectation of the population that that is how their health care is managed. The focus is on prevention. You only get to hospital if everything else has failed. You only get to hospital if everything else has been tried. Here we say we will make our hospitals like Hilton hotels and we just hope that the system before that stops people from getting there. It is not hope and pray-type stuff; it has to be systematically structured.

Mr WILKINSON - You said that it is the only document that you had read. Are you able to point us to that document?

Mr EDMONDSON - That is Barbara Starfield stuff. I have read hundreds of documents about it. There is no one thing. There is a lot of literature out there about it and a simple Internet search will throw up a whole heap of stuff for you about the value of investment in primary care. It is not only in Canada; it is in nearly every other well-developed country. Australia has some good evidence about the value of investment in primary care; they just have not acted on it very well in the past.

CHAIR - Has any State done it in a reasonable way in Australia?

Mr EDMONDSON - I hesitate to used the term 'basket case' in relation to Tasmania's health system but that is how we are viewed by the rest of the country. States like Victoria and Western Australia have invested very heavily in primary care service access. Victoria has the primary care partnership model which is seeing a really strong investment in community-accessible primary care. They have a hospital system that only manages what a hospital should, that is the inpatient service and what is necessary to get the patient back out. Here we do a whole heap of things in hospitals that possibly over time are going to start -

CHAIR - Like birthing babies?

Mr EDMONDSON - The reality is that because we do not have that backup in the community, hospitals end up by default doing things that they should not do, and it is 10 times more expensive to do it in a hospital bed than it is to do it in a community health centre or a GP practice -

CHAIR - Or at home.

Mr EDMONDSON - Or at home with an outreach nursing service or otherwise. A conscious decision needs to be made to move resourcing from one point to the other. We certainly do not want to see hospitals raided and pillaged to the point of not being able to function as hospitals. Good quality hospital care is an absolute right and an expectation and we need to have it, but we should not be investing in that to the exclusion of all else.

Dr GOODWIN - Has there been an exercise looking at what is in our hospitals that could be out in the community, some of the things you were just talking about?

Mr EDMONDSON - As part of the process when the initial national health reform process was undertaken, the State, I know, did an analysis of the types of things it was doing that could be called primary healthcare activity that were at that particular stage going move under the funding jurisdiction of Medicare Local. When that was changed by the COAG process, which is what happened, and States retained control over all their primary health care funding, I am not sure what happened to that process at that point. So there are certain people within the State Government who were undertaking that work.

Mr WILKINSON - In relation to costs, the initial high cost is the first day in, so emergency or whatever it might be, so your first day in is the initial high cost and the longer you stay in, if you are getting better, the less the cost is. Now what is happening is that people are not remaining in hospital for a longer period and therefore that tapering off of cost is not there because it is all high-end stuff, day in and day out. Is that a fair conclusion?

Mr EDMONDSON - It probably is. I am no expert on hospital costing so I could not give you a definitive answer on that.

Mr WILKINSON - It makes sense, doesn't it?

Mr EDMONDSON - It does make sense and I guess the propensity to move patients out of hospital more quickly in order to save costs at the other end also runs that risk of the bounce-back effect where patients come back in because they were discharged too early or the system is not in place to support them in a community-care sense when they do leave hospital, including everything from the communication on discharge to their normal GP or otherwise through to access to allied community nursing and otherwise. I have no reason to believe that is not accurate.

Mr WILKINSON - You spoke about the systems not being in place and lack of communication and we had that evidence as well. I just wondered whether you have seen any of that, where say your GP carries out your test one day, the person is in hospital two days later and they carry out the same tests because there is no communication.

Mr EDMONDSON - Without question that is a longstanding problem within the Tasmanian system - poor communication on admission and on discharge. Often, for example, a patient will be discharged and the GP will find out two or three days later that they were even there. That is absolutely a problem and an issue. Duplication of testing - a lot of that comes down protocols in relation to management and treatment in particular facilities or institutions. It automatically is a protocol that you retest for *x, y* or *z*. We need to lose some of that stuff.

CHAIR - This has been a problem for years; it is not related to the cuts.

Mr EDMONDSON - Absolutely. It is not related to the cuts at all. That is a longstanding communication, engagement and sharing-of-results issue.

Mr WILKINSON - If sorted out it could certainly be a significant cost saving.

Mr EDMONDSON - It could be but you have to look at what point that cost is saved in order to work out what the motivation on various aspects of the system might be to change it or want something more.

CHAIR - Thank you very much for your time, Phil.

THE WITNESS WITHDREW.

Dr BRYAN WALPOLE WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Welcome Bryan. Have you given evidence to a committee before?

Dr WALPOLE - I have.

CHAIR - So you understand that it is all recorded and is part of the public record and obviously will be used in the report?

Dr WALPOLE - Yes, I do.

CHAIR - What you say is covered by parliamentary privilege during the process of the hearing, but anything you say outside may not be. If you want to provide evidence of a confidential nature, you can request the evidence be heard in camera and the committee will consider that.

We have your submission that you sent in some time ago, so there may be some more information that you wish to provide. Perhaps you could give us an overview of your concerns, focusing particularly on the terms of reference, and then members will probably have questions.

Dr WALPOLE - Okay. It has been a really challenging time. I have been in the public hospital here since 1984 and successive ways of cost-cutting have come at us, but this is by far the most serious. It just seems to me to be odd that in a liberal democracy BHP makes $22 billion, the four major banks make $6 billion each while a chap in Glenorchy cannot get a joint replacement and you get your mother into hospital with pneumonia and she lies on a trolley for 36 hours. Something is clearly broken. I say at the outset it is not the Health department's fault. I have worked for the Antarctic Division, I have worked for Repat, and DFAT. The issue in this country is that the Commonwealth Government collects all the money, spends it on all the things they want and what is left goes to the States. You go as a locum to the Canberra hospital and you cannot believe the riches that they have there. You come back here and you see what we are struggling against. It is a democracy in a federation and I just think that Tasmania doesn't seem to get a fair go. We are all scrabbling around trying to fix something that is unfixable. But, on the other hand, I think there are good opportunities to look at what we do and how we do it because there are things that have grown up over the years in the health system that are fundamentally inequitable.

There are things such as mammography, which the Cochrane collaboration says is doubtfully useful. Things like IVF, which has become a commodity, and costs $8 000 a cycle. Infertility is not an illness - it is a bit like being left-handed or a bit thick; you get on and live with it. We are able to spend money on Medicare and a whole lot of things that people really don't need, but the things that people really do need for a good quality of life - and elective surgery is one of those - we cannot get because, structurally, there are issues in the system that are very difficult to solve. That's the sort of big thing. On the minor issue, there have always been problems in Tasmania with north versus south. You've been through this endlessly; I don't need to go on about the Mersey hospital, but the Health Department did a really good job with places like Toosey and Scottsdale and

Smithton and St Helens in racking them back and saying, 'We don't do surgery in these places; we look after the local community and we move people on'. If you look at Launceston General you see that it is a good functioning hospital in a big region, but if you look at the north-west, there's a sort of broken dichotomy up there that we nearly solved with Lara Giddings but in came the white knights of Abbott and Howard and solved a problem that didn't need solving.

If you look at the south you see that the Royal Hobart just dominates the whole of the south; there's not an issue here with another hospital, only the Royal Hobart, but it gobbles up 90 per cent of the budget and all these smaller places like the peninsula, Esperance, Dover, Ouse, Triabunna and so forth are just starving for funds because Royal Hobart is the colossus. Within Royal Hobart we just eat money because your clinicians just spend it and nobody steps back and looks at issues. If you look at people who are dying and are in the last year of their life, the patent measure is that they are admitted to hospital up to six times. They have scans and blood tests that they don't need. If you ask them, people want to die at home but it's almost impossible to do so - the system won't allow you because palliative care is not on demand. It is such a paradox; if you're having a baby and turn up at Royal Hobart or Calvary, they don't say, 'Sorry, the beds are full' - it's laid on. Well, if that happens at the start of life why shouldn't it happen at the end? When you're dying you should be able to get palliative care services, not necessarily in hospital but at home, because they're not expensive but they should be on demand.

CHAIR - Palliative care services need to be engaged much earlier in the dying process.

Dr WALPOLE - Yes, and I think clinically we are all aware of that and we've made terrific progress in the past five years, but it needs to be mirrored like obstetrics and, having practised in emergency medicine for about 35 years, I find the greatest disappointment is when admission is the default option because it's Sunday night or four o'clock on Tuesday morning or something like that and the family pull the plug because the person's vomiting or moaning or whatever so they call an ambulance. Then we can spend $10 000 in a couple of days with no trouble at all, no questions asked, when really what they wanted was $250 worth of palliative care nurse, a GP and a morphine syringe drive or a nasogastric tube or something. Structurally, those things just aren't available to us.

One of the ways to cut costs is to close beds and when you put on palliative care, you need to say, 'Well, we're removing 20 beds from Royal Hobart Hospital, we're supporting community palliative care, the Whittle Ward or what have you, and those beds are closed so $1 000 a day from there is now allocated to that', but what happens is that when we pull those patients out we just put other people in the beds, so the hospital costs just keep going up.

There are a whole lot of other things. For instance, I was surprised to see they're building more intensive care beds. I mean, intensive care is $5 000 a day. You look at the outcomes of intensive care of what percentage of people are dead within a year and it's a hell of a lot depending on where you go, but 70 per cent of people are dead within a year of being in intensive care. Now, is that good value for money?

Dr GOODWIN - Sorry, how many?

Dr WALPOLE - About 70 per cent are dead within a year of being in intensive care. That's because it's risk management stuff.

CHAIR - Is that because they went to ICU?

Laughter.

Mr WILKINSON - I'm one of the 30.

Laughter.

Dr WALPOLE - We don't count coronary care. Coronary care heart stuff is quite different. That has a very good outlook because it is different patient set. The people with chronic airways disease, cancer and strokes -

CHAIR - They probably shouldn't be in ICU to start with.

Dr WALPOLE - That's the point.

CHAIR - That's the question, isn't it?

Dr WALPOLE - I'm glad you've said that and not me. I've got a lot of colleagues in intensive care but there's no sort of gate like there used to be in the olden days. When we had the one or two specialists there was a gate because we had something like five ventilated beds. If someone came along like a young person in a car crash, we looked around - you, cold turkey, which means off the ventilator and off you go to the ward and see how you go; take this one in. It has grown and grown and grown and it is hugely expensive. Then there is this knotty issue of neonatal intensive care, where the thing that would fit in the palm of your hand gets salvaged, but a 25-weeker is a third of a million dollars. Might you be better to start again? It is a tough decision but the gate used to be about 30 weeks and then it came back to 26 and now it is back to 25 or 24 weeks and there is one or two at 23 weeks born with significant disability. These are hard questions.

As I said in my submission, you probably know what they did in Oregon, where they drew up the big list and said liver transplantation is below the line because it is hugely expensive with poor outcomes, although the outcome is much better now. IVF was below the line because they said Oregon can't afford it and the Governor of Oregon at the time, John Kitzhaber, was an emergency physician which is where he engaged the public in this sort of debate, and if you actually want these things that are below the line then you pay for them yourselves.

CHAIR - Who leads this discussion in the community?

Dr WALPOLE - I think that is a tricky issue. Firstly the clinicians have to be involved; secondly, the people who allocate the money, and that is you guys, Parliament, needs to have a leadership role in setting it up; and thirdly, the public needs to be part of it. John White sort of started this when he had his community health forums when he regionalised Tasmania. It never really worked for some reason and then Field lost government and it was all swept away, but that concept of having a regional health board and community

health forums and the forums saying what they felt they could afford and telling the board what they wanted and then the board working with the clinician and government to deliver it, although it was a bit cumbersome I think ethically it was quite a good one.

CHAIR - Do you think now we need to have that discussion on a statewide level, though, because even though we are still the same sized State and we still have the dispersed population to have a statewide approach so that everyone is engaged in the debate and you are not just having these little isolated conversations -

Dr WALPOLE - I think one of the things that this State really misses out on is academic medical centres. I would get rid of the Royal Hobart Hospital altogether. I don't like the word 'royal' for a whole range of reasons, 'Hobart' sticks in the gizzard of all the people up north, and it is not a hospital, it is a medical centre. Most of the people actually never get into a bed. They have day surgery, endoscopy, minor surgery, Emergency department outpatients. The university has three campuses - in the north-west, north and south - because the academic people know what works because they research and they do clinical work as well, those who are brokers, they keep in touch with the clinical stuff. They teach because it is a university and that is a key role of teaching the doctors, the nurses and the pharmacists and so forth, and admin supports them. If you go to Stamford, Yale, Mayo, Nuffield at Oxford, or Addenbrooke's in Cambridge - world centres - they are academic medical centres. The university leads the hospital. Treasury folk, admin, control the money but they spend it where the academic people say you get your best value for money and clinical outliers are discouraged.

CHAIR - So we have one University of Tasmania hospital?

Dr WALPOLE - I think a Tasmanian university medical centre with three campuses.

CHAIR - Let's call it a health centre.

Dr WALPOLE - A health centre, yes, that is fine. A health centre is good. The 'Royal' and 'Hobart' stick in the gizzard of people up north, so wipe them out.

CHAIR - And 'Launceston' sticks in the gizzard of southerners as well.

Laughter.

Dr WALPOLE - It creates a parochialism that we don't need because the patients need to move seamlessly through the system with an electronic health record and a quality transport and retrieval system which you have made a lot of progress towards getting and so they don't perceive they're moving outside the same institutions.

CHAIR - That is why you need this one statewide approach.

Dr WALPOLE - Exactly.

CHAIR - Because there are some services that are only provided in Hobart, and that is the way it should be, for neurosurgery and neonatal intensive care. If you have one system it makes it much easier for people to accept that this is our system.

Dr WALPOLE - If you look at Geelong, Wollongong, Newcastle and the Gold Coast, all of which have populations of about 500 000, they are all one-hospital places and you never hear of them having to have 'Save the Royal' campaigns and things.

CHAIR - They serve much more centralised populations -

Dr WALPOLE - I accept that.

CHAIR - but some of them have a decent take-in -

Dr WALPOLE - Geelong certainly does and the Gold Coast does, yes, though Wollongong and Newcastle don't. But we can overcome that with a transport and retrieval system, which we have.

CHAIR - We do not have very good support accommodation and those things outside the region. That is one of the things that is lacking, would you agree? Ronald McDonald is different when looking at babies and children. But for a young adult who has a neuro issue following a crash or something like that, there is very little support for the families down here as far as accommodation goes.

Dr WALPOLE - There is. The social workers can usually find them something. Before Robin Gray's Government sold them all, we had Standage Court in New Town and we owned Gattonside and we owned four terrace houses in Hampden Road, and the social workers used to put people down there at $20 a day or some very limited amount. But of course the trouble with that is Medicare does not pay for any of that because it is not health. But I agree, as part of that, you would have to have an empathic system for looking after the families.

Dr GOODWIN - I would like to ask about the current cuts and the lack of clinical input.

Dr WALPOLE - I now work in hypobaric medicine; I do a day a week there. So I am quite remote from the day-to-day stuff. A lot of that is second-hand and what I read in the paper, so I am no better informed than you on that.

Dr GOODWIN - Right, but your perception is that there was not enough clinical input into -

Dr WALPOLE - Yes. Over the new Royal campaign there was initial great enthusiasm between the clinical staff, the Health department and the planning architect over what we were going to get, and then something went wrong. I think it was the change of CEO or something. The clinicians all felt totally disengaged from it. I remember Lara Giddings saying, 'Why won't the clinicians engage?'. Frankly, they were all sick of it because they had seen the thing was running away from them and they were not being engaged anymore. Now clinicians like us go in and you do your work and you go home and you do not consider yourself part of the administrative structure of the hospital. The current CEO has done a pretty good job to try to turn that around but she is acting; I think she has done a pretty difficult job pretty well. I saw the jobs advertised a couple a weeks ago and that often makes your job more difficult. If you go to Royal Melbourne and the Walter and Eliza Hall and Melbourne Uni, which are for teaching, research and clinical, they are absolutely inseparable. So you cannot dissect Walter and Eliza Hall from Royal Melbourne Hospital from the University in Melbourne, nor the Baker Institute from

Alfred Hospital from Monash University, because when you go to work at Alfred they say, what are your teaching responsibilities? Right, you have Monash University students, what are your research responsibilities? Do you want to do specific search, yes, okay then Baker Institute half a day a week or something like that. So everyone is in all three, so they all know what they are doing and there is a cooperative arrangement. Admin's job is to support the clinicians to provide the quality care. Currently it is a bit top down because there has always been this nasty antipathy between the Health department and the hospital because the Health department sees the hospital gobbling up money and the hospital sees the Health department as trying to control them all the time from doing good work. So they really need mixing up.

I had three weeks in the Health department on the flu campaign. I was one of the controllers when the guy in there fell sick. I did not find anybody in there who was not doing a worthwhile job. The mantra that there is this vast administrative machinery wasting money is rhetoric. Everybody in there is accountable. This is the age of accountable medicine and accountable medicine means you need to know where the money is going and to find out where the money is going you need people to trace it, annotate it and produce the information.

CHAIR - We are in a situation in Tasmania where we only have one university.

Dr WALPOLE - Which is a huge strength.

CHAIR - It is, yes.

Dr WALPOLE - We have a nifty little campus in the north-west. We have one of Australia's best rural clinical schools. We now have the med school in Launceston getting top honours around the nation as a rural clinical school and the students want to go there as a preference.

CHAIR - The nursing school there has huge accolades from around the country.

Dr WALPOLE - There are good things happening in academic medicine and there are bad things happening in clinical delivery. We need to bring the two together. I would have a clinical governance board statewide that looked at all the appointments for medical, nursing and pharmacy and allied health for the whole State. I know that sounds cumbersome but other places do that.

CHAIR - We are only 500 000 to look after so we should be able to do it.

Dr WALPOLE - We should be able to do ti.

Dr GOODWIN - If I could touch on the unified health record aspect you raised in your submission because that has cropped up before. This seems to be a bit of an issue, the difficulty in tracking patients around the health system.

Dr WALPOLE - IT in health lags 20 years behind IT in business. You look at the banks; their IT is absolutely brilliant. Employment agencies and their IT and their communications are big business. But in health, because of the difficulty with confidentiality and encryption and intranets and so forth, IT is always so far behind.

When I arrived in 1984 we had just got primed to put computers into the hospitals, old unix systems and things, but they made this fundamental mistake of each hospital having a different system.

CHAIR - And a different UR number.

Dr WALPOLE - Yes, around the State. I remember going to the statewide medical records in 1992 and saying that we have to break this down and the medical records people would not have it. They said that the institution has to hold its own information; it is part of ethical code. If I want to get the ECG of a man who was in hospital in Burnie, you ring up and they put you through to medical records and they say to fax up a written request. So you fax up a written request and two, three, four or five hours later you might get it faxed back. So I ring the doctor in the emergency department and say, 'Can you get down the record of Fred McGurk and have a look at his ECG and ring me back and tell me what it says?'. That happens just like that. The doctor gets the record and tells me because you need to know that if someone has had a heart attack and the ECG changed. If you can do it in a personal basis it is easy, but it ought to be possible. When I did a locum in Queensland and you can sit in the emergency department in Bundaberg and you look at the pathology of people all around Queensland - the whole lot. When you are with your patient you say, 'You have been in Royal Brisbane, you have been in PA', it is all there for you. Now is that breaking confidentiality? Well, you have to surrender a bit of that to get safety. When you want their X-ray, you get X-rays taken all around Queensland as well.

Dr GOODWIN - I am sure that patients would prefer you to have the information instantaneously rather than wait four or five hours.

CHAIR - You talk about the banks having great IT; I am as much concerned about the security of my money and my details in my bank than I am about my health details. So why are we having this massive problem with sharing of this information. My health records are a private matter too but so are my pin numbers and my bank account details and everything else. The security should be the same.

Dr WALPOLE - The key for older people is what drugs they are taking. It is much better than it was but for actually finding out what they are taking the only way you could get it was to ring the pharmacist and say, can you fax me through the list of what was on their last prescription? Then you show it to the patient and then you have probably have it right. Because the GP's information system spits out every drug they have ever taken, two pages of it, because that is the way their software is built. It ought to be so easy to tap into that when you think that every PBS prescription is recorded in Canberra.

CHAIR - Also when they had their last blood test done. It might have been done yesterday, so do you need to do it again.

Dr WALPOLE - I am sure other people have talked about that. In emergency medicine it drives us bananas trying to get all the information about people. It is actually available in an electronic system somewhere but it is not coordinated.

Dr GOODWIN - And you are wasting time tracking it all down.

Dr WALPOLE - And often you have repeat things, which is not in the patient's best interests anyway. In actual fact Tassie's gone - there's one unit record for the whole State now. We've actually done that - we're retaining it -

CHAIR - But only within the public system. We've still got separate numbers in the private.

Dr WALPOLE - Yes.

CHAIR - I've probably got two or three UR numbers floating around somewhere.

Dr WALPOLE - That would save money, I am sure, and it would certainly improve quality and safety if you unified IT and the digital medical records.

CHAIR - It's interesting that we don't seem to have much problem giving a woman a handheld record that's a hard copy that she can drop in the street and have her HIV status and so on written in there. There are contradictions to the system everywhere.

Dr WALPOLE - The Federal one is going awry at present.

CHAIR - Is it?

Dr WALPOLE - We're well two years behind with the patient-controlled electronic health record and now they're saying that the patients have actually got to be able to edit it, which is really problematic.

Laughter.

CHAIR - What, change their history if they don't like it?

Dr WALPOLE - Yes, if there are things that they don't want the doctor to know in it, and that's run a glitch with the AMA. It's more than two years behind. PCEHR, yes.

CHAIR - Yes. There are clearly some barriers to overcome.

Dr WALPOLE - I'm delighted you people, this high-level committee, are pulling all this information together. They're all nice people in health and they shouldn't be fighting and arguing with one another; we should all be pulling together.

CHAIR - The purpose of this committee is not to solve all the problems of the world, unfortunately. We'd like to be able to do that but it's really to get a lot of this information on the public record that might provide some clearer direction but also to say, 'Well, come on, this is what everyone out there is saying and surely we can action this'. It won't change the world; it certainly won't change it quickly.

Dr WALPOLE - It never does in health.

CHAIR - No.

Dr WALPOLE - Ten years.

CHAIR - But it adds to the body of evidence about the sort of things that perhaps really need to be considered above others. Thanks for your time.

THE WITNESS WITHDREW.

Dr LEN CROCOMBE AND **Dr DAVID BUTLER**, AUSTRALIAN DENTAL ASSOCIATION, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - I know David has been before committees of some sort in the past but just so that you aware of how things operate, everything is recorded by Hansard and it will become part of the public record. What you say is covered by parliamentary privilege during the proceedings but if you repeat anything outside of the hearings that may not be the case. If you have information you would rather give in confidence you can request that and the committee will consider that request and make a determination on that.

We are focusing on the terms of reference and I know you have addressed that in your submission but we are taking a little bit broader a scope as it draws in and impacts more broadly some of the cuts so it is not just in the acute services obviously. Whoever wants to take the lead may speak to your submission and anything that has come up since then, because it is a couple of months since you put your submission in, and the committee will probably have some questions for you.

Dr CROCOMBE - I am representing the Tasmanian Branch of the Australian Dental Association and David is the Clinical Director of the Oral Health Services Tasmania.

Dr BUTLER - Yes. I am a non-public servant as well as a counsellor for ADA Tasmania.

Dr CROCOMBE - I might not have made it that clear in the submission that Oral Health Services Tasmania is only treating the tip of the iceberg in the general meaning of its clients and I think a couple of ways to describe that is that out of 198 dentists in Tasmania, according to registration figures, there are 25 full-time equivalents in the Oral Health Services Tasmania who are expected to treat 42 per cent of the population who are eligible for public dental care and these are healthcare cardholders. Another way to put it is that of the budget that was done before the budget cuts just over $26 million was allocated to Oral Health Services Tasmania to treat all schoolchildren and all the people who hold healthcare cards. So if you assume that there was absolutely no administration services within the service, you divide that by the number of eligible people, you come out at about $125 per person which is less than the cost would be for an examine and for some X-rays in the private sector.

Another way to look at is that they have one dentist for 11 000 to 12 000 people in the public sector. So what this means is that they are basically only able to do largely emergency treatment on adult healthcare cardholders. This was the situation beforehand and this was made clear in the Auditor-General's report 2006, I think it was. So it is a problem to start off with. The healthcare cuts have basically made this worse.

The thing that we would like to make clear is that for some reason in looking at these things a lot of people seem to be separating the oral health away from the general health when the two are linked together in a strong capacity. It has been shown well and truly that there is a link between oral health and diabetes and it has been shown that there is a link between oral health and cardiac health. So you can see that these limitations in supply in oral health care flow onto the whole general health of the person at the same time. In the report by Richardson - it came out today - which he did for the Brotherhood

of St Laurence he looks at some of the figures and works out that it is basically a false economy.

CHAIR - Jeff Richardson?

Mr CROCOMBE - Yes, from the University of Monash. Basically, oral health plays a big role in the quality of life of people. It is very difficult for a healthcare cardholder who is looking for a job to get access to that job if they are walking in with half their front teeth missing or something like this. It is difficult for a child to learn if they have a toothache at the same time.

The Oral Health Services Tasmania from our point of view is doing a good job under very difficult conditions that basically can only really supply emergency care. We do consider that when they did the healthcare cuts - and this is the dental association talking here - basically it was mainly to front-line-type services and there was no looking at whether the administration could be looked at and whether it could have been cut in some way.

One area that we looked at from the point of view of where the cuts have been made was in accessing the theatres at the hospitals. If it is okay with you, David, I might pass on to you about what effect that has had in cutting theatre time.

Dr BUTLER - Thanks, Len. From my perspective as the Director of Clinical Services, Oral Health, I have a clinical component, I work clinically as well as in policy and administration and always managed to do that. The budget cuts to a health agency per se have flowed onto oral health and I think a lot of that in the Surgeon-General's report 2000 in the United States shows that we cannot ignore dental health and general health; they are not two separate things. I think for historical and political reasons they have been separated and it has been delivered in isolation. But we have to be quite clear that any cut to general health areas of an agency flow onto oral health. You cannot have good oral health with all the other areas being cut and then expect oral health to be maintained the same. So if you have high levels of diabetes, premature birth, low birth weight issues, malnutrition, high stroke rates, cancer rates, high smoking rates, you cannot have good oral health there; they work hand in hand. Holistically, oral health and general health work hand in hand. So any cut that another area of the health agency makes flows onto oral health and one of them, as Len said, is the general anaesthetic area. So if a hospital decides it is going to cut elective surgery lists and they consider dental surgery elective, I disagree vehemently on this; dental is core business for us to have access to general anaesthesia. The children are uncooperative or precooperative children, special needs patients and complex care; they're just normal. As far as I'm concerned, a national standard is that we have access to perform dental procedures under general anaesthesia. So, if you have a cut to a health agency where they're struggling to meet their budget savings and targets, oral health quite often is dropped off the bottom. They say, right, you are first to go and you can't have access or we'll reduce your access to general anaesthesia. Where do we go with that? We struggle to treat them in the chair under local anaesthesia. Two-year-old children when we take out 10 to 15 teeth at a time, how do you treat those under local anaesthesia in the chair? You can't. So they've got pathology, they've got abscesses, learning goes down; nutrition goes down. We need general anaesthetic, so with cuts to the acute area where elective surgery lists are cut, then dental services will be cut and they're the first to go. That's my issue.

Dr GOODWIN - Has it been impacted already or is it still too early?

Dr BUTLER - It has impacted already. At the LGH already we have been told that in 2012 we will have no dedicated dental list. I've drafted a letter in response to the CEO and Director of Surgery outlining my dismay and very strong disappointment to such a decision. As far as I'm concerned it's not elective; it's mandatory and it's not an add-on thing. We don't have any alternatives here. It's not as if we'll just go and treat them under local anaesthetic, give an injection in the mouth and do it. It doesn't work like that. If we get a special cerebral palsy case, there is no way they can be treated in the chair. They have a major swollen face and we've got to treat them.

CHAIR - How many lists were being provided?

Dr BUTLER - What they've said is we won't have any dedicated list. In other words, if they have a spare list or a surgeon goes on leave or whatever, we'll be able to pick that up, or if we have an emergency. But I consider all our patients to be emergency, so they are urgent; they've all got pathology. They can't be treated in the chair under local. We treat them under general anaesthetic and they are all managed so we are pumping them, young children with swollen faces, full of antibiotics or pain relief for periods of a month, two months or six months. What we do by treating them under general anaesthetic is to relieve the pressure on accident and emergency departments. So it is sort of robbing Peter to pay Paul.

CHAIR - Did you have dedicated lists previously, though?

Dr BUTLER - Yes, we had.

CHAIR - How many have you had?

Dr BUTLER - Weekly, a weekly dedicated list to zero.

CHAIR - So, you've lost 52?

Dr BUTLER - Yes, to zero.

CHAIR - Just like that?

Dr BUTLER - Just like that.

CHAIR - Was there any consultation with the Australian Dental Association?

Dr BUTLER - No, just a letter.

CHAIR - After the event?

Dr BUTLER - Yes, after, just telling me that's what's going to happen.

Dr CROCOMBE - That was to David, not to the Australian Dental Association.

Dr BUTLER - To me as head of the clinic.

CHAIR - Right, so ADA didn't have any input?

Dr BUTLER - No, no communication.

Dr GOODWIN - So, you don't know what the impact might be with the Royal?

Dr BUTLER - No, I don't know what's happening at the Royal. The Royal has been reduced; the percentage has been reduced. The only area that hasn't been reduced is possibly the north-west area but that's because they can't fill their theatre sessions with other areas. A lot of it is the funding model that we use. Obviously they get a Commonwealth incentive target if they reach targets and dental and oral general anaesthetics don't measure up; the Commonwealth doesn't recognise it. In other words, if they want to get their bonus payment, they're going to do ophthalmology and orthopaedics; they're not going to do dental because that doesn't measure. If they want their dollars we are going to be dropped off and they say we'll put someone else in there. So we don't rate. It's a false economy as far as I'm concerned. Oral health is not separate to general health and if we get our oral health right then we can assist other areas of health in meeting their KPIs. In diabetes, adverse pregnancy outcomes or people post-stroke who are twice as likely to require urgent care. A lot of people with stroke can't be treated under local. They have to have a general anaesthetic or a heavy sedation if we need to take teeth out. It's a false economy, as I see it.

We've been compartmentalised and we have to have a certain budget saving and we are all business units. I believe that the process for the actual budget cuts - and I'm not going to get into whether there should be cuts or not - but obviously if there need to be budget cuts then it's the process behind that. If there is a certain amount for the agency, then rather than saying this unit has to reduce by $3 million and that by $20 million, if acute services is closing beds and another unit hasn't even looked at their administrative staff levels but they've met their budget target somewhere else, then their number goes up. There is no coordination so I think the process around how it has been managed from the agency perspective, from my perspective, is not correct. If we're looking at an agency as a health agency where we've got common risk factors and we've got a quantum of dollars to save, then that should be coordinated. So you would have a list of budget savings from top to bottom and you say, okay, we've come down so this area now is having to cut its second-level priority but this other business unit hasn't met this down at the third level. So they then have to go to that other business unit and say, your budget savings now will be increased because we are having to close paediatric beds, for instance. So that's the process but that's probably a different issue from this committee. Certainly the flow-on effect of GA is quite critical for us.

CHAIR - You said it had a weekly dedicated dental list. Was that always fully utilised?

Dr BUTLER - Yes. We have waiting lists. We would have three-month waiting lists for children. There are three categories. We have paediatrics with very young children; we have special needs patients such as cerebral palsy, intellectual or physical disability, or post-stroke; and we have adults with complex care. So they have a significant surgical procedure to be done which can't be done in a chair, which would be done in a hospital

setting where you have the support of a medical team if something went wrong, and other specialists.

CHAIR - So on an average list - I know they vary - how many patients would you treat in one session?

Dr BUTLER - Depending on the type of work, probably six to seven patients in a morning session or an afternoon session; so 14 if we had a day session.

CHAIR - And you had a day session once a week?

Dr BUTLER - Yes.

CHAIR - So we are talking about 14 patients, 50 times a year, because I imagine you'd have a two-week shut-down.

Dr BUTLER - Yes, that's right.

CHAIR - That's just at the LGH?

Dr BUTLER - Yes, exactly. What we are being forced to do now is push those patients up to the north-west area to treat them across boundaries and get them to travel up there to be treated. That's our only alternative. The quantum hasn't been conveyed to me for the Royal Hobart. I know there has been a reduction in lists but as for the quantum, I don't know. Again, it's a follow-on from requirements of the budget task.

Dr CROCOMBE - On top of that - it doesn't stop there - unfortunately Mr Graham Hall, the director of the oral and maxillofacial unit at the Royal, couldn't come but all oral and maxillofacial surgery is meant to be a statewide service so it's meant to be all handled from the Royal. It had also been struggling along before the cuts were made. Basically, previous to the cuts the agreed staffing position for 2011 for all of Tasmania was two visiting consultant surgeons, each at 0.16 full time equivalent, which is less than a day a week. What these guys do is tackle oral cancers, fractures of jaws, major trauma type cases. They tend to do a lot of this in big teams because the cancers that you get in the mouth tend to be life threatening; a five-year survival rate is not the best. So you have a team and get together with the plastic surgeons to make decisions along these lines.

There was meant to be these two part-time visiting consultant surgeons and one resident dental officer. The importance of him or her is that before you can start treating a cancer, say for radiation treatment or something like that, you need to have the mouth in perfect condition, because if they have radiation treatment and then have an infection in the mouth, it will basically kill them. It's life threatening because you kill off all the bone in the jaw and you've got no immune system left. So they needed that and one specialist in training, a registrar. All of these staff were based at the Royal. The Tasmanian tertiary referral centre, as per the COAG Health minister's agreement for Medicare funding, and tertiary referral trauma neurosurgery centres, must include a 24-hour on-site dental facility. So allocated access to operating theatres at the time was meant to be nine sessions monthly for the unit. The position now is that they have the same two visiting consultants and the registrar, they don't have the dental officer, and the registrar has to have blocks quarantined for travel to the mainland for college training

sessions which are approximately six weeks every 26-week period for a Victorian program and their allocated operating access for the unit is now seven sessions per month so it's dropped by two. Effectively, the unit can now manage emergency and urgent cases only and then not always. The waiting list for surgery for the oral and maxillofacial unit is for oral and maxillofacial surgery only. It doesn't involve anything to do with teeth or dentolabial surgery so that includes things such as active wisdom teeth which can be constantly getting infected; these things just aren't published in the requirements. Currently there is in excess of 350 patients on this dentolabial list and some have been on the waiting list for 10 years by 2012.

His general comment is that the already minimal State service has been reduced and the reliance on two private part-time visiting surgeons to provide a State service for weeks on end is not viable and has already downgraded care to a dangerous level. There are some times when it's not manned which is against the COAG agreement so don't break your jaw, have a car accident at that time.

CHAIR - In those circumstances, though, you'd rely on an orthopaedic surgeon, perhaps, to fix the problem.

Dr BUTLER - That's the problem.

CHAIR - That's right.

Dr BUTLER - It's a statewide referral so you might have a car accident on the north-west coast and you'll be helicoptered down to the unit here at the Royal; if no-one is here, where do they go? The people that actually manage them are ENTs or plastics groups; they are forced to do that. Yes, they can do it, there's no illegality there, but the specialisation is around a general surgeon doing neurosurgery and there are problems. We've come across that where plastics have done their best but they haven't had the skills or the knowledge and the pieces have to be picked up.

CHAIR - I know that it's not illegal but then you do run the risk of a patient being unhappy with the result and then suing the department and a payout which costs more.

Dr BUTLER - Yes, that's exactly right.

CHAIR - And because we're self-insured, it has to come out of the State coffers.

Dr BUTLER - And that's happened already. It comes back to us. It's been remedied by a plastics in a dire situation and then it ends up with an adverse outcome and we either have to pay out, there's a legal action, or we then have to push them interstate and have the jaw refractured again, replated or -

CHAIR - And pay for that.

Dr BUTLER - And pay for that.

CHAIR - What sort of costs are we looking at when that sort of circumstance occurs?

Dr BUTLER - Well, it's done under interstate charging and I'm not privy to that level, to those dollars.

CHAIR - Okay.

Dr BUTLER - But there's patient travel assistance and there's an interstate charging component.

CHAIR - And there's potentially the compensation to the patient.

Dr BUTLER - Yes, that's right.

Dr GOODWIN - So that's one aspect, that the patient might not be happy with the result. What else can occur?

CHAIR - Some will be resolved.

Dr GOODWIN - Then you have to patch them up.

Dr CROCOMBE - Yes, and then post-operative infections and problems like that if you have to open them up again and redo it.

Dr BUTLER - Well, anecdotally, I can name one case recently where no access call was made because there was no access to the oral and maxillofacial unit at the Royal. There was a person with a fractured jaw in Launceston who was going to be shipped down but no, it didn't happen; they had to manage it because it was an embarrassment of an airway and so they had to plate it quickly; they put a plate in and nine screws but they forgot to look to see if there were any teeth there so five of those screws went into teeth. The teeth should have been removed before. It is because they are not dentists. They saved the person's life, they pulled the jaw up, but screwed the screws into teeth which were buried in the jaw. That ended up with a major infection, a major swelling which embarrassed the airway anyway and the person ended up in ICU. That is a perfect clinical example that I've been involved with and exactly what Len has just been talking about. These are the sort of things that can happen and have happened because of this issue and because of the restrictions in capacity.

CHAIR - So this sort of thing has happened in the past before these cuts?

Dr BUTLER - Yes. As Len said, in the oral health service at the moment we are seeing 10 per cent. We have 1 000 to 10 000 to 11 000 eligible population. Evidence shows that you have to have at least one dentist to 2 500 to 3 000 to make a difference to their oral health. If you make a difference to their oral health, you make a difference to their general health. You can't fix one up without the other one, and I keep stressing that. We are only the tip of the iceberg and any budget cut is going to impact on that. We're managing quality of life through relief of pain and urgent care and those who are diabetic and those with special needs but we should have two to three times the number of dentists in this State. We're looking at budget cuts that are affecting us either directly or indirectly by other units having budget tasks because if they cut, that's going to affect us. It's a flow-on effect. Cuts in one area are not isolated. They think it's just going to affect their diabetic unit, but it affects us because oral health is not isolated and that's the issue.

CHAIR - There is a perception in the community that if you have private cover you'll be right, whereas some of the other medical professionals who have been before us today have said that that is not the case. In Tasmania in particular the private practitioners also operate in the public system and if we lose them from that system because of their accreditation risk or whatever then they are not even there to do the private surgery. Would that be the same in the dental situation?

Dr CROCOMBE - As opposed to the rest of the medical area, dentistry is largely in the private sector; it is more than 85 per cent. We probably wouldn't lose them to the State but whether you would get them back into the public sector is another issue.

CHAIR - They'd all go to the private sector?

Dr CROCOMBE - Yes.

Dr BUTLER - But then the private sector doesn't cope. Principally we're dealing with those complex areas, those special needs, complex medical.

CHAIR - So they made need ICU afterwards?

Dr BUTLER - Correct.

Dr CROCOMBE - They would see it as a community obligation to be going into the oral and maxillofacial unit because they wouldn't be making the same money as they could in the private sector. The other area is that they have reduced the voucher scheme where people have been referred to the private sector.

CHAIR - They have reduced that?

Dr CROCOMBE - Yes.

CHAIR - Was that one of the cost-saving strategies? When did that happen?

Dr CROCOMBE - That was my understanding.

CHAIR - That was one of the current Government's big promises to improve dental health for all Tasmanians, to provide vouchers to the private sector to treat public patients. Are you saying that's been cut back or stopped?

Dr BUTLER - It would have been statewide Mental Health but we are no longer in that area.

CHAIR - It would have been under statewide Mental Health - statewide and Mental?

Dr BUTLER - Yes.

Dr CROCOMBE - That's a good spot to put it. Someone said, 'Don't let mental go the way of dental', and I thought that sounded about right.

CHAIR - It doesn't have it listed, but it's worth a question to the minister. As I understand it - and you may be able to correct me if I am wrong - the vouchers were only for emergency care in a lot of places; it wasn't for preventive care. That is how is was meant to be used, particularly on the west coast, for example.

Dr CROCOMBE - There has been both a general and an emergency scheme.

Dr BUTLER - We had a pilot general scheme, which worked well. In other words, that was for people in remote areas being able to go to private practitioners to save them travelling in, but we don't have the money to do that now. That would have been evaluated and that was a positive outcome, but we're not continuing with that because of the budget issues.

CHAIR - In spite of the positive outcomes?

Dr BUTLER - Yes, the positive outcomes from the emergency scheme. That has obviously held back the numbers of vouchers. We are trying to keep as many internally rather than sending out to the private sector at this point in time as far as the emergency scheme goes. There is nothing written there, though. There is no detail and I think that's the issue that probably needs to be looked at.

Dr CROCOMBE - In the north of the State there's been a reduction.

Dr BUTLER - There is missing of 0.4 FTE. We have 2.6 FTE dentists in Burnie and with the 0.4 we can't go back to the three because of the budget issue.

Dr CROCOMBE - The oral health of adults in Tasmania is arguably the worst in the country, and the more rural you go the worse it gets. We're cutting it in the north-west, which probably has the worst area in Tasmania for oral health.

CHAIR - I think people tend to overlook the links between dental wellbeing and general health wellbeing.

Dr BUTLER - Yes, and that's critical. If we had no budget savings, I'd still be here. Because you have budget savings in all these other areas it affects us, like the lack of GA access. They come to me and ask, 'What are you going to do about this?' On our GA list at the Royal Hobart, if we have a paediatric list we only have an extraction list. They are extracting between four and 15 to 20 teeth at a time on a two-and-a-half-year old. How do you do that in the chair? It's impossible - more antibiotics, more pain relief et cetera. The child is malnourished and it flows on. There is also the common-risk factor - the child is undernourished, brain development and other issues. Say a pregnant lady needs to have significant work during the pregnancy. We can't do it because we can't access GA. Low-birth-weight children have more risk of early childhood problems; it's a flow-on. Even if we had no budget task -

CHAIR - The cost of a premature baby we can potentially prevent through good dental care.

Dr BUTLER - Exactly. If you have a type 1 diabetic and the blood sugar is going all over the past, their mouth is full of pathology, you need a GA but can't get it so you need

more antibiotics and then blood sugar is all over the place. Then there is a huge cost for the endocrinologist to try to keep that person well.

CHAIR - And keep the baby alive until it's born.

Dr CROCOMBE - You'd need to triple the funding from what was happening before the cuts.

Dr BUTLER - I understand the funding issues, that there is a certain pie and we all have to have a slice of it. I am realistic about that but ultimately reductions in other areas flow on. Oral health is a mirror of the body. She clearly said that in 2000 and nothing's changed. If you don't get the mouth right, you can't get the body right and you can't get the body right without the mouth being right.

Dr CROCOMBE - The one thing that would have the biggest influence for the cheapest effect would be if we were to fluoridate all water supplies down to communities of 800 people. According to the World Health Organisation, fluoridation was one of the major top 10 things that had an effect on world health. I am thinking of areas such as St Helens that has just had a reticulated water supply put in. There are 800 people and the water is not fluoridated.

CHAIR - It's not?

Dr CROCOMBE - That was my understanding.

CHAIR - I'd be surprised if that's the case.

Dr BUTLER - I sit on the fluoridation committee and I am pushing to reduce it down to 500 people. For any community below 500 we instigate an aggressive spit-no-rinse with fluoride toothpaste regime. If there are only 400 or 500 people we do aggressive prevention. A simple oral health message is brushing with fluoride toothpaste twice a day, not rinsing but spitting it out and leaving the fluoride in your mouth in lieu of fluoridated water. There is a push to push that population down for reticulated areas.

Dr GOODWIN - For the kids who come in and lose all their teeth, that won't save them because it is poor nutrition.

Dr BUTLER - It's not just that; it is the family. You usually find a sibling has gone through the same thing, or the parents. You get that vertical transmission. We can't fix an adult so they transmit their strep mutans back with bacteria which causes the rapid decay. They kiss them, test food and put it in the child's mouth, which causes a massive overgrowth of strep mutans. Bottles at bedtime, sugary food to keep them quiet, Coke at bedtime, Coke in their bottles. If you start to treat the oral environment of the greater family unit - the parents, siblings - the new child, even before they have any teeth, is on a much better wicket before they even get a tooth at six months.

Dr CROCOMBE - It's the same socioeconomic factors that affect general health that also affect oral health.

Dr BUTLER - You get common risk factors all the way through, such as smoking. One of the very good things with oral health in Tasmania is that we are capturing our own data. We have an area in our information management system so if someone is a smoker we go through the issue of assisting them in reducing and ceasing tobacco smoking.

CHAIR - Mouth piercings, tongue bolts and that sort of thing are particularly bad.

Dr BUTLER - Yes. The ageing population goes on more and more drugs for their other medical conditions and it dries the mouth up, and saliva is nature's protection of the oral environment. You dry up the saliva and gum disease and decay become rampant and then their medical condition becomes worse. They go hand in hand.

Dr CROCOMBE - I think there's a crisis between aged care and oral health. The simple way I describe is that my parents' generation had lots of tooth decay and had all their teeth out. They are in nursing homes now and they put their plastic dentures in little cups beside the bed. They can't wear them because they have no saliva. When my generation gets there, we have had this heroic dentistry done with crowns, rigorous implants et cetera, so we will hit the nursing homes with teeth. We'll possibly lose our manual dexterity, maybe forget whether we cleaned that morning. When I take students I usually say, 'It's not going to be my problem. I'm the one who's going to be dribbling in my bed. What are you doing to do about it?'. You can see that there's a crisis coming there.

CHAIR - Thank you very much for your time, gentlemen.

THE WITNESSES WITHDREW.