THE LEGISLATIVE COUNCIL GOVERNMENT ADMINISTRATION COMMITTEE A MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART, ON FRIDAY 9 MARCH 2012.

COST REDUCTION STRATEGIES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr GEOFFREY COUSER, ASSOCIATE PROFESSOR OF EMERGENCY MEDICINE, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Ms Forrest) - Welcome. Have you given evidence to a committee before?

ASSOC. PROFESSOR COUSER - I have.

CHAIR - You understand that it is all recorded on *Hansard* and what you say becomes part of the public record. It will be on the website in a few days or a week perhaps and may form part of our report. If there is information that you want to give us of a confidential nature, you can make that request at the time and the committee would consider that.

ASSOC. PROFESSOR COUSER - I am very happy to present my opinions as to the way I see health on the public record and the consequences that may or may not arise from that.

CHAIR - We received your submission before Christmas and are happy for you to speak to that but also any things that you have observed over the intervening period and obviously it has probably been a little bit quiet over Christmas. Can you can give a bit of background to start with about where you fit into the health scheme?

ASSOC. PROFESSOR COUSER - Absolutely. I did just make a few little notes and it is almost an opening statement. I can either read that out or offer it to the inquiry. It is consistent with the submission I made.

CHAIR - Feel free to read it out if you like, if that helps you.

ASSOC. PROFESSOR COUSER - Okay. But in response to your question, I have a co-joint appointment at the Royal Hobart Hospital. I am a staff specialist in emergency medicine at the Royal Hobart Hospital. I am Associate Professor of Emergency Medicine at the University of Tasmania and I am a retrieval coordinator with Ambulance Tasmania. Those are my clinical and academic roles.

I am here today speaking in my capacity as a practising clinician and academic. My thoughts are my own and represent no institutional or political policy.

The Tasmanian health system is in serious trouble. Anyone who thinks it will get back to business as usual after these budget cuts is wrong. Anyone who thinks that the current round of capital works programs will lead to an improved health system for Tasmanians is wrong. Services are only going to become more expensive and will decline in quality due to the community's inability to provide them and pay for them.

Health sees costs increasing by over 6 per cent per annum, rising unsustainably well out of proportion of CPI. This has been well documented around the country. As an example of how skewed our health system is, we spend 50 per cent of a typical Australian's total lifetime health budget in their last one to two years of life. So we need radical reform. I believe reform can be a good thing and if done correctly, can position Tasmania as the exemplar for the rest of Australia to follow. The rest of Australia will have and is having the same problems we have here; it was just that the wave has broken on us first for a range of different reasons.

One of our advantages, though, is that we are effectively a closed system. We can control and measure our achievements. So how do we reform our system so it not only survives but works for the people who need it most? We need to understand that a lot a public funding goes into both the public and private systems and hence the community has a right to demand good outcomes from both systems and they need to work together. We need to recognise the strengths and the weaknesses and harness the resources of both systems effectively. We need to stop protectionist work practices by embracing true workforce reform, soften the role delineations, such as being open to alternative skills being performed by other providers for less cost. An example could the role of nurse practitioners, which is already happening, but expanding into other workforce role reform, such as nurse anaesthetists, nurse endoscopists, which are two that spring to mind. We need to examine what services we, as a community, pay for and ask whether there is a true community benefit, such as considering issues of offering futile care and a lot of the issues that I have mentioned where we spend a significant amount of the health spend on someone in their final year of life.

We need to improve productivity of the health workforce and also, and this is perhaps beyond what we are capable of doing but we can initiate the conversation, redistribute wages through the national workforce, work to prevent the national option of scarce resources which drives up costs in every jurisdiction; when Western Australia and Queensland put up wages and then you get this bidding war and every jurisdiction then has to scramble, and that is unsustainable.

How can you help? Be open to considering the excellent work being done in other jurisdictions and here, but to engage with the community and to innovate and seek to reform their health care systems, seek input from those within the Tasmanian Health system - which I note you are doing, which is wonderful - be remembered as people who had vision, who made decisions for radical reform that will have far-reaching consequences, not decisions based on the electoral cycle. Keep an open mind when it comes discussions about appropriate and compassionate end-of-life care rather than expensive interventions that don't benefit anyone, and focus on a just distribution of health care, wages and opportunities for people to be responsible for their own wellbeing. Let us make a radical shift. What we have done in the past isn't working. There are people who are doing health in different ways so let's be clever and make Tasmania a showcase for innovative and effective whole-of-life health care. This is our burning platform; let us not waste the opportunity.

I heard Ken Henry refer to the 'burning platform' phrase in the role of economic reforms in the early 1980s. The reason a whole range of quite radical reforms came through was because there was a burning platform; Australia was in serious trouble and people saw

the need to respond. We have our own here right now and this is our chance to do some fairly radical reforms.

CHAIR - You have made some very interesting comments there, some we have heard bits about previously. This comment of needing broad reform and focusing on some of these perhaps more difficult discussions, where do we start?

ASSOC. PROFESSOR COUSER - Health is such a big topic. It is the largest department and the largest consumer of the Budget. From my side of things and the profession - from that point of view - I ask for you as legislators and representatives of the community to give me permission to act in a way that realises the community's expectations. When I am in the emergency department I need to make decisions based around people's health care. I am very conscious I am spending public money at a huge rate. I am talking about recognising that instead of having a knee-jerk reaction when somebody comes in sick and automatically our health system, the whole paradigm, is based around it being acute and reactive. We have to cure the sick - that is a good thing, appropriately - but we need to recognise when we can't do things, and the community needs to recognise that as well. I guess the community needs to understand - and this is slowly changing but we need it to be driven from the top as well as from the bottom - that sometimes it is appropriate to not keeping going and doing things but to step back and say enough is enough. For instance, somebody might come with a ruptured aortic aneurism or an ischemic gut or something that has a high mortality. Take into account someone's co-morbidities and a range of things, instead of just saying, 'This is a medical emergency. Let's dash off to surgery'; that is just the start of it. It is then off to the Intensive Care Unit and huge consumer resources for no benefit to the individual because we know that the outcomes are almost universally poor. We have then spent a huge amount of money that would be better used in the other part of the health system. Instead of us automatically saying, 'Right, let's do this', let us just step back and instead of maybe calling the vascular surgeon, call someone like Jane Tolman, who I am sure you have heard from. She is a geriatrician who has a very good view of things. People such as Michael Ashby who has a very good view of futile care. Let us recognise that this is an end-of-life event - and this is becoming more and more common with an ageing population. Instead of us as a profession diving straight in and saying, 'Let's do this' -

CHAIR - Focusing on the aneurism and not the patient.

ASSOC. PROFESSOR COUSER - That's exactly right, and that is why I think as a profession we need to get out of this, 'Here's an emergency. Let's call the surgeon', it is, 'Let's step back and call someone like Jane Tolman or Michael Ashby who can give us that big picture'. I have thought about this myself and maybe you have thought about where you might be in this circumstance. If you have a serious medical condition that suddenly declares itself and you are presented with some pretty serious options, maybe you do need to step back and say, 'Perhaps this is it'. Rather than these painful and prolonged interventions - it could drag out for days to even weeks - maybe let us have the courage to diagnose dying. I do that. That is what I do in my practice. I don't do it inappropriately, I hasten to add. I am not actively going out and -

Dr GOODWIN - I am relieved to hear it.

ASSOC. PROFESSOR COUSER - I want to just make that really clear. I will give you a red hot go, I really will, and I do. This is why there are things like advanced care directives. I can't read people's minds and sometimes I have to make decisions for them and people's expectations need to come around. There are a whole range of things from the bottom up but it also has to come from the top down. This is not an extreme, right-on-the-edge example either. Every day we do things that are unnecessary. I am not saying we need to tell people, 'We're not going to treat you. Have you seen the budget?'; it all feeds into it, though. You have a serious condition in Greece at the moment; they have no money to pay for stuff, so there are two sides of it. When the party is coming to an end people either like to pour vodka into the punch bowl or you take the punch bowl away. If we are out of vodka it's time to take the punch bowl away.

We need to make that point. We need to be sensible. We need to have a really serious discussion with people so that when these things happen - and with an ageing population people are living longer. Not as many people die at home and that is something I have noticed. A lot of people do and that is great and people have good palliative care but we need more of it and that is really important. This isn't just me picking on the elderly or the end of life; it is general futile care in any circumstance and that is a range of things that we need to take into account.

CHAIR - We don't make the policy; we scrutinise legislation. Do we need to have a more constructive debate around advanced directives so that this discussion is had before people arrive at their death?

ASSOC. PROFESSOR COUSER - Absolutely, so that we clearly know what is going on. When it goes well, it goes well. People understand they are coming to an end of their life and we have wonderful palliative care services, but somebody who is a bit out of the loop turns up in the final days of mum or dad's life and then in the heat of the moment they call an ambulance - and this happens a lot. They end up with us at 10 o'clock at night. We have no notes, we have no idea, what do we do? Our instinct and natural reaction is, let us go for it. Let us give it a red hot go. That is great as well because you don't get a second bite of the cherry, but so often it happens that you start going down this path and then you realise maybe we should not have done that. Sometimes the ship has sailed and you have the person intubated and they are through the CT scanner and maybe they are going to theatre or up to intensive care. All of this adds a lot because at the end of the day it is still public money going into this. I don't want to relate it purely to the economies but there is so much more to health than us being acute and reactive. We have to take responsibility so that people's expectations aren't so much that we can keep people alive forever. We have to understand that life comes to an end. Sometimes you are dealt a bad blow and we need to, as medical professionals, have the permission of society to be acting within our good moral judgment, as I would like to think that we have. I would like to think I gave a good lecture on consent to medical things yesterday. I presented a few issues about implied consent and acting in the best interests of the patient. Really, it is in the best interests of the patient to sometimes say, 'enough is enough'. But we need to keep that in the front of our mind and not just as an afterthought. It needs to actually be driving us, particularly in these end-of-life decisions. You can have an unsurvivable event or injury at any age. I am not just picking on the elderly as such. It is just seems to be the state of aged care in nursing homes where overnight you might have an agency nurse with 100 patients whom he or she has never met before and one gets sick. At 2 o'clock in the morning, what are you supposed to do? They call an ambulance and they

come to the emergency department and we go, 'What can we do?' because we are busy at 2 o'clock in the morning. It used to be quiet in emergency departments at 2 o'clock in the morning and now it is busy the whole way through.

CHAIR - When you say that it used to be quiet, how long ago?

ASSOC. PROFESSOR COUSER - When I was a registrar, 15 years ago.

CHAIR - What has changed?

ASSOC. PROFESSOR COUSER - Access block is probably the big thing, where there are fewer inpatient beds. Do you understand the concepts of access block?

CHAIR - Yes.

ASSOC. PROFESSOR COUSER - The Royal' got it bad. We have patients who we say, 'You need to come into hospital, you've got a cough, a temperature, you've got spots on your chest, you have a temperature of 39°' - it takes 30 seconds - 'You've got pneumonia'. I've made the decision to admit them to an inpatient bed. The problem is the inpatient beds may not be there because the hospital's running at over 100 per cent capacity. You would have heard Jane Holden present more up-to-date figures but certainly even when the hospital gets over 85 per cent capacity things start slowing down and you get that reduction in flow.

I realise I'm going off on a tangent here, but the way the Royal Hobart gets beds created is that poor old Joe who has been waiting two years for his knee replacement gets rung up the night before saying, 'Mate, don't come in, we've got somebody with pneumonia who's acutely unwell'. But if there is no bed they stay in our emergency department so even though we might 40 beds there, 30 of them could be taken up with people awaiting admission. So for the City of Hobart we have 10 active beds but the people still keep coming. It is like a blocked drain that is full of gunk - and I'm not saying patients are full of gunk but you know what I mean. You know, you've still got the tap running.

CHAIR - A bottleneck.

ASSOC. PROFESSOR COUSER - It's a bottleneck, absolutely, and that's what access block is. When there's no access block, life's great - it really is - we can deal with 150 patients a day if the flow's happening.

CHAIR - So will the new acute care unit make a difference to that?

ASSOC. PROFESSOR COUSER - Yes. That is part of some of the good things that are happening on the ground, little issues around that that will improve our flow, provided they have the capacity to deal with that. Also it's a culture change. There's very much that inpatient culture that before they accept a patient they want to know what the white cell count is, they want the pathology, they want everything back, but yet I just said in 30 seconds I've made a decision saying, 'This person's not going home, they're coming into hospital'. Why do we have to wait doing all that there? Let's have our four-hour rule, which is one of the health reforms that came in this year, one of the real health reforms

that might just light a fire under the system to keep that flow happening. It's absolutely critical.

But that's only one thing. We still have the issues of demand and the numbers that are presenting to the emergency department, not just at the Royal Hobart but in every jurisdiction around the country, are rising because of the increasing complexity of patients, the increasing aged population, and people's expectations of what the health system can do. One of the things I feel that we really need to do, and I said this in my submission, is that we as a community need to have a conversation about what the health system can actually do for us.

CHAIR - What we're prepared to pay for.

ASSOC. PROFESSOR COUSER - What are we prepared to pay for, because if there's no money to pay for things, that makes it difficult. But it's not just a money thing, it's a lot of issues.

CHAIR - Focusing on the cuts that have been made at the moment - the broader picture, I guess, and it's under discussions that probably need to be had around the whole challenge we face - there has been some concern that the people on waiting lists that are being delayed or cancelled at short notice because of a medical admission overnight or whatever -

ASSOC. PROFESSOR COUSER - That's always happened, yes.

CHAIR - Yes, that has always happened, but are we seeing an increase in those patients presenting to the DEM at this stage?

ASSOC. PROFESSOR COUSER - I expect we will, because where does somebody go who has chronic pain who's been waiting for a knee or hip replacement for two years? In the meantime what's happening to that person? They're not just getting on with their life waiting for the call to go into hospital, there are somebody whose life is impacted, whose mobility is impacted, they may be caring for somebody and that's causing problems. That would impact upon their ability to care for somebody. They may be on a multiple range of different medications - regular paracetamol, non-steroidal anti-inflammatory drugs, they may be moving up to some oral opioids, that sort of thing - they're on a range of different medications just to control their pain. Their mobility gets to the point where sometimes you get acute admissions because where else do they go when they physically can't walk? They need to go to an emergency department and often they will need to be admitted to hospital.

So it's a massive cost shift from dealing with this elected surgery and, sure, it may be saving money in one part of the health system but it's leading to costs in another through the PBS, through visits to their local doctor, through the Federal Medicare system, through presentations to the emergency department, to unplanned admissions to hospital. It is a range of things that leads to this really disjointed hospital system which leads to some perverse outcomes.

CHAIR - Are we seeing that yet in your experience?

ASSOC. PROFESSOR COUSER - We have always seen it because the waiting lists have never been under control and I expect that we would see it further.

CHAIR - Yes, but you don't have any evidence of it increasing at this stage.

ASSOC. PROFESSOR COUSER - I can't present any. It's only my own observations. There would be data there I would imagine.

CHAIR - Some people said it is a bit early to tell because the wind-down over Christmas means that there is usually less access.

ASSOC. PROFESSOR COUSER - We have less access because surgery is not being performed. From an emergency department point of view it is actually quite good because there is the capacity for unplanned admissions. Actually maybe there is some evidence because just in the last couple of months it has been very busy at the Royal and this is in a period that is traditionally slower. You know, summer is a nice time, so how are we going to be come flu season? We are all a bit scared about that.

Mr HARRISS - Just on that, I suppose the evidence you refer to is the opening of some of the beds which were closed. Is that what you are referring to?

ASSOC. PROFESSOR COUSER - That happened a couple of weeks ago, you mean?

Mr HARRISS - Yes.

ASSOC. PROFESSOR COUSER - Yes, I would expect so. The thing is with the State public system you do get this variable demand and when you get the peaks you have to be able to deal with them and of course they are unpredictable. For example, yesterday there was a nasty road trauma. The hospital has to have the capacity to deal with that which means you have to run at that built-in redundancy almost to be able to deal with those peaks. That is a bit of a difficult concept I guess, you know, 'Hang on, there are empty beds there but there are people on waiting lists'. There needs to be that built-in redundancy to deal with the flow issues.

I just want to talk a little bit about some of the elective things. It is still public money that goes into the private system as well so if you needed a knee replacement and you have private insurance you could get one in the next week or two. If you needed a colonoscopy next week and you have private insurance you could get it next week, but if you go into a private hospital maybe 70 per cent of the money that is going into that is still public money, either through Medicare or the health care rebate. I think I gave evidence at a previous inquiry here where I may have made this comment - I think when Mr Wing was the Chair - but it is still public money and so we've got an expectation that how do we harness this $120 billion a year that goes into health - that is not all public money but a significant proportion of it - which every year goes into our health care system, how do we harness the relationships between the two? That is a question that I think really no-one is asking because in any political and policy discussion it refers to almost two different systems but it is still public money in the private system. I think as a community we have an expectation that we get a community outcome for that.

CHAIR - What is your view on addressing that? This is one of the criticisms that has been made not just in recent times in the face of budgets cuts but previously about the cost-shifting with the Federal Government paying for some, the State Government paying for others, it depends where you have your procedure or your investigation, whether your blood tests are done as an outpatient.

ASSOC. PROFESSOR COUSER - Yes.

CHAIR - It depends who pays for it. How do we deal with some of these things because we are seeing tests being repeated unnecessarily as a result of that and lack of communication between the two systems.

ASSOC. PROFESSOR COUSER - Absolutely. I think some of us look enviously at the model in New Zealand where it is just one system. I do not think we want to necessarily be like the United States but if we want a glimpse of the future that is what we see, where you have about 16 or 17 per cent of GDP going into health but 35 million people cannot get the health care they need. That is what happens when you have poor (or pooled? 10:28:40) distribution of funds.

The UK has some problems with its NHS. There are different systems around the world. To harness these different systems, everyone loves talking about the single funder but I am not sure the Feds are that capable of dealing with it either, particularly on the ground. I am not just referring to some issues that happened in the last two or three years, it is just not what they are necessarily trained to do.

I have raised this before. Tasmania really does have this opportunity to try stuff that you cannot try anywhere else in the country and I am wondering if that is in fact our future given that as a State we have a very poor ability to pay the wages as a result of what is happening everywhere else. We do not have the cost base at this stage. The State is in a precarious financial situation. I do not believe we have seen the worst of it yet but the costs are still rising and we cannot avoid that.

I am wondering whether in fact our future is actually instead of being reactive and saying, 'We need to cut elective surgery, we need to do this', that we actually try something new and put ourselves forward as always being a test tube for some of these work force reforms. We are a closed system so we can say to Queensland and Western Australia, 'Look, you guys can poke the finger at us all you like but this is going to happen to you soon enough where the health costs will just completely overwhelm your budget'. If I could just give credit where credit is due, when the Premier was the Minister for Health with the Tasmanian Health Plan, there were some really good ideas that came out of that, and I would really like to emphasise that. It is just that it wasn't executed in the way that I think people in the profession and perhaps in the department and the minister would have liked.

CHAIR - The Federal Government did intervene at that point too.

ASSOC. PROFESSOR COUSER - That was unfortunate, but there was more to it than that as well, because it made some very good points, the whole thing. But I just think Tasmania does have an opportunity to try something new, and with this idea of a private system and a public system, a lot of people adopt the attitude, 'I am okay, I've got private

insurance; I don't have to worry about that'. Well, you do, because they are interlinked. It is public money, and in a small State like Tasmania we can't justify the couple of billion dollars that go into health every year in public and private as such. It is all linked.

CHAIR - How do you see the model then, looking at a greater collaboration between public and private? Of those who have private cover, most would recognise the fact that if you need neurosurgery you are going to be in the public system and that's it - in Tasmania.

ASSOC. PROFESSOR COUSER - If you need cardiac surgery, absolutely, so it is linked. You have the State public system dealing with these acute unplanned things, and I would like to think we do that fairly well. We are reactive to that and we have the capacity and we have the staffing there. The Federal public system - also known as the private system, and I call it that because it has the underpinning with the Medicare and the Healthcare rebate - is very good at elective surgery. I am thinking maybe the difference is not so much the fact you have a Federal public system or a private system and a State public system, it is that they are focused on the elective stuff. They do not get inconvenienced by these unplanned admissions where people go and get pneumonia or crash their cars and the like. They can simply deal with a very efficient business model of dealing with elective surgery. When you try to run elective surgery and then you have to stop theatres because there has been a massive road trauma or these acutely unwell people, really if you are acutely unwell you do go to the Royal. If you need a knee replacement I would suggest that perhaps the private system is more efficient regarding that, but it is still public money so we have a responsibility to work out how we harness the strengths of both of those systems. I think I have told you this before, so I do apologise if I am repeating; it is some of my other experience in life. One of my hobbies, I guess, is that I am the president of an organisation called the Tasmanian Land Conservancy. We purchase land for management of conversation. We receive funding to run programs from the Federal Government, the State Government, private donors, private corporations and a range of other things, and so the funding all comes through to our organisation. We then have a landscape view of where is the best use of that. Instead of the Federal Government in that silo, State Government in that silo, everyone in individual silos trying to do everything for everybody in those individual areas, we receive of all these funds and then, using science - and I would like to really make that emphasis; we have a very scientific approach to landscapes; sometimes other things intervene but for the most part we do take it very seriously - we say that is the greatest need. These are the hot spots, whether it be the Southern Midlands or the Northern Midlands where there is a biodiversity hot spot, working with landowners there. We recognise this. We can have a global view and we can then send the funds for that to get those outcomes, so it is almost like a filter.

I am wondering if that same model can work in health, where it is just so big, $120 billion a year. It is a lot of money, isn't it. We talk about the cost of the NBN being $43 billion over the lifetime of the project. We spend $120 billion, growing at 6 to 10 per cent per year, every year on health. That is a huge amount. It is 9 per cent of GDP. Health is very important, but the idea that health is totally confined to the Health department is also naive. It is other things - social inclusion and issues regarding education and employment and all those sorts of things which are very, very important, but the health budget consumes all these other things. I am wondering whether we do in fact - I have referred to this in my submission - need that middle area, and I am not just saying this because I have a role with the university. I just cannot think of anyone else

who would do it, but you have a university that is in touch with the workforce or you have a body that has the community support and is driven by evidence, receives the Federal funding, the State funding, private moneys, DVA, MAIB, that whole thing there, and then we look at the needs of the community and we can send the resources so it gets to the right people at the right time, irrespective. It's a way of pooling these funds and then we use evidence and just say, 'Well, the Royal Hobart Hospital is very good at dealing with the acute unplanned and it's also good at doing neurosurgery and cardiac surgery and it's the State's centre for burns and what not'. That's where that is. Just the last week the Australian Institute of Health and Welfare reported on the bowel screening program and one in 11 colonoscopies show a pre-cancerous or a cancerous lesion. We know that the state of being able to get a colonoscopy at the Royal is quite precarious but you can get one next week at Calvary or Hobart Private if you really need one.

CHAIR - Or the North West.

ASSOC. PROFESSOR COUSER - Or the North West. We can use these different ways of dealing with it. We can send the resources where they are wanted based on taking that global view instead of okay, we've got the State public system here and it's trying to do everything, we've got the private system here trying to do everything - there are only 500 000 of us so we need to have an evidence-based sensible approach. That would be an excellent model, I believe, for the rest of the country because costs are rising. We've seen what's happening with Victoria and the wage claims with nursing staff there. We've got a range of other issues in providing health care in different areas. It's very tricky and it's not just going to be Tasmania.

It's okay to borrow to invest if it's going to grow. It's not okay to borrow for recurrent expenditure. That's my view on my household budget. I would hope that it's perhaps the way that you guys take the State Budget approach. That would be my view; that if we can really do something with support from the Feds, it could actually be that we could really do something that's going to carry our health system, not just in Tasmania but in Australia, forward and meet the challenges that we know are out there but at the moment we are extremely ill equipped to deal with. That would be my view.

Dr GOODWIN - I appreciate what you're saying in terms of the bigger picture but I suppose the focus of this committee is on the budget cuts for health. The savings target was pretty significant because the department hadn't met previous savings targets with the former Health minister. Do you think the cuts have been made in the right area, and that's assuming that you accept that cuts had to be made -

ASSOC. PROFESSOR COUSER - Absolutely.

Dr GOODWIN - or have they been made in the wrong area and where would you have done things differently?

ASSOC. PROFESSOR COUSER - Thank you for bringing me back on track because I do understand the terms of reference and maybe I went a little further than that.

First of all I would like to state that I think the hospitals, presented with that, are doing the best they can in dealing with the cards that they've been dealt. I think Jane Holden has a very difficult job at the Royal Hobart Hospital and is doing an excellent job in

trying to do what she can but it's going to get harder. I think my view of making cuts to elective surgery is a very reactive one, that whilst it may save money in the short term, it will lead to some shift of costs to other areas and it will also lead to costs being delayed when we'll be even less able to deal with it.

I guess at this point in time, the actual costs are not going to make a big impact because we're going to be having the same conversation next year. I guess, taking, as they have with the document, the savings, in a lot of places it's a good start and that's very important. We have to understand that with health the party can't go on; we can't just keep pouring vodka into the punchbowl. We've really got to say how can we bring this back into line.

So this is one thing. I fear the elective surgery cuts do have an impact on the health of the population and whilst I would certainly commend a move to taking that big picture towards preventive health and moving towards dealing with the ageing population and the role of chronic diseases, that's a very long-term view. People want and need their operations now so they can continue to live well and to be independent within the community. With elective surgery you do get a bit of a skewed thing where you have surgeons doing some minor stuff to clear lists when the bigger-ticket stuff is just not being done. My fear is that from a political point of view we really do need to look at efficiencies to make a serious impact on waiting lists, just to prioritise it so that we are not getting these cost-shifts happening.

Infusing that culture of change I was referring to earlier is something that we can do now and are starting to do. There really has been in the last year or two a move toward us examining our practices and what do we do. Is it really doing the right thing by the patient? Is it really a good thing?

I do not want you to think that the first thing I think of when I see a patient is, 'My god, how much is thing going to cost?'. But it does need to be there as well. It should not be driving it but we should be aware of that because I can burn through a lot of public money in a day. That is not a good thing in the long term. This is slowly happening but we really do need to understand that we just cannot provide everything for everyone at every stage of their life. I think that this is a good opportunity to really focus on that and I think that is just as important as actually going through every item number and saying, well let's cut 10 per cent off that. Health needs a haircut. It seriously does. This just cannot go on. The rise in health costs is outpacing CPI. We really do need to do it. The impact of us changing our culture I think could be quite significant. It will be in the short term, there will be a difference, but long term it will put us on a sustainable footing as long as the community understands. I think more and more people are understanding what their expectations are but I think we have to have that serious conversation.

CHAIR - Early on you mentioned other jurisdictions and you mentioned New Zealand and the challenges for some of the others. Is there a model that you think could be applied like a case study or a pilot study, whatever you want to call it, for Tasmania?

ASSOC. PROFESSOR COUSER - I only mentioned New Zealand because they do not have States. They are four million people with one political system and that would be desirable. You have not got the States competing with each other. We really need to have a look at that. That is one element of it.

You mention Oregon and people immediately think of PAS - Physician Assisted Suicide. I am not talking about that. I am talking about their view on how they assess the benefit of an intervention for an individual in the community, where it just says we are not going to initiate dialysis over the age of 75. Thing like that. We have to balance our budgetary requirements with equity issues as well, and that is difficult. We need to look at saying we simply cannot afford to keep going on the way that we are going. So we do need to actually draw the line under some things. We need to say this is an intervention that is not going to benefit. There was an excellent paper in the MJA a few years ago; it talks about these things. We just have to look at what is the benefit to the individual. Is there a benefit to the community? We have to ask ourselves is it worth spending $500 000 a year keeping an individual alive with a poor quality of life and all the things that go along with that. These are hard decisions and I have looked people in the eye and said this just does not win. I cannot offer you anything. We need to have a conversation. I have had to do this in a matter of minutes sometimes, particularly if someone has a leaking triple A. They are already near death and people are saying, 'You have got to do everything you can, Doc'. Well, I can't do anything.

Mr HARRISS - How do you reconcile that with the fact that some of those very people may well have not been in need of access to the public health system all of their lives. They say, 'Well, I have paid my taxes, I want the best shot', in the hope of a miracle drug or a miracle medical intervention being discovered?

ASSOC. PROFESSOR COUSER - There is a lot of focus on that. That is an interesting conversation. You have to back things up with the reality and what the wish is. We don't discriminate based on what people have used in the past, so we take every instance on its merits. Regardless of whether they have had a healthy life or whether they have been at the Royal every second week, if there is an issue of futile care I am looking that person or a family member in the eye and saying, 'I honestly can't offer anything here. There is no miracle'. Often with issues around neurotrauma and those sorts of things sometimes it may be inappropriate for me to make that call there and then, but after 24 hours you may have a good idea. You may want to wait for a longer time. Everyone can recite a story of someone who was in a coma for, say, a year or a year and a half and then woke up. That may be the case and that is great for that individual but the statistics don't reflect that that is likely. The key thing is, are we as a community prepared to pay for that at the expense of initiating some very good public health programs that will lead to thousands of people being healthy. That is what it comes down to if we can't fund that. It is a rationing of some point of view

There are 7 billion people on the planet, so in the next 100 years more people are going to do than ever before in history. We can get a good idea of the course of a lot of conditions. We are not going to get it perfect every time, but using a range of things we know that if somebody has a ruptured aortic aneurism and they have required some cardiopulmonary resuscitation pre-hospital and they have had some IV fluid resuscitation and their conscious levels have picked up, I know that that person is pretty close to 100 per cent mortality. There is a chance you might get away with it but it will be weeks of intensive care. The question we have to ask is, are we as a community prepared to pay for that chance at the expense of other things not working? These are the issues we need to talk about. If I may respectfully suggest, I don't think we can afford that. I think we have to be able to say, 'The time has come. This is a terminal event'. What if you were

to say to most patients, 'There might be a 1 per cent chance you'll get through this. There is a 99 per cent chance you're going to die after weeks of intervention'? I have had conversations with people, when they have been conscious, who are dying and I've said, 'Make your peace with your family'. It is a terrible thing, but I have to have the courage to do that, and it is worthwhile when it goes well. It is very confronting but that is what you do. I am not saying this should be made by anyone but most people want that good death. Ask what you want out of life. Do you want to be surrounded by your family? Do you want to have a painless death? There is a time and a place to go for it and there's a time and a place to say enough is enough. Waiting for that miracle drug or that miracle cure, can we afford that as a society? I don't think we can.

Mr HARRISS - Are you alluding to lifestyle choices impacting on the person's health and therefore making some societal judgments?

ASSOC. PROFESSOR COUSER - I think we might have to. I don't think you have taken evidence from one of my colleagues, Bryan Walpole. Bryan is a very experienced physician and he wrote a very good letter to the editor of the *Mercury* a few months ago. He made the point that somebody who behaves irresponsibly, drinks a huge amount of alcohol, drives while intoxicated and is involved in a motor trauma, is brought in with signs of life into the emergency department and immediately all the resources are diverted to this person. They are intubated and get everything scanned, it is off to the Intensive Care Unit and they get the Rolls-Royce treatment. That funding displaces old Joe who has spent his whole life working hard on a low wage and has buggered his knees as a result of hard, physical labour. He doesn't get his knee replacement because the bed has been taken or the resources have been consumed. As we know from the Health system, we are always there for emergencies and that takes those resources away. Is it just? Where is the fairness in that? I think absolutely that people have to take responsibility for their own health and there is no free lunch. It is not a free public hospital system and I think we have to maybe just say, 'If you're going to do this' - you also have to have to keep issues of equity and all that there - 'you're going to have to take responsibility for it'. I don't think there's enough of that going around, quite frankly.

I do not know if you remember the letter, but I think Brian nailed it in a paragraph talking about those inequities that you asked me about. It is not for me to do this but what do you think? I do not know. I would be curious on your thoughts on that but obviously not today because you're the ones asking the questions.

CHAIR - Geoffrey, we're just about out of time and the bells are going to ring shortly for a quorum call, so we will have to end our hearing at that point. Do you have any closing comments you would like to make for us, looking at the impact of the cuts, on how things could be done differently or better?

ASSOC. PROFESSOR COUSER - I think you need to support the people making decisions to make some hard decisions. I think you need to take on vested interests and by that I mean people who are trying to protect their patch, as such, and have done for generations. I think we need to be open to doing new ways of things. I think you need to look at evidence. You need to understand that if we do make some cost savings to make our health systems sustainable, everyone keeps going on about our having the best system in the world, and that is great, but at what cost? We need a pretty good system but we cannot afford the best system in the world. Maybe if Tasmania was made of iron

ore we could, but even then, Western Australia is running into some problems and already they are tightening the belt in a range of areas.

This is a tsunami that is heading everywhere and it is not just Tasmania because we do not have much of a cost base or tax base as such, but we could really be a guiding light for the rest of the country. We need to have the courage to say, 'Yes, we're going to do this because we want to connect our health system with the community's expectations'. It is a two-way street and I would really support the Government in making some of those calls. It is going to be painful, it is going to be uncomfortable, it is going to be politically and professionally difficult, but we have to do it. I really think that we are in serious trouble here. We are in serious trouble. We cannot afford to continue to pay for what we have been paying for all these years and it is really time it stopped. It is just nonsense what is going on. We have to do something differently and we cannot simply keep working in the same way of doing things, otherwise we will be having this conversation in 10 years. I will book my hearing now.

CHAIR - Does that discussion need to be led by clinicians or who?

ASSOC. PROFESSOR COUSER - As clinicians I think we do need to be involved but I do not think we have any special right to necessarily be involved and sometimes you need somebody from outside. If this was a business an administrator would have been appointed years ago who would have then said, 'Right, this is what has to happen and you can complain all you like but there is no money for this'. We almost need that external administrator, and I think I think I made that point in my submission, because I think everyone is protecting their own turf. That is fine. The ANF is standing up for nurses, the ANA is standing up for doctors, and HACSU is standing up for other workers, but everyone has their own silo and they are protecting that at all costs and that really has to stop.

We have to look at this whole system. We have to reconnect our health system with the needs of the people it is purporting to serve and there has been that disconnect, there is that disconnect and the disconnect is going to keep happening. We know it is disconnecting because we are just not geared towards this huge number of chronic diseases and the consequences of that, whether it be diabetes, the ageing population, or a whole range of things. We really have to make some hard decisions and it is going to be uncomfortable.

With respect to the electoral cycle that comes around, you try to have this conversation and it is very easy to oppose, it is very easy to knock it down, but we have to have it because no matter who is in government -

CHAIR - Are you saying elected members should be leaders in the discussion?

ASSOC. PROFESSOR COUSER - I think you should be leading it. You need to build up that trust with the community but I'm not saying that you all have to be sitting around holding hands and singing *Kumbaya*. We are all in it together but we have to all recognise that there is a problem and I don't think Labor, Liberal, Green or independents necessarily have the answer. It is not as if, 'We've got all the answers and this lot doesn't'. It is not that sort of thing and we have to think of a completely new way of

doing things because if it is simply changing sides at the next election it is still going to be that same paradigm within which we are working.

CHAIR - We have to get the medical professionals to come on that journey. The neonatal intensive care specialists who want to save a baby are one end of the discussion and then the intensivists, by their very name and nature perhaps in some cases, want to do everything and even -

Dr GOODWIN - A challenge.

CHAIR - Yes, 'We can save this one'.

ASSOC. PROFESSOR COUSER - We need to have that discussion but we need to also say these are the rules of engagement. That is what we need.

CHAIR - Thank you very much.

ASSOC. PROFESSOR COUSER - I wish you well in your journey as well because we do need you guys to make these hard calls, we really do, because someone has to.

CHAIR - Thank you very much.

ASSOC. PROFESSOR COUSER - Thank you for giving me the opportunity to present.

THE WITNESS WITHDREW.

Dr FRANK NICKLASON, CHAIRMAN, MEDICAL STAFF ASSOCIATION, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Ms Forrest) - Just to explain how our committee works here, everything you say is recorded on *Hansard* and made publicly available on our website. Then we will prepare a report which may include some of that in our report. If you have information you would like to provide of a confidential nature you can make that request if you feel that is the case, but the preferred basis is that information be provided to the public as much as we can.

We have the one term of reference which, whilst it is relatively broad, is also narrow, focusing on the cuts and the impact of the cuts, but of course it does take in health services more broadly to a certain extent. Would you like to make any opening comments?

Dr NICKLASON - I would just like to frame the context of why I get to say something in this meeting. I am the chairman of the Medical Staff Association of the Royal Hobart Hospital and I have occupied that position for about 10 years. It is not a popular position. I have tried to pass it off to someone but no-one wants to take it. The way I have used the position, and which is relevant to this committee, is that I try to make myself the set of ears that is hearing what my medical colleagues, both junior and senior, are saying about the situation in the hospital. A lot of it is to do with morale, but there are also the issues that are pertinent to the profession itself and training and the experience of practising in the hospital. That is where I am coming from.

With respect to the budget cuts, I have attended meetings, I have had briefings from a number of senior colleagues, but often the opinion leader types, and I also developed a survey of my senior colleagues last year just to get a feel for the way they were feeling about the situation, to try to gather what suggestions they might have.

CHAIR - At what point did you do that survey?

Dr NICKLASON - I cannot remember the exact date of it. There was some publicity about it. I did an interview for the ABC. It was probably October/November, something like that.

CHAIR - That is before the cuts had really been implemented but they had been announced.

Dr NICKLASON - Yes, when there had been announcements. It was in response to the issue of the cuts.

CHAIR - Just going through some of those points that you have raised, morale is always an issue that tends to be a bit of a gauge of how things are going. What was the morale like amongst the junior cohort of medical staff to start with, and then senior, before the cuts and how does that compare with now?

Dr NICKLASON - It is hard to be certain about morale without doing formal surveys, but I think the cuts have had an impact. What we rely on as a university teaching hospital is to be able to attract the very best of the people that we are training in the medical school and the very best of the junior doctors to stay in our hospital and to enter our training

programs, and we have had more leakage away from our hospital in recent years, and that seems to be an ongoing feature. Certainly we have had more difficulty filling some of the intermediate grade positions in the area of general medicine, for instance, this year in the medical training positions - and that partly relates to us being in general less attractive as a training site.

CHAIR - So this is before the cuts?

Dr NICKLASON - Yes, it is before, and I think it has probably been exacerbated, from what I can gather.

CHAIR - So why are we seen as less attractive as a training site?

Dr NICKLASON - Because in the area of surgery, if you take that as an example, the reduction in elective surgery means that the people who are going into the surgical training programs are not getting the practical experience that they need to get to satisfy the colleges that we will have an ongoing training program, so it creates an uncertainty about the viability of training programs.

CHAIR - So what about the senior staff?

Dr NICKLASON - When I surveyed the senior staff - they had just had a 10-point survey - I asked them questions such as where they saw hospital in terms of their experience. Many of the people that I surveyed have been working at the Royal 15 to 20 years and one of the striking things was that there was a clear recognition that the financial circumstances of the State are now worse than in the memory of that long experience so people recognise this is financially the worst situation Tasmania has been in, and they recognise that the amount of money that is going into the Health budget is unsustainable and that there will need to be some changes made.

If I can just use an analogy that my senior colleagues have put to me, they felt that the situation we are in is analogous to having a person who is severely injured and bleeding or in the process of bleeding out and that what really is required is a recognition of that situation but also, in order to have the possibility of reconstituting the Royal at a time when our financial position improves, we must maintain the vital organs so of course you know we are talking about the brain.

CHAIR - We need a blood transfusion, don't we?

Dr NICKLASON - Yes.

Laughter.

Dr NICKLASON - It could be partly to do with that to stop the bleeding but it is preserving the brain. And the brain is the senior people in the hospital, the training programs, the medical schools, so it is the hospital as a teaching and training institution, it is the reputation of the hospital in that area and it is retaining those key people who are basically irreplaceable. Obviously we have some specialists that are more important than others in a way that they cannot be replaced if they find that they cannot keep up their skills, if the hospital is not able to work in a way that helps them to maintain their skills

then they cannot stay. That came across in the interview that there are people - the survey was anonymous, and there was a worrying number of people who would be considering leaving the hospital.

CHAIR - That is a question we asked the CEO yesterday about senior staff that have left. The comment we got back was at this stage none have left.

Dr NICKLASON - Yes, that is right.

CHAIR - That is the case but you are saying in your survey there is a number -

Dr NICKLASON - In the survey, it is under review that they are thinking seriously about that, and that is the way the question was worded, so there was quite a worrying proportion of people saying that they were seriously considering it.

CHAIR - And mainly from the risk of not having the adequate experience to maintain their accreditation with their colleges, is that the predominant reason?

Dr NICKLASON - Certainly in the area of surgery, a surgeon is nothing if they cannot maintain their skills and reputation and they have to do that by operating and operating with appropriate technology and if those things are not available to them a surgeon will consider whether it is the right thing to do to continue working at the Royal.

Another thing that relates to this and it came through very strongly from conversations both from the surgical, medical and intensive care side and the emergency department side is that there is a great mutuality and interdependence between the private hospitals and the Royal Hobart Hospital in Hobart, in that many of the people who provide services, for instance, in ICU at the Royal Hobart Hospital also need to provide those intensive care services at Calvary Hospital. We just do not have the population of that group of people that we could have two camps of people, one servicing the private sector and one servicing the public sector.

CHAIR - Isn't that a positive thing then, the fact that these people get to maintain their skills in the private sector?

Dr NICKLASON - Absolutely. I think it is entirely appropriate and it must be supported and if we lose a viable private hospital intensive care, if we lose emergency department capability in the private sector, the Royal is swamped. That is a very important point and it needs to be borne in mind with any of the changes that might be happening.

CHAIR - Does there need then to be greater collaboration between the public and the private and, I would say, share of resources, which is probably not quite the right term, but greater utilisation of both for the skills maintenance for the medical and nursing staff, and also to ease the pressure on the public system?

Dr NICKLASON - Absolutely there does need to be. Where we might be having difficulty, for instance, exposing a person in a training program to sufficient, if you like, clinical material in the public sector then certainly the private sector can help us. There has been a symbiosis but it can be threatening and it must not be.

CHAIR - These challenges are not necessarily new though. I remember back in possibly the 1980s our friendly obstetrician did a stint down here. He once got a letter from the Joint Consultative Committee telling him he needed to increase the rate of forceps birth because his registrars were not getting enough experience because we had a 3 per cent epidural rate and things like that so we were not seeing the forceps births. These sorts of things are situational.

Dr NICKLASON - They are not new but what seemed to come up in the conversations and in the survey is that it is understood that we need to live within the budget that we have but the abruptness of the budget cuts seems to be the concern people have.

Another analogy that people allude to in different ways is that it is almost as though there is a tap being turned off very quickly now and it is as if the hospital is not a living organism but it is a machine that has a tap that at some later point can be turned on and there will not be any damage.

The concern that people are expressing is that if we damage the brain, that is, the training programs, the educational status of the hospital, the reputation, the special staff that we have to retain, then that cannot be recovered in two or three years. That might be a decade-long or longer change that persists to recover the reputation as a teaching and training institution.

Mr HARRISS - How much at threat is that?

Dr NICKLASON - I am not in a surgical area so I think it is really important to speak to the surgeons that are involved in those training programs but I would imagine that it is under very significant threat because of the reduction in elective surgery. The elective surgery is an important part of the training of a surgeon.

CHAIR - There have been some broad cuts across a whole range of areas that have not directly impacted front line services but then the big-ticket item is the elective surgery. Does that have a flow-on effect to medicine?

Dr NICKLASON - Yes, it does.

CHAIR - We talked up at the Launceston General Hospital about medicine. Some of the medical or surgical techniques - I would still call them surgical techniques but they are still classed as medicine - there is still an impact on those because of bed blockage issues and things like that. Does that impact on the medical training program?

Dr NICKLASON - Can I give you a couple of very typical examples? One that Scott Parkes has brought up that is worth mentioning is gall-bladder surgery. Gall-bladder surgery might be put off but a person can get a really nasty complication having an inflamed gall bladder. A person can develop pancreatitis which, as an ICU nurse in the past you know, is a life threatening complication that can mean that person winds up in ICU with all sorts of nasty morbidity and a significant mortality associated with it so in the end a much more expensive episode of care than if it had been possible to remove the gall bladder in a timely way with laparoscopic surgery with a patient in and out of hospital after a day or so.

Sometimes there is a very clear false economy of reducing elective surgery. Probably the more important common ones - although that is important enough - is large joint replacement. We have the oldest population in Australia, or nearly the oldest population in a State in Australia, and severe arthritis of the knee or hip is a really disabling, painful, demoralising condition and I have done quite a bit of consultative on the orthopaedic wards. I make a practice of spending two or three minutes with a patient who has had a large joint replacement just to see what their experience of how quickly it was that they were able to have their needs met with respect to joint replacement. It certainly seems to me that my overwhelming experience is that the people have waited too long. They have had to wait too long because we just do not have a system that is able to move people through that elective surgery in a timely way and when the operation is done, the orthopaedic surgeons will tell you that it is technically more difficult. The person has lost physical condition, they are often demoralised and the rehabilitation to get them back on their feet and out of hospital and doing well at home, that process is longer and therefore more expensive.

Dr GOODWIN - Could they have also been unable to work during that period as well?

Dr NICKLASON - Yes. I suppose if you want, Vanessa, another case that I saw last year that was really distressing was a woman in her 50s who had a terrible knee arthritis that stopped her working. She was a tough northern-suburbs woman who really had to be working. She was a single woman and she got so desperate that she got in her car one night and she was going to drive into a tree. Fortunately something in her mind told her to go and talk to a friend and her friend talked her through it and she eventually did have her surgery. But she was deadset going to do that. That is the case, that there will be things like this that can happen that we might not necessarily realise have happened because there has been a problem in elective surgery.

The same day that I heard that story I was driving down to Nubeena to do a clinic and I saw a 75-year-old man who had bilateral very, very severe arthritis of the knees and he needed to have them replaced. He was driving a taxi. He wanted to work and he would have been capable of working if he could get to his taxi but he was taking quite a large dose of narcotic medication to ease the pain, and driving and narcotics do not mix.

There are all sorts of ways that there can be a really negative backlash of the reduction in capacity to do elective surgery.

CHAIR - This is probably a bit of a guess in some respect. You have described some classic situations of delayed surgery in terms of the patients' recovery, their fitness for surgery when they eventually arrive there. Can you put a figure on this or is this just too difficult?

Dr NICKLASON - I cannot. If we are talking about things that we possibly could do better. I feel like I am, in a way, perhaps speaking a little bit out of place but I think that there may be more that we could do to really carefully assess those people who are on waiting lists for painful conditions like, for instance, large joint replacements - to just really see if we can identify that woman who is virtually suicidal, if we can identify that guy that wants to drive and he is on narcotics. Even if we cannot do all that much about moving the surgery through, do something that is different. Work out whether we can prioritise some people who are suffering further up the list. See if some people's situation has

changed so that they do not need to have surgery any more. See if people's general medical status needs to be improved before they get the surgery so that we can hit the ground running when they have their surgery.

I am not sure at this stage whether we do that well enough.

CHAIR - Does that fall back to the GPs?

Dr NICKLASON - I do not think, unfortunately, we can rely on the GPs to be able to do that. The reason I say that is there is a shortfall in general practitioner numbers in the whole of Tasmania, including metropolitan Hobart, and the GPs are feeling stressed as well. I am sure other representatives of this committee have told you the stress that is mounting in the emergency department because of the reduced capacity in general practice to meet the needs of people. Sometimes it is translating to emergency department presentations.

CHAIR - When their pain is out of control and the GP is not going help them either, I guess.

Dr NICKLASON - Yes, there is a limit to what you can do in a brief consultation, working on your own.

CHAIR - You mentioned earlier that there has been some consultation, can you talk to us about what sort of level of consultation there has been? Is that as chair of the medical staff association or is it as a commission?

Dr NICKLASON - I have attended meetings but I think our CEO has really understood the need to talk to senior members of staff to see how there can be the best ways possible to reduce the most serious impacts of the necessary budgetary restraint that is happening. I am not sure she could do much more. I know my colleagues are not universally happy that there has been enough made of that consultation or that the result of that consultation has been exactly to their liking but I think, to her credit, she has tried to do that and I think she deserves, in general, a pretty high regard from the senior staff of the hospital.

CHAIR - You might not have read the media reports this morning but she gave evidence yesterday to the committee saying that whilst she was able to consult at a higher level with a small group of senior staff, she was told not to broadly discuss this.

Dr NICKLASON - I am glad that she felt that her duty was more with the needs of those people whom the hospitals serve and that is why she did that, I am sure.

CHAIR - She said she did not seek permission to disclose that.

Dr NICKLASON - Yes, so I understand. I think you would feel that was appropriate - I do.

Dr GOODWIN - Through you, Chair, in terms of the survey, Frank, and I suppose the other feedback you have received through your position in the staff association, have you fed that back up the chain? Who would that have gone to?

Dr NICKLASON - I sent a copy of it to Jane Holden. I did not get feedback from her but I am sure she was pleased to have it. I do not think that it was telling her anything that she

did not know. I have not sent it further up the chain. As I said, I did an interview that was on *Stateline* about it. I have not had any formal requests from anyone to have a look at the survey. I should be able to dig it up and send it to you if you wish.

CHAIR - That would be helpful, yes.

Dr NICKLASON - Perhaps I should have brought it. Maybe I was thinking that there might have been more interest in it.

CHAIR - Is it worth repeating again soon?

Dr NICKLASON - Perhaps it is, yes.

CHAIR - Over Christmas there is a bit of a bowl even though the Royal has experienced unusually busy times in that traditionally quiet period but with surgery you expect to ramp it up a bit and then the flu season can start. Is it worth repeating?

Dr NICKLASON - I think that is a good idea. Without having the jurisdiction to do this, I can certainly recommend it to the junior medical people that they do a similar survey - they did not get around to it.

CHAIR - So you do not have the -

Dr NICKLASON - No, I could not tell them to do one amongst the juniors. I guess I could do it - I was more interested in the senior doctors at that stage. Perhaps I should do that with the juniors as well.

CHAIR - I think from evidence we have had earlier today, it seems that the junior doctors and the residents are feeling uncertain about their job prospects and their training - specialty training is one thing but so is the training at the other end.

Dr NICKLASON - That is a good idea. I am willing to do that.

CHAIR - Yes, because we would be interested in the results.

Dr NICKLASON - Yes, okay, that is great. It is very simple to get it done very quickly.

I do think it would be a really good thing to try to survey nurses as well because the nurses are under a lot of strain. I do not need to reiterate the things that you already know about that but really works in a big institution is to have a lot of nurses that retain corporate memory and know how things work very well and have really good working relationships with both the senior medical staff and that they are able to interact with the interns.

CHAIR - The interns would be lost without them.

Dr NICKLASON - Yes, absolutely - completely. When we are relying on nurses that are jaded by double shifts and by a lot of agency staff that really do not know how we work as a hospital there are a lot of problems, I do not need to tell you.

CHAIR - I guess you are telling us a lot of what we have heard from others, which is fine. It does confirm a lot of those areas. You said earlier, the morale has been low for a while, does it seem to be getting particularly bad or are people rallying to the cause or what has been going on since October?

Dr NICKLASON - I am not really sure I can tell you that. I think that your suggestion about getting that repeat survey is important. I think this creates uncertainty, what is happening. There is stress of increasing workloads in many areas and the emergency department is one area in particular. I think that there is not always a very clear understanding of what is happening in the community. That is part of the reason why sometimes I agree to do an interview. I think it is a very difficult path to tread between unnecessarily alarming people about what is happening but not wanting to falsely reassure people. I think probably other people have also said there really is a need for in the community in general to understand what is going on and to realise that now is the best time of all to safeguard your own health by doing things as healthily as you can.

Dr GOODWIN - On the last page of your submission you have a quote and I will read it out: 'The question that the community needs to ask is whether it wants the outcome that current economic and political thinking will produce. That is, catastrophic damage to the long-term viability of the public, private and university healthcare sectors of Tasmania.' That is a pretty diabolical prediction, do you think? Has that come out of your survey or is it overstating the situation, do you think or is it potentially on the money?

Dr NICKLASON - I just want you to understand that that survey is a synthesis of lots of opinions. It is not my opinion, it is what other people have said to me. That is the important thing and the people who I think are on the money mostly are the senior people who really seem to know the workings of the hospital best and better than me. I identify that as the key issue, that there may be some unpredicted long-term, serious sequelae to do with our reputation and to do with our ability to perform at the level of a tertiary university teaching hospital, training and education.

Dr GOODWIN - Once you lose that -

Dr NICKLASON - It is very hard to get it back. Reputation is hard to get back and training programs are hard to get back. I do not know if you have had enough chance to interview the surgeons about this but I think all the colleges would be good people for you to talk to, representatives of all the colleges and see what they make of the situation. You have probably done that already but I suggest it.

CHAIR - No, I have not talked to the colleges.

Dr NICKLASON - I would also suggest, if I might, that there are some key people who work between sectors, the private sector and the public sector, or maybe even work mostly in the private sector but also do important services for us at the Royal. For instance, the orthopaedic surgeons are a really important group of people. David Smart, who works in emergency medicine, I think is one of the most insightful people and most clear about the importance of a well-functioning private sector to the Royal. He works in hyperbaric medicine and emergency medicine at Calvary and the Royal. I think if you have not already talked to people like John Burgess and Tim Greenaway, I think they are able to be more articulate than I can be about that relationship. I think Guy Marquis

would be a very good orthopaedic surgeon to talk to. He has committed himself to the e-mail debates that we have had around our circle very well. I do not know if he is prepared to talk but I think he would be someone who would give you some very good information.

CHAIR - How many members of the Medical Association are there?

Dr NICKLASON - Everyone is a member, if they like it or not.

CHAIR - They are, right.

Dr NICKLASON - The survey probably went to 150 or more people and within a week I had over 100 responses so it was not hard to dig up.

CHAIR - That is senior and junior?

Dr NICKLASON - That was the senior medical staff. All the junior staff are members too. For some reason, perhaps wrongly as you indicated, I did not survey the juniors at that time. I probably should have. I wanted them to initiate their own survey but they just did not get around to it so I should do this one, I thought.

CHAIR - It was 150 surveyed.

Dr NICKLASON - There was 110 who responded at the end of the week.

CHAIR - They were 110 seniors?

Dr NICKLASON - Yes.

CHAIR - There is no silver bullet for this obviously.

Dr NICKLASON - No, there is not.

CHAIR - We know that the budget is under pressure. Do you think there are other cuts that could be made? We heard from Jane Holden yesterday about a number of areas that she has changed, or that she and others have worked on, that have perhaps removed a bit of the fat. I know she certainly did quite a good job on the north-west in that regard as well but are there areas we should be focusing on? This may be outside your area of expertise, in that broader area.

Dr NICKLASON - It is. I subscribe to the view that most senior staff have and that is that our hospital services are too dispersed and that we do not have the ability in the current situation to have two hospitals on the north-west coast. I do not know what you feel about that.

I do provide some medical services in the north-west. I think a lot of people think that there should be one hospital there and that maybe the Mersey should be more an outpatient service delivery site rather than an inpatient site. That is a common statement. I would say that there is a significant majority of people who think that it may be a luxury, that we cannot afford to have three health area services.

CHAIR - Why THOs?

Dr NICKLASON - Yes. I have not directly surveyed that question; maybe I should. Maybe it would be helpful to do that.

CHAIR - The issues at the Mersey have been raised at different times. The clear evidence from the north-west is that the demand is clearly there for the number of patients that come through DEMs, that you need both, but it is what you provide. You have one hospital but two sites. Again you run the risk of spreading yourselves thinly but if you do not provide everything at both then you can achieve the same outcome, would you agree?

Dr NICKLASON - Yes, I do.

CHAIR - They stopped doing major surgery at the Mersey some time ago.

Dr NICKLASON - I am not sure what the plan is there.

CHAIR - It is a bit hard to do anything while the Feds are still funding it as they do.

Dr NICKLASON - Yes, that is right. It has obviously made it more difficult to have a definite plan of what to do there in that situation.

CHAIR - Without you take, what is it, $71 million now that is extra?

Dr NICKLASON - Yes.

CHAIR - Effectively.

Dr NICKLASON - I think that there have been some significant areas of improvement. I think that there has been a lot of effort to try to see what we can do to help hospital admissions. In geriatric medicine, for instance, there has been a lot of work done to try to see whether crises that happen to elderly people, particularly in residential care, can be handled in the home, in the nursing home. I think that the hospital and the home program was a useful thing to have and it helped us to get people who had certain fairly simple medical problems out of the hospital more quickly.

CHAIR - Is there anything like that in Hobart?

Dr NICKLASON - There was but -

CHAIR - Was that a consequence of the cuts?

Dr NICKLASON - No, that came beforehand. It is something that could be done that could reduce the length of stay of certain types of hospital admission - DVT and defibrillation where the anti-coagulation people are waiting to have their anti-coagulation stabilised. That could be done outside the hospital. With COPD exacerbations, this is emphysema exacerbations, some of those patients can clearly be managed out of the hospital and are probably better off for it.

Dr GOODWIN - What happened to hospital-in-the-home down here?

Dr NICKLASON - I honestly don't know what happened to it. That is worth exploring.

I have been working at the Royal Hobart Hospital for 15 years. There was something quite exciting that I was interested in that happened in the early years, in the mid to late-90s, where we had a Federal program to assess what would be a very good coordinated care trial for elderly people who had lots of different medical problems and problems with physical and mental function who were at risk of entering hospitals or nursing homes. We had a brilliant study set up here but it stopped as soon as there was a requirement for State funding.

Dr GOODWIN - That happens with a lot of things.

Dr NICKLASON - Yes, it does. Not only do we lose what could have been a very good program that would have been good for the people who were involved in it, and it would have taken pressure off hospital beds and probably institutional-care beds, but when that sort of thing happens - I was quite involved in it and we worked very hard to get the GPs on side and we pretty much had them; they thought it was good and they were working generally with a nurse who was a care coordinator of about 50 or more of those very frail, very vulnerable people - when the plug is pulled it creates a cynicism. When you get the stress and cynicism mixed up, it stops people thinking of solutions and thinking that they have some power to do something that is positive. I think we have seen a bit of that and I think I have that reflected in my survey.

CHAIR - Jane Holden made similar points yesterday about the need to have a really well-integrated system that kept people out of hospital and supported them in more appropriate places, whether that be at home, a nursing home or other facility.

Dr NICKLASON - Yes, that is right.

Dr GOODWIN - If this current approach has potentially quite dire consequences, is there some other way that these cuts could be made if we accept the position that there needs to be some savings?

Dr NICKLASON - I think that's understood. I am not probably the best person to answer that. What I hear is people saying it is the speed and depth that is the problem, that if it was more like that than that, we could hope better with it, but that is the general vague answer and it is probably not that helpful.

CHAIR - The first announcement of the cuts was in October when CEOs were basically told not to consult to any great extent. Jane Holden said yesterday that she thinks it is unlikely they will meet $20 million of the savings target; she is not really sure what budget she will have - there is likely to be additional savings found, do you think there needs to be a much broader consultation around how that is achieved or should it be done in a similar way?

Dr NICKLASON - It is hard to design things by a committee, but I think there are some people who have a lot of corporate knowledge. They have been in the hospital and they

know how it works; they have been there for a long time. I think it is only fair to Jane that she has access to those people, to let them help her.

CHAIR - Maybe you could ask for volunteers in the survey.

Dr NICKLASON - That was quite interesting because I did ask a question something like that. I asked the people whether they had felt involved and there was a follow-up question, 'Would you like to be?' People weren't so negative that they said, 'No, I can't be bothered'. There was quite a strong core of support for being more involved.

CHAIR - You would have to work out how to involve them, but it sounds as though there is a will there to try to work on this together.

Dr NICKLASON - Yes, I think so. What naturally happens when there is a big stress and it's seen that maybe one department of the hospital is wheeler-dealing better than my department is that it can create tensions, and that is another thing that has to be managed. It is good to have a broad spectrum of people involved so that you don't get the better wheeler-dealers protecting themselves.

CHAIR - Thank you for your time today.

THE WITNESS WITHDREW.