THE LEGISLATIVE COUNCIL SELECT COMMITTEE ON THE PUBLIC HOSPITAL SYSTEM MET IN LAUNCESTON ON WEDNESDAY 18 MARCH 2009.

Dr PAUL PIELAGE, DIRECTOR OF MEDICAL SCIENCE, LAUNCESTON GENERAL HOSPITAL, WAS RECALLED AND RE-EXAMINED.

CHAIR (Mr Dean) - Thank you, Paul, for coming back and answering some further questions from the committee.

Mrs JAMIESON - Dr Pielage, do you have a record of people who cannot or do not wait but return to the hospital as a condition has deteriorated? If yes, how many and what is the effect on them and staff and on increased cost to the hospital? The reason I ask is that, as we know, people get very frustrated waiting around, for whatever reason, and it can be an added cost, particularly if their condition has deteriorated.

Dr PIELAGE - The fine detail is difficult to answer. The percentage of patients who do not wait is less than 5 per cent, which Australia-wide is a reasonably good number. It is certainly a record low for us. Historically the last two years have been the lowest did-not-waits for many years. Last year I think there were 1 806 people who did not wait, and 286 returned within three days - that is a fairly generous return time. Of those, about 9.4 per cent were admitted either to the LGH or some other hospital, which is under half of the normal admission rate. A significant proportion of those who do not wait have either psychiatric or drug and alcohol problems and these people often wait a very short time before leaving. In fact, a very large proportion of our do-not-waits leave within an hour. Some people wait patiently for very long times. The proportion of people who did not wait who returned within three days with a psychiatric or drug and alcohol problem was more than five times the ratio in the overall population of patients.

We also looked at the number of patients who returned and had their triage scale up-rated when they come back, which was less than one-quarter of the returning did-not-waits, and the admission rate was the same. So there was no real difference. The numbers over a year are not that high. It works out at well under one a day.

Mrs JAMIESON - So not a significant impact?

Dr PIELAGE - No, it's not a major issue. It is something we try to avoid but a lot of the did-not-waits really don't wait very long.

Mrs JAMIESON - Do you feel that the emergency department is the appropriate department for the admitting and assessing of non-accident, psychiatric and paediatrics, for example? This flows on from the question you have just answered about those who don't wait.

Dr PIELAGE - The short answer is yes. Accidents and injuries only make up a relatively small proportion of emergency department attendances. By far and away the biggest group is medical illnesses. Our role is assessing acute or severe problems, usually things which have deteriorated - or new problems. Our job is not to look after people with chronic illness that hasn't changed, but if people suddenly deteriorate or have a heart attack, a stroke or something, then the emergency department is definitely the

appropriate place. Acute psychiatric problems fall into that group, although we do have problems in that the psychiatry services in the north of the State are deficient in quantity. A few years ago we had a substantial increase in the number of psychiatric patients attending, but that has plateaued down so it's not getting any worse. Paediatrics are the same as adults, really. If they are acutely ill, we'll see them, it's our job.

Mrs JAMIESON - It's been brought to our attention of course whether people who have chronic psychiatric conditions are appropriately placed in being admitted.

Dr PIELAGE - Chronic psychiatric conditions in a stable state, no, but like people with chronic heart disease, they can deteriorate. They can get acute or chronic episodes, they can get ill from other reasons. People with psychiatric disease are more prone to other ill health than the average person, so for the acute problem we are there. But we are not really set up to deal with chronic stable situations; it's for acute deterioration or the acute event.

Ms FORREST - Do you get many chronic psychiatric patients presenting without an acute episode, or without another co-existing medical problem?

Dr PIELAGE - We do have a group of what one would call regulars.

Ms FORREST - They aren't experiencing crisis at the time?

Dr PIELAGE - They are obviously having some sort of problem which takes them to the emergency department, but from an objective point of view the average person may not consider it a big crisis. Obviously they think it's a crisis, but some of them don't have a stable network of health care out in the community. Some people just want attention now, and the fact they have an appointment tomorrow or the next day is not sufficiently soon.

Ms FORREST - That's a nature of their illness to some degree, though.

Dr PIELAGE - To some degree it's the nature of the person and the illness, so there's always going to be that. Some of these people come and they go, they wait 15 minutes and then vanish. There's no way of really dealing with that; it's just something we have to wear. When you look at the overall numbers, it's frustrating but it's not a huge component of the workload. Someone who comes and goes in 15 minutes is not actually creating a lot of work for us.

Mrs JAMIESON - Is there a problem with staff attitudes towards people who are continually returning - regulars - particularly if it's seen as non-urgent?

Dr PIELAGE - I think the main problems we have are with the people who cause trouble, who are abusive, who cause damage, who threaten. They occupy a disproportionate amount of staff for one person and cause a lot of emotional angst. This is part of the job; we would like to reduce that but it's not possible to reduce it to zero.

Ms FORREST - People with mental health disorders, drug and alcohol problems or ones that cause trouble, can you identify if they're just drunks who come in and cause trouble, or if they're under the influence of some of the hallucinogenic drugs or whatever? You would

expect they could be a bit of trouble but is there a particular group that you are talking about?

Dr PIELAGE - We know of people who are trouble, yes. There are some people in the community who are trouble.

Ms FORREST - Is it just their personality as opposed to some illness or drug and alcohol problem?

Dr PIELAGE - It can be any or all of the above.

Mrs JAMIESON - Do you have the resources, then, to screen them before they've hit the door?

Dr PIELAGE - The ones we know, we know about. Whether we have the resources to deal with them is another issue. The hospital has insufficient security staff; it is approaching zero but not quite. There is certainly a problem if someone arcs up in the department because we don't have sufficient security. The police resources in the middle of the night are, one might say, limited and they might be some distance away.

Dr PIELAGE -The police tend to bring us patients we do not really want.

Ms FORREST - They do not want them either.

Dr PIELAGE - No, but all they have to do is mention the 's' word and they come to us rather than the lock-up. The trouble is we do not really have the infrastructure, the staffing, security or anything to deal with such patients, particularly in any sort of numbers.

Ms FORREST - The attendants are not provided any in-service training or a package of training that could equip them to deal with these patients, or are they?

Dr PIELAGE - The attendants are attendants not security officers, bouncers or that sort of thing.

Ms FORREST - I appreciate that, but what about within your resources?

Dr PIELAGE - There are not many of them, particularly at night. They cannot be really detailed to guard patients. Often there are not enough of them to restrain patients. Hospital security is minimal. We have one person in the department who is there to provide a bit of security cover.

CHAIR - Is the security not provided by hospital staff employed in the hospital; is it a private security company?

Dr PIELAGE - Some is private security. The person in our department is a member of staff, but has other duties as well.

Ms FORREST - What other duties does that person have?

Dr PIELAGE - They have various general duties within the department, but a key aspect is to provide a security back-up.

Ms FORREST - When you say 'security back-up' what are they backing up? You say there is nothing else.

Dr PIELAGE - They provide an element of security for the nursing and medical staff.

CHAIR - What sort of training, to your knowledge, do those staff performing a security role have, apart from their other roles?

Dr PIELAGE - They usually have a security background when we employ them. The hospital security is usually supplied by an outside agency. I have no knowledge of who, how or why.

Ms FORREST - This is obviously an occupational health and safety issue for the staff as well as the other patients. What measure should or could be taken? Should you either employ more security staff as security staff and that is their entire role, or should you train up some of your attendants to take over that role as well, particularly during the night when there are obviously not a lot of other duties that they may need to do? How do you see this being addressed?

Dr PIELAGE - I think it is beyond my role to address it. From a hospital point of view, they would need to employ people. Not all of the attendants are suitable for a security role.

Ms FORREST - I am not suggesting they are.

Dr PIELAGE - Also, not all of them are interested in that sort of role. There are training schemes available and a lot of the attendants, I think, have done various training courses in handling people.

Ms FORREST - My question is, is that a way that it could be progressed to address this problem?

Dr PIELAGE - It could be. It would need money and staff. You would need to increase the staffing. There is no question; if you want to up the security you will need to recruit additional staff and the right sort of people. Doctors, nurses and clerks have full-time jobs. There are not that many attendants, especially at night. They have other duties.

Ms FORREST - Would it be preferable to employ just security people in their own right? You probably do not work nights a lot, do you?

Dr PIELAGE - I come in often enough.

Ms FORREST - When you are there at night, what do you think would be the best way to manage the situation? Should security staff be employed specifically for that role or 10 staff - suitable people - trained up so that when situations arise they could be called more quickly perhaps or provide a greater range of services.

Dr PIELAGE - To some extent you are comparing professional security people with part-timers. You also have the issue of having lots of security people who do not do anything else, which is a waste of resources.

Ms FORREST - That is what I am asking. What do you think is the best way forward?

Dr PIELAGE - I think probably a combination is the best way. Certainly having in-house people with a combination of other duties would be more useful for the institution, but the other duties might impact on their availability.

Mrs JAMIESON - Are the numbers of the chronic returnees who nobody wants increasing and what of their future?

Dr PIELAGE - I suspect not. I do not think they are increasing at a rapid rate. If you just look at people who are affected by drugs or alcohol or psychiatric illnesses their numbers have been fairly constant over the last three years or so; there has not been a big rise. It tends to be personality-driven, so you have particular people who are troubled and spend some time in Risdon or somewhere and we have a bit of a breather. The police certainly do bring patients in who do not really have a medical problem as such, but are intoxicated with something or troubled and they do not want them.

Mrs JAMIESON - One of those difficult ones.

Mrs SMITH - Do most of the security issues with your clients occur in the evening?

Dr PIELAGE - Most of the security problems are in the late evening and night. Probably there is a two-fold reason: there are fewer people in the department for starters so there are fewer resources. Also, that tends to be the time when people get stoked up on substances.

Mrs JAMIESON - Would you see your numbers reducing if these new super clinics have an effect in the community?

Dr PIELAGE - No. I do not think they will make any difference.

Mrs JAMIESON - Thank you.

Dr PIELAGE - Any difference will be extremely small and will be swallowed up by the general ageing of the population and the increased workload that is happening anyway. I do not see that these clinics will change things.

Doing preventive health on people merely delays things a bit. We all get crumbly and die and most of our medical care and expense come within the last couple of years of life. We all get there in the end so if you push it back a few years it will still happen it just takes a little longer.

Mrs JAMIESON - Following your comments, I would like to look at the use of advance directives which are now available with end of life decision-making. Have you had any experience with them within the system, particularly in your department?

Dr PIELAGE - Yes.

Mrs JAMIESON - Are they effective, do the staff understand them, are there any problems?

Dr PIELAGE - A properly written, witnessed et cetera advance directive is very useful, depending on how well it is put together. We really only see them in any numbers for people from nursing homes.

Mrs JAMIESON - Do you see a role for having that expanded into the community and more generally accepted?

Dr PIELAGE - I would think so. You have to be pretty careful with them because you have to be able to distinguish things which are quickly fixable from things which have a very bad or poor outcome. I think for people with severe chronic disease close to end of life or whatever, an advance directive is probably useful. It has certainly been useful for people in nursing homes because one can spend a lot of resources and time on what essentially is a relatively fruitless exercise and it could all be nipped in the bud if we knew -

Mrs JAMIESON - Had a clear direction?

Dr PIELAGE - Yes, at the beginning. If there is no information then one has to treat until one gets the information. So we sometimes end up with a situation where people with a terminal illness will be treated inappropriately because we have no information as to the fact that they have a terminal illness until we have already started the treatment, and we would like to avoid that sort of thing. I think people should die once and not be made to do it several times.

CHAIR - Doctor, as I understand, when those people who are presenting now in that at-risk group of requiring some security or some other intervention they go into the Emergency department area where there are a number of other people present or people waiting. Should there be some system whereby those people, and they are pretty quickly identified, aren't they, should move into another area that is more controlled and you take them away from those other people who are waiting? That seems to be a problem from the information I have been given. Is there a way around that?

Dr PIELAGE - The police lock-up sounds good.

Laughter.

CHAIR - Rather than the lock-up.

Ms FORREST - They bring them to you.

Dr PIELAGE - I know.

The issue is where? Remember that somehow it has to be staffed. Some of these people are sufficiently intoxicated or drugged to potentially be a medical risk to themselves so you can't just put them into a room, lock them up and walk away. They need to be properly observed and you need staff and you need a place where you can do that.

The Emergency department is one of the few places in the hospital, particularly after hours, where there is a high level of medical and nursing staff constantly present. The intensive care unit is another one but the wards tend to run on low levels of nursing staff in the middle of the night and do not have fixed medical staff - in other words, there are medical staff available but not there. So there is really nowhere else that you can send them.

The problem is if you divide up your Emergency department into too many specific locations then the staffing requirements go up disproportionately. You cannot leave one person on their own in an isolated area looking after people because it is not safe.

Ms FORREST - There is a similar situation to what you were talking about, Ivan. When you have had communication from a service provider out there in the community or a GP during office hours generally to say that a person has a mental health disorder or they are having a crisis, they have not taken their medication or they have taken something else or whatever, is there a way of streamlining that person who is coming through? You already have advice that this person has been assessed to a degree?

Dr PIELAGE - There is to a limited extent. One of the problems we are having particularly with psychiatry at the moment - and it may be fixed now, I do not know - is that we have had basically a revolving door of directors of psychiatry. There have been so many over the last five years I cannot even remember all their names. The referral rules and everything seem to be in constant flux.

There is an agreement, and I cannot answer as to how effective it is, between the general practitioners and Emergency department psychiatry. If they have done a full assessment then we can fast-track them into a psych review. I am not sure; I have no numbers on that.

Most of the time they get assessed depending on the urgency of the problem. Acute psychiatric crises are recognised as a relatively acute problem and are triaged accordingly. People who have taken overdoses or who have engaged in other forms of self-harm likewise are triaged accordingly as to what they have taken or what their physiological status is. They tend not to wait around a very long time. In fact when I did a review of admissions into the hospital from the time of arrival to the time of actually leaving the department for an inpatient bed the two areas of medicine which had the fastest admissions were psychiatry and paediatric.

Mrs JAMIESON - If there were funding available - and looking to the future, of course - would it be appropriate for patients receiving their entire treatments in the Emergency department to be transferred to an adjoining transition - call it whatever you like - separately staffed day ward?

Dr PIELAGE - In parts of the country in various hospitals one may have what is called a short-stay ward attached to an emergency department. These usually have a time limit of 24 hours. These are the people who need a few hours of observation or treatment and are then almost certainly discharged. A certain proportion of them may fail to thrive and end up being a full admission but really the short-stay unit approach is to treat people and get them out within a 24-hour period. We have quite a lot of patients who would fit the

criteria for a short-stay ward. Quite frankly, this hospital is not suitable to have a short-stay ward because in hospitals that have a huge bed-access block, short-stay wards just become de facto inpatient wards full of patients waiting for beds. That has been shown around the country in many other departments; there is no point having a short-stay ward if you have a huge access block problem because it just becomes a holding bay and does not function as a short-stay ward. From the LGH's point of view there is another development in the pipeline - I think they are still waiting for funding - to develop an acute medicine unit. This is something which is a bit different from a short-stay ward in that you are looking at medical inpatients who either are not going to be inpatients very long or who need quite a lot of relatively intensive management initially. This is a ward which has a length of stay of up to 72 hours. It is a different concept, a different principle. However, it would be suitable because some of the patients that stick around in the Emergency department as a short stay would be suitable to go to an acute medicine unit. It would only be a small proportion of what we would otherwise send to a short stay or observation ward.

Ms FORREST - How many beds are you looking at for that?

Dr PIELAGE - I think they are looking at about 30 or 32. It is a different way of managing medical inpatients. It is not an emergency department process, it is an inpatient medical process, but instead of scattering fresh medical admissions throughout several wards the acute admissions, with some specific exceptions, go to the acute medicine unit and have their early management - I think 'front loaded' is the expression. So a lot of stuff happens fairly quickly and it is very well staffed. Then, if they do not go home, they are dispersed to the relevant wards in the hospital, whether it is slow stream, whether it is rehab or whatever.

Mrs JAMIESON - Has this been trialled anywhere before?

Dr PIELAGE - Yes. This is not breaking new ground.

Mrs JAMIESON - Where are some examples?

Dr PIELAGE - I do not know where the examples are. As I said, this is an inpatient medical thing. This is not an emergency department.

Mrs JAMIESON - Yes, I appreciate that.

Dr PIELAGE - So I cannot give you examples because, although I have been told them, I cannot remember them. I just know they exist.

Mrs JAMIESON - We will find them.

Dr PIELAGE - The person to really ask about this is Dr Alasdair MacDonald, who is the Director of Medicine, who is well versed in this subject and is driving this particular issue. I know he has seen other departments and other places where it works. It seems to be a good concept but it is separate. It has close connections with the Emergency department, but it is separate from the Emergency department. So I'm involved to some extent with the process, but it is not my area.

CHAIR - We have evidence that one of the problems currently is that people don't have access to GPs, therefore they're going to the Emergency department of the Launceston General Hospital or Royal Hobart Hospital or what have you. It has been suggested that perhaps the hospital should consider setting up GP clinics in the public hospital so that those people presenting in that category go straight into that clinic to see a GP, and they're processed from there.

Mrs JAMIESON - We had that at the Mersey some years ago.

Dr PIELAGE - I think there are major issues with that. First of all, if there's a deficiency of GPs in town, where is one going to find GPs to staff the clinic? Secondly, if it runs as a fully government-subsidised free clinic, you are going to attract an awful lot of patients, so you're going to get an increase in workload. What happens when the GPs go home at 10 o'clock and there are still patients in the waiting room? They will just drift into the Emergency department. I see it creating more problems than it would potentially solve.

When you put general practices in or next to EDs, you increase your workload because you attract patients. We want to attract and treat the sorts of patients that need us; we don't want to attract more.

Ms FORREST - Do you have a ballpark figure of how many people present to the DEM that really would have been better in a GP surgery? How many people are we talking about currently?

Dr PIELAGE - It's an extremely hard question to answer, and I'll tell you why. Let's say you have an accident at home and you cut your hand. You could go and see your GP and a lot of GPs would be able to sew up your hand and send you home. However, you can't get in, it's bleeding, they're busy, they can't see you. So although it could be done by a GP, it falls into that grey zone that also belongs to us. A lot of these very acute things are in that grey zone. It can be handled by a GP and it can be handled by an emergency department, but the GP service is not able to deal with it. So there are these injuries or illnesses which could be treated by a GP, but end up with us.

Then you have people who are coming with a more chronic problem that doesn't need to be seen now or very soon - definitely is a GP-type problem. We don't get many of them. A goodly proportion of them are visitors who don't have a general practitioner and it's very difficult to get access to a general practitioner at very short notice.

I can't give you a number. It is not a huge proportion of the patients and it is a very minor proportion of the workload because these sorts of things are quick. They sit on chairs, they don't occupy trolleys, they don't take a lot of time, and in terms of the actual workload, they are not much. If they were all to be extracted and disappear, our workload would change very little.

What is our major problem in the Emergency department now or yesterday or on Monday? It is bed-access block. On Monday morning at 8 a.m. we had 22 patients awaiting admission to hospital.

Ms FORREST - I am aware that the department has brokered an arrangement with The Manor, formerly Philip Oakden House, as a transitional care arrangement, and that is

constantly full. As soon as one patient is discharged another one is in. There is that ongoing work with a person employed at the LGH to facilitate that as well. I am aware that on Tuesday last week there were 35 empty beds in aged-care facilities on the north-west coast. What if there was a brokering arrangement with those providers such that transitional care could be provided to people through those, because they are getting elderly patients in now who have been there for less than a day sometimes before they die? This is the people who are going to placements so they are quite used to quick turnovers at times. Is this one way? You could actually clear your 32-bed ward of patients waiting for beds. Is that something that should be considered?

Dr PIELAGE - This is me talking from a hospital perspective, not from an emergency department perspective. The patients awaiting residential care, and the manoeuvres to place them, are other areas of the hospital. As soon as we start moving patients out of the immediate precinct of where they live, the complaints become very loud and very persistent. If we move someone who resides in Launceston for temporary care, say, in Deloraine, let alone Campbell Town or St Marys, people complain very loudly because they can't visit them and can't do this or that. If we were to send them to Ulverstone, Penguin or wherever there are places, there would be a huge hue and cry. If the Health department is prepared to wear that then I suppose it could be done.

Ms FORREST - Some of those people may have relatives in those parts of the State. Some of those people might rarely get visitors anyway; they might not have any family in the State. Some of those people have been transferred to these smaller hospitals such as Beaconsfield in the past and Campbell Town and it has been reported back to me that they have had a great time.

Dr PIELAGE - I know it happens but believe me when the move is made there is a lot of noise and complaint in many cases.

Ms FORREST - Is that a reason not to progress something that could help with greater access to service?

Mrs JAMIESON - I think part of the problem is also tied up with funding through aged-care assessment teams. There are a lot of issues.

Dr PIELAGE - There are all sorts of issues here. There certainly will be a very political issue about it, with crossing between regions and funding and everything else. From a very pragmatic, non-emotional point of view, if there is a bed we should be using it. There are all sorts of other issues which come into play. From a very selfish emergency department point of view, I definitely think that if there is a bed available and it is appropriate in terms of its facilities and care and everything, then it should be used. People with acute illnesses are being denied a bed and appropriate care because beds are being occupied by people who are now fine to be looked after in some other facility.

Ms FORREST - In fact you could argue that patients who are awaiting placements are not in the best place in an acute hospital ward; they would be much better in an aged-care facility. Isn't there another argument here to look at this seriously?

Dr PIELAGE - I am agreeing with you entirely; they are not in the best place. A person who needs residential care is not best managed in an acute four-bed ward. I don't think you will find any arguments on that.

Ms FORREST - People from the north-west coast have to travel to Launceston and Hobart for treatment and they stay for extended periods away from home. They do it because they know that's the deal; if you want that service that is where you go. I know there would be a hue and cry and that people would complain, but when the alternative is to deny people in the Department of Emergency Medicine access to the most appropriate treatment in the location they are best treated, and at the other end the people receiving care in a setting that is not ideal for them -

Dr PIELAGE - I am not arguing with you at all. It is all about the mechanism for achieving it.

CHAIR - How did you resolve the situation on Monday morning with the 22 beds that were needed but were not available? How was that resolved?

Dr PIELAGE - Very slowly because some of the patients were still there on Tuesday.

CHAIR - On trolleys?

Dr PIELAGE - Yes. I am not sure on the details of how they solved it. Some people were sent home, some I think went to other institutions. They winkled away at it all day but even in the evening we had a large number of patients still awaiting admission and the following day there were still patients left over. Today is fine, there are only seven or eight awaiting admission, I think.

One of the problems is that the hospital still largely functions during office hours. There are limited facilities on weekends; no allied health, the pharmacy works Saturday morning only. The medical staff acts as basically a care and maintenance, firefighting service on weekends apart from the emergency department and ICU so patients are not discharged on weekends. By the time Monday comes around, it is usually pretty messy. Tuesday is usually not much better because on Monday people who have been sitting on a problem all weekend go and see their GPs. The GP could take one look and send them to hospital. Mondays are one of our busiest days; in fact on average we take more admissions through the ED on Monday than any other day of the week. A Tuesday after a public holiday is generally worse for the same reason.

Ms FORREST - Do you think there is a way of effecting discharges on weekends that is relatively easily achieved?

Dr PIELAGE - I do not think it would be relatively easily achieved, but it could be achieved a bit better.

Ms FORREST - How would you suggest that you could progress that aspect because obviously that is a problem for you on Monday mornings?

Dr PIELAGE - I think we need more services in the hospital on weekends. We also probably need more medical staffing and a different philosophy on the weekends to get people out.

One of the other problems we still have is the tendency for patients not to leave in the morning. Sometimes that is for a reason, such as they need more investigation or treatment and they leave in the evening. In my understanding and I have been told this many times, some patients do not leave because there is no-one to pick them up and take them home, so they lie in a bed which is needed by somebody else purely because their lift is not available or there is no-one at home to look after them.

Mrs JAMIESON - If there any delay in getting their medication and any other discharge paraphernalia, shall we say?

Dr PIELAGE - Yes, I think getting the medication and the other services, although it is better than it was I do not think it is as refined as it could be, and certainly on the weekends it grinds to a significant halt.

Ms FORREST - Does the pharmacy open at all on weekends?

Dr PIELAGE - Saturday mornings, that is all. I think they are looking extending their hours but, I do not work in the pharmacy, which is chronically a bit understaffed. They probably need more staffing anyway to do what they are doing. To do weekends they would definitely need more staff which is a money issue and there is not a lot of it around at the moment.

CHAIR - It is a little bit like policing; most of the resources are needed on the weekends and of a night rather than during the day office hours.

Mr WING - With so many GP practices having closed lists I would have thought that a lot of the people who come to the emergency department are really treating it as an outpatients department. How many, or as a percentage, do you think fall in that category?

Dr PIELAGE - We tend to see people with acute problems. We don't get a lot of people with chronic problems, given a lot of them are visitors running out of medications because they left them in Melbourne. We do see some people who don't have GPs or who can't get in. They're often new in town. There are GPs who don't have closed books, and we tend to refer them to those GPs. We might treat them when they're here, and then arrange for their follow-up to be elsewhere. We certainly don't arrange follow-up for chronic conditions.

Mr WING - Are you able to say approximately how many GP practices have closed books and how many don't?

Dr PIELAGE - No. You'd have to talk to the Division of General Practice for that. We get told of practices that are taking new patients, so the nurses at the triage desk usually know of some and we tend to refer to them.

Mr WING - It seems that is not causing your department a particular problem.

Dr PIELAGE - It does cause something of a problem, but it's well down the list of problems. Again, these patients are not a huge part of the workload.

Mrs JAMIESON - You mentioned in your previous evidence the possibility of a communications officer. What do you envisage as the necessary qualifications for that role and their active duties, apart from communicating?

Dr PIELAGE - We haven't really drawn up a full position description. Lots of departments around the country now have someone in that role who basically takes all the incoming phone calls and diverts them to the appropriate people instead of them all coming to someone who has another job, like the triage nurse or the clerk. That person also does a lot of the outgoing calls chasing up people, instead of the doctor paging somebody and having to sit near the phone waiting for them to answer. Someone else can do that and then call the doctor concerned. It improves the efficiency. In some departments the role also includes doing some of the paper work around admissions, and things like that.

Mrs JAMIESON - At the moment you don't have that position at Launceston General Hospital.

Dr PIELAGE - No, not at all. It's merely on our wish list.

Mrs JAMIESON - Right. We're looking at wish lists.

Ms FORREST - In your submission, Dr Pielage, you made a number of comments related to the changes being made to the information systems, and the potential problems with that. You have given quite a good overview of it, and I would be interested to ask the department about the actual plan. When you say that writing from EDIS to the Homer systems has caused immense problems in the past, can you explain why the problems are occurring to such a degree and what challenges that is posing?

Dr PIELAGE - I am not a technical person, but the normal process when a patient comes in, is their demographic details are put in the mainframe system, which is currently called Homer. That information is dragged through an electronic link into EDIS, which is Emergency Department Information System. EDIS does have the capability of writing to Homer. If we do that, because we often don't have full information at the beginning of a patient's admission because they're not talking to us or they're confused, or whatever, if we enter data into EDIS and put it into Homer, we can corrupt Homer. It's much safer to put it in Homer and drag it in one direction rather than having it reading and writing.

We know this from experience because when we first started EDIS we were doing reading and writing to Homer and we had problems. It became obvious that it was much better to put it in one and drag it to the other on a one-way basis. The other thing that is a benefit is that we can then compare the two databases and pick up errors. If we write from EDIS to Homer we effectively turn it into one database and we cannot do any audit checking, whereas if we keep it separate we can do a lot of auditing and correction. It has been extremely valuable to us over the years. Sorry, it was a bit dry. You probably wish you had not asked that question.

Laughter.

Ms FORREST - No, I do not because this is an issue that can create a whole heap of extra work for people who should not be doing it. That is why I wanted to pursue it for a moment.

Dr PIELAGE - Absolutely. There are many other issues with the new information system. For some reason - I think I know the reason - with the new information system, which is the Homer replacement, they want to go to a nine-digit UR number as a patient record number rather than the current six-digit patient record number. With nine digits you can basically have about a billion people which I think will subside. It would be good for Tasmania for quite a long time. The problem is there are two issues. First of all a lot of the computer systems currently existing in the hospital can cope with up to an eight-digit UR number but not a nine-digit UR number and it is very expensive. For radiology, for example, to have to completely upgrade their system we have to get extensive modifications to EDIS which is, I think, in excess of $50 000. The other thing is that the nine-digit UR number bears no relationship to the current six-digit UR number so every patient record will have to be completely changed from their UR number, which has the potential for great confusion.

Ms FORREST - And errors.

Dr PIELAGE - And huge errors. If you have a six-digit number and you put a two-digit prefix in front of it, or even a one-digit prefix, your file has a six-digit number down the side which is used for identifying it and you could put the prefix in front of the existing number. If you change the number completely, you cannot use that file. You basically have to refile all the records. I have been told that to refile all the patient records in the LGH, taking into account time and materials, would be well in excess of $1 million.

Ms FORREST - Have you been told what the benefit is supposed to be? I was going to go on to the nine-digit UR number. From what I read in your submission I cannot see why you would want to do that and what benefits there are. It is something I will ask the department as well.

Dr PIELAGE - I can explain some of it. Underlying all patients in the State there is an individual electronic identifier which is nine digits, which was not related to hospital UR numbers. When Hobart went to their so-called digital medical records, which is just an archiving system, they decided to use that unique patient identifier as the UR number. Now they want to create a statewide UR number so all patients have one number instead of maybe different numbers at different hospitals and they have decided to use the unique patient identifier as that number because it is convenient to do so. It lack rationality but it is just convenient.

Ms FORREST - Do you agree that the unit record number is an important step forward for the State?

Dr PIELAGE - The statewide UR number is a good idea. We could do with a seven-digit UR number which would cope with 10 million people, and in actual fact it is known that if you read a number or you are told a number and you want to remember it to transcribe onto something else, most people can cope with seven digits. When you get to eight a lot of people have difficulty. When you get to nine it is very difficult.

Mr WING - We hope this never happens but if a major disaster occurred in this area with a large number of serious injuries, how would that be coped with, apart from with difficulty? How well-equipped are our emergency services generally to cope with that?

Dr PIELAGE - I can't talk for the outside emergency services; the hospital, I think, would seriously struggle these days. There are never any empty beds in the hospital. In fact the hospital doesn't even have spare beds, as in things with wheels and mattresses, so there is not really an option of saying, 'We've got 30 beds in the store, let's wheel them out'. They don't exist. The Emergency department is chronically full with patients awaiting beds and there is nowhere to send them to. It is going to be a very interesting time, and I hope I am on holiday because the whole disaster management plan - or emergency management plan - for this sort of thing is predicated on being able to create beds and at the moment doing that at speed I think would be very difficult. We don't even have enough mattresses to lie on the floor. The system is absolutely at capacity all the time.

Mr WING - It seems that there is no plan for the total emergency services that would enable that to be coped with?

Dr PIELAGE - I would say that a decent mass casualty situation or some sort of horrible epidemic would stress the system unbelievably.

Mr WING - And as far as you aware, there is no plan about how to deal with such an occurrence?

Dr PIELAGE - There is a plan but the point is whether it can be implemented and that is another matter.

Mr WING - What is the overall nature of that plan?

Dr PIELAGE - There is a plan on utilising beds, moving patients out to district hospitals, private hospitals and all this sort of thing, which is probably going to be very difficult because these places don't have a lot of beds. Sending patients home is very difficult; most of the patients are not fit to go home. As for doubling up spaces or putting extra beds in four-bed rooms or whatever, the beds don't exist.

Mr WING - Nor the mattresses.

Mrs SMITH - So if you had a bus this afternoon at two o'clock with 42 patients who came in with differing types of injuries, you would have to deal with them in emergency in some form?

Dr PIELAGE - Yes. The initial phase would probably be okay to a point. We have an overflow plan where we keep all the patients out of the day procedures unit and open that up as a secondary emergency department. Up to a point we will cope, but if lots of them need inpatient care or operations and subsequent care in the hospital, that is going to see the system under enormous stress.

Ms FORREST - They'd have to go to Burnie, Launceston, Devonport or Latrobe, wouldn't they?

Dr PIELAGE - We would probably have to ship them out, but the issue is the health system around the country is fairly stretched. There is not exactly lots of beds available anywhere. The second thing is that the ability to move people is very limited because the ambulance fleet is only so big and it takes so many hours for a round trip. The ability to holus-bolus move patients elsewhere is very limited; you can't do it. You have an aircraft that can take two, an ambulance at a pinch may be able to take two and you have a round trip that is several hours by the time you unload, reload et cetera. As I said, I hope I am holiday but I probably won't be.

Mr WING - If you are, it will probably be shortened.

Laughter.

Dr PIELAGE - No, I go overseas without my mobile phone, believe me.

Mrs JAMIESON - You mentioned earlier in your evidence about the reduction in accreditation times and the potential loss of accreditation. Would you care to expand on that, please?

Dr PIELAGE - This is accreditation for training in emergency medicine, people training to be specialists in emergency medicine. This hospital had accreditation for 12 months of advanced training in emergency medicine which is about as much as a hospital in this location and of this size could get.

To do that we need to have five specialists in emergency medicine who are Fellows of the Australasian College of Emergency Medicine and we had that number early last year, but with resignations and whatever that has diminished to a point where our accreditation was dropped to six months. If we drop below 2.5 Australian specialists we will loose accreditation for training altogether. At the moment we are staying above 2.5 FTE by employing short-term locums.

Mrs JAMIESON - Do you see the future for that as unsustainable as far as accreditation goes?

Dr PIELAGE - We will probably maintain accreditation. Someone will be joining us in August and will be with us for at least a year. The problem with short-term locums is they do not do the other stuff; they see the clinical stuff but all the other things that need to be done such as the planning, administration, teaching, all the committee work, everything else falls upon the permanent staff of which we now have about 45 per cent of our full complement.

Mr HARRISS - Dr Pielage, about today's and previous presentations by you, I will make an observation and seek an answer to a question from you. The observation is that there is a lack of a strategic approach to delivery of health services in the State. When I say that I am including the bureaucracy in Hobart, if you like, and possibly also successive governments. You have indicated that a similar situation occurs around the rest of the nation in terms of shortage of supply. Do you have any view regarding what I would term as constant and ongoing offers by the medical profession to be engaged by the bureaucracy to work collaboratively to develop better clinical services outcomes? Do you believe that successive governments and the bureaucracy have ever taken the profession up on those constant offers to deliver better outcomes?

Dr PIELAGE - I have been here for a while now; I am into my eighteenth year. I think governments, particularly in the 1990s, implemented incredible cost cutting so all sorts of things were trimmed and pruned and every time there was a bit of an efficiency and we had a few spare beds they closed them. Facilities kept on shrinking but there was no expansion. Wards were closed, the beds dropped. They closed a numbers of wards in the LGH. When beds keep on closing and it is very hard to re-open them. They closed beds and removed the infrastructure.

There was no looking at the future. Everyone has known for years that the aged population is going to increase disproportionately. Everyone knows that there is going to be increased demand but the planning has been crisis planning. In the north-west from a medical point of view and for someone coming from the outside, there seems to be an inefficient way of doing things is that you have, in the region with the smallest population, the only region with two public hospitals and therefore a division of resources of medical staff. It is very hard for a physician or a surgeon to cover two hospitals. They are closer together now in time than they used to be but they are still a reasonable distance apart. It is hard to cover them with specialist services so recruiting and retention is difficult when you have a hospital that does not have a lot of specialists.

It is all right for a while to be on-call one in two, but if you want to see your children grow up and have a happy family then sooner or later you have to stop. You make a lot of money being on one in two but you cannot stay on it. Hospitals tend to reach a certain size and then become fairly stable in the staffing. When you do not have a lot of staff you tend to work very hard, with lots of on-call, do it for a while and move on. It is not a very sustainable situation.

This issue was flagged for a generation before I came to this State and it is still grumbling on. The LGH in most specialities, not all of them, but in a lot of them, has now reached a critical mass; in other words we have enough specialists to cover for leave, to have a reasonable on-call system and that sort of thing. Even so in some areas we do not have not have enough staff. I think future planning does not happen.

As far as the bureaucracy goes my gut feeling is that it is too big. For instance, I have been receiving statistics regarding our workload derived from at least three different people data mining the information system in Hobart. You get three different answers, most of which are wrong. Why does it need to be done by three different parts of the system? Why can't it be done by one part and dispersed?

There is one part that gets good results now, mainly because the bloke who runs it came up and talked to us. We exchanged information and we have a good working relationship. There are still other areas of bureaucracy that are data mining and making weird conclusions because they have no idea what we do, no idea how we work and they extract stuff and make statements. Some of the stuff that comes out is extraordinarily frustrating.

CHAIR - I would like to thank you so much for giving your valuable time to be here and to express very openly your concerns in regard to the hospital system.

THE WITNESS WITHDREW.

Dr CHRISTOPHER MIDDLETON, STATE PRESIDENT, AUSTRALIAN MEDICAL ASSOCIATION; AND **Dr MICHAEL AIZEN**, AMA, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Mr Dean) - Welcome, gentlemen.

Dr MIDDLETON - Thank you for the opportunity of presenting this evidence. The AMA is the peak lobby group for medical practitioners in Australia and represents about 27 000 medical practitioners around the country. The evidence you have received has been compiled by a committee representative of our Tasmanian membership, and those members are detailed, I think, on page 29. The committee was chaired by Dr Michael Aizen, a previous president of AMA Tasmania. I will be deferring to Michael in matters of detail during the presentation.

Our members in Tasmania have been concerned for many years about the inability of the Tasmanian public hospital system to provide timely and high-quality service to the public. We know from independent analysis that many of Australia's public hospitals are running at dangerously high capacity and patients are waiting longer for care. All public hospitals appear to be underperforming, but Tasmania seems to be often at the bottom of the ladder. Indeed, in the AMA national hospital report card in 2008 unfortunately Tasmania got the wooden spoon again. You would have seen that report, I'm sure. The Australian Institute of Health and Welfare Report, State of Our Public Hospitals, which was released in June 2007 indicated that whilst Tasmania spent the fourth most per capita on public hospital patients in the Commonwealth it performed last and second-last on the major criteria of waiting lists for surgery and the percentage of patients treated by surgical category. We make reference to that in the report.

In the AMA's view, there are major improvements that could be made to improve the provision of public hospital services to the Tasmanian public. These are listed in the recommendations on page 2 of our submission, which you should have in front of you.

At the Federal level, the AMA has called for all public hospitals in the nation to be funded to provide for an average bed occupancy rate of 85 per cent. We know that if hospitals run in excess of this figure then there is no capacity to deal with emergency cases. Tasmanian hospitals constantly run well in excess of 85 per cent. I don't know if you have had a chance to look at the paper today but I think on about page 7 there is an item of a hospital running at 107 per cent capacity. The CEO there is saying that there were a series of serious motor vehicle accidents over the weekend. Patients were brought into the hospital emergency department but the emergency department was absolutely full with patients waiting to go up to the ward. It is very difficult for emergency staff to deliver good care to patients who are coming in through the door and requiring urgent care, because there is really nowhere to put them. All the places are taken up with people who should really have been admitted to the ward.

Mr WING - Or a nursing home.

Dr MIDDLETON - Or nursing home, perhaps, from the hospital inpatient ward.

You would have heard, I am sure, from Dr Pielage in some considerable detail about the difficulties that he and his staff face there. It is a major problem and we know that the longer the patients wait in emergency departments the worse their outcome. They have higher rates of morbidity and mortality. They do worse and they are more likely to die if they are kept in emergency departments rather than being put in a ward. The problem is there for the urgent patients coming in; there is nowhere to put them, to assess them and look after them. The difficulty is also for those poor patients who are waiting around in emergency. They may have been there for two or three days, or perhaps even longer. I think the record was five days. Those patients of course are then looked after by Emergency department staff who are really caught with who to give care to - the sick and injured coming in through the door or the poor elderly person with a stroke lying in the corner not complaining but perhaps developing a complication because there's simply no-one to keep an eye on them. So it's a very difficult situation. As I said, the problem is bed block and the problem is due to inadequate resources in the hospital system to allow those patients in emergency to get admitted to the inpatient part of the hospital.

The AMA believes that there are several specific remedies that can be introduced to improve this situation, even in a climate of budgetary restraint, and I direct you to the other recommendations as listed. You can see recommendation number 3, creation of a statewide medical services planning committee. Really, for too long the bureaucratic response to any problem at all in the public health system is to form a committee, engage outside consultants, get focus groups and stakeholders and all of these other buzz words together, endlessly analyse the problem, but then it's rare to see any solid recommendation or action coming from any of that.

I have some examples of it here - Tasmania's Health Plan, the Clinical Services Plan; thick documents and not bad reading, but all they do really is to overly analyse the current state of the problem. As yet we haven't seen a plan. So it's very difficult, but this is the sort of thing - whenever there's a problem you just get an avalanche of committees and paperwork, with nothing much happening.

Ms FORREST - If the Government didn't consult widely with the community at large, whether they have secured experts from within or without - I think Heather Wellington who prepared that report is a GP, so she has medical experience at least, maybe not in Tasmania, I am not sure about that - if they didn't go through a similar process, would they not be criticised for that?

Dr MIDDLETON - The point I'm making is that this process is endlessly repeated. I have spoken with Heather Wellington, I have been to her presentation; she is a person of great insight and intellect, and her report makes good reading. But this may have come from her report, this isn't her report.

Ms FORREST - No, and I appreciate that.

Dr MIDDLETON - What I am saying is that outside consultants are always engaged, there's no thought given to perhaps actually asking the people who work in the system, who have been there. I have worked at the Launceston General Hospital since 1990. I know Professor Einoder spoke to you the last time you were here. He has been in the system for somewhat longer than I have. We will be here long after all of the bureaucrats and politicians have moved on to other tasks and we will still be picking up the pieces of this

inactivity. We really think that it's time to ask the people at the coalface what they think, rather than having some huge committee which is often disconnected from the actual process of providing care.

The third recommendation, as you can see there, is the creation of a statewide medical services planning committee with authority to develop, implement and monitor clinical services in our hospitals. That statewide medical services planning committee would be comprised to a large extent of senior clinicians, but of course would require secretarial assistance and assistance from the department.

You can see the rest of the recommendations that we've listed there, and a lot of them do, I guess, elaborate on the same sort of theme, greater devolution of management functions from DHHS out to the public hospitals where the decisions need to be made. It's often very difficult to get timely decisions made about human resources. You have a vacancy on your medical staff, somebody makes an application and then what happens is the application disappears off into some complex process where multiple people and committees have to sign off and review, and for what real reason is unclear. By the time that process has actually run its course, often that person who would have been highly valuable to fill the vacancy has got sick of it and gone to work somewhere else.

Ms FORREST - It is obviously a very different system from that employed in the private sector. If you apply for a job and you get it, you get it. There are no appeal rights. That is it, you are employed for a probationary period sometimes, depending on the role. Do you think that we need to head more down that path so that when a vacant position is available you go through the usual process of attracting and trying to secure staff but once you make a decision that is it?

Dr MIDDLETON - There just needs to be a streamlined process. Clearly the candidate for the job needs to be qualified for their job, all the references and checks and everything need to be done, but those can generally be completed quite quickly at the local level. Then really in an ideal world the local hospital and their medical staff board would look at this or the Department of Surgery would look at this - whichever department - and make a recommendation that this person will be employed because they fit all the criteria. It should not take long for that to occur but it does take a long time.

Ms FORREST - What would you consider, from what you have described of that process, a reasonable time frame? We know it does take some time. How long do you think that process should take and how long does the current process take?

Dr MIDDLETON - It should really take as long as it takes to be sure that this is the person that you want, to get all of the information, the references, get them in for interview if necessary and then simply make a recommendation to whoever has to sign it off. Clearly there will need to be a sign-off at some higher level.

Ms FORREST - Are you talking weeks, months?

Dr MIDDLETON - I would have thought that if it cannot all be sorted out in two or three weeks there would have to be something wrong because if I want to hire some staff at my office, once you have the right person it does not take very long to employ that person at all. You just make sure that everything is in place and get it going. But in

terms of employing people in the public hospital system, it can take a long time. It can take months sometimes.

Mr WING - Where is the person who signs off? Locally, where the position is, or centrally?

Dr MIDDLETON - Generally speaking, it has to go down to the central department in Davey Street to be finally signed off. At least that is my understanding.

Mr WING - You would not be supportive of that, would you?

Dr MIDDLETON - I can understand that there may have to be some central control perhaps, people who are actually doing the final employing, and the final employing is done by the Department of Health and Human Services. That is based in Hobart.

Mr WING - So all appointments are signed off in Hobart?

Dr MIDDLETON - I believe that that is the case.

Ms FORREST - Are you talking about medical appointments, nursing appointments, allied health or the whole lot?

Dr MIDDLETON - I believe that is the case with senior appointments.

Mrs SMITH - If it is a replacement of somebody and within budget of a hospital, why is there a necessity to go outside a protocol within the hospital that that person is being replaced in?

Dr MIDDLETON - I am uncertain of the reason for it.

Mrs SMITH - As I say, if it is a replacement and within budget, could it be managed within the system as you know them at the moment, whether it is the Hobart public hospital or the Launceston general public hospital?

Dr MIDDLETON - There is no reason that a local selection panel and the CEO of that hospital could not perform that process.

Mrs JAMIESON - Further to that, just looking at your recommendation 7, if we had a return maybe to the individual hospital boards that we had 30 or 40 years ago and they could have the power and the expertise to make those decisions, would that expedite matters?

Dr MIDDLETON - There certainly has to be devolution of management functions. Whether you need hospital boards as they previously existed I think is an open question, we do not have a position on that, but we feel that the hospital should be able to make these sorts of HR decisions themselves.

CHAIR - Just on the filling of positions and the slowness with which it occurs, sometimes that is a deliberate ploy, of course, because it is seen as, I guess, saving money, is it not? If they can avoid filling a senior position for six weeks, two months, three months there is normally a considerable money saving to the budget at the end of the day. I think that that is an observation that has been made by other people as well.

Ms FORREST - Can I just clarify that point that you make, Mr Chairman?

CHAIR - I will let you do that but I am just asking Dr Middleton if he wanted to make comment on that. Have you seen that? Do you believe that to be the situation or not?

Dr MIDDLETON - I would not definitely state that I believe that is the case. I think that might be overly cynical.

Ms FORREST - Surely if it was an essential position then the hiring of locums to fill those positions would be more expensive than paying someone in that position. In your experience are most senior positions filled by locums?

Dr MIDDLETON - Locums are not often used to fill positions at considerable cost because they are usually sourced from international locum provision agencies who also take a cut from the arrangement. It is not a good use of the public's money to be employing locums in situations unless you really cannot source adequately skilled local staff and certainly locums are more expensive than just paying someone to do the job.

Ms FORREST - With the appointment of senior positions - and we are talking about specialists and the like - the buck stops with the minister. What if we get a doctor who is employed and then subsequently found to not be properly registered, to not have the experience they say they do - and we know about Dr Patel? Isn't it reasonable, then, that all these appointments are ticked off by the minister at the end of the day because the minister is responsible?

Dr MIDDLETON - The Dr Patel case is an example of where local health authorities have made recommendations to employ people who have not been properly accredited by national accrediting authorities in Australia. So Dr Patel was certainly not a fellow of the Royal Australasian College of Surgeons; he was a gentleman with overseas qualifications. There was a difficult political situation in Bundaberg. They did not have a surgeon in the hospital, despite the fact there were six surgeons in the town who would not work at the hospital because it was very difficult to work there, so the local health authority made a decision to employ a person who did not meet the criteria for full Australian accreditation in that position. The consequences of that are only too clear now.

In the situation which normally applies when you are employing someone who has full Australian qualifications, is fully credentialed and who has good references and no concerns at all about a previous practice then it is very hard to see how going as far as having the minister sign it off is really going to improve the situation - so long as there are proper processes in place to make sure that all of those provisos are met.

Mrs SMITH - Is this usual compared to what happens in other mainland States? Is the way we manage employment of clinical staff here comparable to, say, New South Wales and Victoria?

Dr MIDDLETON - I cannot answer that question.

Dr AIZEN - Perhaps I could answer that. In Queensland most applications are in fact on-line and they have regional health authorities which make their own decisions about employment of medical staff, particularly senior medical staff. The point that Dr Middleton made is an important one because, while each State has its own medical board, the reality is that standards have to be met. While the minister, as you say, has the ultimate responsibility, there is no reason for the minister not to delegate the authority for approval in straightforward appointments.

Mr WING - Does that refer to regional health authorities; are they local boards?

Dr AIZEN - No. In Queensland and I think in Western Australia the regional authorities are departments of the health department itself, but they have their own management responsibility - which is the integration of hospital services within that region. Included in that is the employment of staff.

Mr WING - Do they have any other autonomy?

Dr AIZEN - They have their own budgets, which I understand are given to them by the health department per se, and nearly all administrative functions are managed within that authority.

Mr WING - Would you like to see a similar system operating in Tasmania?

Dr AIZEN - We have three natural regions in Tasmania. For most of the bread-and-butter decision-making we would like to have the authority of the minister devolved to the CEO of the major public hospital in that region.

Mr HARRISS - You have indicated in your submission to the committee that both the Wellington and Richardson reports were somewhat critical of the centralised management process that we operate under in Tasmania. Against that backdrop, with both of those reports identifying that as a weakness in our system, can you advise the committee as to whether any account has been taken of those assessments by Wellington and Richardson?

Dr MIDDLETON - Not to the best of my knowledge.

Dr AIZEN - I haven't seen it. That would be a valid question to ask the minister or the secretary of the department - just what recommendations from those findings have been taken up.

Mr HARRISS - You referred to recommendation 3 in your submission and you further went on to say that it's a matter you had raised with Mr Roberts at a meeting in April last year and to this stage you have received no response to that suggestion of the establishment of such a committee.

Dr AIZEN - That's right. I must point out that at that stage, though, that was a meeting that Mr Wing and Mr Dean kindly organised for me as an individual. The Federal AMA 2007 public hospital report card indicated what Dr Middleton had said - that is, despite spending fourth-most per capita on public hospital patients, Tasmania was performing last or second-last on the major criteria. When I raised this with Mr Dean and Mr Wing

they both concluded exactly what I excluded - while the money appeared to be spent in the system it did not appear to be wisely spent. That was the reason for having that meeting with Mr Roberts. At that time John Kirwan was recently appointed to his job as the CEO. I think Catherine Katz came to that meeting, too. We felt there appeared to be a problem: there hasn't been a lot of active involvement of senior medical staff, so is there a way we can help? There has not been any acknowledgement of that meeting or any positive response to our request.

Ms FORREST - That it was a private meeting, but is it the AMA's view?

Dr AIZEN - Once it became apparent that there was a going to be a committee of inquiry set up - and I am pleased to see that it has been set up - we then decided that as an organisation there should be a response from AMA Tasmania rather than from me as an individual.

I came in on the tail end of Dr Pielage's comments to the committee and he seemed to think that 'planning' was reactive rather than proactive. Is that the sense that I picked up?

CHAIR - I think he referred to it as being 'crises management'.

Dr AIZEN - What we have recommended in recommendation 2 is the development of evidence-based funding for hospital care. We believe that evidence of need for patient outcomes is not included in the criteria for funding of public hospitals. There does appear to be a lot of adhockery in recurrent funding and also at some times in capital funding about the public hospital system.

Mrs JAMIESON - My question is a follow-on from the comments in your recommendation 4 on the decision-making, planning and implementation being completely transparent. How do you envisage it becoming more transparent and accountable at a State and local level, as an AMA policy?

Mr MIDDLETON - Clearly, I think recommendations 4 and 7 need to be looked at together. We do not have a specific model in mind. However, it would seem to us that the CEOs of the hospitals should be able to formulate sufficient talent and planning abilities to fulfil those ranges.

Mrs JAMIESON - I understand what you are saying, but how would they because we need to give some guidance when making our recommendations as to how this could be done, rather than just making a statement?

Mr MIDDLETON - I think we would need to consider that question and make a supplementary recommendation statement.

CHAIR - Yes, thank you. You can take it on notice.

Mr AIZEN - In essence I believe it is a relatively simple process to plan for acute hospital care in this State. First, we need to identify what it is we need to achieve and I would have hoped that, at the minimum, Tasmanians would have access to public hospital treatment at the median level of all jurisdictions in the Commonwealth. Rather than coming last or second last in terms of waiting list times or percentage exceeding the

ninetieth percentile and so waiting for some time, that we are at least in the middle compared with all other jurisdictions.

The Australian Institute of Health and Welfare is an organisation set up by the Council of Australian Governments to provide figures for the benefit of State health departments and also for the Commonwealth Department of Health and Ageing to plan patient care. We already have the data available and the state of the public hospital reports released by the Commonwealth Department of Health and Ageing are based on research of that institute. The institute also provides clear guidelines as to what constitutes reasonable waiting times for treatment. They have three categories. Category 1 is for really urgent things that cannot wait more than 30 days - things such as acute heart disease, newly diagnosed cancers and so on would clearly fall into that category. Category 2 is for treatment that should ideally be provided within 90 days. Category 3 ideally should be provided within 12 months of the patient going onto the waiting list. We already know what we should be doing and where we are in terms of those criteria.

We know what our population is and through the good work of the department we have these reports which have excellent demographic backgrounds showing where we are in Tasmania. The department does know what is ahead of it. What we do not have is a matching of the data with what needs to be done. We know the case-mix separations - the diagnostic category of patients leaving hospital or the diagnosis that they are given as they are put on the waiting list. We know roughly what the costs are for each of those patients. With the resources of the department they should be able to draw up a giant spreadsheet. They should be able to add in projections for the ageing population, for population shifts within the State with net migration out and net migration in. They should be able to compile all their data and calculate what needs to be done and what costings need to be provided.

Ms FORREST - Dr Aizen, you said we are looking at recommendation 2 - that is evidence-based funding programs. You said that we need to have evidence of the need for patient care. Can you expand on what you mean by that?

Dr AIZEN - We need to identify the waiting lists as they are, so we identify a need in patient care as defined by doctors once they put patients on to a waiting list.

Ms FORREST - Are you only talking about elective surgery?

Dr AIZEN - Elective surgery.

Ms FORREST - Okay. You are confining your comments to that area.

Dr AIZEN - That's right. I would say that despite the constraints in the system, emergency care is done very well in this State. I think people when come in in extremis, motor vehicle accidents, strokes, and so on, despite the hiccups in the emergency department - and I'll expand on that a little later on - by and large those people receive timely and appropriate care.

Ms FORREST - When we're looking at the interventions and the evidence for patient care in the very elderly or the micro-premature, do you have a view on that?

Dr AIZEN - Again, they would fit into the categories; there are no categories specifically for premature babies or the elderly. The problem that some people have with the category classification is that it's a doctor-driven classification. While there are guidelines, in the end it's the doctor who admits the patient, or plans on admitting the patient to hospital and who decides the category into which those patients fall.

Ms FORREST - Yes, that's fine.

In regard to the categories for elective surgery, categories 1, 2 and 3, in the UK there's a maximum wait of 18 weeks for any surgery, even all their hips are done within that time frame and a variety of methods are used to do that. Do you think that's achievable in our system and how would you do it?

Dr AIZEN - I think it is achievable. I think if we understand the job ahead and adequate funding and planning are based around the identified need, then it can be done.

Ms FORREST - You say adequate funding and planning. There's not an endless bucket of money, obviously, so we need to use the money wisely. How can we plan to achieve similar outcomes? If you believe it can be done, how can we do it?

Dr AIZEN - You will see in our report, we talk about having more beds and fewer desks. We believe that -

Ms FORREST - Desks are a bit hard to lie on.

Dr AIZEN - Exactly right, but the reality is every dollar that's spent on a desk is a dollar not available for a bed. We need to look at the actual cost involved, but I think savings need to be identified within the department first, particularly at the bureaucratic level, and to try to establish a reasonable balance between the number of administrative and research officers against the need for hands-on patient-care officers supplied by the department.

Mr WING - Have you given a figure of 3 000 people employed by the department not actually directly involved in health care?

Dr AIZEN - We have been unable to identify that. You'll see that one of the specific questions that we have asked you to ask the minister or the secretary is to identify that, because this is a particularly vexed question. From our attempts through questions in Parliament and questions directly to not only the current minister but also the previous one, Mr Llewellyn, we were unable to get any sensible replies.

Ms FORREST - Dr Aizen, you said an increase in the number of beds is the answer, in your mind. Obviously, you can't open the beds if you don't have the staff to provide the care for the patient in the bed. Do we need to increase the productivity of those staff we already have? If so, how do we do that? If not, again we come back to the limited bucket of money to fund the staff. Are there ways of increasing the productivity to achieve this by increasing beds without having a huge increase in the number of staff?

Dr AIZEN - Our staff, I think, work very hard in the public hospitals, and attempts to increase productivity in the end would result in people leaving the system.

Ms FORREST - I'm not just talking about doctors, I'm talking about nurses as well, because they provide care for the beds.

Dr AIZEN - That's the point I'm making. The AMA has researched this thoroughly, and the international research is quite clear that unless we increase the number of beds in the State to provide an overall capacity of 85 per cent, we will continue to find that we are working in a very stressed system providing sub-optimal emergency and elective care to our patients.

Ms FORREST - Is there any area that you can increase productivity?

Dr MIDDLETON - I think the AMA report card last year identified that we needed another 3 750 hospital beds around the nation, at a cost of about $3 billion, to give enough inpatient beds so that you could have about that 85 per cent bed occupancy. To answer your question about productivity, when I go up to the ward - I can't give you an evidence-based answer - the nurses on the wards I visit are really flat out. I don't believe that there is anybody sitting around not doing anything.

Ms FORREST - I'm not suggesting that is the case. Operating theatres are one area that often get interrupted, for a variety of reasons. Often staff have worked too many hours and they have to pay overtime for them to continue. With orthopaedic surgery it takes an hour to set up for a hip replacement, then you have to do an arthroscopy before you can do your next hip et cetera, and the clean-up from the last hip or whatever takes a couple of hours as well. The orthopaedic surgeon is not involved in the set-up and clean-up. Are there ways of improving productivity in, say, operating theatres so you can get more operations through without the having the cost of paying overtime?

Dr MIDDLETON - The only way to do that is to have more theatres available, so while one theatre is being set up for the next case, the surgeon can be in the next theatre doing his arthroscopy and going back and doing the total hip. You require sufficient resourcing of theatres to do that. I don't believe that is something that happens in the public hospital system, although it is not at all unknown in the private hospital system, which seems to be able to get through a larger amount of work. I agree, it is hard to know why that is.

Ms FORREST - So that should be looked into more thoroughly, as to how that is achieved in other settings perhaps?

Dr MIDDLETON - I don't think it would hurt for there to be some investigation of why things seem to move more smoothly in the private hospital system. One of the reasons for that is that the public hospital system has to deal with all of the emergencies, whereas in the private hospital system it is very unusual to have a list - a carefully planned, efficient list -

Mrs SMITH - It is quite clear through your submission that more beds, not desks, is your message, that it is the bureaucracy that slows the process to some degree and probably where a lot of the money goes. Quite clearly those in the bureaucratic process aren't going to see that they are better off to replace themselves with medical people in hospitals, even though the community sees that. Would you agree then that the only way to find some of these answers you're looking for would be an external audit of what our bureaucracy really is within our hospital system, to then line it up in a comparison with

what is happening, not particularly in other States because they are probably as bad off as us, in the world's best practice? How do we solve this issue of bureaucracy being top heavy, not enough beds on the ground, in a way that gets us to the factual end of the process?

Dr MIDDLETON - I think we solve it with adequate data, which we don't have. We have a list of questions here for this committee to ask the bureaucrats and politicians who are responsible for DHHS and public hospital systems, to ask them how many people are working in their system, how many people are involved in hands-on care, how many people are down at head office working on innumerable projects in little cubicles all day. We don't know the answer to that. We are hoping that in the course of this inquiry it might be possible for the committee to clarify some of our knowledge gaps and perhaps, with that information then in the public arena, solutions may present themselves.

Mrs SMITH - At the end of the day who makes the judgment? We can do whatever we like with data and statistics; you can adjust statistics by the way you ask the questions. If you get all the statistics about who is doing what at a desk, as against who is doing what at a bedside et cetera, surely until you have something external that audits that process then the bureaucrats will say that is typical because the doctors want everything and we have to have a head office process, and the medical fraternity will say it is most important to have all this clinically on the ground. We will continue this same argument that has been in the arena for a long time unless we have a process so that someone makes the judgment of what is the relevant ratio of a desk to *x* amounts of beds?

Dr AIZEN - In relation to the first part of your question we have asked you to perhaps ask the minister and the department some specific questions about cross-tabulating the various administrative and clinical positions at full-time equivalents across the department by institution and by site. So for example they would include all employees of the acute division or kids services division of the Department of Health, whether it is Davey Street or an ambulance office or in a hospital or in a clinic, so we can identify by site whether they are likely to be administrative or not. Then look at benchmarks. We attempted to do this within hospitals and found that the administration within Tasmanian hospitals is pretty well comparable to administration within hospitals in other jurisdictions. What we do not know is the number of full-time equivalent administrators outside the hospitals, so we do not have a balance between those and the clinical workers.

Right at the end of our submission we did point to a recommendation from the Productivity Commission. The Australian Council of Health Care Research recommends that the next lot of health care agreements should provide for data to be collected on the cost of activities et cetera of the bureaucracies. That would mean that not only would we see that in Tasmania but also how we compare against other jurisdictions. My colleagues give the anecdotal reports of overstaffing of bureaucratic offices in their own health departments as well.

I agree that no data are available and it is only by research that we can develop benchmarks. One of the things I have mentioned to Senator Barnett is that there should be a Productivity Commission report into the administrative staffing of health departments and that they should come up with recommendations of appropriate benchmarks that would enable lean, mean health departments to be funded better for

direct health care and for bloated bureaucracies to be penalised in some way for being bloated.

Mrs SMITH - The Federal Government suggested that perhaps hospitals might be better off in a process that is federally managed. Do you have an opinion on that? Would we be leaner and meaner in the bureaucratic process or would we be worse off if we were more distanced by the hospital system being funded and run federally rather than by a State?

Dr AIZEN - As you know currently it is about 50:50 and -

Mrs SMITH - And all can blame the other person.

Dr AIZEN - All can blame the other person. We are looking at the administration of our services and it does not really matter whether the funding is State or Commonwealth or both. We believe that if the administration of services is as close to the patient as possible then we are more likely to see efficiencies, rather than by a remote office, whether it's in Hobart or Canberra.

Mr WING - I referred earlier to my thought that there was a reference to 3 000 employees in the submission, and I found that on page 18 it says:

> 'In broad terms, therefore, nearly 3 000 DHHS Tas employees work outside the hospitals'.

Dr AIZEN - That's only a guess, Mr Wing. We would like this committee to specifically ask the minister and her department exactly what the breakdown is.

Mr WING - Yes, I understand that, but I just had that figure in my mind, having read it in the report. In terms of the waiting lists for elective surgery, is there any validity in the suggestion that's been made that operations that are likely to take some hours are given lower priority generally because it has a better effect on the waiting lists if shorter operations are performed? Is there any policy or is there any practice on that that you're aware of?

Dr MIDDLETON - I doubt very much that that would be written policy anywhere. I personally have heard similar concerns raised, but as to the veracity and validity of those concerns, I'm afraid I can't answer that question. It might be a question better for Professor Einoder, perhaps.

Mr WING - Yes. You're not aware of any practice which would indicate that's likely to be a strategy?

Dr MIDDLETON - This is an area I am a little unclear about. There was an incentive payment to clear waiting lists. As you know, there was some Federal money made available, I think it was about $3 million and it was to be expended by a certain date and a certain number of cases all had to be done to meet the requirements for that. I'm pretty sure that Tasmania was able to adequately expend that amount and I believe that in fact the numbers treated were exceeded. I spoke to Bernie Einoder just recently and he told me they'd made a large inroad into waiting lists with that money.

I am not entirely sure whether I can answer your question as to whether that was achieved in terms of the numbers done by doing a lot of the smaller cases, I am just uncertain -

Mr WING - Certainly that requirement that a certain number be performed within a certain time would tend to prejudice people who need surgery that would take longer, no matter how urgent.

Dr MIDDLETON - I think the aim was to clear patients from categories 1 and 2. Those are patients who require urgent surgery, say within a month or for category 2 within three months. I think most of those patients came from those two categories. Again, it must seem as though I am evading the question but I'm not entirely sure about whether or not it was easier to do 10 carpal tunnels than one total hip.

Dr AIZEN - Mr Wing, if I could refer you to page 3, question 10, we have suspicions that that indeed is the case, but it's not until we get hard evidence that we can confirm that. Because of the way patients are classified it's easier to separate day case only from overnight-stay patients. That information would be of immense value and it's one question I believe that this committee could ask the minister or the department, particularly with the recent $3 million incentive money that was provided by the Commonwealth.

Mrs SMITH - You would accept, would you not, that like everything the Commonwealth's doing with its funding, they are putting time lines on? That seems to be it, that you must do things within time lines. When you look at the lack of beds and the lack of staff to facilitate those beds, the only time you could meet the time lines was with day surgery as against surgery that required an in-hospital procedure because with day surgery in most cases it's easier to organise. The people come in and they are gone within the day - no beds needed, no extra nursing staff needed. Is that a fair assumption, in your opinion?

Dr AIZEN - I would say, if I had the role of poacher, that is exactly the strategy that I would adopt, simply to reduce numbers. What we are talking about here is not numbers but individual people and patients with often prolonged pain or other problems.

Mrs SMITH- To make it quite clear when we talked about the 3 000 who were external to hospital, we are not saying they are bureaucratic staff, we are saying clearly for the Press and everybody else that that includes disability service workers, child care - all of those particular people in those numbers.

Dr AIZEN - We were actually talking about acute services, not the other divisions of health. So we may in fact have ambulance officers, community nurses and clinic nurses. The answer is we do not know until we get that cross-tabulation available.

Mrs SMITH - On page 17 with your full-time equivalent staffing it could be a dangerous page unless there is an explanation. Your number 1 is that Tasmanian hospitals have slightly below-average staffing using a crude measure of patient days. Your next statement is that salaried medical officers in Tasmania as a percentage of total staffing are on average of all States and Territories. Are we saying all States and Territories are undermanned because we are on average with them?

Dr AIZEN - Yes.

Mrs SMITH - We are no better, no worse off but we are all undermanned?

Dr AIZEN - Yes.

Mrs SMITH - The next one: nurses in Tasmania as a percentage of total staffing are slightly above all States' average. Do you want to expand on that? We are better off than other States but we still do not have enough?

Dr AIZEN - I would say that, yes, we are slightly above average but clearly we still do not have enough. Our reference point is that 85 per cent average occupancy. Unless we have more nurses, more doctors and more support staff, there is no way known that we can open up more beds to achieve that level of occupancy.

Mrs SMITH - So on what percentage of occupancy are these figures and ratios done?

Dr AIZEN - No, this is really just a cross-tabulation, a crude comparison of Tasmania with other jurisdictions.

Mrs SMITH - When you get to looking at the overall dollars and you see domestic and other staff in Tasmania as a total of staffing are well above average, and if an average was there there would be 260 fewer of them, is that telling us we have too many domestics and other staff in that area?

Dr AIZEN - No. I think the importance of domestic staff cannot be underestimated. We need them for patient care, porters, cleaners and so on. If we do not have enough cleaners in a hospital then we could end up with severe infections. One only needs to look at some of the larger mainland hospitals where they have horrific problems with cross-infection in the hospital, emergency departments are filthy. These stories are anecdotal. Thankfully we do not have those in Tasmanian hospitals so I think, if anything, that reflects that other hospitals are cutting back on basic cleanliness and hygiene rather than us necessarily being overstaffed.

Mrs SMITH - So we are much better off than other States but we do not have too many of them, that is what you are really saying?

Dr AIZEN - Yes.

Mrs SMITH - And the clerical and administration?

Dr MIDDLETON - I wonder if I could make a comment about that? I think these are probably full-time staff employed by the department. It may well be that other hospitals - and I do not know this - are getting in contract cleaning staff who are not appearing in their statistics.

Mrs SMITH - That is what I meant earlier about statistics and why I wanted to clarify this. This could be a very dangerous page for department people if there was not an explanation given alongside these bland figures here. We have just talked about bureaucracy and yet in direct health care we are saying that in clerical and administration

staff we are 50 short in this bland process here of calculations. That is what I mean about explanations being needed because you could look at this and say, 'Enough nurses, too many domestics' et cetera. I wanted to clarify that so that there was no misinterpretation by others.

Dr MIDDLETON - Without information from the department it will not be possible to be entirely certain about all of these figures. I am sure they will be able to give some explanation as to why there may be these variances with other States but we do not have that information. We are just working on the crude data as it is available.

Mrs SMITH - Thank you.

CHAIR - Looking at nursing staff, we are above average and just about set the benchmark there, however when you look at the processes that we have looked at around the country to look at where each State is going in the public hospital system we rate very low and I think we are one of the lowest-rating public hospitals in the country in regard to services. Where does the real problem lie if we are better off in nursing staff and we rate very low right across the whole system with all the services we provide? You have given evidence, so where is it going wrong?

Dr AIZEN - I think that the cost that we are looking at is the per capita cost of public patient care. That would include the cost of doctors, nurses, cleaners, pharmacists and so on, but it would also include the bureaucracy that we can't see outside the hospital. That is why I wanted this committee of inquiry to take evidence to find out about that mismatch between performance and cost - in other words, the inordinate expense compared to our performance - may not be due to non-patient care costs that we can't identify.

Mrs JAMIESON - I want to refer back to recommendation 1, where you would like to have an 85 per cent bed occupancy. How would you do that? Are we looking at having a long-stay hospital for recuperation - you have the acute LGH and Royal Hobart Hospital and then people are automatically sent out to their local area where they might have a long stay in some clinic type of thing?

Dr AIZEN - Yes. That was one of the recommendations that we gave in transitional care and also in placement for older patients, and Mr Kirwan himself raised this quite independently a number of months ago.

Mrs JAMIESON - How would you see this being funded - Commonwealth funded? We are talking mostly about aged people for rehabilitation, convalescence et cetera.

Dr AIZEN - Currently there are beds available in the area if we look at places such as Campbell Town, George Town, Deloraine and so on.

Mrs JAMIESON - So that could then become a Commonwealth-funded hospital, as it were, for long stayers and rehabilitation?

Dr AIZEN - Regardless of who funds them, there is money available by the State for those hospitals anyway.

Mrs JAMIESON - My other question relates to recommendation 11, funding for training and all graduates of the University of Tasmania. Have you any comment to make about the difficulties that some patients and families have about the overseas-trained doctors? They are not talking about the overseas doctors with their skills, it is the comprehension, the different values and things such as that. Patients are having problems, apparently, with their comprehension of what has been said, particularly when they are stressed. Have you had any comments or complaints? Have you had any thoughts on the matter? This would include nurses, not just doctors.

Dr MIDDLETON - I personally have not had any complaints directed to me about those issues. It can be quite difficult for overseas-trained doctors from another culture, especially if they are put onto the wards or in the Emergency department without sufficient supervision. They often feel a bit adrift.

Mrs JAMIESON - I am referring more to the values - for example, being patronising and not liking women being assertive when it comes to decision-making et cetera. It has not become an issue?

Dr MIDDLETON - That has not been an issue to the very best of my knowledge.

Mrs JAMIESON - It is talked about in some areas of the community, and our reliance on overseas-trained staff generally. A lot of them are transient anyway so you don't get that continuity of treatment and thought.

Dr AIZEN - That's right. This goes back to a comment we made in the report, that because of decisions made by previous Commonwealth governments to restrict medical training, we indeed do have a shortage of Australian-trained doctors and we have then had to look overseas to fill the gaps.

Mrs JAMIESON - A lot of our staff also go overseas and we have to ask ourselves why? Very often it is to third world countries, where they don't have all the resources we have here, and yet they choose to go there. Is there any reason you think people are doing that? Is it just out of the goodness of their heart?

Dr AIZEN - I really couldn't say.

Mrs JAMIESON - Does the AMA have a position on GP Assist as a program?

Dr AIZEN - I personally use GP Assist, and it's a godsend in my practice. I am a very busy general practitioner, seeing around 40 patients a day. When it comes to out-of-hours and weekends, I would rather spend time with my wife and other things outside of work. One of the problems of doing your own calls is that the calls you get tend not to be filtered if you take them directly. When I started off in general practice, weekends were spent just going backwards and forwards to the surgery. The whole idea of GP Assist is to have trained doctors and nurses who take the phone calls. Often for relatively simple things nurses are very well qualified in reassuring patients or giving simple recommendations, which is really all the patients need. In other instances where the nurse isn't confident or qualified to respond, a doctor will take that call and can often sort those problems out, either with a prescription or some other course of action. So I have a

really filtered out system. I know when the doctor from GP Assist phones me that the patient does need to be seen and I will see that patient knowing it will be important.

In my practice I have a high proportion of privately insured patients. If those patients need hospital admission, I can admit them to a private hospital. I don't have to send them into the emergency department. If, for whatever reason, for want of health insurance or medical need, they need to go then I know they are not going there unnecessarily. So I find GP Assist a godsend from that point of view.

Mrs JAMIESON - So have there been any statistics on the success of it from the point of view of keeping people out of the hospital system? Do you see any complications coming up if GP Assist becomes a national administrative body rather than just State-based as it is now?

Dr AIZEN - I have asked Guy Barnett to institute a Senate review of the HealthDirect process. HealthDirect is the Commonwealth Government scheme to provide a national call service along these lines. The difference between HealthDirect and GP Assist is that there are no doctors involved in the clinical process; nurses are the only professional staff there. I think in most cases nurses would be very well qualified to handle complaints, as they do with GP Assist, but for the complaints that are beyond their competence or their confidence, the end of the algorithm is to go to the Emergency department. I feel this is a potential adverse impact on our emergency departments after hours from the implementation of HealthDirect.

Mrs JAMIESON - Does the AMA have a position on physician assistants as they are used overseas, and/or nurse practitioners? Physician assistants that are available overseas have been used for many years. Do you see a role for them in Tasmania to try to relieve the health system?

Dr MIDDLETON - The one word answer is no. To return to your original question about interns and junior doctors, there is going to be a major problem in about two or three years, and it is due to poor health policy from 10 years ago. About 10 years ago the Federal Government decided there were too many doctors and too much of a drain on the public purse, so they reduced the numbers. Of course when it became apparent that Australia was going to be very short, what did they do? They put lots more students into new medical schools. When I graduated from the University of Tasmania in 1980, I think there were about 40 of us who graduated. In three years' time there's going to be 110 students coming out of final year university. We had 83, I think, at the end of 2008 and the biggest problem for them is going to be finding postgraduate positions.

In the past it has been possible for the excess doctors to go interstate, those who haven't wanted to or haven't been able to get jobs in Tasmania in public hospitals as interns, which is the first year after you graduate. An intern year is absolutely essential. If you do not do a proper intern year that is recognised by the medical council in Hobart or medical councils around the country then you are unable to practise. You are not a legally qualified medical practitioner until that intern year has been completed and signed off. There has to be sufficient capacity to absorb those graduates and in the past, if there have not been enough positions available, they have gone interstate. The difficulty, of course, is that exactly what has been happening in Tasmania is also happening interstate. They have opened new medical schools, medical schools have

increased their input and output and in about three years time there will not be a spare intern position in the whole country. So anybody who does not get a job here will not be able to get one in Australia, and we will be having 110 students coming out in about two years time.

Mrs JAMIESON - The same is happening with nursing, isn't it?

Dr MIDDLETON - I think so, yes. At a COAG meeting in 2006 all the State Premiers gave an undertaking that they would make sure there were sufficient places available for intern training in their hospitals. Paul Lennon was there and gave that undertaking and that is on the public record. As far as we can see it will be very hard to see how that is going to be met because we see no planning for it at all. There have not been any excess positions created so far and D-day is going to be about two years away. Quite what is going to happen is really a matter of grave concern to us. So we would be very pleased if the committee were to actively pose that question to the minister when you get a chance.

Regarding the problem of introducing new health care practitioners into an already overcrowded system, we are already going to have an increase in the number of interns who need to be accommodated in clinical positions and these students, before they become interns, also require to be taught. There have to be people to train them. That is undertaken by the universities and also by the medical staff of the hospital in their own time. So a lot of the teaching of medical students that is undertaken at the Launceston General Hospital is done by specialist doctors such as myself in an unpaid capacity basically. If you were going to have sufficient training for non-medical health care practitioners such as nurse practitioners or physician assistants, then there has to be capacity in the system to train them. I am not quite sure how these other health care workers are going to be trained. Considering the huge number of doctors who are going to be looking for work in the next three to five years, especially as junior medical officers, I do not believe that there will be any possibility of finding positions for these other health-care workers.

Mr WING - How many medical students could be accommodated each year in the hospitals in Tasmania when the influx comes?

Dr MIDDLETON - I understand that there are currently approximately 65 intern positions. I am not entirely certain, but I think that's about the number.

Mr WING - I thought it was somewhere closer to 83.

Dr MIDDLETON - There was an excess but at the moment there is spare capacity around the country for those graduates who didn't want to or didn't get a position here to go off and train elsewhere. That door will be closed in a couple of years' time because, again, they have the same issue with a large number of graduates who will graduate in a couple of years' time and that will completely saturate any spare capacity in the interstate hospitals. There will not be that possibility available for graduates from the University of Tasmania medical faculty.

Mr WING - So you wouldn't have any idea how many we could accommodate in our hospitals here?

Dr MIDDLETON - Again, I know about what the current intern position numbers are here.

Mr WING - Now, and is that the maximum, do you think?

Dr MIDDLETON - I really can't answer that question.

Ms FORREST - I think we've had unfilled position for a number of years, certainly on the north-west coast.

Dr MIDDLETON - Yes.

Mr WING - Who would know the maximum capacity we have in the hospitals to train the medical students?

Dr MIDDLETON - The problem is not the training, we seem to be able to manage to train these numbers of students. The problem will be finding the intern positions for them, which of course are salaried positions, once they graduate.

Mr WING - I see, so as students there won't be any difficulty about accommodating more?

Dr MIDDLETON - We seem somehow to have managed but I am not quite sure how.

Mr WING - With the increased numbers in the future, will that still be the case, that you expect we will still be able to manage the student numbers?

Dr MIDDLETON - It doesn't look as though we're going to be asked to graduate more than 110, from what I can tell; that is going to be the number that will be coming through. Again, that is a question that is probably better asked of my colleagues who are coordinating the courses, the various professors, as to how they think they are coping. I know that there is a fairly strong feeling that the hospital and its staff are being asked to cope with an inordinately large burden of teaching with probably not sufficient in the way of resources and funding to provide all of that. Most doctors were taught by other doctors who were doing it for nothing, and the tradition continues.

Ms FORREST - And nurses, too; nurses teach a lot of the interns.

Mrs JAMIESON - Would there be any merit at all in a specific nursing home, for example, being accredited to do geriatric internships? I can remember the days when student doctors came out into general practice and worked with the general practitioner - I know we had them in Devonport - to get a feel for what general practice was all about. That included getting up at two o'clock in the morning and going off with the GP. Is there any merit in considering those situations again as a way of giving people much more familiarity with the proposed job?

Dr MIDDLETON - There are rotations through general practice for junior medical officers -

Mrs JAMIESON - This is after they have finished their training?

Dr MIDDLETON - Yes, after they've finished.

Mrs JAMIESON - But what about during their training, as a junior?

Dr AIZEN - Currently there is a Commonwealth program, the Prevocational General Practice Placement program - PGPPP - and the whole rationale for this is for doctors beyond the intern year to have a term in general practice, regardless of whether they are going to go into general practice or not. Page 25, while it doesn't directly address your question, provides a general pointer. We have a neglected area in this State of private hospitals. Currently, as you are aware, doctors who visit private hospitals are generally specialists or perhaps GPs who put in their own patients but who provide all of the care themselves. There are no junior resident staff like we see in public hospitals. The thrust of this is that we see the private hospital system and by extension private general practice and even a private gastroenterologist, for example, providing a scope for teaching and training outside the general hospital system not only to soak up the excess demand and to provide quality training but also to give these people hospital experience in a private hospital system under the care of the same doctors.

Mrs JAMIESON - And you usually have more time to expand it.

Dr MIDDLETON - It would be fair to say that those schemes - and I understand Calvary is participating in such a scheme for a medical registrar this year - are more for doctors who are a little further out than their first year. The problem that intern positions have is that the interns must have a certain core exposure to essential disciplines. They must spend, I think, about eight weeks in medicine, and perhaps the same amount of time in a surgical discipline. They must spend some time in emergency. There must be exposure to other environments for them. Unless they are able to have jobs that meet those criteria, they are not registerable with the medical council. So it is not as though you could take an intern out to a nursing home and say after a year, 'You'll be right' because you did not have your eight or 10 weeks of surgery, you did not have your eight or 10 weeks of general medicine or your emergency experience or any of that.

Mrs JAMIESON - Yes, but I would be looking at it as the position that you had before you got to the intern so that you actually were exposed to the experience of looking after geriatric people along with the nursing staff that were in charge of the nursing home.

Ms FORREST - Make the rotation broader, is that what you saying? You still do your surgery and everything else?

Mrs JAMIESON - Yes, you still do all of that but you just have it as a rotation. But also just to get the experience and the feel for it, particularly as we have this ageing population that is going to become critical. In about 10 years' time we are going to have a huge number of people over 50 that we have never had before.

Dr AIZEN - Mr Chairman, I would also like to add a point that not only is there pressure within Australian jurisdictions - and all the States and Territories are graduating far more graduates and will, I think, apart from Tasmania and South Australia, guarantee places for all of those students graduating and provide them with the very important intern year for the registration - but also another avenue is closing. In the past doctors have been able to travel to the United Kingdom to get training often at a more advanced stage in specialist training. Currently there are reciprocal arrangements between the Tasmanian

Medical Council and the Medical Council of the United Kingdom that will recognise intern training. However, recently the United Kingdom made a decision that it would not take in doctors from outside the European Union. Local graduates or whatever can no longer go to the UK and unless they are provided with training in an Australian jurisdiction, they will not meet Tasmanian Medical Council or any other State or Territory medical council or board accreditation for registration.

Mrs SMITH - On page 23 of your submission you talk about a perception that has arisen that elderly patients are potentially bed-blockers and should not be admitted unless they are near to death. That is clearly from the AMA GP perspective, that Accident and Emergency do not want to admit them. Yet we have had evidence from Accident and Emergency that their biggest problem is the bed block created by the aged. In the last year 76 days was the average that an aged person would be taking up an acute bed waiting for a position in a home and in fact they could utilise a 32-bed ward if they did not have this issue of patients within the hospital waiting to be moved into accommodation within the aged-care system.

Dr AIZEN - Yes.

Mrs SMITH - On this side we have the GPs saying if a person is elderly they might not admit them, they want to send them back to the aged person's home or their own home because they are seen as bed-blockers. We seem to have a difference of opinion between yourselves and the Accident and Emergency Department. Would you like to clarify your paragraph there?

Dr AIZEN - Yes. I do not think it is so much a difference, it is just a difference in the way hospitals now operate. We have a report which shows the number of beds available over the last few years. There has been a steady decline in the number of beds per weighted population in the public hospital system generally. So notwithstanding all the productivity efficiencies with day surgery and so on, the actual number of beds available continues to decline. While the beds diminish in number, competition actually increases, so every patient waiting placement, or not getting adequate post-treatment rehabilitation, is a potential bed-blocker. Where there is reasonable discretion in the eyes of the emergency department, they will actually send elderly people home, more often than not inappropriately in the eyes of general practice. In an ideal world, if those beds were available those patients would be admitted, but given the extreme competition for admission into those beds, more often than not age is a factor, unfortunately, in deciding whether in those patients will be admitted.

Mrs SMITH - On last year's figures they had an average 76 days for an aged person waiting for a bed in a retirement home. Surely those people came from home, were admitted by accident and emergency, and appear to be one of the major bed-blockers. Because of problems we have in our aged care process, not enough beds are in the north for that aged care. They are taking the aged in from their home and they do have this issue because there is nowhere to move them to.

Dr AIZEN - That's one of the issues, and rehabilitation services, regardless of age, is also a very important point. In our submission we referred to a self-commissioned report by the Department of Health and Human Services which only saw the light of day following freedom of information requests. It was a damning report of the lack of organised

rehabilitation care for patients receiving emergency and elective surgery. In other words, if a patient goes in for a hip operation, you just can't put in a joint and wave them goodbye. They need a lot of therapy, and often they leave with substandard post-operative care, often to the detriment of their health.

Mr WING - And cardiac surgery?

Dr AIZEN - And respiratory admissions and so on. The list just goes on and on. Part of the thrust of our submission - and this is clearly a State responsibility - is that there needs to be development of rehabilitation services and integration with mainstream in-patient hospital therapy to expedite the throughput of patients, clearly because of the demand for beds, and as a means of providing reasonable and decent care for these people.

Mrs JAMIESON - And the same for people when they have come out of the nursing home or out of the hostel section with a broken leg. They end up back in the nursing home section, and there's not always the staff there to do the follow up care.

Dr AIZEN - That's right. Chair, I am just circulating a graph which indicates the availability of beds for elderly patients 65 and over the last 20 years.

Ms FORREST - Was that in Australia?

Dr AIZEN - In Australia.

Mr WING - In homes or in hostels?

Dr AIZEN - No, in public hospitals.

Mrs SMITH - So if those are the Australian statistics we can presume that the Launceston General Hospital is actually being exceptionally generous in the number of aged care cases that are 76 days. The evidence they gave tended to be lack of nursing homes, and they couldn't send them home. It's an interesting issue that has arisen through this process. It has come to light that there are 35 vacancies in aged care on the north-west coast at the moment. Aged people have choice: 'I don't want to go to Latrobe until a bed becomes available in the Launceston area'. Considering the stresses of the Launceston General Hospital - and we know the media reports the stresses weekly, if not daily - do you believe it should be fair and acceptable that aged clients should be requested, as Health department policy, if there is not a position for them in their local area at that time, to accept something at a little distance from the local area until a bed becomes available in their area of choice? Do you think that is fair and reasonable?

Dr AIZEN - I think there have to be provisos. Firstly that the quality of care they get is suitable and that the local GPs in those hospitals are happy to -

Mrs SMITH - Aged care homes, I am talking about.

Dr AIZEN - That is fine but when they move to an aged-care home they still have to have general practitioners calling and visiting to look after them, so there would have to be agreement with local GPs to provide that care until some more permanent placement closer to home could occur. If there is an issue with transport, and often families may

have limited transport for visiting, then I think that should be a consideration as well. Simply to, for want of another word, dump people in a distant location purely for that reason of freeing up beds is a difficult one to contemplate.

Mrs SMITH - Everyone understands that but it is quite clear there is a desperate situation in the Launceston General Hospital about bed blockages. As they move six into Philip Oakden House until such time as they can permanently allocate them, if we have to move wider, as people have to for lots of other health reasons, then for the benefit of the entire populace of the Launceston area that should possibly be a consideration. Then it becomes Health department policy that we have somewhere in the interim in Deloraine, Latrobe or wherever, or you must take your family member home.

Dr MIDDLETON - In some ways that might make it easier for those patients to get into a local Launceston nursing home. There certainly does seem to be a perception that nursing homes are somewhat loath to take hospital patients because they tend to be very high care. The reason they are in the hospital is because they cannot go home and they require quite considerable care - most of them. I have certainly had it put to me by more than one general practitioner that it would seem that the nursing homes, when beds do become available in the local area, are more likely to take a low-care resident or client from home who is waiting for placement rather than the patient from the hospital.

Mrs JAMIESON - With all due respect that is changing because now the nursing homes and hostels require somebody to have a shower. Even if you do not need any assistance with your shower we are going to shower you because there is funding attached to the shower. We have that real problem with the Commonwealth.

Mrs SMITH - It is interesting that you make those comments. Three years ago Latrobe hospital had an average of 14 aged people waiting for placement in a nursing home on the north-west coast. We now have a situation on the north-west coast where there are 35 empty aged-care beds, and more to come with the building of a new home in the Shearwater area, so with the home care capacities that the Federal Government has put in place, with assistance for people staying in their own home, quite clearly that is overworking in one area of the State at the moment, and may change depending on people's disabilities. So we have stress in that area because of the lack of numbers in homes, and stress one hour away in a public hospital in Launceston because of bed blocks of aged people who are waiting for a placement in an aged-care home.

It appears to me you are saying it should be considered conditional in that those people have a local GP who would say I will take on Mrs Smith, Mrs Jones and Mrs Brown for the interim while they are in this community until they go back into their localised area.

Dr AIZEN - Yes.

Mrs JAMIESON - That is exactly the program we were running at Devonport 19 years ago, but because the State Government would not fund it we had to drop the high-care people whom we had taken from all the hospitals, including Melbourne. It was a place where people could convalesce and the people paid themselves. They were not subsidised by the government. They paid $30 a night to stay. We worked with two trained nurses and personal carers and we were being flooded. We would have 30 people waiting each month to come in. Now with the way the funding went after I left we have low care and

spare beds. Nobody wanted to look at it, but that is another issue. It is the transitional care that people are looking for in their local area.

Mr WING - I assume the position is going to be improved in Launceston when the developments at Cosgrove Park are completed. Are you able to say how many additional aged-care beds there will be in this area when the Cosgrove Park work is completed, as I understand it will be in the next few months?

Dr MIDDLETON - I'm uncertain.

Dr AIZEN - I don't know the number, Mr Wing.

Mr WING - I have heard that it may be about 60 extra beds.

Ms FORREST - I was informed it was 60.

Mr WING - That would make a significant improvement if there were 60 new beds just there, would it not?

Mrs SMITH - If they take them from the hospital first rather than from the wider stream.

Mrs JAMIESON - It depends on how they are assessed through the hospital system. It's the assessment process that really blocks that.

CHAIR - Any other questions in relation to aged care?

Ms FORREST - You did make the point that the aged-care facilities have often been a bit reluctant to take patients directly from hospital because of their high-care nature. I just put the situation to you that a person who is in hospital occupying a bed and receiving the care the hospital can provide while awaiting placement is probably in the worst place, except perhaps at home with no attention at all. Being in an environment where they don't get the care they really need, they are bound to become high care, if they are not already. We are also finding that the Commonwealth funding that has enabled many more people to stay at home longer now means that the majority of people who go into aged-care facilities from the community are also high care. This disproportionate funding arrangement means having low-care beds empty and the high-care beds under stress. If we could clear some of these patients who have been assessed for placement on a transitional arrangement, as the president was suggesting, and particularly when Cosgrove Park opens, it would only be a short-term strategy potentially. Do you think this is something that needs to be acted on more promptly? This committee won't report for several months yet and it is an immediate issue for the Launceston General Hospital. These beds are immediately available. The Government has brokered a deal with the Manor, formerly Philip Oakden House. Do you think this needs to be progressed more urgently than just saying, 'It might work, but' -

Dr MIDDLETON - Are you talking about giving patients no option but to be convalesced -

Ms FORREST - I'm not suggesting no option; I'm suggesting that you look at the patients you have. There may be patients who have relatives in these other parts of the State; there may be patients who don't have any relatives in the State. What is keeping them

here? They may own a property in the northern area. You look at people who have access to transport and people who get visitors anyway. There are a whole range of issues - and the availability of the GP to take on that care.

Dr MIDDLETON - I am certain that if the patient said, 'I'd quite like to go and convalesce in Latrobe' the hospital would have no difficulty in granting that request.

Ms FORREST - But the Government has to have a policy decision that brokers an arrangement with that aged-care provider. I don't think they can just ring up Eliza Purton or Uminah Park and say, 'We've got this old dear here you'd love', and send them up. The Government needs to make a policy decision around this, surely, and then arrange to broker a deal, as they have with the Manor?

Dr MIDDLETON - It would certainly be helpful to have 35 beds available for however many people are currently awaiting placement in the Launceston General Hospital. I am not sure what their current number is, it is usually somewhere between 20 and 30. It seems to vary from time to time. I am not sure how many of the 35 beds available that Mrs Smith talks about are available for high care.

Ms FORREST - I got the information myself and spoke about it in Parliament last week. There is a mix, but there is certainly a range of high-care beds in that mix.

Mrs JAMIESON - There are some problems in that ACAT only assesses now at age 70 for elderly, you are no longer aged at 65, so there is a bit of a problem there with age disability. The transitional care funding is Commonwealth funding and you have to be accredited, as Philip Oakden is, whereas the nursing homes are not accredited for transitional care. We have a funding problem there as well. You can't just ring up Eliza Purton or anywhere else and say, 'I've got this lovely old lady who comes from Ulverstone' and unfortunately that is one of the problems we have.

Mr WING - You have done it.

Mrs JAMIESON - Yes, but that was because I ignored the system.

Dr AIZEN - I would like to refer you to page 26 of our submission, the fourth paragraph. Under the current health care agreement and presumably under the next one there is an obligation by Tasmania to improve integrating those services. One of the major failings of this Government and presumably others before it has been the lack of planning for this. They are quite happy to play lip service and perhaps to accept funding but not invest intellectual and financial effort in bringing these improvements to fruition.

Mrs JAMIESON - I have one more question on aged care. Where does the AMA stand on the issue of advanced directives as routine part of documentation for people?

Dr AIZEN - I think we would have to take that question on notice.

Mrs JAMIESON - Do please. I am just thinking of the end of life decision-making et cetera. I am not talking about voluntary euthanasia, I am talking about palliative care - will I have more treatment or no treatment - and the way it works through guardianship, enduring guardians and all that sort of thing.

Dr MIDDLETON - I know there is a policy and I am sure you would agree with it.

CHAIR - Thank you. We need to stick strictly to our terms of reference.

Mrs JAMIESON - There is all kinds of aged care.

CHAIR - Yes, I know. I accept that.

On page 24 you made the comment which is the opposite of what we have been told by some other people, that GPs are propping up the hospital system by caring for hospital-type patients on a daily basis. I think the information that has been provided to us is that it has been the opposite way around, that the hospital system has been propping up the GPs because there are not enough of them, they cannot take in additional patients so those patients instead are going into the hospital system in the emergency area or what have you, so can you explain that a little more to us, please?

Dr AIZEN - Sure. We wanted to clarify that because there has been a lot of comment about that. I would not call it misinformation but the reality is that - and we have some Emergency department figures - GP-type patients constitute fewer than 10 per cent of all attendances and they consume less than 1 per cent of all resources in the Emergency department. Dr Pielage might have told you that -

Mr WING - It is consistent with what he said.

Dr AIZEN - they like seeing GP patients because they are vertical, they don't have to lie down, their problems are often simple and they can go home, and the numbers are few and far between.

Mr WING - That is what he said.

Dr AIZEN - I think what is more important is the fact that with the long waiting lists we are talking about category 2 and category 3 patients who might have chronic pain, incontinence and other problems which do not qualify to be rated as category 1. They are the ones who come in to us in general practice for pain relief, for other medications, for other tests and can constitute an inordinate load on a busy general practice.

We also find when patients are discharged from hospital, and we are talking about the very rapid turnover - we have data to show the decline in average length of stay given the constraints on beds - that we often need to see patients to re-prescribe medications that we may not have given them before. They come out with a list and only five days' supply of medications. Clearly when that starts to run out they need to see us very quickly and I think with most general practices in town to get an appointment with a GP within five days is really difficult to arrange so that is an extra pressure on general practice.

We often have to take out sutures because the hospital was too busy to see them again and we often have to interpret reports such as colonoscopies and endoscopies because the doctors do not do it.

Often we have to chase up information from the Emergency department and from other departments within the hospital when patients have been to the Emergency department. As a GP I get a notice of attendance saying that Joe Bloggs was seen with condition A or B, but that doesn't mean anything because it doesn't tell me what treatment was given, what tests were done and what the suggested management plan was. We have to spend a lot of time following up on that information in anticipation - because we do get notification of their attendance - that this patient will turn up very soon for follow-up. The problem is that there aren't enough resources at the hospital, and while patients are not being treated promptly it provides a real problem for general practice in terms of extra load.

CHAIR - If those category 1s and category 2s could be treated quicker it would take some of the pressure off GPs?

Dr AIZEN - Yes.

Mrs JAMIESON - Would you like to comment on the advent of the GP super clinics and their role?

Dr AIZEN - I think any attempt to increase the number of general practitioners and general practice services in the community would be welcomed. Our position is that when patients are sick they want to see a doctor and they should be entitled to see a doctor, rather than someone who is not a doctor at the first point of call. We would encourage provision of extra services to cope with demand but not at the expense of patients not being able to see a doctor.

CHAIR - How often do you meet with the minister and the secretary? What sort of support do you get for issues that you put forward that you're concerned about?

Dr MIDDLETON - Since I have been president, or acting president, since about September last year I met once with the minister in November and we haven't met since then. That is not due to any reluctance on the part of the minister or the department to meet; it is just a matter of finding the time to do that. At the last meeting with the minister we had numerous issues to raise. I think we were given a good hearing and action was taken on a couple of the issues that we raised. My interactions have been positive so far, again on some of the smaller issues. The larger ticket issues tend to find their way to these sorts of fora.

Ms FORREST - We were talking about the full utilisation of the operating theatres and increasing productivity. You made the comment that if extra theatres were available it would be easier to achieve. Is the big argument about sustainability and operating within a budget that is realistic, whatever that is, really about critical mass? In regard to the problem about separated services on the north-west coast, we were trying to provide the same services across both areas. The LGH obviously has increasing demand and potentially we would increase the capacity there. Is there a critical mass and is that really a vital part of providing health services into the long term?

Dr MIDDLETON - There certainly is a critical mass for many services. For instance, there are only half a million people in Tasmania and that number of people can only support one cardiothoracic surgical unit, and that is based in Hobart. It can only support one

neurosurgical unit, and that is based in Hobart. For most other things, it should be possible to provide services reasonably close to where patients are. The problem we have in Tasmania of course is the decentralised population. When we have discussions with our interstate colleagues they are all in States where about 80 per cent of the population is in the capital city and these debates just don't come up. All the major services are in capital cities and then the smaller hospitals provide local services.

The AMA's position in Tasmania is that those services which can be provided at a local level should be provided at a local level if they don't require a particular critical mass to make them work. The difficulty arises when you have a population of say 25 000 located 100 kilometres between two other centres. Trying to provide intensive care services in a hospital of that size and is where you run into problems. So for some services such as intensive care, cardiothoracic and neurosurgical you certainly do require a certain critical mass because they are expensive services to provide. Further, if you do not have a certain number of people coming through then the staff running those services are not sufficiently skilled to provide them. So the AMA's view is that services such as intensive care have to be localised in areas where there is a sufficient critical mass.

Ms FORREST - What is the critical mass for ICU then?

Dr MIDDLETON - I cannot answer that question.

Ms FORREST - Is that information available?

Dr MIDDLETON - It would have to be available. It would be available from the College of Intensive Care. We know that trying to reproduce all services across numerous small sites is very cost inefficient and is not associated with good health outcomes.

Ms FORREST - We touched on registration earlier with regard to registering specialists and the appropriate process and how the councils in various States do it. What is the AMA view on national registration?

Dr MIDDLETON - We have a very strong view about national registration. The AMA considers that it would be very useful to have a national database of fully accredited doctors and other health professionals so that once they are accredited fully in their own States there will be portability of their registration to other States, so you are not having duplicated registration across many States. The AMA has no problem at all with that national registration model. The difficulty that we have is what is currently proposed by the COAG process which started last year, the intergovernmental agreement -

Ms FORREST - It has been passed in Queensland.

Dr MIDDLETON - Yes, unfortunately; whether it will be passed in Queensland again if the Government changes is less clear.

The difficulty we have with the current national registration legislation as proposed is that it is called national registration and accreditation. What is proposed is a national accreditation system. Currently accreditation is masterminded, if you like, by the Australian Medical College, AMC, which then accredits the royal colleges to train up specialists, for instance, in their area and monitors their training for that. So if I am training in, say, orthopaedic surgery then I will train under the aegis of the orthopaedic

association or whatever. At the end, when it is considered that I have reached the standard, I will either pass or I will not and that is completely at arm's length from government. So those accreditations occur and they are not at all influenced by any work force or political considerations.

Ms FORREST - So you want the accreditation and the registration to be separate?

Dr MIDDLETON - The Productivity Commission recommended to the Government that accreditation and registration were entirely separate. COAG ignored that and has lumped them all together. Basically what they are proposing now is that these arm's length arrangements with colleges will be dismantled and there will be a central council, the Council of Health Ministers, that will have the final say on health accreditation. If you have a system where the final accreditation of a doctor, for instance, is made in a situation that is not at arm's length from the political process then there is all sorts of potential for many more Dr Patel-type incidents. What happens of course is when you have a shortage then political pressure is often put to fill that shortage. At the moment all the pressure in the world can be put on the College of Surgeons to say, 'Graduate that doctor' and they say, 'No, he hasn't met these criteria. He can't be graduated', whereas what they are proposing now is that all of those safeguards be dismantled. Nicola Roxon has said that she considers this new system is essential for the safety of patients in Australia. That is an absolute nonsense. It is going to make it much less safe to have a national accreditation that is not at arm's length from the political process. The AMA is very much opposed to it. We have made our vehement opposition known to Federal and all State Health ministers when I have been actively lobbied, to say that we consider this to be an extremely unsafe and unwelcome development for patients but it would seem at the moment that it is all going to go ahead, assuming they can get bill B, as it's called; bill A, as you have alluded to, went through Parliament in Queensland. That is an enabling bill that only had to be passed in one lower House. They put it through Queensland because it doesn't have an upper House. I am very pleased to be able to address an upper House committee on this issue because it is likely that the AMA will be coming to the upper House and saying, 'You really need to think very carefully about this'. It has implications not only for doctors; it also has serious implications for nurses. Our major concern is that requirements and qualifications will be done down to allow less-qualified people to provide services because it is cheaper. So it is all about health on the cheap.

Ms FORREST - I have an increasing file as we speak.

Dr MIDDLETON - I am sure you have heard from the nurses about this. They are extremely concerned for all the reasons I have just alluded to. They will be in the same boat. It is a bit off this particular topic, though.

CHAIR - Dr Aizen, you wanted to make a comment?

Dr AIZEN - Just to follow up from Dr Middleton, we are already seeing this in the United Kingdom. The Government has set up its own accreditation process in competition with the colleges and they now, for example, have surgeons who have three years' training compared with the traditional college-based training of six years. The scary thing is that when patients go to hospital they don't know the difference between the three-year and the six-year trained surgeon. We are increasingly seeing an increasing focus of incorporation of NHS models into our State bureaucracy. This is of concern because,

while the NHS might work well in the United Kingdom, we have a completely different health system in Australia generally, but in Tasmania in particular. We have a strong focus on private health and hospital systems in parallel to a strong public hospital system and I think any attempt to distort the balance will be fraught with problems.

Mrs SMITH - Are you saying that the British system is creating unfortunate deaths because of this? We heard of an 18-week maximum waiting list in Great Britain compared to years here in Australia. Do you have evidence that that system has created problems or is it too early to tell?

Dr AIZEN - It is a little early to tell, but I can quote - and I think I have mentioned this before in private - that the European Union has ranked all of the various health systems within Europe. There are 30 participating countries and the NHS ranked thirteenth out of 30 in Europe. That is one step below Estonia and one step ahead of Hungary in terms of ranking. We have a system which I say is not only alien to the way we work here in Australia but we run the risk of dumbing down the quality of the services we provide with a potential for risk to patient care and safety. I think that this committee has to look at the way things are progressing in the Health department at the moment. I will say no more on that.

Ms Forrest raised some questions about operating theatres. If you look at questions 11 and 12, I think they are the kernel of her concerns. We have identified in our submission that one of the biggest stumbling blocks to timely and appropriate care of patients in the Tasmanian health system is the relatively small number of operating theatres and operating theatre capacity available. I strongly believe that we should put this to the minister and her department to find out what the current capacity is and how we are measuring up. In terms of the Tasmanian care plans, we have not seen this issue addressed at all. We have seen recommendations about more committees to manage waiting lists but we have not seen a commitment to increase funding or to address the bottlenecks in our hospital system and we have not seen any real commitment other than to blame the Commonwealth for the shortcomings of our system. I would strongly recommend that this committee look at the bottlenecks that we have identified in the system, look at the constraints, look at where efficiencies might be made and, most importantly, to really get some evidence-based movement in the plans. I feel very frustrated about this, but I feel that for too long we have seen governments working on historical funding bases, 'Treasury says there is not enough money and we have to cut our cloth accordingly'. I would like to see a different approach to that, including our theatre system.

Mrs JAMIESON - Is there a push towards encouraging doctors not to recommend surgery - in other words, look at alternative forms of treatment so that people are not necessarily being told, 'You need to have your hip operated on, but if you did a, b, c and d, maybe you won't'? Is there any encouragement amongst surgeons to talk with their patients about that?

Dr AIZEN - I think the word 'elective' is a little misleading because it implies that it is discretionary. Knowing the standard of medical and surgical practice in this town, this State and across the country, I would say that no doctor in his or her right mind would recommend an operation to a patient who did not need it. I would say that, as a GP, I have exhausted all my possibilities and skills in delaying surgery or avoiding it, by the

time I ask a surgical colleague for an opinion it is pretty well a given that the patient will be assessed as being appropriate for surgery.

Mrs JAMIESON - My question was referring back to recommendation 10, where you were talking about your IT stuff. Is there any thought about a more robotic-type of surgery being introduced into Tasmania? It is being used elsewhere and more IT assessments are being done, the whole use of computerised assessments in medicine. I am looking into the future, of course.

Dr AIZEN - There are two robots named after some famous scientist - da Vinci - and it is terribly expensive. The surgery can be done by remote control but as an immediate aid to the work force shortage it is not on but it is something that could be considered. I think when we talk about IT we are talking about very basic things such as things I take for granted in my surgery, a humble general practice, that are not available to salaried and visiting doctors in a public hospital system and that is clinical software that would come anywhere near the very basic clinic software I have in my rooms.

Mrs JAMIESON - IT has been used in nursing homes and what have you in Japan, for example.

Mr WING - Dr Aizen, you made reference to needless deaths in hospitals in the UK. In the last few months I saw quite a staggering statistic of deaths needlessly occurring in Australian hospitals: how does Tasmania rate in this? Do you have any statistics on that?

Dr AIZEN - No. I think the term is 'excess expected mortality'. When people come in to have treatment one would expect that, as part of their treatment and the nature of the conditions, a number of people will die regardless of what you do. Certainly I will take that question on board and we could look at avoidable excess mortality rates for you.

Mr WING - Thank you. On a nationwide basis and in Tasmanian hospitals.

Dr MIDDLETON - We would encourage you to look carefully at the questions that we put down and we would be very keen to know the answers to some of these things. The inquiry will be completed when?

CHAIR - It will be several months before we have the final submission on it.

Dr MIDDLETON - I would like to thank the committee very much for their time in accepting our submission and listening to this expansion of our views.

Dr AIZEN - We are very appreciative of this opportunity. In the papers, I referred to the enormous frustrations in getting anything substantive discussed either with the minister or with senior bureaucrats. It is really out of frustration and some relief that we have been able to express our concerns in a public forum such as this. We hope you do take out concerns on board and hopefully keep in mind what we are all about - good, safe, accessible and timely care for our patients.

CHAIR - Thank you both very much.

THE WITNESSES WITHDREW.