THE LEGISLATIVE COUNCIL SELECT COMMITTEE ON THE PUBLIC HOSPITAL SYSTEM MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE, HOBART, ON FRIDAY, 21 AUGUST 2009.

Mr MICHAEL KRIEG, CEO, CALVARY HOSPITAL, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Mr Dean) - Mr Krieg, thank you very much for your attendance and I apologise for the delay. There were a couple of issues that we had to discuss in the first instance.

Mr WING - Not concerning you.

CHAIR - No, not concerning you at all. Before we start, there are a couple of things that I need to say. If at any stage during this process you would feel more comfortable or feel that you would like to give evidence in camera, then the committee will certainly take that issue on board and we can move in camera before personally discussing anything that you feel that we should do, to assist you.

The evidence that you give today is recorded on *Hansard*. After the appearance today you can generally go out and speak about the evidence that you have given but just be a little careful on identifying any particular point, as such. But generally you can speak about it. There is no difficulty with that at all.

You have not made a written submission. Our terms of reference are fairly wide but I would ask you to try to address, if you can, those terms of reference. I do not know whether or not you are able to do that in accordance with the terms of reference as they appear in the documentation.

Mr KRIEG - I have the terms of reference here. I will run through them briefly, point by point, and then feel free to ask questions because I do not have anything written.

CHAIR - It might be appropriate if we can take questions as you are going through it on each area. I think that might be easier for the members.

Mr KRIEG - I will work through the terms of reference, if you like. In terms of elective surgery, Calvary Healthcare Tasmania is a very large provider of elective surgery in the State and I will give some rough calculations. We do something like 29 000 elective surgical procedures a year on our four sites. In terms of where we are, it is our Lenah Valley Campus here, St Johns, St Vincents and St Lukes in Launceston. We do a fair number of surgical procedures.

Mr WING - Are you CEO of the entire operation?

Mr KRIEG - Yes, that is correct.

CHAIR - How long have you been in that position, Mr Krieg?

Mr KRIEG - I have been in the position for about the last six months. I started in February of this year.

Mrs SMITH - You have four sites and you quoted 29 000 elective surgical procedures. Can you divide them into what is day surgery and in hospital? Can you give us the number of beds over those four sites that you have?

Mr KRIEG - I can give you some of that information, in a rough sense.

Mrs SMITH - The number of beds first, perhaps, over the four sites, so we can get a comparison on how our public bed numbers sit currently.

Mr KRIEG - We are currently actively running about 400 beds across our sites. We have licences for closer to 600 beds. So we are not using all of our licence bed capacity right now.

Mrs SMITH - Would you like to expand as to why?

Mr KRIEG - There is always a lot of reasons. It is about the physical capability to operate some of the beds. There are quite often issues about whether we need the beds because the usage of beds has changed over time. We have moved from a lot of inpatient stays to a lot more day surgery. For example, at Launceston almost 70 per cent of their patient throughput is day stay rather than inpatient stay. So the need for physical inpatient beds has diminished over time. It just depends on what is going on.

Mrs SMITH - Regarding the breakdown of the 29 000 elective, you have 70 per cent in Launceston.

Mr KRIEG - Yes, and it is about 60 per cent in Hobart. So it varies by area. But the vast majority these days are day surgery. I do not have the exact numbers here.

Mrs SMITH - That is close enough to give us a comparison of the two systems. That is what I was looking for.

Ms FORREST - Do any of your facilities provide emergency services and emergency surgery?

Mr KRIEG - We provide emergency services on the Lenah Valley campus and this current year we will probably do 10 000 private emergency attendances. We do some emergency surgery within that, although we impose some of our own limitations on emergency surgery based on what type of surgery it is, so there are certain things which quite rightly need to be done in the public sector, so major trauma from motor vehicle accidents; we do not do any cardiothoracic surgery.

Ms FORREST - An appendix you would do?

Mr KRIEG - An appendix we would do. The other limitation with the private sector is always about the availability of doctors to perform that surgery because in the public sector what you tend to find is the registrars in residence are there 24 hours a day seven

days a week. We do not have that luxury so there are times when we have to transfer because we do not have the doctors available to do that surgery.

Mrs SMITH - You quoted 29 000 elective surgical procedures in the year. Can you give us an indication of waiting lists?

Mr KRIEG - We do not have waiting lists. In the private sector what happens is that the doctors are very much the gatekeepers so a GP will refer to a specialist who will then decide the priority and the waiting time. But generally in the private sector waiting times are very short. There are always exceptions to that and that usually relates to a particular speciality which is of high complexity or high seriousness such as neurosurgery, for example. There can be a bit more waiting time because there are very few doctors that can do it. Sometimes that creates a bit of waiting time. But we do not actually have waiting lists.

Mrs SMITH - Of the 29 000 you quoted, are any public patients that you have managed on behalf of the public system on a do-and-pay basis? That is terrible 'do and pay', isn't it?

Mr KRIEG - I have some statistics on what we do for the public sector but they are not exact because of the way that we track things. Roughly, we did 188 operations in the last financial year on public patients.

Ms FORREST - What sort of operations are we talking about?

Mr KRIEG - The majority of those will be things that, again, there is high demand for and they need to be done quite urgently. A lot of those have been things like neurosurgery and there is some orthopaedics in there. There is a variety of things but usually things that for whatever reason need to be done quite urgently and for whatever reason cannot be done in the public system.

Mr WING - What financial arrangements do you have in those cases with the public system?

Mr KRIEG - We have a range of what we would call uninsured rates, rates that people who have no insurance would pay, and our arrangements with the public system is that that is what they would pay us.

Mrs SMITH - Are we paying more or less if we are insured?

Mr KRIEG - It is about the same. We are very careful. It sits in the middle of our range because all the funds pay different rates but it sits about in the middle of the range of insurance.

CHAIR - Have those public hospital cases that you have dealt with been spread evenly around the State?

Mr KRIEG - No, most of the surgical admissions are in Hobart because we have our more acute services down here and it is usually the more serious surgeries that we would do.

Mr WING - Who pays for the surgery, the patients themselves or the public hospital system?

Mr KRIEG - These are public patients so the State pays for them.

Mrs SMITH - Do you have the capacity to take on more than the 188 that you took on last year? Does it depend on the type of surgery? Can you give us some indication of the future in that relationship?

Mr KRIEG - We have some capacity but it is not endless. I think from my point of view we can build the capacity if that is what is required and there is some arrangement where we are asked to put more capacity in. If, for example, the State said to us, 'We want you to do more orthopaedic surgery, we want dedicated time and we want to do so many procedures per year, with a lead time we can build that into our structure. But we are very conscious that we are private facilities and we have to maintain the integrity of that otherwise we destroy the whole system. What I mean by that is that if we suddenly do a stack of public cases, you start diluting the value of private insurance and therefore everyone drops private insurance because they will get treated as quickly in the public system and you dilute that benefit of being privately insured. So it is a very fine balancing act. There are ways of us managing that but we would want to build the capacity to do it properly if we were going to do it in large numbers.

CHAIR - I think I am right in saying that the public hospital system have said that they are going to try to strengthen that partnership with the private hospitals. Have there been any changes between them and you in, say, the last six months or three months? Has it changed at all with a request for taking on more patients?

Mr KRIEG - No, not in a formalised way but we quite often talk about demand issues and where one side or the other is under pressure, we will offer them support particularly at Lenah Valley where we have our intensive care unit. There are times when we will accept public patients into that unit because the Royal is at capacity and so we will support them in that case. I think a fundamental part of the Calvary group is that we are here to support the community not just to be profitable. So we will do things that other providers may not because we are here to support the community.

Ms FORREST - Could you tell us how many uninsured patients you have come in, or self-insured we should call them once they are there?

Mr KRIEG - I do not have exact numbers on that but I would estimate it is probably less than 5 per cent. It is very low. The majority of our patients are insured in some form or another so there are very few uninsured patients.

Mrs SMITH - The self-insured patients who come to you tend to be day surgery, am correct -

Mr KRIEG - Yes.

Mrs SMITH - where they know the standard cost?

Mr KRIEG - That is correct.

Mrs SMITH - Can I make a presumption that they know that with the public system they are on a long waiting list and they have said, 'This is going to cost me $5 000. I'm not going to wait. I'm going to go to the private system and I'll pay for it myself'?

Mr KRIEG - That is exactly right.

Mrs SMITH - Is that the usual type of self-insured patients you get?

Mr KRIEG - The self-insured patients come from a couple of groups. There is one group that is exactly that. They think there is something seriously wrong with them and they do not want to wait for that to be resolved in the public system so they will have the surgery privately. You have a group that has a condition - most commonly something like orthopaedics where they might need a knee reconstruction, which in terms of urgency is not very high. It causes them some functional disability where it makes it difficult for them to walk or play sport but in terms of seriousness, it is not life threatening. So those people can sometimes elect to pay rather than waiting in the public system.

You have another group that wants some sort of cosmetic procedure performed and in that case it is not covered by private health insurance anyway so they will pay for that procedure to take place.

Ms FORREST - You talk about the change in surgical procedures, more day patients, and you have potentially 200 beds that you could operate. Do you have problems with attracting enough nursing staff? Is that what the reason is?

Mr KRIEG - Absolutely.

Ms FORREST - Would you elaborate on that issue a bit too, please?

Mr KRIEG - Absolutely. The staffing generally is probably the biggest thing holding us back. We do have demand from surgeons for additional theatre time and additional beds and we simply cannot get enough nurses. If you have noticed in the papers recently, we have advertised nearly every week in the last few months. We cannot get enough nurses. It is that simple.

Mrs SMITH - Is that because you are looking for experienced nurses? We had evidence last time we met, I think from the nurses federation, about the numbers. The public system will take something like - don't quote me - 120 and yet there are 400 and something coming out. Do you demand a higher level of experience in the private system?

Mr KRIEG - No, not necessarily. When nurses finish their nursing training there is almost a need to support them for a period of time to get their skills up. In Launceston I know we took 12 nurses last year. In the south I think it was 16. I am guessing that figure but it was around that number. We cannot take a lot more than that because of the level of support we have to provide and the financial implications of doing that. But we would take a lot more if they were available. I think the nursing federation is right to an extent in that we are graduating a lot more. But there is a percentage of those that do not want to work as a nurse when they finish their nursing. They see it as a step to another degree. So they will finish nursing and then go and do another degree. There is a group that, for

whatever reason, move interstate or overseas. So there are limitations with that nursing training. The reality is there are simply not enough nurses now. You play a numbers game. So you get them at the graduate level and train them for a few years but you then have to teach them the advanced skills. The further down that path they go, the more difficult it is to attract the right people. So intensive care, theatre and maternity all have limited staff numbers and that is the same across the State.

Mr WING - Are you in a position to make an assessment about the effectiveness of the present graduate system, the university trainee system, compared with the previous system where nurses were trained in the hospitals? I am wondering if, under that system, they had to have extra support after finally qualifying.

CHAIR - I just noticed we are moving off the elective surgery side at this stage, Mr Wing. Answer that question, if you do not mind, Mr Krieg, and then we will try to keep on track.

Mr KRIEG - No, that is fine. I can answer that with a fair bit of experience because I am actually a registered nurse, by profession.

Ms FORREST - Another one who has left, see?

Mr KRIEG - I have not technically left because I am still working in hospitals. I have been wondering about this question for a while because, for me, university-educated nurses have a lot of benefits in a lot of ways. But there are limitations with the fact that they are not job-ready. They do not have a real understanding of what it means to be a nurse because their exposure is very limited during their training. In most professions when you walk out of university, you start the job and you are pretty much right. You need a little bit of support but not a great deal. I think, over time, we have got to a point where, for the first 12 months after they finish their degree, we are giving them a high level of support. I just wonder if we need to change the mix between university and hospital so that they spend more time in the hospital so that when they finish their degree they are ready to go. In that case, if you had 400 graduates, we would be able to take a lot more of them because we would not have to support them quite so much.

Ms FORREST - Just to clarify that point, you are suggesting that it is really a problem not with the structure of a university degree course but more with the components within that course?

Mr KRIEG - The mix of that course.

Ms FORREST - So it is not putting them back into the hospitals to train? That is not what you are suggesting?

Mr KRIEG - No.

Ms FORREST - I just wanted to clarify that.

CHAIR - I want to raise one other issue with you on elective surgery if I can. We need to move on. I have trouble, at times, identifying what is elective surgery and what is major surgery and why it is termed 'elective surgery'. I had a lady ring me last night from a

country area - and she should remain nameless at this stage - who has an acute medical problem. She is in a lot of pain, a lot of suffering as a result of it. It is not a huge operation to fix the problem. She was told by the public hospital system in Launceston that she would have to wait six, 12 to 18 months to have the procedure completed. She said, 'I can't wait. I'm in agony'. This is her advice to me: she was told that if she went to a private hospital she would probably get it done much quicker, if she could raise the funds. She is now proceeding down that track to have that occur. I understand she is being pushed into a private hospital to have it done in about three weeks' time. So quite obviously there is capacity in the system, your system, to bring in elective surgeries, as you are able to, and fairly quickly.

Ms FORREST - So long as people pay.

CHAIR - Yes, she is going to pay. She has asked me to help her raise the funds for it to be done. I wondered if you wished to make a comment on that as to when does elective surgery become major surgery, I suppose? Is that it? What terminology do we use?

Mr KRIEG - I think it is quite often at the doctor's discretion as to what they term urgent surgery or non-urgent and they balance that up on the risk to the patient in delaying that surgery. I think the difference that you are seeing is that in the public system they have to deal with all the emergency cases that come through the door and, quite often, what happens is they are so full of patients that need urgent care, for what ever reason and need to have a bed right now, that they cannot fit all that elective surgery in.

In the private system we do not generally have that same level of pressure because, firstly, three of our four hospitals do not have an emergency department, so they do not have that pressure on their beds for patients who need urgent care straightaway. The types of patients we see generally through our emergency department are the ones who are less acute, in some ways. For example, the major trauma from road accidents all goes to the major public hospitals and they do occupy beds for extended periods of time, which we do not have, and that makes a big difference. The vast majority of patients, via ambulance, go to the public hospitals. They generally need beds. We do not have that same pressure.

The easiest thing to stop, when you run a public hospital, is elective surgery because you cannot stop people coming to the front door. Their only mechanism for controlling how many beds they can use or how many beds they have is to cancel elective surgery. It is the only way in running a public hospital that you have any control. You cannot stop patients coming to your emergency department.

Ms FORREST - On that point, I accept that major traumas and a lot of major surgery needs to be carried out in the public system. A number of those people would have private health insurance. Do you see a lot those then transferring? I know at the LGH, for example, with their private maternity patients, there is no birthing at St Lukes anymore, unfortunately, so the women are transferred within hours of giving birth for their post-natal care. Are we seeing that happen or are people, once they have been ensconced in the public system, tending to stay there?

Mr KRIEG - No, we do get some transfers for some things. But once they are in the public system it is like anything, they are unwell, they do not want to move from one place to

the next if they can avoid it so they do not move that often. They do move sometimes. Probably one of the key areas is for rehabilitation, up to St Johns. So we do get motor accident victims going to St Johns for rehabilitation after their acute stay at the Royal.

Ms FORREST - Do you think that is an area that perhaps should be looked at more, with some capacity within the public system to identify the people who do have private health cover? You are asked the question and you can say no, that you are going in as a public patient or not even declare that you have private health insurance. There is no compulsion for you declare you have it. But do you think there should be some way of perhaps identifying those people and making it easier for them to move to a private hospital for their post-operative recovery, to free up those beds that are often longer-term beds?

Mr KRIEG - I think there are reasons that does not happen. The patient has a right to make an election to stay in a public or a private hospital and even which system they are going to use. Generally, the fact that they go through the public emergency department means they have made an election anyway, that they -

Ms FORREST - But if they in a car crash?

Mr KRIEG - If they are in a car crash they are covered under the motor accident insurance and it is then up to the treating doctor, to an extent, to decide, if they do want to go to a private hospital, whether they should go and there are all sorts of reasons they do or do not. Some of the facilities required to treat those patients are not available in the private sector and it is not reasonable for us or realistic for us to think we can do them. I think it is more around whether the patient elects to go, whether the doctor thinks it is appropriate for them to go. We do have patients transfer from one to another and we do have discussions about when the public hospitals are under bed pressure, how we can support them in all sorts of different ways. We have that at the CEO level regularly. We have those discussions where they are under pressure and can we help them out.

CHAIR - We have covered that area so we can move forward.

Mr KRIEG - The one other thing on elective surgery is that there has been discussion on and off, and it has been in the media a little, about cardiac surgery. Calvary has an interest in cardiac surgery but we would not want to do just private cardiac surgery. Fundamentally it is a high-cost procedure, not just in terms of how much it costs to do the procedure but also the equipment required. One of the things that needs consideration, not just for cardiac surgery but more broadly, is for those high-cost equipment specialities and whether the State think about one facility rather than spreading it out. For example, with coronary care the Hobart Private, Calvary at Lenah Valley and the Royal all have a catheter laboratory which costs around $1million just in equipment to put in. There are specialised staff and none of them is flat-out busy. Clearly to me that is a lot of money.

Ms FORREST - We need one on the north-west coast, the heart attack capital of Australia.

Mr KRIEG - And we have cath lab in the north of the State. I cannot instigate the discussion because of ACCC implications but I think that somebody needs to instigate those discussions. The same exists to an extent with neurosurgery. Some of the things have to be done in the public system when they are very acute, but again there are

millions of dollars of equipment in doing those things. We need to have a bit more of a statewide approach in dealing with them rather than everybody doing their own thing. I think that is a flawed idea.

Mr WING - Should the one unit be a public one, not having any private?

Mr KRIEG - Quite possibly. I think there are ways of doing certain things in the private sector. One of the things the Government could look at is whether cardiac surgery could be done completely in the private sector. Because, again, when you are talking about elective surgery it gets cancelled unless it is exceptionally urgent and these people have to wait. In the private sector we would have a dedicated space for that and it would just happen automatically and you would have less of the waiting issues that you have with that type of surgery. It is one area where we could look at alternatives to what we currently do.

Emergency department is the next on the list. As I said before we have roughly 10 000 attendances to our emergency department. Of those we are admitting around 20 per cent at the moment. That has slightly increased in the last few months to about 27 per cent of attendances actually admitted. I think that compares fairly closely to what happens in the public system.

Mrs SMITH - And you only have emergency services in one campus.

Mr KRIEG - That is correct.

Mrs SMITH - Is there any consideration to putting emergency services into any of the other three?

Mr KRIEG - Not under the current funding model.

Mrs SMITH - So this is an issue between yourselves and the Federal Government?

Mr KRIEG - Yes.

Mrs SMITH - So they encouraged you to open or not open?

Mr KRIEG - No. I will give you some sort of idea of how it works and then you can draw your own conclusions. On average across Australia a private emergency department runs somewhere in the order of $1-2 million lost a year, just on straight cost. That is because we receive a medical rebate for that care and then we have to impose a gap on the patient. That still does not cover the cost of providing that care. The reason people are put in private emergency departments is usually based on a need for the community or a need for the hospital to get that volume through the door. They are the predominant reasons why they do it. Generally nobody is putting in new emergency departments because it costs you money to run them.

Mrs SMITH - If you take the one campus where you have emergency services, what percentage of those people that come would end up in your in-house system? As such that compensates to some degree for the loss that you are making in emergency services? Would that be correct?

Mr KRIEG - That is the theoretical argument that the health funds run but the reality is that we get funded the same way whether they come in as an elective patient or an emergency patient, so there is no compensation specifically because they come through emergency. We know that generally if they come through emergency they are sicker, they stay longer and they quite often have more complications or other illnesses that we have to treat as well. So it costs us a lot more to care for those patients than it does for an elective patient. So there is really, other than getting more volume through the door, no incentive to have a private emergency department.

Mrs SMITH - So you have one at Lenah Valley?

Mr KRIEG - Yes.

Mrs SMITH - Calvary is a significant player in the health and welfare of the north of Tasmania now with your two campuses in Launceston. There has been significant debate over a period of years within the media and other areas about the lack of capacity of the public emergency and accident situation at Launceston General Hospital. On a basis of ethics et cetera has there been any consideration for saying we are doing this at Lenah Valley and we should at least be looking at the situation in the north?

Mr KRIEG - In my time it has not even been discussed because the cost and the difficulties with running an emergency department are absolutely massive. If you just look at the most simplistic basis, firstly no matter what you do you run at a $1-2 million loss on doing it. Secondly, there are huge problems across the country in recruiting emergency doctors. Just to give you some sort of idea, we have seen a price escalation of around 40 per cent in what we are paying them in the last 12 months.

Ms FORREST - Emergency specialists or specialists generally?

Mr KRIEG - No, emergency. And not just emergency specialists but also emergency doctors. The pay has gone up by about 40 per cent in the last 12 months.

Emergency nurses are also difficult to recruit. They generally want to work in the acute setting as exists in a public system, so to get them to work in the private is a very difficult thing. We do not have that problem here because we have a well-established unit but establishing a new one would be extremely difficult in the current environment.

Mrs SMITH - Do you believe your organisation would consider it if the Federal Government would solve the issue of the financial costs in their funding arrangements?

Mr KRIEG - We would possibly look at it. We would need to do the analysis on what that would mean. Fundamentally the problem is around how you staff it adequately. Even in our existing emergency department at times the staffing of that is quite difficult, particularly for doctors, because you cannot just put any doctor in that environment. They have to have a higher level of skill than in other areas. General practitioners can do most of it but there are times where you need a higher level of skill than what they have. We do use a lot of local GPs but we also have a lot of career medical officers and that is what they do. I do not think the capacity exists for that in Launceston.

Mrs SMITH - The message you are delivering to me is that, from a private perspective looking in, you have great sympathy for the efforts of the public system in what they have to deal with in public emergency situations. It is not just the finance; lack of knowledge of how many are coming through the door each day, the staffing of those because of the expertise needed et cetera.

Mr KRIEG - Absolutely.

Mrs SMITH - So you difficulties are their difficulties -

Mr KRIEG - Absolutely.

Mrs SMITH - compounded even more so?

Mr KRIEG - Absolutely. One of the big differences between public and private, however, is that they do provide the doctor training. They have residents and registrars which we do not have. That means we do rely on those more senior doctors completely.

Ms FORREST - Your costs are greater as a result?

Mr KRIEG - Exactly right.

Ms FORREST - Are you paid under a case-mix funding model?

Mr KRIEG - Our funding model is a mix of case-mix and per diem funding, depending on the health fund that we are working with. So it is a bit of a hybrid model that we work under. But over half now is case-mix funding, yes. Continue on?

CHAIR - Yes.

Mr KRIEG - On emergency, I think the big thing is that we see that as a supportive role, again, particularly here for the Royal. Again, one of the bigger issues is not just the staffing in that department but also having doctor access. One of the things that has changed in the last 10 years in the public system is that they now recruit a lot more staff specialist positions. While that helps them a lot, it means that these doctors do not work in the private system. So the more of those you have, the more limitations you place on the private system. The other thing that has occurred is that doctors have become more and more specialised. Fifteen to 20 years ago every physician that came out was a general physician. They would look after a wide variety of patients. They have now become highly specialised.

So one group will only look after infectious disease patients, another group will look after diabetics, another group will look after people with kidney problems. But patients coming through an emergency department do not present like that. They could have a wide range of problems. That creates a lot of limitations on what we can take through the private system so on occasions we have to transfer to the Royal Hobart because we do not have a doctor to look after those patients. Simply, in having a broader spread of doctors able to look after those patients in our hospital, we would take a lot more patients. It is a big challenge and it is not one that can be fixed simply but I think it is an important one.

Just moving on, I cannot really talk about admission to the public hospital system at all and I do not think it would be appropriate for me to do that. If I talk a bit about staffing levels and staffing generally?

CHAIR - Yes.

Mr KRIEG - I know we have talked about that a lot already.

CHAIR - We have raised it.

Mr KRIEG - It is a major problem in the system in Tasmania. The last six years I have worked in Victoria. One of the things I have noticed is that we have a fixed and limited pool of staff. If you look at other States, there is a lot more flexibility because you have a lot more volume of staff whereas here, we are capacity-constrained. So even though we might graduate 400 nurses in the next 12 months, not all of those are going to want to work in the system. We cannot take them all. Then, at the specialist end, specialist training, say, for intensive care really only happens at three sites: Launceston General, the Royal and Calvary are the only ones doing that specialist training. We only do one or two a year so we are struggling to keep pace with the turnover of staff because they are all getting to that age where they are starting to talk about retirement.

Ms FORREST - It used to be that they were leaving to have babies but obviously we are now to the baby-boomer stage.

Mr KRIEG - We are. Because the work force is predominately female, they are all moving to retirement age, or they want to work part-time or they are having babies. So, for a number of reasons, they are not putting in as many hours as perhaps they once were. But the less capacity we have to train them, the more acutely we feel the shortages. That is happening. The real key areas are intensive care, theatre, maternity and emergency. They are the ones that really struggle to get enough of those qualified staff.

Ms FORREST - Do you have any suggestions then for how we can improve that? They are there, whether in public, private or wherever, and they are the specialist areas. Do you have a suggestion for resolving that issue to a degree?

Mr KRIEG - I think there are a few things that I would consider looking at. Fundamentally, I understand why the nursing education is predominantly out of Launceston. But from a strategic point of view, the majority of the population and the hospitals beds are actually in Hobart. So we are training all our nurses predominantly in a smaller location. Straightaway, you may be locking them into a location for the rest of their lives where the demand does not exist.

Mrs SMITH - That situation, surely, has been solved now? We are told there are 200 nurses in training at the Hobart campus and that is that capacity.

Mr KRIEG - Yes, in Hobart, and I think that is important but there is a lag time to that. We have to wait for them to finish.

Ms FORREST - Learn to be skilled up, as you said?

Mr KRIEG - That is right. I think the need to skill them up is a fundamental limitation and the same exists now with the extended doctor training as well. We have lots of doctors in university but what happens when they finish university? Where are they going to go and how are they going to get that experience? I do not think that has been fully explored on a national level.

CHAIR - I think it has said that a lot of those are going to the mainland, aren't they, and going elsewhere and then they do not come back? They get offers made to them, they are good ones and they do not come back.

Mr KRIEG - Absolutely.

Mrs SMITH - Do you have the capacity to take on some of these out of university into training or don't you have the appropriate system for that?

Mr KRIEG - We have the capacity to do it. There are issues about it being private and the rights of the private patient and whether they should be seen by medical students. That has been resolved in a lot of places. They do have those training places. There is a funding implication and how that is addressed. But ultimately, it does not matter whether it is public or private, we all need these doctors and we all need these nurses. So I think there is a real need for a combined approach on how that gets managed. Our funding model simply does not allow for it. So we need to think, I believe, as a State, how we can address that because, realistically, the public system is at capacity in lots of different ways. But, training more staff, they are probably at capacity as well. We have more capacity to do that just because of our current structure and the fact that we do not large volumes of them already. So there is some capacity for us to help with that but it does come down to a funding issue and how that would be resolved.

CHAIR - How often do you meet with the CEOs of the public hospital system around the State? How often does that occur and does it occur?

Mr KRIEG - I meet with the CEO at the Royal Hobart Hospital on a monthly basis. We talk about a range of things. I meet with the CEO at Launceston a little less frequently but my operations manager in Launceston meets with him regularly. If we have particular issues, then we will get on the phone. So if either of them has capacity constraints and they think they have something we can help with, we will be straight on the phone and discuss it. So we do talk regularly.

Mrs SMITH - Regarding the issue of employment of staff, you look at the city of Hobart and they are looking to get a specialist in, or you are. Usually there is a mix between public and private with a specialist. Do you have some relationship with the department that if a specialist in neurology wants to come to Tasmania and we need him at the Royal, you can you take some capacity? Does that arrangement go on?

Mr KRIEG - We do have those discussions, yes. We have had a number of approaches. The approaches sometimes come to me and they sometimes go to the Royal and we do have those discussions about whether there is any private capacity or public capacity to take that person and we have had those discussions in the past. But, again, the limitations in the system at the moment are that in all regional areas there are more and

more area-of-need doctors who have overseas qualification and they do not qualify to work in the private system, so they are employed as staff specialists.

In terms of staffing, at the moment my estimation in the south of the State is that we would be able to take another 20 experienced nurses straightaway, tomorrow. That is a minimum number. We could probably take more than that if they existed. We are particularly short in the areas I have mentioned before. We could take them straightaway. It would mean for us the ability, possibly, to do more procedures and take more patients. Quite often, our limitation is the ability to staff adequately the facilities we have. For example, in intensive care the beds are not usually closed because they are full, they are closed because we do not have enough staff and that is the primary, fundamental problem.

Ms FORREST - Do you have a lot of overtime and double shifts and things like that?

Mr KRIEG - We do have some overtime and double shifts.

Ms FORREST - Do you close beds in preference to that? How do you manage that?

Mr KRIEG - Once the patient is in a bed you cannot close it. It is a fundamental issue. In that case -

Ms FORREST - No, but accepting new ones?

Mr KRIEG - Quite often we will not accept new patients if we know we cannot staff it. For example, the most common case of that occurring is where we have a patient who needs to go to intensive care through emergency. Our doctors will triage and assess them and then we will say they need to go to intensive care; do we or don't we have a bed? If we do not have a bed then they are put in an ambulance and taken down to the Royal. From our point of view that is not optimal either because we would rather take them, but if we do not have staffing we just cannot do it. That creates pressure on the public system yet again.

Ms FORREST - We hear of quite high levels of overtime and double shifts being worked by the nursing staff, particularly in ICU and in other specialist areas; can you give us an idea of how much is done?

Mr KRIEG - Our level of overtime is much lower than what they are experiencing. I do not have figures but from a management point of view it is not significant in numbers of hours or time.

Ms FORREST - So you have the capacity as a private hospital to say, no, we will not accept this patient?

Mr KRIEG - Absolutely.

Ms FORREST - Whereas the public hospital does not.

Mr KRIEG - It does not have that at all. That is a fundamental difference in the systems. One of the differences is that we would rather take more patients because of the way that

works for us under our funding model, whereas the public system is more geared towards controlling demand. We want to increase demand. It is very different. Having run both systems, I can say that it is very different.

The big question that I have generally is about how we increase our staffing capacity; both doctors and nurses are a major issue.

CHAIR - We have been told that there are a lot of students going through the universities in this area but it would seem that at the end of that process they are not coming back into hospitals within this State. There is some information contained within our records to say that a lot of our nursing staff also are leaving this state to go elsewhere to continue their training. They do not come back either because they get an offer that they cannot resist.

Mr KRIEG - That is right.

CHAIR - So we need to change a lot of things in that area to entice them to stay here?

Mr KRIEG - It is not an unusual thing. Nurses are a very mobile work force anyway. The issue is whether they come back. Either we need to train more here or find ways to get them to come back to the State. Particularly in those speciality areas you have the most difficulty.

CHAIR - Try to tie them into a contract somewhere.

Ms FORREST - The pay structure is also an issue. You look at the differential in pay structures in various jurisdictions as well. It has improved somewhat I believe but it still lags behind a bit.

Mr KRIEG - I am not up to date on the pay structures across the States but they vary across the board. While the pay structure is different, there are other benefits and things that are different in every State as well. It is very hard to compare from one State to the next. I actually do not think the pay structure is horrendously out of line with other States at the moment.

Ms FORREST - The pay structure is a little bit less. The career structure is less appealing and you are required as a specialty nurse to work double shifts frequently, so lots of overtime and therefore poor quality of life and probably poor health as well. That is an issue. The pay structure in itself is only aspect of that. I do not see an easy solution either. Pay is not an issue itself so there must be more to it then.

Mr KRIEG - The whole system is based on the Florence Nightingale era almost. We have not moved from nurses being there to do everything. You are talking about nurse practitioner models and other things. Nurses now have a university education and there are certain things they do not need to do anymore, so we do need to change the structure of how we provide care.

Ms FORREST - So has Calvary considered assistants in nursing?

Mr KRIEG - Yes we have.

Ms FORREST - Where are you at with that?

Mr KRIEG - We have not rolled it out to a great level but we do have some. It is brought about primarily by the inability to get enough nurses. Secondly, the thought processes are whether some of the things nurses are doing need to be done by nurses, so we need to move away from nurses having to do everything for every patient. We can have alternative people looking after patients.

Ms FORREST - What sort of ratios, if you were to bring them in, would you suggest would be a reasonable ratio for AIN to RN?

Mr KRIEG - Nationally our group runs on about 75 per cent RN and 25 per cent EN/AIN. That is across the board but different areas have different demands and needs for different skills, so it varies by department almost.

Ms FORREST - Are your AINs registered?

Mr KRIEG - No.

Ms FORREST - Are they regulated in any fashion?

Mr KRIEG - No.

Ms FORREST - Is that an issue for you?

Mr KRIEG - No.

Ms FORREST - Is it an issue for the other staff, the nursing staff?

Mr KRIEG - No, not generally. They are there as a support worker; they are not there to provide the high-level care. I think we get confused between what you need a registered nurse to do and what you can have other people do. You do not need a registered nurse to make a bed. You do not necessarily need a registered nurse to help somebody in the shower. There are a number of those procedures that you do not need a registered nurse for.

You do need a registered nurse to give a patient medication or apply dressings and those higher level care items are what we should be using our registered nurses for.

Ms FORREST - Do you think the public sector should be heading down this direction more? What is your percentage now? You are not 75 per cent and 25 per cent at the moment?

Mr KRIEG - We are about 80 per cent and 20 per cent at the moment.

Ms FORREST - You are close, then.

Mr KRIEG - We are close.

Ms FORREST - What would you suggest the public system should do?

Mr KRIEG - Across the board we need to have that open discussion about the right model of care given the current ability to staff and one model does not work everywhere. So in some units you need registered nurses to be providing all of the care because of the acuity of those patients, but in a lot of areas that is not necessary.

Ms FORREST - In the UK they use AINs in ICU.

Mr KRIEG - They do. In some ways it is fine but in others it is not. The benefit of having them is really about providing a level of support to the nurses so that the nurses are not doing things they should not be doing. That is the way I look at it.

Ms FORREST - So you have not replaced your nurses with them as such?

Mr KRIEG - There is the possibility to have fewer registered nurses if you have enough support to allow them to do what nurses should be doing. So if you keep your nurses for those items where you need that expertise and you use other staff for things where you do not need the expertise then you can alter that mix of staff.

Ms FORREST - Is it important then to clearly define those roles?

Mr KRIEG - Absolutely.

Ms FORREST - Before you move down that path?

Mr KRIEG - Absolutely. You have to be very clear because there is a lot of nervousness about the dilution of nurses' roles and responsibilities and about having unregulated workers in the health environment. I think it is absolutely critical that you define the roles very clearly.

Ms FORREST - So you have done that?

Mr KRIEG - Yes.

Ms FORREST - Are you able to provide some evidence to the committee of what you have done in that regard in defining those roles?

Mr KRIEG - We can probably send through some job descriptions of what our assistants do.

Ms FORREST - That would be good.

Mrs SMITH - Palliative care and aged care within your system: we have had evidence of bed blockages in the public system while people are waiting on an aged care placement. Do you have a percentage of clientele who would fit into that category?

Mr KRIEG - We do have some aged care patients who end up in our system. Our numbers of patients waiting for an aged care bed have dropped significantly over the last few years, predominantly due to the way we manage them internally. We have made sure that we have good management systems to identify them early on and then move them through the system as quickly as we can. So we do not have as many as we probably

once had. There are some hospitals I know of in the private system where up to 20 per cent of their patients are waiting for an aged-care bed. We probably, at most, have one or two at any given time. But that is more about the way that we manage them and the acute nature of our hospitals. We do take everything that comes in the door, but what comes in the door is usually not the type of patient that needs an aged-care bed.

Mrs SMITH - In the public system they usually come in because they have a medical issue and then the decision is made that they cannot go back home.

Mr KRIEG - You do get some that cannot cope at home by themselves so the family bring them in as well. We do not have the same issue as the public system.

Mrs SMITH - And palliative care?

Mr KRIEG - Regarding palliative care, as I am sure the committee is aware, in Launceston we provide the public service as well. We provide that on a funded basis where we get the funding and then provide the service, so the beds will flex up and down depending on demand. We are funded for three beds but sometimes we will run up to six public beds depending on the demand for those beds and sometimes we will not have any patients in, just depending on demand. We also run a private palliative care service both in Launceston and in Hobart. There is demand for those beds but I do not think we have excessive demand that we cannot meet at the moment.

Mrs SMITH - You are funded for three but at times you have six public patients?

Mr KRIEG - Yes, we can have up to six.

Mrs SMITH - Would you prefer a contract that is flexible, tied to the bed, rather than three and if you have six, too bad?

Mr KRIEG - For our owners, which is the Little Company of Mary, palliative care is a key platform - absolutely key. While we average about three over a year, we are happy with that arrangement. If the numbers went up significantly then of course we would want to discuss how that worked. But at this point in time I think the system works well for everybody, and we do provide, I think, a very high level of service in that regard.

Mr WING - Are you considering extending it in terms of numbers in Launceston?

Mr KRIEG - Again, if the funding allowed it and there was the demand to do so, we would absolutely be able and willing to do that.

Mr WING - Would there be the demand for that?

Mr KRIEG - I cannot answer that question really. I am just not familiar with those numbers. But if the demand was there, we would certainly be able to do it. I think the question is always what is the demand and whether it is there, and I do not really know.

Mr WING - The funding would need to come from the State Government, would it not?

Mr KRIEG - That is right. We already provide it on a private basis as well. So we do provide a number of beds in the north.

CHAIR - Mr Krieg, thank you very much for your attendance today. We are out of time. We do appreciate you providing your time to come here to raise these issues with us, to talk to us. It is a very important matter that we are dealing with and we want to move on as quickly as we possibly can and come out at the end with some good suggestions and recommendations, very clearly. So we thank you very much for your input.

Mr KRIEG - Thank you.

CHAIR - If there is anything further that you would like the committee to have then certainly you can provide that information to our secretary and we would certainly consider that as well. Thank you very much for your attendance.

THE WITNESS WITHDREW.

Mr MARK HOWARD AND **Ms LIZ CARROLL**, ONECARE, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Mr Dean) - Welcome. I apologise for keeping you waiting. There were a few issues we had to discuss in the first instance. The information provided is recorded in *Hansard*. At the end of the process you are entitled to talk generally about it to the Press or to anybody else that you wish to but just be a little careful when identifying any specific point of detail on specific issues. But generally you can speak about it; there are no difficulties there. If at any stage during the procedure you would like evidence to be taken in camera, we can certainly facilitate for that to occur as well.

No written submission has been made, as I understand. The committee saw it as very important that we call you here to give us some information and evidence. The terms of reference have been provided to you and I would suspect that there are two areas there in particular that we would like to hear from you about - in relation to bed blockage and where you fit into the process and how you can see things moving forward and the changes that probably need to be made to relieve the pressures on hospitals in relation to the bed blockages that have occurred because of aged people. Perhaps at this stage we can leave it open to you to address those issues and we will have some questions, if you do not mind, through the process.

Ms CARROLL - I have made some notes for myself. I am happy to provide you with a copy of these afterwards, if you would like.

CHAIR - Thank you.

Ms CARROLL - We did not really have any comments to make about point 1, elective surgery. Regarding point 2, we did not really have any comments to make about (a), the waiting times but with point (b), admissions to inpatient service, we first of all wanted to point out that we really welcome the establishment of the various hospital liaison services that have been set up around the State - for example, the aged-care services southern area team. We found that really helpful because it allows us to have a direct link with the health-care team which specialises in aged-care liaison. However, we find that the gap is in the after-hours provision of assistance to aged care.

OneCare works across all of Tasmania, so I have consulted with all of the other directors of care across the other OneCare sites and in the north-west there are specifically issues relating to admissions of residents with exacerbation of challenging behaviours associated with dementia. There have been examples of cases where residents have been transferred to the emergency department and then returned to the facility with no change in their treatment. In that case, there has been a blockage back at the facility. We have not been able to accept this person back because of the risk they pose to other residents. Then it is a negotiation between the emergency department and the facility. We cannot take this person, they will not take this person and the poor resident is in the middle. It is really difficult.

Sometimes, in that case, we have had to put on extra staff to then special this person and that is fine but it is not sustainable in the long term. From what I have been told from the Director of Care of Umina Park, the trend across the north-west coast is that facilities are closing their dementia-specific beds because of this and other dementia-related issues.

So it is having an impact. If we do not get that emergency after-hours support when we need it, it is having an impact on what service we will be able to provide.

Ms FORREST - The north-west coast has had challenges in this area for a long time with the Roy Fagan Centre being bed-blocked itself a lot of the time. The Adards centre is now undergoing some change. This is an area that crosses over into mental health and aged care. With aged care being a Federally funded area and mental health being a State government responsibility, is this creating some problems as well? We do not have the psycho-geriatric side of it; is that where the challenges lie, in the cost shifting?

Ms CARROLL - Exactly. In the south of the State the 1 800 line that is the older persons mental health line actually flicks through to GP Assist after a certain period of time, I think it is 5 o'clock in the evening. GP Assist is the after-hours GP thing. They do not have the specialty knowledge of aged care or mental health either. It gets flicked to them.

Ms FORREST - Why doesn't it go to the mental health line?

Ms CARROLL - It just flicks across. I presume it is a resourcing thing.

Ms FORREST - The mental health help line operates 24 hours a day.

Ms CARROLL - It doesn't; it goes to GP Assist after 5 o'clock.

Ms FORREST - The mental health help line?

Ms CARROLL - The emergency mental health line that we have been given goes through to GP Assist. It is not good. It puts the poor resident in the middle of this.

In the south, still talking about admission to an emergency department, specifically for our southern facility in Kingston, and I know that it also applies to Mary's Grange in Taroona, GP Assist do not have a GP that will actually visit out facility after hours, so they do not actually have a visiting GP. If a resident really needs a medical review after hours, GP Assist will say just send them into emergency. That has happened quite a few times where we have ended up having to send residents into accident and emergency. If they had been able to be reviewed at our facility it would prevented them from having to go to hospital - a much better outcome for the resident as well. I have listed a few examples here. There is one really sad case where a palliative resident had been at Bishop Davies for a while. The family really wanted him to be medically reviewed. The palliative care community nurse said that the only way we can do that is to get them into emergency. He ended up going to Whittle and died in Whittle a couple of hours after he got there. It is really sad to send someone for a couple of hours before they die. If we had GP after hours who could have come to us he would have been reviewed and maybe nothing would have changed; the family could have been happier and he would have died peacefully.

Mr WING - Those people would travel normally by ambulance and that is an extra burden for the ambulance service, an extra cost?

Ms CARROLL - Yes. I do not know that the situation is the same for everybody in the south. I think GP Assist do have other doctors that will visit other regions in the south; it is just particular to the area that we are in.

Ms FORREST - Are you aware of the gold standard of care in the UK?

Ms CARROLL - No, tell me about it.

Ms FORREST - I only have a brief understanding of it but I understand that it is a gold standard that aged care facilities achieve. They are lining up in the UK to do it, I understand from people who work there. It basically involves a direct link with the GP service and the aged care facility where this sort of thing that you have described would not happen.

Ms CARROLL - It should not. I have spoken to GP Assist about it and I am still in the process of talking to them about it. They are trying to negotiate something like what they have in remote areas, such as in Zeehan, where they have a local GP who is contracted with GP Assist to provide these after-hours services. We are still in the very early stages of trying to get something.

Ms FORREST - The GP won't be in Zeehan, though, they will be in Queenstown.

Ms CARROLL - Someone who is put on some sort of payroll or on a retainer or something who will be willing to provide that after-hours service. We have not got it at the moment.

Mr HARRISS - On GP assist, is that in any way linked to the Medicare Plus process that the Federal Government have announced with regard extra attention to aged-care facilities by GPs?

Ms CARROLL - No, I do not think so. I think it is a separate initiative but I cannot say 100 per cent.

Mr HARRISS - Is it an appropriate time to talk about Medicare Plus and the Federal Government's encouragement? I just do not understand the detail of all of that.

Ms CARROLL - I am not 100 per cent familiar with it either. I am thinking it is about care planning reviews, medication reviews and things like that but I would have to go and find out more about that.

Mr HARRISS - I understand the intention is to provide an expanded service by GPs into aged-care facilities and thereby reduce the call on the public system.

Ms CARROLL - Yes. There are definitely a lot of Medicare incentives now to get better case management by GPs for the elderly. There are some financial incentives. They get paid extra if they do a care plan review - things like that. That may be what you are talking about.

Mr HARRISS - If GPs are available.

Ms CARROLL - Yes, and also if they think it is financially worthwhile. Whether it is enough, I do not know. You would have to talk to the GPs about that.

Point (c), alternative workforce and management strategies, we obviously would be asking for better after-hours mental health services, and better after-hours GP cover. We would prefer to see specialists or better training in accident and emergency around issues for the elderly, and increased outreach services to aged-care facilities from the emergency department - perhaps a flying squad or something like that - so that you can avoid these unnecessary transfers.

CHAIR - Have you actually discussed that with the appropriate people? What has happened as a result of those discussions?

Ms CARROLL - The most recent time we raised this was with the southern DONs - directors of nursing - who get together every now and then and have a meeting. People from the Aged Care Services Southern Area Team came and introduced themselves and spoke to us. These issues were raised with them. They said that they were going to take it to a higher level and see what can be done. That was only recently. These issues are long-standing and I am sure that they have been raised plenty of times before.

Mrs SMITH - One would think that a contract with a GP facility in the area where a particular home is for after-hours service paid for by the public purse - through Medicare or whatever - should be a simple solution.

Ms CARROLL - Yes. It would be cost-effective.

Mrs SMITH - It appears to be about after-hours service by GPs. So if somebody is going to pay them, and someone does the roster, then we have simple after-hours services in my community. If you dial and the other surgery in town happens to be on duty for the weekend or after hours, the number you dial to the doctor's surgery clicks straight through to the doctor from the other surgery who is on call. That is clearly a private arrangement between surgeries.

Ms FORREST - Do they do home visits? That is the question.

Mrs SMITH - It does not appear to be hard to solve if somebody is prepared to pay either at a Federal or at a State level.

Ms CARROLL - Yes.

Mrs SMITH - Right.

Ms CARROLL - Going onto point 3, general treatment and/or admission to the public hospital system, I do not have comment to make about point (a). On point (b), OneCare would like to see improvement in discharge planning and communication with aged-care facilities, both from the emergency department and in-patient services. Often residents are returned to our facility with minimal information and sometimes with treatment regimes which are not able to be implemented in the facility itself. For example, our Launceston facility reports that often there have been changes to the medication chart but there has been no follow-up letter accompanying the resident and no communication.

Often they do not have enough medication to last 24 hours. That is a problem. If the resident returns to us on a Friday evening and the GP is not contactable until Monday, we cannot get any more medication because the scripts come from the hospital and they cannot be filled from the pharmacy, and the pharmacy at the LGH will not fill the scripts for our residents. So we ended up with this bind where we actually cannot get the medications. So that improved communication and discharge planning, even from A&E, is very important for us. We do not have any comment to make about section 3.

Ms FORREST - One of the comments has been made concerning the public hospitals system about the bed-blockers, people who have been assessed and are awaiting placement in an aged-care facility, when there are beds available, perhaps not in the location they wanted, to take them short-term, even within the region. They might have particularly wanted to go to this facility but there is a bed available here, and they could be moved to the other one of their choice at a later time, but the funding, it has been said, does not really encourage or enable that process. Can you elaborate on that a little bit?

Ms CARROLL - Yes. When you admit a resident there is a very detailed 28-day assessment process that someone has to go through to then achieve our funding from the Federal Government. So you may do all of that really intensive documentation and work, and it is quite intensive for the staff and resident, and then maybe on day 21 they are transferred to another facility.

Ms FORREST - You do not get any funding in that circumstance?

Ms CARROLL - You will get the funding for that 21 days but it has been a heap of work and then that person is gone and you have to do it all again for the next person.

Mrs SMITH - Surely a simple calculation of is this resident permanent, hopefully, or are they in transition, with different paperwork, could solve that?

Ms CARROLL - That would be great.

Mrs SMITH - If the Launceston General rang your facility and said, 'We have Mrs Smith here. Her choice is to go to Rosevears but there is nothing available. We estimate that it could be a three-month term. She is seen as transition' and the paperwork was different because they were not a permanent resident, that could solve it?

Ms CARROLL - That could solve it.

Mrs SMITH - Is there a different funding level, though, in that? If you get somebody in transition, does there need to be a new tranche of Federal funding for a transition patient?

Ms CARROLL - There isn't but that would be a really good solution. The other thing is three months is not too bad. It is often less than that. We get them because they cannot stay in hospital any longer and then a week after we have had them, they get offered a bed somewhere else and they go.

Mrs SMITH - Early in our committee we were given evidence that one entire ward of the Launceston General Hospital technically was utilised by people waiting for aged-care placements on an average of 76 days. So that was one entire ward of a medical system

for people who should have been much better accommodated in an aged-care placement because there were no aged-care places for them.

At the same time we had a situation of 35 empty beds on the north-west coast, in a quick calculation by my colleague. We asked why the Launceston General Hospital could not have said to the family, 'Your mother wants to go to Sandhill. There is no vacancy at the moment but what if we send her to Deloraine or to Latrobe short term?' Some evidence has been given that there is nothing in the system that allows that to happen. Interestingly enough, I have noted that the Launceston General Hospital, if the media is correct, have solved some of those issues by short-term beds. I am not sure how they are getting around it and I will be interested to see their evidence. What problems do you see in a situation like that where they ring you up, you have two beds and say, 'We can take this person short term outside of the paperwork if that was shortened.'? Is there a problem in the financial component of that for your placement?

Mr HOWARD - Recently I had a meeting in the north-west with the CEO. When you have inpatients in the public system like in the north-west, what we obviously have there is the issue of those patients coming across to residential aged care. One of the first stepping-stones is they go through the aged-care assessment process; they are assessed as being aged-care placement or able to be aged-care placement.

You mentioned before that they have a home of choice. We cannot force them to come into our home; it is really up to the family or that particular resident at that particular time to say, 'Yes, I am happy to transition across to the aged-care facility'. Then I guess provided that the hospital has the funding arrangements in place to transition that person across, what effectively happens is that we can, under our current arrangements, take that person in for respite care. Under that respite model or under the legislation, the Aged Care Act, we have 52 days of respite and we can ask for an extension, which I think is some 10 days. Once that expires and if they are still not placed in the home of their choice, we have to transfer them back to DEM, so they are on this cyclic turntable of going between respite care with our aged-care facilities and then having to transfer back to the hospital. That is on the basis that the hospital then has a bed available to accept them back in.

Mrs SMITH - So in your professional opinion, 52 days may be too short for transition arrangements between a hospital and aged-care facilitators. What do you believe would be an appropriate time line? Or should they just be called transition and no time line? So transition accepts they are only here as a choice.

Mr HOWARD - I would agree with what you say. I think that if the Commonwealth relaxed the 52-day delivery point and, obviously, the extension period, we could take them again. I guess you always have that issue that the patient can say, 'No, I do not want to transfer to this particular site because it is not a home of my choice'. I think around that level of independence, that we have to offer the resident that independence to make their own decisions, that is another hurdle that we have to get past as well because it can be difficult for families as well. If, for argument's sake, you have someone in the North West Regional Hospital, they have travelled from a remote location and they obviously want their family to be closer to them - let us say it is Forth or Devonport or somewhere like that - we need to continue to provide their care needs; when there is an extended

distance between where they are being cared for and where their family or support mechanisms might be.

Ms FORREST - Who pays for that respite care? Is that the Federal Government or the State?

Mr HOWARD - The Commonwealth Department of Health and Aged Care will pay for that respite fee.

Mrs SMITH - Even on transition beds? You made a comment that you have an arrangement with a hospital. Who is paying, though?

Mr HOWARD - The discussion that we had with the North West Regional Hospital was that they did not have the transitional funding for the aged-care facility at Umina Park to provide that transitional care. What we would be trying to negotiate, obviously, with the Commonwealth, taking them in under an aged-care assessment, would be to get respite funding under the Commonwealth funding.

Ms FORREST - What barriers are there to that?

Mr HOWARD - Again, provided that the resident will accept to come into the nursing home, we would take them as we would any other resident. As Liz said before, we have to be careful as well under the current respite arrangement or the funding arrangements because respite residents are funded quite low. The situation there, as Liz said, is that you have a lot of initial start-up cost, a lot of cost goes into that resident when they first come in, obviously through care planning and through settlement et cetera. If they only stay two days, then the cost to our organisation can be far greater than the funding that we will receive from the Commonwealth.

Mrs SMITH - Surely that is why it does not need to be called respite. Respite is when my mother in-law says, 'I think I will have a little holiday in a home' because she does not want to go in permanently and she goes and has a couple of weeks. That, to me, is respite. What we are talking about is something totally different, something new really - transition from a medical hospital to aged care - and, as such, I think in the system there needs be a totally new package, a totally new, named process of transition-aged beds with a simplified regime so you are well aware of the patient's needs et cetera, whether it is two days or 200 days, rather than trying to put it under a package you already have of respite because it becomes too hard then, in my opinion, wouldn't you think, to try to slot it into something it is not meant for?

Mr HOWARD - I agree. I think you need to have the right model of care. I know we have a number of vacancies at one of our homes in the north-west. We could virtually take everyone who is in the North West Regional Hospital tomorrow if we had the correct funding and correct model of care for, as you call it, transitional care.

Mrs SMITH - Are you aware of what arrangements there are in the north between, clearly, aged care and the Launceston General Hospital, that they are picking up some transition for the Launceston General Hospital? Is the Launceston General Hospital paying for that?

Mr HOWARD - We have a current arrangement with the Manor in Launceston, one of our nursing homes there, where we are funded by the Launceston General Hospital under a funding model which is termed transitional care, which is under a MOU arrangement, to assist the Launceston General Hospital.

Mr KRIEG - to assist the Launceston General Hospital. The manor is actually working as an arm of the LGH, using our aged-care model to look after those residents.

Mrs SMITH - Is that system something that could be transferable across the State if the State and Commonwealth come to arrangement of who pays. Clearly Launceston General is saying, 'We have bed blockages and it's urgent. We need to do something', whereas the north-west coast is saying, 'We don't have the funds to transition-fund the beds'.

Mr KRIEG - That is right.

Mrs SMITH - So it is the funding issue, otherwise that MOU could be transferred across the aged sector with the department?

Mr KRIEG - I think there is the funding model and there is also the legislative framework in which we have to abide under the Commonwealth act and which perhaps the State operates in regard to our health system.

Mrs SMITH - So we could expect, if it was recommended that there be a new tranche of transition beds and funding, it would become an argument between the State, who fund a part of the hospitalisation of that person, and the Commonwealth who are responsible for the aged?

Mr KRIEG - That is right.

Mrs SMITH - So that is where the disagreement would come, not within the system itself?

Mr KRIEG - That's right.

Mrs SMITH - The capacity would be there, in your opinion, if the financial arrangements were there.

Ms FORREST - A lot of work goes into a resident when they first arrive and even if they were under a transition package there would still be that component. If the funding arrangements address that - if there was more funding at the front end - then that is what you are suggesting would need to occur?

Mr KRIEG - That's right.

Ms CARROLL - It could probably be streamlined. If it wasn't under the ACFE, which is quite complete, it probably would not have to be as comprehensive. We still get a really good care plan out of it - still know what the residents' needs are - and if the funding was streamlined to recognise the short stay, then yes. The only other consideration is that we would have to square it away with the aged care accreditation process and make sure that was considered, that they knew about that and we weren't going to leave ourselves open to being called non-compliant in any of those issues.

We got to work force planning strategies. We have nothing to say about (a) and (b) although the previous speaker talked about student nurses. We find it very difficult to find the resources to manage student RNs in aged care and we would welcome some support in that. We really want to do it, we recognise the professional requirement to do it but it is just very hard for RNs working in aged care to get the resources and time to spend with student nurses, because there is no funding.

Mr WING - Could you make comment about the disparity in the payment of trained nurses in acute-care hospitals compared to homes and the difficulties that arise from that in your case?

Ms CARROLL - We are in the fortunate position at the moment of not having a shortage of RNs yet. We always worry when the next RN resigns as to where we are going to get someone from, especially night shift. I presume that the disparity contributes to that, although we benefit from salary packaging, which offsets that a bit. Without any evidence or data, the disparity does make it more difficult to attract RNs into aged care.

Point (c), workplace reform; we already touched on the concept of strategic partnerships between residential aged-care facilities and hospitals to establish transitional care units and we strongly support that. OneCare would also like to see improved discharge planning and communication with aged-care facilities.

Comments from our Community Care Program focus pretty much on the Launceston General because that is where our EACH packages are. They focused specifically on discharging and planning and they thought there was an inconsistent discharge planning process; poor communication regarding changes to patients' conditions and treatments; those in discharge planning positions are not available daily; lack of understanding of the different community referral processes in DVA nursing and veterans home care; lack of understanding of the services available in the community and lack of understanding of the services provided to patients prior to their hospital admission. That was specifically related to the community program.

Ms FORREST - I would like to touch on a bit of a contentious issue. We touched on it earlier but we did not really go down the path of elderly residents who have a number of medical problems and get pneumonia when they are 98. It seems that the only avenue here, when you cannot get a GP out to see them, is to send them the DEM. The decision then is to treat to not treat. Invariably the patient ends up being treated in the absence of an advanced directive of some sort. Is that a major problem and do we need to have that broader discussion about allowing people to die when that is really what they are trying to do?

Ms CARROLL - We always encourage our residents to give us an advanced directive prior to admission. We put it up front so that there is no last-minute agonising. Most of our residents have advanced directives and most of those advanced directives are not to treat, to be kept comfortable in the aged-care facility. So we are not often in the position of sending someone in that situation to hospitals. You would find that is common, especially in the south of the State, that aged-care facilities do take that approach. To us it is not a major issue. The issue of that person having to go in because they wanted a

medical review was unusual. It was mainly the family; they wanted a medical review of this resident.

Ms FORREST - Can't that be facilitated in place rather than send them to the hospital?

Ms CARROLL - We would love to have done that except that we did not have someone who could come and do it after hours.

Ms FORREST - It sounds like the gold standard is the approach that would facilitate that.

Mrs SMITH - So if you have an advanced directive from the client who has come in and they have done that up front in the paperwork, and then you get to a situation later in life where the family take a different pathway, does that create complications or do you stand strong on their advanced directive?

Ms CARROLL - It is difficult. The resident has always got the right to change their mind at the last minute. With family members it is usually a consultation process with them and we always get the GP involved at this point. It is not black and white, it is not hard and fast, it is very much a negotiation and trying to get the best outcome. Usually family members will end up abiding by what the resident has said.

CHAIR - Thank you both very much for coming to us today. This issue of aged care and bed block and respite has been raised within this committee throughout the process so far. It is a big issue for us to deal with, and in the interests of the hospitals as well.

THW WITNESSES WITHDREW.

Mr JOHN KIRWAN, CEO, LAUNCESTON GENERAL HOSPITAL, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Mr Dean) - John, you would be aware of the process of *Hansard* recording the information as we go through. If at any stage you feel that you want to go in camera for the purposes of providing any information or evidence to the committee, please ask and we can facilitate for that to occur.

You are quite free to talk generally about your evidence today, outside to the Press or anybody else, but just be a little careful in identifying and talking about a particular issue. Just be general and there is no real problem with that at all.

Having said that, John, we will leave it you. There is no submission provided by you. You have our terms of reference. If you can address those terms of reference as they appear in our documentation, it may be easier for us, as a committee. We will ask questions on the way through, if you do not mind.

Mr KIRWAN - I am happy to do that, Mr Chairman. If I can take the liberty of providing some handouts, they are a copy of a presentation we were using last week as visited district hospitals within the northern area. I have attached the presentation and also three fact sheets about the establishment of our area health service. I will not speak to them but they are there for your information. But I may refer to some of the presentation because it provides some information.

I am aware what my colleague, Jane Holden, has said. I will not repeat that because our situation is very similar, but I am happy to take questions on that without going into repetition.

I will give a little bit of background for the committee about myself.

CHAIR - Yes, if you can and how long you have been in the position.

Mr KIRWAN - I am a bit of an atypical CEO in that respect. Hence you may see that some of the answers are a bit different but not necessarily, hopefully, wrong. I have been in and around health for almost 30 years now, predominantly in Western Australia. I came into health as a trade union official and was with HACSU for 14 years, although I spent some time in some other unions. I was then Director of Human Resources in the Health department in Western Australia, which became the General Manager of Work Force Reform when we went through a very major regionalisation and integration process which I had a fair bit of responsibility for. At that stage in Western Australia, for example, mental health were employees of the minister, public servants were in the department in community health and public health, and hospitals were separate employers. So you could easily go to a country town and find four different employers and three different unions for the same occupations. It was a very disparate model which was integrated some time ago.

I was then the Executive General Manger of Public Health and Purchasing, which gave me responsibility for our acute sector, Aboriginal health, community health and public health.

I then left the department and went to the Northern Territory as Commissioner for Public Employment and then spent a number of years in consulting work, which was enjoyable because it was not exactly a lot of time and you could do what you wanted when you wanted, which was probably the first time.

I was then doing some work consulting for the department. Then, when Stephen Ayre left as the CEO, I was asked to do a locum in his position, not intending to stay because I do not particularly enjoy day-to-day operational management. But for all sorts of reasons, including the attraction of the north, I have since chosen to stay and am now on a five-year contract.

Mr WING - Very wise and understandable.

Laughter.

Mr KIRWAN - If I can go to the terms of reference I will go through them probably fairly quickly. On elective surgery, LGH at the moment is doing record levels of elective surgery. Last year we did record levels. The year before we did record levels. At this stage we are still looking year to date at about a 15 to 16 per cent increase in activity over last year. So we are doing a lot. A lot of that is funded through various Commonwealth programs and others but a lot of it is funded simply through our own activity levels. We are likely to reach a peak in our capacity - that is, a physical capacity. We nominally have six theatres on the fifth floor and one day-surgery area. We really only run five theatres and we only have the recovery room for effectively running four. There is a story that I didn't believe until others validated it, that when the hospital was being rebuilt we ran out of money and they reduced the funding by some 10 to 15 per cent. In doing so, in the recovery room, if you put the beds end to end, you cannot walk around them, so we have an issue there.

Ms FORREST - So you put them on an angle-parking arrangement?

Mr KIRWAN - We fudge across a range of areas and rely heavily on the quality of our nurses and anaesthetists when we are running the fifth theatre. That is the problem with a 30-year-old hospital, but I am happy to explain that we are only a year or so away from addressing a lot of those issues. As we rebuild over the next three years, that will all be addressed.

As to elective surgery, we do well in emergency and category 1s, but we have a problem in respect to category 2s and 3s. We have about 800 to 900 people on the waiting lists who have been there for quite a long time who are listed for surgery that we would say is probably unlikely to be done within our existing resources. There is currently a process to address what we do with that, within the department and with the minister. We are improving, as I say, and although people focus on what we are not doing, we should be focusing on our high levels of activity. That is not to say that we cannot improve in that area.

What we are also facing at the moment, unfortunately, is that we only have five ICU beds and that has meant that over a period of time - and that is a longstanding problem - although we have addressed to a large extent our bed-blocking - which I will

touch on a little bit later - we now have a capacity issue for our elective surgery and our ICU. That means that with our larger, more significant cases we are unfortunately seeing too many cancellations since about May but we are in the process of trying to address that. We have the medium- to long-term solution, which is the redevelopment of the hospital on levels 4 and 5 and that is will occur over the next couple of years, as I have indicated, but we need to put some plans in place in the short term. It is also subject to agreements from the ANF, which we are in the process of addressing with respect to staffing levels, which they may have mentioned.

In respect to the possible reforms, I have touched on them. A number of them are, I would say, our responsibility - patient flow, efficiency, making sure we are getting the right mix of our patients. As Professor Einoder states, we also need to make sure we are getting the right mix of patients for our teaching hospital responsibility, particularly for our junior surgeons in training. It is important to make sure they get the right mix. We have very good surgeons and we have a very good teaching program to the extent that we have had some recent successes in respect to getting them placed at national levels and we want to maintain that. It means it is always a balance and at the moment when it is likely to have surgery cancelled because of winter flu and simply capacity issues, we are trying to make sure that we have secondary lists and others where we can say to people, 'We can't tell you you have a booking, but if we get cancellations of larger cases, for example, can you come in?', and we are starting to see some improvements in that area. We are trying to keep our efficiency high.

The patient flow unit that we have created with funding from the department is also a new initiative. Although the Royal Hobart Hospital has those services, we traditionally have not and we are now in the process of establishing a unit, which is now mapping the processes and making sure we are keeping the most efficient use of our theatres and of our beds in the use of 23-hour beds and a range of other initiatives like that. The biggest problem for surgery had been the bed-blocking, but we are under way to address that. There is now an ICU capacity issue which is structural but with the rest of it we think we are starting to see some efficiencies and that will continue.

There will also have to be a discussion about northern clinic surgical services with us and the north and the north-west but also in areas like Scottsdale and other places: where is the best place that some of the surgery is undertaken? That includes the private sector, but I will not get into the politics of that. We use the private eye hospital for the broad range of ophthalmic surgery. We don't use the Calvary Hospital for surgical procedures, with a couple of exceptions, but we do use them for post-operative care. If we are bed-blocked we will move them there, if we can purchase the beds from them. If the patients are privately insured, we will move them to Calvary if we are bed-blocked, although that is the cost to us but again if they are privately insured and they can be treated in the private hospital.

CHAIR - What is the reason for not providing surgical treatment to, say, the private hospital, Calvary?

Mr KIRWAN - A couple of things. One is that the Calvary hospitals do not have an ICU so we are the only provider of the high acuity work. This is a discussion that is probably best had with AMA and others. We would pay our doctors on our rates; our doctors are sessional doctors, we not have fee-for-service arrangements. When they are working in

the private sector they charge their rates, which are AMA or similar rates and which are far higher than what we would pay, and there is the philosophical issue of private hospitals not treating public patients, particularly at public rates.

I am used to not having public work done in a private system unless you can reach agreement. I have to say that in Western Australia we did contract with private hospitals, particularly with the newer ones and with the younger surgeons, with HCI, Mayne Nickless and other groups, and we did actually move waiting list work in to the private hospitals. But that was done with the surgeons' agreements and the AMA's agreements, albeit they are generally reluctant.

I would have to say from a philosophical perspective I like the private sector model. I like the Launceston model; Calvary is very complementary to us, we work well with them and that gives the private patients and the doctors working privately, which are predominantly ours - I think of all the surgeons in Launceston only one does not work in both systems, so we have a high penetration of both. Of our 23 surgeons only two are not VMOs, so they work part-time for us, part-time in the private system and part-time for themselves in their rooms. It is probably more than that because most of them also have a teaching and research commitment as well. So they are split four ways.

Mr WING - Why could you not have a similar arrangement in Launceston to the one that you experienced with the private hospitals in Western Australia?

Mr KIRWAN - One, because they do not have an ICU so that is a limit to what they can do. Two, because they work within our system at the moment, and at the moment we do move public patients into the private hospital to be treated by our doctors but not all of the doctors agree to do that. At the moment they do that under our pay regime. There becomes a disincentive. I need to be careful here because I think if you asked the doctors in the private hospitals, and if we are treating public patients in private facilities at public rates, then where is the incentive to keep your private insurance?

I am not the best person to get into a debate on that, other than to say that the balance at the moment between private and public is good for us. We deal with high acuity public patients that predominantly are not insured; that is the role of the public system. The private system is to deal with the privately insured and in private arrangement.

Mr WING - And we know that the private hospital system feels the same way.

Mr KIRWAN - Getting the balance right is always the challenge. You could use the same argument with education and others. I am not a supporter of an all-public or an all-private model. I think that a blended model is always the way to go. Launceston has a good balance.

CHAIR - With the changes that are going to occur at the LGH over the next three-year period, can we expect that categories 2 and 3 will become greater? What have you in process here to try to decrease the numbers on category 2 and 3?

Mr KIRWAN - We are focusing not so much on category 2 and 3 although we do not perform as well in those areas as we do in emergency and category 1, albeit we would argue that emergency and category 1 are the most important ones to focus on for obvious

reasons. What we are now focusing on is our over-boundary work across all of the areas. Fortunately there are many in category 1. On occasion there are one or two and although the figures are low they sometimes distort our figures a bit. By looking at the over-boundary for those who have waited longer than the recommended waiting times of the three months, 12 months and others, that is where you also come to a conclusion. If they have been waiting more than a couple of years, do we need to review them? If they have been waiting, is this actually something that is needed? There has to be a discussion for some of the surgery as to whether it is desirable or clinically appropriate. It is different obviously if someone is in pain or it is affecting their quality of life. Our doctors are very good at categorising quite accurately, so we do not have a problem with looking at, say, the category 2s and asking are they really category 2s or should they be category 3s. They are actually very good at doing that and they are quite consistent in how they do that.

For the over-boundary ones, of which we have about 800-900 who should be seen, it is a question of how we can get those figures down to within the boundaries. There is probably a number of those for surgery about whom we would have to be honest and say it is unlikely they will done, and some plastics and other work that are cosmetic by nature. Then there is other work where we really do need to try and do it. For some of that we can move as we have done in the last year, to open up the fifth surgery, which we have, so we now try to run five surgeries rather four, and improve the efficiencies of those surgeries. We think that will make inroads into those over-boundary patients. Obviously we will focus any additional funding, if we get it from the Commonwealth and the State, in those areas, which they are asking us to do.

It would be our desired position so that we do not have many over-boundary patients. You will always have some because some are not ready for care and some have multiple entries on the waiting list for different operations. So if they have just had one, they cannot have the next one even if they get a slot, so to speak. Those are the issues.

Our focus will be on the over-boundaries, that is where I think we need to focus. There are other issues we will obviously need to focus on too, such as our cancellation rates, particularly for those people outside Launceston who have been cancelled more than once and who have to get up early in the morning, fast and come in. They are always the difficult ones to deal with. On occasions I meet with those because they are very distraught, and rightfully so.

Ms FORREST - They come to our offices.

CHAIR - Probably more come into our offices than yours at the present time.

Mr KIRWAN - Unfortunately my office is very accessible and you walk straight into it, so I do not have a choice either. All we can do is apologise. Some of those are beyond our control. For example some of the more recent ones are simply because the ICU has been full.

Ms FORREST - With swine flu?

Mr KIRWAN - It has had an impact but not a huge impact. Our emergency department has been busy and we have been setting all sorts of records, ones we would prefer not to set

this year, but it is not surprising when you look at the age and the burden of disease in the community. We have some structural problems in the emergency department; it is simply not designed well and it is not big enough. We are in the process of fixing that. One could argue that it would have been nice to fix it some time ago but it is happening now.

The difficulty with the cancellations goes very much to bed availability. We have gone a long way to addressing cancellations because of no bed availability, so that is in significant decline. Where we do have cancellations that is usually because we are busy because of what has come through the front door in the emergency department. That is only going to get worse unfortunately. The population is ageing, the population is growing and the burden of disease in the population unfortunately is not going away.

Ms FORREST - Has consideration been given to perhaps doing weekend theatre sessions to clear the elective backlog?

Mr KIRWAN - We did do some of that in December but it is a resource and cost issue. Theatre nurses are a relatively scarce commodity. Last year, and you will see that from the Estimates process, to gear up to five theatres we used locum staff, which is relatively rare for LGH but it enabled us to operate five theatres. We operated on Saturday mornings in December. The problem there is that we are dealing with a finite number of surgeons and theatre staff. They are already working fairly long hours Monday to Friday. We do the emergency work on the weekends but they also have their private sector work. We are running an issue in respect of fatigue in our staff, so for us to extend we would then have hesitancy, other than on exceptional cases, without an injection of resources.

Ms FORREST - So your overtime and double-shift payment is excessive in the operating theatres?

Mr KIRWAN - It is a problem across the hospital. It has just gone down a bit in the last week or so but we had an early impact of not necessarily H1N1 but the seasonal and other flu. We were seeing high levels of sick leave and therefore overtime double shifts. We were seeing up to 40 nursing staff off on a day. We have a policy, other than four rehab beds which we closed, of keeping the beds open, so we rely heavily on our nursing staff to agree to do extra work to keep the beds open, and those rehab beds are now open again. So with the exception of eight beds, which I am happy to explain, the hospital has all beds open but that is heavily reliant on nursing staff.

What we are also seeing is the acuity of the patients. So we are seeing not only the issue of having to have nurses on overtime or double shifts because of sick leave of other staff, but also the fact of calling them in to special patients, again simply because of the chronic disease profile we are dealing with. That, in itself, is across the hospital - women's and children's have the same issue, as does medicine and surgery.

Ms FORREST - When you do not have the issues with the illness amongst the staff, do you have enough nurses?

Mr KIRWAN - Yes.

Ms FORREST - You do? So the eight beds that are closed -

Mr KIRWAN - The eight beds are closed are for two different reasons. Sorry, we have four surgical beds that are closed. We use those in rotate and clean because they are four-bed wards. That works well because with the terminal clean requirement to get a clearance before you can reopen because of MRSA and on occasions BRE, although - touch wood - not recently, we need to keep them closed. Having those beds, to use that as a swing cleaning, works reasonably efficiently for us, otherwise there would be other issues. So we are in the process of changing and doing different things in our cleaning area and seeing some significant improvements with the use of new technology, a dedicated clean team and a few other things. So we are seeing quite good first-clean results. But again, we have to keep them cleared until we get the results back from pathology.

Ms FORREST - How long does that take?

Mr KIRWAN - It depends on when they go in but often it will be closed for 24 hours. Given that at the moment we are running at about 75 per cent of the clean-right first time, that means that if you do not get it for the other 25 per cent, those beds have to remain closed until they are cleaned again. The four medical beds we use as an overflow for the emergency department and that has been very successful. That means that when the emergency department has patients ready for admission into the rest of the hospital, we can admit them into that area now. We tend to use that as a day ward facility but more often than not this year, that has been open. So although we say they are closed - that is, they are not staffed to 24-hour/7-day models - they are staffed during the day, and on occasions if we have the staff and the need, we will again, through overtime, have them staffed during the night.

Ms FORREST - Where are they staffed from, the DEM or the medical ward?

Mr KIRWAN - From a mixture of DEM but also the pool. So there are extra nurses put in there. That effectively means that, although we say those beds are nominally closed - that is, they are not generally available for just direct medical admissions - they are actually used.

Mrs SMITH - On your reporting, are those people reported as a DEM client, if they are waiting to move through?

Mr KIRWAN - No, until they are actually admitted into their ward, they turn up on the DEM figures as patients awaiting admission.

Ms FORREST - Regarding some of the patients we see waiting for five days on a trolley, if they were in there for 24 hours would they show up as a 24-hour stay in DEM?

Mr KIRWAN - Yes, but they are rarely there. Apart from a couple of occasions, the long-stays that we saw last year are occurring less, although we did have some peaks in access block-out of DEM. Certainly in January it was terrible. There was a peak again in July, but again only for a couple of days, not for extended periods.

Mrs SMITH - Easter?

Mr KIRWAN - No, Easter was not too bad in relative terms.

Mrs SMITH - I might be misconstruing then. We requested some minutes of meetings, which you sent through, and I perused one in April - around Easter - and the longest stay was just under three days. Are they in this centre block you are talking about but they are classified as a DEM patient until they are moved through?

Mr KIRWAN - Yes.

Mrs SMITH - Thank you. That sounds much better than imaging someone lying on a trolley in a hallway.

Mr KIRWAN - Unfortunately, in the worst periods they would not be in a hallway. We do not prefer to do that. They would normally be in the emergency department, taking up one of the bays. That is obviously problematic in an area that really has only 18 bays. On some of the worst days they have all been full with patients awaiting admission, and we have not had beds for them. Some of those lengths of stay - you need to drill down the patients - are also sometimes due to patients requiring single beds or because of other issues. That has caused some issues. But there are a number that have waited unacceptably long periods of time.

Mrs SMITH - Can you explain to the medically uneducated, 'Requiring single beds'? Do you mean isolated in a single room?

Mr KIRWAN - They may well be MRSA-positive, for example.

Ms FORREST - Single room, not single bed.

Mr KIRWAN - Sorry.

Mrs SMITH - That is okay. I presumed that.

Mr KIRWAN - Sorry, my mistake.

Mrs SMITH - The issue of only five ICU beds is significant. Of those beds, do you have a breakdown of where generally over a year the patients would come from? Would they come from surgery, coronary or some other area?

Mr KIRWAN - No, coronary care beds are separate. We have five ICU beds, five coronary care beds and one isolation room.

Mrs SMITH - So you already have that. In the department's evidence they talked about a new cardiac care unit, which will free up some of your ICU.

Mr KIRWAN - In the new acute medical unit we will move the cardiac-care post-operative patients into the acute medical unit, which will be a 26- to 28-bed unit where the current day procedure unit is. That will free up the CCU beds, which are combined ICU-CCU at the moment. That is also an area that suffers space and some of the original design faults of the original hospital. As part of the level 5 redevelopment, that will be addressed. What we will often have is seven, maybe eight, ventilated patients who are in a unit that

is designed for five. They will overflow into either the isolation room or the CCU beds, on occasions even being managed by the intensive care physicians either in the recovery area or on the wards, in the worst situations. We were quite concerned in the H1N1 situation - and touch wood it hasn't occurred and we are hoping that we have passed the worst of it but it is too early to say - because some of the patients we were seeing in New South Wales and Victoria were quite young and requiring one or two weeks of ventilation. That really does create some issues in respect to capacity when you are running a small unit. That is a structural issue that has been known for quite some time. As I said, it is now going to be addressed. We just need to manage our way through between now and when it is redeveloped. The plan is to separate out the cardiac care from the ICU. That will be part of the acute medical unit that will be on level 3, which will be integrated with the emergency department.

CHAIR - On the elective surgery side of things, I think we are being led to believe that with the changes that are going to occur within the hospital over the next three years that will give you the ability to catch up on some of the elective surgery problems you currently have. If you do not have the increases in staff and doctors and so on, how can that occur?

Mr KIRWAN - There are some efficiencies that I alluded to - that is, how we schedule our work both within the theatres and the type of cases. The department has purchased a program called 'Checklist', which is a planning tool that can be used so that we can look at the type of cases we are dealing with and make sure we are getting the right mix. As I said, there is a balancing act there between the right mix for large cases and the smaller cases, so you are using your theatre time efficiently and training your junior staff appropriately and keeping the skills of your current staff up. There is a fear in respect to the type of work we are doing that some of the lower-acuity work is not being seen, and that is an issue for both training and skills. Because of the ICU and our current theatre configuration, we are seeing some natural blockages. As I said earlier, we will hit a natural peak. We are still improving each year but we are probably not that far away from saying we may well have hit that peak, but I still think we have some areas.

Just within out own efficiencies, scheduling and communication and others, we will see some increases to address particularly those over-boundary patients for what is unmet need in the community and growths in our waiting lists. Our waiting lists are at a bit of an equilibrium, but they have slowly come down. That is because of all the extra work, but I think they could increase quite significantly. What we are seeing in the community is that that will require the extra theatres and staff, but that is a physical issue. Other than working weekends and others, which I think would be problematic in our existing spread of staff. This is until we sort through some of our bed management a little bit better, which we are well on the way to doing, and until we get the theatres rebuilt so that they are efficient, and with the recovery area. Part of that is to bring the day procedure unit up on to the fifth floor so that the fifth floor becomes predominantly a surgical floor and they can have flexibility across the surgical, anaesthetic and theatre staff. At the moment it is difficult because they are located separately. So we miss some efficiencies because of that.

Mrs SMITH - What is the percentage of day surgery to long stay, or short stay to long stay?

Mr KIRWAN - I think our figures are around our target, which is about 65 per cent. They have dropped a little. I think it is either 65 per cent or 85 per cent. I am sorry, I have forgotten now. So we are not doing too badly. It has dropped a couple of per cent in the last figures I saw at the end of June, but we could not identify any trend in that. We are doing quite well in that area, as we have done traditionally.

CHAIR - We might now proceed to the emergency department area.

Mr KIRWAN - We have touched on some of this. There is a real issue with the physical layout, which is now being fixed with the $12 million injection from the State Government. That will not only give us a new department, but with that comes a re-engineering of how we work in the emergency department. Thanks to additional funding from the Federal Government we can now create the acute medical unit. So for the first time at Launceston we will have an acute medical unit with an emergency department integrated. That will allow us to remodel our models of care. It depends on how you define it but 40 to 60 per cent of our patients are acute medical patients fronting at the emergency department. They will go through the acute medical unit, not through the current model, which is the emergency department. As you have just indicated, you may be waiting on a trolley for a while and then going up to a ward as and when the bed is available. They will be able to be held in the acute medical unit for up to three days, if it is a case of stabilisation and treatment and testing, and then discharged. It will allow direct admissions from the general practice areas, which will be a significant improvement.

We think that will significantly improve both the emergency department and patient flow. Obviously being in a far better, well-designed department makes a big difference as well. The acute medical unit is a significant improvement as well. That will also bring to the front of the building general physicians, senior nurses, senior allied health personnel, senior paediatricians, senior O & G and senior mental health people. At the moment that is not quite the case. In that respect we are a little different from the Royal because those resources had not been provided in those areas in the past.

Ms FORREST - The North West Regional Hospital is implementing this hot position approach for direct access for GPs. Is that to be included in this redevelopment of your DEM structures?

Mr KIRWAN - Not as such. The acute medical unit is a more comprehensive approach using similar principles. It is based on successful models in Auckland, Australia, the United Kingdom and other places by bringing the general physicians, as the physicians rather than one referring doctor or other, into the emergency department. You will understand we have a different critical mass from the North West. I am not saying our model is what they should apply or vice versa. Their model is a good model for their areas. Our creating an acute medical unit means providing those resources at the front, where the patients come into the building, particularly the acute medical patients, a lot of whom would be frail aged who have a number of co-morbidities that need to be treated rather than put into the system and then treated in an episodic way. That is the model. It has similar principles to the hot physician, but it is a whole department with a whole focus on the patients to triage them and treat them up-front. If they then require admission, then we get them very quickly.

Ms FORREST - So you are doing that special involvement early on?

Mr KIRWAN - Exactly.

Ms FORREST - You said that was in place in New Zealand in Auckland.

Mr KIRWAN - Yes.

Ms FORREST - Anywhere else that you know it is working?

Mr KIRWAN - They are called different models and Dr MacDonald is probably the better one to explain it from a clinician's perspective and through his role as the President of the Australia and New Zealand College of Internal Medicine. There are AMUs and RAPUs and various other acronyms and they keep changing them, which confuses me. In a lot of other places, because you have facilities that are quite set and not able to be moved, as hospitals tend to be, you will create these acute medical units or medical assessment units but they will often be physically separate from the emergency department. What we have is a very rare and unique opportunity to create the acute medical unit as an integrated part of the front of the hospital, which is the emergency department and which is our front entry for our highest acuity patients. So when they come in they will be co-located; they will be jointly organised together and integrated together so we can remove double-handling and duplication. We can have our most senior staff up front dealing with our highest acuity patients. They can be involved in their care and their care plans right from the beginning, rather than get triaged through the emergency department, referred to a ward and then they get to see their specialist maybe one or two days later. This reverses the whole model.

Ms FORREST - Do they call it something?

Mr KIRWAN - It is the acute medical unit. These are general physicians with an interest in emergency and acute medicine but it is not the same as our Fellows of the Australian College of Emergency Medicine. They will still deal with the emergency trauma and other work.

Ms FORREST - The co-morbid patients.

Mr KIRWAN - But instead of three or four steps through the system it provides for that large cohort, just the same as we would like to see a higher profile in areas like mental health at the front of the emergency department. We are in the process through various funding models of putting in more allied health staff in those areas so that they can assess people, particularly frail aged and other areas like that. Do these people need to be admitted, can they be treated somewhere else, can we access the range of Commonwealth funded programs to then have them back out in their home rather than coming into the hospital at all? There is an issue in respect to our model of care; that is, people tend to use LGH as a general hospital for everything. That is good but that is actually not sustainable for the future.

Mr WING - To what extent does the lack of general practitioners and the fact that some practices have closed their lists aggravate problems in the accident and emergency department at the LGH?

Mr KIRWAN - Coming from Western Australia and the Northern Territory, I am used to no general practitioners rather than not enough, so it is a bit relative. We have a good coverage of general practice. More recently I have noticed in the press that one of the general practices has their books open and is welcoming new patients in Launceston. So it is cyclical. Our issues come on occasions when they have been short and they are then deferred; that is, they have sicknesses or closed their practice. It does not happen very frequently. I think that we are surrounded by very good and very qualified general practice. There is a view that we are cluttered with category 4 and 5 patients who could be treated by general practice. I think that our emergency physicians would disagree with that. They do not find them particularly demanding, other than when we are full, but we will fix that with the new department, and there is an issue of out-of-hours cover, which is limited in Launceston.

Ms FORREST - It seems that doctors and nurses have a different view on that. The nurses see a lot more of those patients than perhaps the doctors seem to be saying.

Mr WING - I think that we have heard evidence from doctors too that that is a problem.

Ms FORREST - The medical evidence was that it was not such an issue for them. They believed that a lot of the patients who presented to the DEM needed to be there rather than at the GP's. But the nurses felt it was a different story.

Mr KIRWAN - We are seeing figures increasing in our emergency presentations but they are generally across the board. Like I am used to in Western Australia, an out-of-hours GP clinic is part of the emergency department; would you explore that? I just do not think the economies are there at the moment. With the other changes that we are talking about, it is an issue when we are overcrowded and we are busy, which is the normal Saturday, Sunday, Monday, Tuesday. It is an issue in the winter periods but as a preference I prefer us not to get into primary GP care. We are an acute hospital site and when we get involved in some of the other areas we blur boundaries and get into areas that we are not particularly good at. We are good at acute, we are not good at primary. Primary, which is best left with the experts, is general practice, community nursing, pharmacy - all of that suite.

Mrs SMITH - The figures the department presented showed that the Launceston General Hospital presentation to the Department of Emergency Medicine has grown significantly from 2004 through to 2008 when you compare it to the other areas and yet when you look at the medical staffing, for instance, it does not seem to balance up in the same ratio - 23.78 for Launceston and 34.3 for Hobart. Some of the evidence has been closed books of doctors so we are just trying to get our head around are they sicker people in the Launceston area?

Mr KIRWAN - I will try to stay away from the staffing, other than to say we have a business case with the department about when the new emergency department will be open and what that means. It is probably the worst economic climate to be arguing for more resources but anyway we are.

In respect to the GPs, I think it is multifaceted. If the GP services were to be reduced or closed, we would be concerned but at the moment we have traditionally provided the

out-of-hours cover and that has always been the role of the hospital. Is that something we would like to do less of? Probably yes but, again, when you look at the care that is being provided, other than the people fronting up for a doctor's certificate and a few others which I would have to say we would probably prefer not to, a lot of the other work at 4sour and 5s is care that is required to be provided, albeit it is not the higher acuity that you require an acute hospital for but generally there are not services to provide it out of hours. There is one out-of-hours practice. A lot of the GPs provide locum and other out-of-hours services - they actually do - so I think we need to look at the whole picture. I think it is an issue but I do not think it is the issue that we have to deal with in the emergency department.

Ms FORREST - Do you think that nurses have more to do with those category 4 and 5 patients perhaps than the doctors may and that could be a different perception there?

Mr KIRWAN - I think so. I think the reforms that will go through the emergency department with its fast-tracking and a whole range of other initiatives will allow them to prioritise their own workload and I think there are other initiatives, as I said. I would prefer to not get involved with providing GP services in an acute hospital site if at all possible, which I have seen work well in some areas with co-located out-of-hours GP clinics but I have also seen where people have been prepared to wait in an emergency department because they know that if they come to an acute hospital it is a one-stop shop, their price is waiting, they do not pay, and they can get whatever pathology, radiology or other follow-up services in a one-stop shop. That is where we are condemned by our own success, albeit waiting is the price they pay. Some people are prepared to be time rich in that respect rather than pay.

Mr WING - Is there any policy requiring people who present at accident and emergency to be seen within a reasonable period by a doctor or a nurse? I know of one case, personally, recently where I was helping an elderly lady. She was brought in by ambulance, put in the waiting room and nobody spoke to her for about an hour and a half, and I know of other cases anecdotally.

Mr KIRWAN - There is a five-triage system that we work and that all of Australia does that prioritises the patients on presentation and that with another category which is did not waits - that is people who present and then do not stay - are the six areas we would generally report on and those figures are available. In the busy periods that is a problem and even though we have put in additional resources in the emergency department in the last 12 months, both in nursing and medical staffing, there is a physical issue as to how much additional we can provide. In some areas in peak periods - again the worst period would normally be Monday, Tuesday, middle of winter - we often are not meeting those targets but generally we are in most of those areas and certainly in category 1s we are.

CHAIR - Are there any other questions in this area?

Mr KIRWAN - The other challenge to us with the emergency department is that we do need to move to a more 24-7 model. What tends to happen at the moment is that after about midnight, a number of the other services are only available on call, which is really only for urgent cases. So, for example, a patient who is a category 3, 4 or 5 may be required to wait until other services are available in the morning. That does give us natural bottlenecks so you can see the area that aggravates the staff and rightfully so. If it is

eight o'clock in the morning and they have the whole place full already, that doesn't allow the flowthrough. I would have to say that that is a mixture of service design and economics. There comes a time when you get the critical mass - 330 to 350 beds, depending on how you count what we are - and we are not at the right size. We need to somehow work out how we are going to do that, which is one of our challenges at the moment. In our diagnostic and support services, allied health and others, we will need to provide more of a 24-hour/7 service. Again, it would be nice to simply put the extra staff on, if they were available and we could find them, but at the moment that is not possible for a range of reasons, but we are looking at doing that. I should also say that we need to develop a different relationship with our general practice. We need to establish a relationship where we work with them and support them because we are all seeing higher-acuity patients, irrespective of where you are in the continuum.

Ms FORREST - Isn't that part of your northern area health service plan?

Mr KIRWAN - Yes.

Mr WING - I would like to ask you a question that I asked another witness to this committee. What do you consider the capacity of the accident and emergency division at the Launceston General Hospital to deal with a disaster, say an aircraft crash or a bus accident involving injuries to multiple people?

Mr KIRWAN - Fortunately it hasn't happened in my time there and hopefully it won't, but I disagree with the comment of Dr Pielage and I wrote to the committee and indicated that. In an emergency I have every confidence that LGH, as in any other hospital in Australia, has well-documented plans to deal with emergencies. The perversity for us is that if we have a car crash, plane crash, a bus crash or a fire or something like that, we have quite clearly-defined procedures that will be enacted that will allow us to move patients out of the hospital into other facilities and focus on that. I have absolutely every confidence that we will do that and do it very well.

The difficulty we often have, at the risk of cutting my own throat, is in the areas where it gradually increases to a crescendo. That is where we had the difficulties that I inherited or came into last year and that was difficulty getting that timing right, just the same as the current model. We are in a balance at the moment of when we cancel more elective surgery and all that comes with that to keep beds open for the expected avalanche that comes with an influenza outbreak. It is always a day-to-day decision. In fact, on some occasions it is an hour-to-hour decision as to what you do. Obviously if someone is prep, someone has travelled in from Scottsdale or St Helens, we really do not want to cancel elective surgery, but it is a balancing act from our senior medical and nursing staff as to how they do that. Sometimes we don't get it right, I have to admit, but we generally try to.

Ms FORREST - Are all the staff well aware of the procedure, the code brown?

Mr KIRWAN - Yes, and we are surveyed and accredited on it. I am just trying to remember whether it was this year or last year, but it was relatively recently and certainly since I have been there, there was a code brown exercise. For a true emergency I have absolutely 100 per cent confidence in our systems. They are tested and we are surveyed on them and the staff are trained in the procedures.

Ms FORREST - When you test them, do you transfer patients out to the private hospitals? Do you physically do it?

Mr KIRWAN - No, we wouldn't do that, but the plans are there. I am advised - and I wasn't there - that in the past there had been a rumoured or reported bus crash on the highway where they did that. In respect to Beaconsfield and others they also did it. My advice is, not that I have the personal experience, that when it has been threatened in the past, that has occurred.

Ms FORREST - So it has been activated?

Mr KIRWAN - Yes, and the movement has actually occurred. They were not exercises, they were real but were found not to be required to that extent. Again, probably Dr Renshaw is the best to speak to about that because he is our medical coordinator. It is not unique to LGH; I would say any of our hospitals in Australia are well positioned to do that.

CHAIR - John, you mentioned the position of moving to a 24/7 model, or thoughts about it, that is one of the things that has often been said about the system that we currently work with, that we are too staid in processes, that you have never really moved with the times, that this has inhibited the ability of the public hospitals to provide the services that now should be provided. Do you wish to make a comment on that?

Mr KIRWAN - I don't think we are staid and we are already a 24/7 model. What I am talking about is moving some of the services that are not 24/7. They already provide a 24-hour cover, mainly on-call or recall. So my experience in Western Australia, which is a little bigger, is that at a point in time the critical mass actually becomes such that you then have to explain to your pathology, pharmacy, radiology and other staff that, 'Guess what? The on-call, recall, overtime model is no longer there. You are now going to go on shift work'.

Ms FORREST - And less money.

Mr KIRWAN - And less money. I have sat on both sides of the fence in those arguments. As I advised the union officials I now work with, in every case, when we can prove clinical need and efficiency, we will win that argument. You can understand that for staff who have not had to regularly work shift work and rotating shifts, they are resistant to do that. But it is one of those change management processes. The site knows that we have to move to that. We will do that over a period of time as we can afford it. Already areas such as allied health are addressing how they can do that because we obviously need to make sure that it will improve the quality patient care and improve patient flow.

Ms FORREST - You get called in for half an hour to run a couple of pathology tests on a neonate that is then transferred out to Hobart, so four hours double-time, then just after you get home you get another call for something else, and another four hours double-time. Do you have the figures that show the cost of that?

Mr KIRWAN - Yes.

Ms FORREST - So how do the costs compare with having the 24-hour service?

Mr KIRWAN - It is close in some areas.

Ms FORREST - But we are getting to that point.

Mr KIRWAN - Yes, but having only been there just over a year now, as I understand there have been previous attempts to do that which have been resisted. One of the things about LGH - which is one of its attractions - is that it is a very stable, very loyal work force. They have long lengths of service and so change in some of those areas is not going to be necessarily easy. Part of that is people like myself saying, 'Guess what? It is coming'. It is not a case of 'if', it is a case of 'when'.

Ms FORREST - So get on board.

Mr KIRWAN - I am not doing change for change's sake. That is stupid. It is a case of conditioning people but it is also a case of positioning all new staff to say, 'Guess what? What you are coming into is probably not what it is going to be here in two or three years' time'. With the investment we are making in the hospital we have to change our practices, not just rebuild the building.

CHAIR - John, we need at this stage to go in camera to discuss an issue.

Professor JOHN HUNN, UNIVERSITY OF TASMANIA, WAS SWORN, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Mr Dean) - Professor, before we commence there are one or two things. If at any stage through the process you feel that you might want to give evidence in camera for whatever reason, please raise that issue and we can certainly move in camera at a time that would suit you, if that should arise.

Prof. HUNN - Thank you.

CHAIR - The information and evidence is all recorded on *Hansard*. After this finishes, you are entitled to talk generally about it to the Press. There is no problem with that at all. Just be a little careful in, I guess, identifying a particular aspect or point of it. But generally you can talk about your evidence. There are no real restrictions or problems in relation to that. Having said that, for the record, Professor, could you give a little bit about your background before we move on? You have provided us with a very good submission and the committee has read that.

Mr WING - And all the background is in here.

CHAIR - And all the background is set out. I guess that covers it. It is in the record.

Professor, at this stage would you make any general comments that you want to and then obviously the committee will want to ask you some questions. Feel free to make comment in accordance with our terms of reference.

Prof. HUNN - Certainly. I think there is a general awareness from comments that are made regularly in the press that we do not have a problem with the professional standard and professional care of the patients in the Tasmanian hospital system. There are individual problems and comments relating to delays within the system but, in general, one would have to say that in all the three major hospital areas there is a very good, high standard of care given, equal at least to the other hospitals in Australia. The problem is a systemic one and in my view, that system relates to the administrative structure of the public hospital system. You may have noted that at one stage I was the medical staff representative on the board of management at the Royal Hobart Hospital when Sir Basil Osborne was chairman of the board and then later Professor Cobbold.

In my view, that system in which the day-to-day operation of the hospital was subjected to a monthly scrutiny by members of the board who were of varying expertise, including business involvement, community involvement as well as university, gave a much better system overall and better results than the system we have unfortunately become used to since the abolishment of the hospital board. I noticed in the press that the minister had at one stage made a statement that the hospital board system had been proven to fail and we would not go back to that. In fact she was misinformed about that. The hospital board system worked particularly well for some 120 years. What did fail was the movement from a hospital board, such as the board at the LGH or the board for the Queen Victoria and so on, to an area health board which failed very rapidly. The context of it was bad, the members were wrongly chosen and the whole thing fell to bits - very happily for the department because they then had the full say-so. In the present situation where the

public at large and those involved in particular have no knowledge of what is going on within the department, who is making the decisions and what the financial situation of the individual hospital is simply not known. If there is one thing that this could committee do, in my view, it is to very closely examine a return to the individual hospital board system with an allocated budget. The question of a budget, of course, means that you must have an adequate budget. There is no point in giving a hospital board a budget that is not adequate. There we come into contract with the policies of Treasury, which are inclined to say that the general inflation rate is 3 per cent, neglecting entirely that the health services inflation rate is something like 6.4 per cent. So in a very short space of time the hospitals become chronically underfunded. Then, of course, they find at the end of the year that Treasury has made their miscalculation, as they are so prone to do, whichever department they are dealing with and say, and they say we have $1 million, so you can spend it. Of course, the time for doing appropriate purchasing arrangements for highly technical equipment is much longer than the month or so in which Treasury has found that money. So that money often is wasted.

I know that is not a problem only in the Health department; it is widespread and I am sure you have encountered that in the Police department also. In Education certainly they found that over the years. So the whole system requires a re-examination in terms of the allocation of budgets. It was never possible to find out, within a hospital, what a department's budget would be. One would ask for a particular piece of equipment and the answer came back from the department, no, that is not within your budget. Nobody ever produced a budget for a particular department.

So that is my general comment and I am very happy to answer any questions about the more specific things. I recognise that my submission is a bit scrappy. The reason for that was that I did get so disheartened, going back through that correspondence, and I really could not bring myself to try to put it all together again. My wife said, 'Just give them the correspondence to read', so I did.

CHAIR - Professor, thank you very much for raising that issue. You referred to the police service and the police service, in effect, works with a board system now. You have each region responsible for the way it does its business. The general things are set by head office here, quite obviously, but then the regional commanders have the responsibility of employing and sacking and running budgets and all of those things. Evidence has been given to this committee that there is a slow down within the system because of the centralised system that is currently in operation.

Mr WING - The submission you sent in October of last year - apart from the correspondence, I am referring to the main submission - refers to the clinical services plan of February 2007. In that submission you refer to the unstable and inappropriate leadership at the top of the hierarchy structure of the hospital and ambulance services. There has been a change of leadership in recent times. I am not sure if that had occurred when you wrote that submission so I would like to ask you what your views are of the current leadership in the area of the structure of hospitals and ambulance service?

Prof. HUNN - I do not really like to comment in detail on that because I am not involved in the situation currently. The clinical advisory committee, which was chaired for 10 years, has been abolished in favour of what is called a clinical advisory council, which has a

lesser input from the hospital clinicians. On the other hand, the present incumbent has long experience in hospitals in the National Health Service.

I just came across some figures that illustrate the problem. The National Health Service in Britain in March 2009 has a total staff of 1.36 million; 39 900 are classified as managers and only 34 900 are classified as medical consultants. So the managerial staff in the National Health Service is greater than the medical staff. The same situation applies here. There was an Australian Centre for Health Research paper in 2008 which showed that, in Tasmania, of 8 992 full-time equivalent health staff, some 45 per cent were classified as administrative or other. It does not go into any more detail than that but it shows that we are heading very much in the same direction. Our whole health expenditure, in terms of staff, is lopsided, which leads to the problem that has been mentioned of a tremendous amount of inertia in the system. Instead of being able to make a movement, as you would, if you were riding a stock horse, you are riding an elephant. It takes a year to change direction and to get a decision out of the situation.

Mr WING - You also referred to the bureaucratic attitudes focusing on structures rather than outcomes, which have been evident in recent years prior to your writing this, so the focus is on Treasury approval rather than patient need. Would you like to elaborate on those points?

Prof. HUNN - I can perhaps give you an illustration with regard to the availability of PET scanning - positron emission tomography - for patients in Tasmania. Some five years ago the medical imaging people at Calvary offered to bring in a PET scanner. The chief medical officer of the department at the time, Dr Paul McCann, and I went to a presentation on this proposition at Calvary. We were both quite impressed with the possibility of it. It was not the latest bit of equipment but it would have stopped people who required PET scanning from having to go to Melbourne, with a tremendous stress on an individual patient given that they are all going to be sick patients because they are being scanned for the presence of secondary carcinoma. So Dr McCann and I made a recommendation that the department should enter into an agreement with the Calvary medical imaging people to do this.

The department declined to do that on the grounds that Calvary medical imaging might rip them off. We are now five years down the track and PET scanning is becoming available. Again, there is argy-bargy about who is going to use the PET scanner at Hobart Private, what they are going to pay for it, and we are still going to send some patients to Melbourne because we might be ripped off. It just does not seem possible for people to get their head around the fact that the reason for these recommendations is to make it better for the patients. It is quite bizarre to encounter that sort of thing. It is bizarre to medically and nursing trained people to understand that there are people to whom money is more important than the patient.

Ms FORREST - You were talking about hospital boards and you said that they themselves did not fail but when they became an area health board they did. There is a move starting on the north-west and now progressing to the north to establish area health services. I am not sure whether they are using a board structure, though. But do you think that is an appropriate way for trying to integrate your primary and acute health services under an area health service as opposed to looking at hospitals and primary health separately?

Prof. HUNN - There is a very important management principle that managerial decisions should be made as close as possible to the problem so to that extent, absolutely it has to be part of it but the structure has to be right. I think you will find that under the old hospital board system the smaller hospitals had a formal association with the major hospitals and I think the LGH had an association with Longford and Scottsdale. Certainly the Royal Hobart had an association with New Norfolk, Huonville and so on. The principle is absolutely true but you have to have the right people running it and you have to have the right people doing it in the right way. The principle is there but up to date we do not seem to have found a process that will work properly.

Ms FORREST - What would you suggest would be an appropriate process in that area of health structure that would see that working?

Prof. HUNN - First of all I suppose you need to take my original premise, a board with involvement as a community, so that if you are in New Norfolk, for example, and there is a problem, you know who to go to. At the moment if you had a problem in New Norfolk you would not know who to go to. You would complain to the Health department and that is a black hole. So you need somebody local, and it is the same as the local council; you need somebody that you can actually see who you know knows about the circumstances of your problem. I certainly agree with the principle but I do not have sufficient information to know which would be the most appropriate structure.

Mrs SMITH - Professor Hunn, the Federal Government is making some noises about taking over the health system Australia-wide, or parts of, and that seems to be the debate between the State and Feds, parts of versus everything. Do you have an opinion on that, considering your extreme knowledge of this area?

Prof. HUNN - It does not really matter who gives the money to the hospitals so long as the money is available and it is adjusted in a realistic way. There is not any real reason for getting the money from the Feds to the States to the hospitals given that every time a process touches a bureaucratic level, you lose a significant amount of money. It is like giving money to overseas aid; only a third of it gets to the shop floor, so to speak.

Mrs SMITH - You quoted some figures there of the administration arm versus the medical arm in our hospitals. Would you have a concern that there might be a danger that at a Federal level further away, the bureaucracy could grow or do you think we would remove a lot of layers of bureaucracy by going to a national system?

Prof. HUNN - I think should we remove a State level of bureaucracy you are not going to avoid the general phenomenon of an increase in the Federal bureaucracy. That happens whatever arm of government or whatever organisation you are dealing with. My view would be that there is a strong case to be made for a specific allocation of money to specific hospitals on their particular role. That role really is in three parts and in Tasmania each of the hospital groups, south, north and north-west, has the same sort of needs to varying degrees and those needs are patient care which can be arranged in relation to a case-mix system whereby each individual case has a financial value allocated to it, as you know. On top of that each, individual hospital has a teaching role, whether it is nurses, medical students, whoever it might be, and then each individual hospital, because they all have a teaching role, in order to attract properly trained staff,

has the research role. The hospitals can be varied on their throughput - for example, you would obviously have more complex operations done at the Royal Hobart Hospital than you would at the North West Regional Hospital but they would be fewer in number because of their length and complexity. That is being done in Victoria quite successfully and has been shown to work. It is a more difficult matter to get the acceptance by the Feds of a teaching role for each hospital and even more difficult to get an acceptance of the research role, although we are doing pretty well here in Tasmania overall because here we have now an increasing association with the university and with the Menzies Research Centre; at the LGH, the Clifford Craig Centre is doing well. The North West Regional, not surprisingly, is not geared up to that much yet but it will be.

Ms FORREST - They have the North West Medical Research Fund up there and they are doing quite a bit of research now. The rural clinical school has helped that.

Prof. HUNN - Certainly.

CHAIR - Professor, you made a couple of comments in relation to elective surgery, and I note with interest that one of the comments was 'there are satisfactory outcomes for elective surgery required' and the first point is an interesting one - I think it speaks for itself, but you might want to enlarge on it:

> 'Total separation of elective surgery facilities from overflow medical admissions. At present cancellation of elective surgery is the first move that management makes when stressed by patient increases or staff shortages. This is very unfair to the elective patient'.

You have a clear position there, that they should separate it. How can that be done in the current structures that they have? You are saying that they need to go back, revisit that whole process and try to separate that whole area away from all of the other areas that they are dealing with.

Prof. HUNN - Mr Chairman, that has been one of my hobbyhorses for the past 30 years. There are moves, you may have noted, in the press recently for the Feds to encourage the establishment of separate surgical hospitals. That is not necessary in Tasmania at all, but for years we have struggled on the surgical side of the hospital to avoid the cancellation of elective surgery when there is a flu outbreak or something of that nature, and I have to say that it has been a very difficult process indeed. At one stage I thought, when I was director of surgery for a short period at the Royal, that we had won the argument in that it was accepted as a principle by the emergency department and the physicians that that should happen, but it slid back. It is certainly something that should be. I can't imagine anything worse than being geared up to have your elective surgery, kids to be looked after, grandma's coming to look after them, and all that sort of thing. You then get into the hospital and in some cases even get up to the operating theatre and the case is cancelled for whatever reason - there isn't an ICU bed any longer or the staff feel they have done enough for the day, or whatever it might be. If you have elective surgery sequestered from the other activities of the hospital, and it is only a mental thing - okay, you might say, 'The physicians don't have enough beds', but the physicians will never have enough beds. That is fundamental. If they have 100 beds, they will do just as well as if they have 150, so why not keep the 50 for the people who had been sent home to stew again for the next week or month about having their operation?

CHAIR - Where their condition worsens, in many cases as well.

Prof. HUNN - The condition worsens, but not only that, every case that is cancelled has a trailing effect. Supposing you take a patient who is cancelled because of the lack of an ICU bed, and surgery is so complex now that 50 per cent of it or more is done as day surgery. That is all the easy stuff but it means that the other 50 per cent is much more labour intensive, being for older patients and so on. So quite a large proportion of patients need intensive care units afterwards and it is not reasonable to try to start something if you cannot finish it off with proper intensive care afterwards. So that is wasted. Beyond that, the theatre time and theatre staff are wasted and the anaesthetist is wasted if the patient is cancelled at the last minute.

CHAIR - Under the heading 'general practice', we have been given evidence on this before in committee and you have some interesting comments: 'Poor referring processes by the GP which can lead to repeating tests already carried out, a waste of time and an unnecessary cost to the hospital.' How can we streamline it?

Mr WING - The lack of communication -

CHAIR - Yes, lack of communication with the GP when a patient is discharged.

Prof. HUNN - Again, things like the lack of communication with a GP when a patient is discharged is another hoary old chestnut that the public hospital system has struggled with for many years. We thought that when faxes became available it would be possible for the resident to write up a discharge summary, fax it to the GP and that would be it. But that did not solve the problem either because, in surgical cases, perhaps the resident was still in the operating theatre when the patient was discharged. So it clashed with the early discharge policy. There is no doubt that with today's electronic systems it should be possible, if you can overcome the human factor, to get the information back to the GP on the same day without any problems. But it is a human factor.

Ms FORREST - An electronic patient record is what you need.

Prof. HUNN - Absolutely, and that has had attention and money thrown at it but it has not solved the problem.

Ms FORREST - Has not had enough money thrown at it yet, I would suggest.

Prof. HUNN - Nothing electronic ever has enough money available.

Ms FORREST - Because you cannot see so much of it, that is the thing.

Prof. HUNN - Sure, but that is a general problem.

CHAIR - You mentioned the referring processes by the GPs, the repeated procedures that they have to go through, the repeated testing and so on. That was previously raised. So how should we get over that? What is the better process there?

Prof. HUNN - That, again, is an electronic patient record. I think it is increasingly available to the admitting individual at the public hospital to have direct access electronically to the patient's tests, so having had blood electrolytes done two days before they don't have to have them done again at the hospital if the patient's record did not arrive. There is a lot to be said for electronic records.

CHAIR - It is good that you refer to that because it has emphasised to us the importance of getting that right.

Mr WING - In the minutes of the clinical advisory committee of 22 August 2003 there is reference to ample evidence being available that we are well behind national standards, due not only to lack of expenditure on capital equipment but, more particularly, to low staff establishments and unfilled positions in many field. It refers to the goal for hospital services in Tasmania to attain national standards within the next three years. That is six years ago. Have we achieved that goal? What do you consider the current position is?

Prof. HUNN - It depends on what you are looking at. For what they are worth, our waiting lists for elective surgery are still worse than those of most of the country.

Mr WING - Worse?

Prof. HUNN - Yes, that has been well publicised in the press. I do not think we are there yet by any means. We are better. The processes of obtaining capital equipment are better because fundamentally there has been more money available in the last four or five years. Overall, our hospital equipment is now approaching a reasonable standard. But there have been - and I am not sure what the current status might be - problems in obtaining allocations of money to obtain capital equipment, as I mentioned earlier.

There is, by the very nature of the purchasing process within a government structure, at least a year's lag. If you want a new X-ray machine you have to make a request and then the allocation goes to the budget review committee - all that sort of stuff. It is a terribly slow process. If that sort of process could be circumvented by a reasonable allocation to a hospital board then we would overcome a lot of our equipment problems. But it does have to recognise - and this has never been recognised, at least in the past few years - that the hospitals would need an allocation for equipment replacement to try to amend things and so on. For example, this endoscope has been mended three times. It is costing us more to get the thing mended by sending it to America or wherever it might be, so why not get the new one? That will be a better standard, but that has to come out of capital equipment cost, and there isn't one.

CHAIR - Professor, is there anything you would like to say now we are getting close to the end of our time?

Prof. HUNN - I would first of all like to congratulate members of the Council on coming to grips with what is a really significant problem for the State. We are all very keen to see our system work and develop properly. There is one point that I could not help overhearing earlier in relation to the GP load on the emergency department. A number of papers have been published in the *Medical Journal of Australia*, so well-documented, in which it is shown that the GP load is not the problem for emergency departments. The problem is that we have been so keen on closing down beds, largely in the belief that this

would reduce costs and also because of a lack of staff. In fact, this is what stopped the emergency department from functioning properly. The GP problem was something like 3 or 4 per cent, varying a bit from place to place, but it is not the major problem. Setting up health centres with GP facilities over the road from the hospital cannot be substantiated with evidence as being a way to overcome overloading in the emergency department. The only way you can overcome overloading in the emergency department is to give them somewhere to put the patients when it has been decided to have them admitted, not to give the emergency department staff the load of looking after that patient for 24 or 48 hours in addition to their proper work of assessing and treating emergencies.

CHAIR - Professor, thank you very much for coming to this committee today and for your submission.

THE WITNESS WITHDREW.

Dr JUDITH WATSON AND **Ms SARAH MALE**, CHIEF EXECUTIVE OFFICER, GENERAL PRACTICE TASMANIA LTD, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Mr Dean) - We do not have a written submission from you but you are familiar with the terms of reference. Could you please talk to us on those terms of reference, or do you have a general statement you want to make?

Ms MALE - Mr Chairman, we do have a submission to table at the end of our evidence today.

CHAIR - Thank you very much for that. I will leave it open to you at this stage to make any general comments that you want to make and then we will have some questions as we go through the process.

Dr WATSON - I have a written introductory item that I would like to read in order to put our case. I'm a practising general practitioner in Launceston and I'm Deputy Chair of the Board of General Practice Tasmania. General Practice Tasmania Network was established by the Commonwealth in the 1990s to enhance the role of general practice and the delivery of health services in Tasmania, as well as to position and promote Tasmanian general practice in its lead role in primary health care and provide informed advice on primary health care policy and service planning. There are similar networks in every State and Territory in Australia.

The General Practice Tasmania Network represents 500 GPs and 160 general practices across the State. My comments will be specifically on the general practice component of the terms of reference to the committee, however I do acknowledge there may be components of my evidence that will be relevant to other areas of the terms of reference. I will also be focusing on the systems issues rather than specific patient examples. In general, overall General Practice Tasmania is concerned that a poorly functioning acute-care system contributes to a strain on general practice, with hospital staff shortages, delays in patient care resulting in increased complexity and acuity of the care required in general practice. Patients who should be being treated in hospitals are instead being cared for in the general practice setting while they are waiting. Whilst we acknowledge that sometimes the same can be said in reverse, that patients who should be seen in general practice are turning up at hospital emergency departments, we need to ensure that patients are getting the right care at the right time and in the right place.

We have seen in the recent release of the report from the National Health and Hospitals Reform Commission that there is widespread acknowledgment of the need to reorient the health care system to be primary health care led and patient centred with focus on early intervention and supported self-management. If we are to achieve this, then the backlog of patients who have been waiting to be seen in the public hospital system must be addressed.

We also believe that all public hospitals, both regional and rural, should be part of one integrated system with seamless entry, exit and transfer of patients with essential and appropriate systems and communication to facility multidisciplinary and continuity of

care approach. We acknowledge the intention of the department to achieve this through the establishment of area health services.

There are a number of specific issues. The systems and processes for patient entry to and exit from the public hospitals are inefficient and often not transparent. Continuity of care is hampered by different technology, inconsistent protocols and procedures, lack of cross-sector communication in some professional boundaries. Clinical information transfer between hospitals and general practitioners is poor. Communication systems and protocols should support continuity of care, shared records and shared management of patients. We must get to the point where information about a patient's care in hospital is provided electronically to the patient's GP when the patient is discharged.

Discharge medications are often inadequate, with the patient discharged with insufficient medication and an expectation they will see their GP within five days to obtain repeat prescriptions for the ongoing management that has been organised in the hospital system. But the GPs have not been provided with the discharge information in a timely manner to support this.

Hospitals will not accept referrals from a general practitioner without reassessment. There is a lack of respect for the knowledge and skills of general practitioners, manifested by repetition of entire suites of expensive blood and diagnostic tests and an unwillingness to contact the GP when valuable, clinical and social input might be gained early in the patient's stay to both the hospital and the patient's benefit.

Hospital culture continues to favour holding on to patients in outpatient settings rather than appropriately discharging them to their general practitioners or community allied health care. A culture where a clear management plan is communicated to a GP could avoid patients being recalled to outpatient clinics ad infinitum.

There is concern about the level of integration between the components of care included in the integrated-care centres, public hospitals and general practice. The model for the integrated-care centres is still not clear. They appear to contain either outposted, outpatient clinics or community health centre-style services, rather than being an integrated component of the health system that services patients with chronic and complex needs between the primary and acute-care levels. There is concern that the development of the area health services, if not managed with statewide consistency, has the potential to create three separate systems and pathways, resulting in further complexity for health practitioners.

There is also concern about staff shortages and high staff turnover within the hospital system. There does not appear to be appropriate systems in place to compensate for staff turnover, maintain corporate knowledge and support continuity of relationships, and there is also insufficient orientation of hospital staff to the role of general practice.

We have a number of recommendations. Public hospitals should not be examined in isolation. They should be an integrated component of a broader health system. Sustainability of the health system will most successfully be achieved if there are effective partnerships with other health service providers, including general practice and private hospitals.

Systems should be developed, resourced and supported to assist a multidisciplinary and continuity-of-care approach to patient care. These systems include information exchange, clinical and referral pathways, and cultures that will allow patients to seamlessly move between primary and acute care and work together to achieve the best possible health outcomes.

The State Government must identify a budget to adequately fund information systems, infrastructure and electronic communications as a matter of urgency. Investment and effective timely use of a communications and record management system that allows for valuable real-time communication between referring providers and treating clinicians in the hospitals is essential. Accompanying this must be a clear change in the culture of the hospitals that ensure that necessary business process changes are made and that such systems are utilised rather than ignored. The system improvements and initiatives outlined in the State elective surgery and improvement plan must be implemented.

Hospital and specialist waiting times should be published, allowing GPs and their patients to make informed decisions regarding treatment options and referrals.

Consideration should be given to new models of care, such as exploring GP-staffed co-located clinics with the departments of emergency medicine to assess the lower priority category 4 and 5 patient attendances and properly resourced short-stay facility serviced by GPs.

General Practice Tasmania supports the national reform to move resourcing into wellness promotion and illness prevention. To reduce the burden on hospitals there needs to be an increase in resources into primary prevention, early intervention and wellness promotion. The State Government should actively pursue opportunities arising from national developments that could allow its State health systems and GPs to work together.

CHAIR - Thank you very much for that. GP Tasmania represents how many doctors?

Ms FORREST - Five hundred, and 160 practices.

Dr WATSON - Yes, which is most general practitioners in Tasmania. It is not a compulsory membership.

CHAIR - How often do you meet with the CEOs and the department? Do you meet with them on a regular basis to raise and discuss your issues?

Ms MALE - Certainly, as the CEO, one of my responsibilities delegated by the board is to meet regularly with the Department of Health and Human Services. We have a memorandum of understanding where we work with the department on service planning and service reform issues. Obviously there are different decision-making processes that we are not privy to but we do enjoy a collaborative working relationship.

Mrs SMITH - At which level within the department?

Ms MALE - I would meet with deputy secretary level. There is also General Practice Advisory Council of Tasmania where the AMA, the College, we and all the GP groups meet with the secretary.

CHAIR - Have you outlined and discussed the recommendations with the department?

Ms MALE - We certainly have. One of the most significant frustrations is the lack of progress around the e-health agenda. We think that is holding us back in terms of integrating the public hospital system and general practice. We know that there is a strong direction nationally to support the adoption of shared electronic health records between the various components of the health system. We have certainly raised that as one of our biggest concerns, along with recommendations regarding the elective surgery improvement plan. So we have raised all of these in the past.

Dr WATSON - As general practitioners we have a limited work force - doctors and nurses and allied health professionals within the State. The best way to maximise the benefit to the community of those individual professionals is to have seamless systems where there is lack of duplication and electronic communication is the absolute key to that. If GPs have access to electronic health records in the hospital and vice versa it will save so much time and so much duplication that exists at the moment.

Mrs SMITH - The issue of communications has come up consistently from both sides in this inquiry, the lack of communication from the GPs to the hospitals with the patient, the fact that the GPs have done certain tests and there is, as you have stated, doubling up because they redo those. They do not trust the tests that have been passed on, and at the other end there is the release plan. We had evidence this morning that they can send someone home having changed their medication on a Friday evening, but who cannot get to a doctor until Monday and they have one day's supply. In today's world of communications with e-mail systems and everything else it should be so easy and it has been talked about for years. Everybody appears to be committed to it but it is not happening. We had an older gentleman here this morning who has been some time out of that field and he thought the fax machine was going to fix this because you could put it on the fax and send it straight through to the doctor with your recommendation or vice versa, yet here we are where you can communicate to the other side of the world and we still have not fixed it. Is it a monetary issue?

Dr WATSON - I think it is multifactorial, like everything. There is money, good will and the ability to coordinate various ends of the system. The privacy issues have been quite a major difficulty over time in terms of decoding and encrypting of information. There seems to be one project after another. One project does a certain thing and then its 10-year run comes to an end, its money comes to an end and then you have to start again instead of being able to build on the previous project.

I think there is also a little bit of distrust from the hospital specialists in relation to what GPs are capable of. GPs have their own view of what they are capable of but because of that lack of trust I think they do not feel the necessity for the transfer of information. Then once the patient leaves the walls of the hospital they are on their own with the help of their GP, so it is essential that we do know.

Ms MALE - This is anecdotal: one of the things that I have heard regarding the electronic discharge summary project that the department has implemented is that the big stumbling block is that specialists then have to log on to a computer to complete the electronic

discharge summary. They are busy specialists and they are rushing from one patient to another so they do not want to do that.

Mrs SMITH - They always have someone running behind them.

Ms FORREST - The junior resident.

Mrs SMITH - It is called delegation. You either have faith in that person to do it in your name or not. Somebody must have to sit down somewhere and write a letter when they have finished with a patient if they are saying to go back to your GP for your ongoing care. That is usually the message in my experience. When you leave a system they say we have finished with you but if you have any worries, go to your GP.

Dr WATSON - The ultimate would be if GPs had access to the full electronic system within the hospital because then you could see a patient had arrived in hospital, follow their progress and be up to date with where they are when they get discharged, which is earlier and earlier these days. The person would not even have to write a discharge summary because you would have fundamentally followed the person through their progress, through their journey.

Ms FORREST - So if everything is entered electronically - the day they go to theatre, the surgery that is performed, the drugs they are on at that time -

Dr WATSON - Any complications they may have suffered.

Ms FORREST - Yes - so you don't need to have it summarised because it is all there.

Dr WATSON - More or less. A summary would still be nice but that would be magnificent.

CHAIR - Do privacy laws impact anywhere in this area at all?

Dr WATSON - Absolutely.

Mrs SMITH - But privacy laws, I would suspect - and you will correct me if I am wrong - are sometimes used as an excuse. If I go to my GP and I have faith in my GP and I sign an authorisation that the GP has total coverage over any of my medical issues, that really should be enough to trigger whether I am at a specialist, a radiologist, wherever I am, that that authority follows me through the system and back to the GP. Is that a fair assumption, because privacy becomes a big issue?

Ms MALE - It is. Privacy has become quite a complex thing to manage. Often people make reference back to say, 'Who locks up the fax when it comes?' - the fax isn't private. These days, through the national e-health authority, any clinical message around a patient's care has to be packaged up in what is called HL7 format, so it has to be encrypted, and to read it you have to be issued from Medicare with what is called 'public key infrastructure' so that you can decode it and authorise it as being something that you are allowed to see. It has gone a little bit out of control.

Dr WATSON - We do have that system in place; we do have the keys, we just need to add on.

Ms FORREST - But is it in the patient's best interest to have that information available to whomever they come across?

Dr WATSON - And they have the right to decline that any particular information goes to their GP or vice versa.

Ms FORREST - You have mentioned that hospitals are perhaps hanging on to patients and treating them through outpatient clinics when they could be better treated through their GP. I know there are certain Medicare cost-shifting issues around this. If I go in for surgery and I need to have a post-operative visit or a follow-up test of some sort, if I have it done in a hospital it is all picked by the State, if I come back to my GP and have it done it then becomes a Federal cost under Medicare. Do we need to look at how this cost-shifting is affecting it? The threat by the Federal Health minister to take over everything - it had better be everything or nothing in my mind, but that is my view - is that the way to fix this problem or can it be fixed more simply than that?

Dr WATSON - I think everyone in this room would be aware that cost-shifting happens, and I am probably not the right person to discuss that with. There are major advantages with having a person going back to their GP sooner rather than later because that GP knows the whole person rather than the leg or the ear or whatever it was that was dealt with within the hospital. That is not that general practice knows everything and can handle everything but if we are given clear protocols from the hospital, we are in a good position to manage the care more efficiently, more cheaply and in a more timely manner than the hospital outpatient setting can.

Ms FORREST - Currently, if I came back for such a visit, I would not be able to claim through Medicare?

Dr WATSON - To my knowledge, if you are a different provider from the person who provided the service, you are allowed to re-bill Medicare. If you are the provider of the service and then the person comes back for follow-up, that is considered after care and as such cannot be claimed. For instance, if a person goes into casualty and has stitches, if they go back to casualty to have the stitches out another claim cannot be made, but if they come to the general practitioner who has not seen them prior to that, they can claim for the removal of the stitches, for instance.

Ms FORREST - So there is not a huge barrier then?

Dr WATSON - No.

Ms FORREST - You made a comment about the area health service being an appropriate way forward to that integration between primary and acute health services. You also made the comment that it is really important to get it consistent across the State. We have had some evidence that the north-west has already started that process and is well down the track and that the north is about to start. The intention is, I believe, to roll it out to the south. Because they are quite different settings, it is possible to have a one-size-fits-all in the area of health service? We have heard from Launceston and Burnie that things are a little bit different in certain aspects already. In Burnie we have the hot physician, for example. At Launceston General there is not going to be the hot

physician, it is going to be a medical hotter physician. The only hot ones are on the north-west coast.

Laughter.

Ms FORREST - I have written it down - an acute medical unit. So there is a similar concept but different. Is that going to undermine the process or do you think we can get a consistent framework?

Dr WATSON - I think we are always keen to have local flexibility because, as you say, Scottsdale is not downtown Hobart. However, I think things like the electronic allocation systems are the things that you can have as a core. If they could be in place then you will be able to have the local flexibility.

Ms FORREST - You are talking about that broad, overarching consistency about localised models that meet the particular need?

Dr WATSON - Yes, and the other thing that we are concerned about is the issue that, in the northern Tasmanian example, the CEO of the Launceston General Hospital has been appointed as the area manager, and as primary health-care people we are concerned that it will have a hospital focus. We very much want it to be a whole-of-health, whole-of-system focus, not just the inpatient side of it. It is going to be a little bit challenging for the CEO to take a more broad view.

Ms FORREST - One other point you raised was if hospitals should publish their waiting lists and specialist waiting lists - that actually happens on the north-west coast. The GPs all get all the surgeons listed with their waiting times.

Dr WATSON - It is there to some extent. It is not very timely. Once again, an electronic system whereby you could just dial it in and see where things are today rather than two or three weeks ago would be very helpful.

Ms MALE - But there is also potential to look at that statewide. There is no reason a patient could not be referred from one area to another if the waiting time in one area for orthopaedics was five years yet they could have their treatment performed. I think we should be looking between area services as well.

Ms FORREST - Is that not the intention of the health plan?

Ms MALE - It was the intention of the health plan, yes.

Ms FORREST - Until John Howard intervened.

Ms MALE - When he bought the hospital?

Ms FORREST - When he came in on his shiny horse, yes.

Mrs SMITH - And was backed up by Kevin Rudd.

Ms FORREST - Yes, true. They were both very complicit in that.

CHAIR - That pretty well answers the other question that I had. It was in relation to the referrals not being accepted by the hospitals and so on. That information has been provided to us previously and it just seems to me to be a duplication.

Mr WING - You have asked that before.

CHAIR - I have asked that before but not today. It just seems to me to be a duplication. For what reason? You would be the best ones to tell me for what reason that occurs. Is it simply because the hospitals refuse to change their systems? What is behind it?

Dr WATSON - I do not quite understand.

CHAIR - You mentioned about referrals on to a hospital not being accepted and that being reassessed, there is a need to reassess.

Dr WATSON - Yes. It is probably a question to put to the hospital more than it is the general practitioner. It is a never-ending area of frustration for us because whilst we are not specialists, we have a broad knowledge and we are able to provide some very effective early assessment of a patient. In our opinion, they need to be reviewed at the next level. Then we find that they go to casualty. They sit around with all the other sprained ankles and everything else that comes in for a number of hours. They are seen by a very junior doctor who then moves up the system to the more senior to the more senior and eventually - surprise, surprise - they end up more or less, usually, agreeing with what we have concluded and being admitted for whatever procedure they may need.

Mrs SMITH - Is there likely to be a liability issue there? If your diagnosis and word is taken and they go through a process and something happens, is it an insurance issue rather than a medical issue, and we need to address it from that angle?

Dr WATSON - I am an immigrant from New Zealand, as you have probably gathered, and where I came from, if a GP referred to a public hospital you spoke to the registrar who was the level just below specialist who has had many years of training. You spoke to the registrar and they accepted the patient. The patient presented to casualty. That junior doctor, but well trained, came down to casualty, looked at the patient, agreed or disagreed with what you had decided, then sent his more junior staff to take the patient to the ward and sort them out. So it did not start from scratch. As it stands, it starts from scratch, no matter what you send the patient in with, unless they go by ambulance.

That is another frustration on my part. Many of our patients know that the best way to get to casualty and be seen is to pop in an ambulance and that is really unfortunate. It is a major waste of resources. If the GP's word was taken more seriously that aspect of wastage could be avoided as well.

Ms FORREST - This acute medical unit and the hot-physician approach is to short-circuit that. The patient that the GP is referring is either directed to the physician through a phone call, initially, with the hot physician approach or by at least a senior registrar or specialist at the DEM.

Dr WATSON - That will help, for sure.

Ms FORREST - How many GPs are in the State? I know you have 500 whom you represent.

Ms MALE - There are 547.

Ms FORREST - In your opinion, is that an adequate number of GPs? We know, particularly up in the north-west and possibly in the north, of real difficulty getting into a GP in a timely manner. There is a view that there is a shortage of GPs. There is a view that there is a distribution problem because they are all down here.

Ms MALE - If you look at national benchmarks of GPs per 100 000 population, so you are comparing apples with apples across the country, we would have an adequate supply of GPs. So the number of GPs per 100 000 population is not far different from the national average. That said, there certainly are distribution problems and the rural areas of Tasmania are the most vulnerable, partly because of difficulties of attracting GPs to work in those areas but also partly because there are so few of them covering such a large, diverse area. Of late, the new additions to rural areas of the State have been predominantly overseas-trained doctors. That brings with it the need to train those doctors in the systems and how to make referrals into the public hospital system and so on. We have heard that sometimes that can cause problems with overseas trained doctors writing referrals that are not adequate for the public hospitals. We are well aware that there are issues from our perspective as well.

Mrs SMITH - How can 547 GPs in Tasmania meet a benchmark, when the system of GPs differs so much from years past? At the local surgery in the old scenario there would be 10 or 12 GPs in that system - for different reasons such as lifestyles, family commitments or whatever. Many of them now choose a husband-and-wife team, so I will do Monday, Tuesday and you do Thursday, Friday. So is your 547 worked out on an FTE basis because, quite appropriately, the doctor's lifestyle has changed significantly from the day when the community presumed, seven days a week, that if you picked up the phone they were there?

Ms MALE - I guess there are two comments on that. That is not the FTEs. I think FTEs are 386 or something like that. We have been monitoring trends of GP work force for some years now. The work force participation has been dropping. The feminisation of the general practice work force has been having an impact because the female GPs are more likely to work part-time. As you have pointed out, the newer graduates are not prepared to do the hours of their older colleague and justifiably so. None of us would want to do some of the hours that -

Ms FORREST - It was not always that safe either. The patient safety issue is more considered these days.

Ms MALE - I am not necessarily saying that we have an adequate GP work force, however given how it is benchmarked we would be considered to have an adequate gross number of GPs. Certainly the work force participation has been falling and there are pockets of Tasmania where the GP work force is inadequate and unstable and vulnerable to the loss of one or two doctors.

Mrs SMITH - In the department's submission to the committee the growth in emergency medicine in Launceston has been horrific in comparison with the north-west or the north. One of their rationales for the improvement in those figures has been an under-supply of GPs, no private hospital with an emergency department and limited GP out-of-hours service.

Dr WATSON - Many patients that present themselves to casualty could be adequately dealt with in the general practice setting. Some of those people go to casualty because they have not been able to contact their GP or there is not a service, but in other cases they go there because they know where to go, it is easy, and they know they will not get a bill. We have an after-hours service quite close to the Launceston General Hospital but it is a small limited service

Mr WING - But it is a very good one.

Dr WATSON - There is also going to be another after-hours service run by another GP later in the year. We have not been able to have discussions in any meaningful or useful way with the director of the Launceston General accident and emergency department on that topic for some time. We can certainly see a benefit with having more after-hours co-located services but that has been rejected by the Launceston General.

Mr WING - Why do you think that is?

Dr WATSON - Apparently there was not the space, among other things. GP Assist remains for the foreseeable future, or for a period of time. GP Assist is a system whereby, after your general practice closes, you can ring GP Assist. You speak to a nurse who has a certain protocol to follow. Then they will pass you onto a doctor who also has a protocol, and then you will be advised to either go to hospital, call an ambulance, see your GP soon or in the morning or whatever. There is a GP on call from every practice that uses that system, so that you as a patient can be directed back to your GP, who will see you within a few hours of your calling if it is an after-hours setting. That is still a very good service, it is not know to everybody but it exists and it is very good.

Ms MALE - That service covers 80 per cent of predominantly rural and remote practices in Tasmania.

Mrs SMITH - Have you looked at the percentage of times that this service after hours would give advice to go to your accident and emergency?

Ms MALE - It is not available to us. We do not run GP Assist. You could seek that information from the Commonwealth because they fund that service.

Dr WATSON - I would guess that if the case was not urgent, and the person was not requiring hospital-style treatment, they would be redirected to their GP and not to general hospital casualty.

Ms FORREST - I understand that for every call that is made there is summary that goes to their own GP?

Dr WATSON - Yes. That is a marvellous service and the general practice community desperately needs that service to continue, particularly the rural practitioners. It is one of the make or breaks for a rural practitioner to have access to that service.

Mrs SMITH - The other issue with GPs is closure of books. You can only have so many clients. It does not matter if you are a GP or a hairdresser, the books have to be closed. Is that becoming an issue that needs to be addressed by all parties? I consistently hear of new people to Tasmania - and we have had a lot of new residents - who ask, 'Where do I go to find a family GP? I have been here and here and here and they say, "Sorry, our books are closed".' Is that becoming a regular occurrence around the State?

Dr WATSON - I think it is. As you say, one practitioner of whatever sort can only manage a certain number of clients. The fear is that if you say, 'Come on down', when a person needs an appointment there will not be any vacancy or there will a one-week, two-week or three-week wait, and that happens already. We certainly have in the Launceston area, where I can speak with more knowledge, a number of doctors who do have open books and we have been urging for some time now newcomers to Tasmania to ring around and to find a practice ahead of time so that when they are in desperate need of a GP for whatever reason they have one that is available rather than having to try on that day to find somebody.

Ms FORREST - The other group that particularly affects is university students who come from the north-west of the State either to the Launceston campus or to Hobart, probably even other places outside the metropolitan areas, they get to university, they get sick and they cannot get a GP.

Ms MALE - Part of the problem also is on the other side. We have talked about the supply side but on the demand side, Tasmanians are more sick on average than their mainland counterparts. There is a higher prevalence of cancer and chronic disease, and we are ageing faster than most other States so the demand for services is increasing while the supply of general practitioner services is not keeping pace with that. When you have patients, as Judith mentioned, who need to be seen in hospital and cannot be seen in hospital, they are adding an extra load to the system.

Mrs SMITH - I accept that we certainly have the higher levels of cancer and heart disease in different areas. Do we also have a community that is getting more neurotic and consistently thinks, 'I am not quite sure; Johnny has a temperature so I had better go to the doctor', less confidence in ourselves as communities and putting more load on?

Dr WATSON - Neuroticism is in the eye of the beholder.

Ms FORREST - That is a good answer.

Dr WATSON - I think there is some of that and that is, once again, where a general practitioner who looks after the whole family on an ongoing basis can help to educate their patients as to what is in need of general practice advice and what is not. If you have that relationship with a person over a period of time, you can reduce a lot of those possibly unnecessary calls.

Ms FORREST - Would you say the Internet has been a benefit or a huge problem as far as people doing self-diagnosis is concerned and always looking at the worst possible case for their symptoms?

Dr WATSON - It is a mixed blessing. I think having informed patients is not a bad thing, as long as you take it with a pinch of salt and make sure that you are comfortable as a doctor that you have made the right investigations and the right diagnosis.

CHAIR - As a general question, have you seen any improvement in the public hospital system as you know it, from your contact with it in, say, the last two or three years? Is there any improvement or are we still going down that same bumbling track?

Dr WATSON - I certainly haven't. I think the numbers of patients seen in casualty are increasing and there has been no significant change of attitude to getting people to go back to their GP. I think people are being kept in the outpatient system as much as they ever were. I think the waiting lists are no better than they were.

Ms FORREST - Judith, how long have you been in Australia?

Dr WATSON - Fifteen years.

Ms FORREST - We are hearing from a few different sources and have been led to believe that in New Zealand they are possibly further down the track with this integrated primary health hospital system. Not having worked there recently, can you comment on how it works over there and whether you think that is a model that we should be looking at as far as an integrated approach is concerned?

Dr WATSON - The Federal Government has clearly looked at the New Zealand system as well as the British system, and the National Health and Hospitals Reform Commission has investigated those systems.

The one thing that I do take from my somewhat dim memory of general practice in New Zealand is that it was always much more integrated. The practice nurse always had a very major role to play and as a GP-sparing role. So the nurse would do a lot of the more straightforward tasks that are currently and sometimes done by general practitioners and therefore the GP was able to see a higher throughput. Those nurses were not nurse practitioners; they were practice nurses.

Ms FORREST - Did they do things like pap smears?

Dr WATSON - Yes, that is right. Nurses do pap smears and immunisations here. The General Practice Tasmania has been coordinating training courses for practice nurses to do those sorts of things and there are many nurses around the State who are doing that now. That is the sort of thing where I think, with our limited work force, if we can provide different levels within the general practice setting, that will help a lot to manage the patient demand.

Ms FORREST - The New Zealand model has the area health services?

Dr WATSON - An area health service gets an amount of money to provide services to their community and so they -

Ms FORREST - Which includes the whole shooting match?

Dr WATSON - That is right. They purchase services from various spheres to provide the services, and it has good points and bad points. I do not think there is any system in the entire world that is not without its fairly substantial problems. But the benefits are that you can focus on what that local community or area needs, which can be very useful.

Mr WING - Dr Watson, how would you assess the public hospital system in Tasmania generally, as compared with the system in other States and Territories of Australia?

Dr WATSON - I cannot comment on that. I worked in Melbourne for a couple of years prior to my arrival in Tasmania. So I cannot comment, I am sorry.

Mr WING - I know of cases of people who go the accident and emergency section of the LGH and just sit and wait for a couple of hours before even being seen by a nurse or a doctor. Have you heard of similar instances?

Dr WATSON - Absolutely. I think the average wait at the Launceston General Hospital is four to five hours and I think, from anecdotal comments, it is longer at the Royal Hobart Hospital.

Mr WING - Do you not consider it is a dangerous practice for at least a nurse or, hopefully, a doctor, not to see those patients soon after they arrive to make an initial assessment?

Dr WATSON - It certainly does not have a very good flow. I agree. I think a lot of those people could be seen by their general practitioners and sorted out, certainly in vastly a shorter time than four or five hours.

Ms FORREST - If they can get in to them.

Dr WATSON - Yes, but many of them have not tried to get in to their general practitioner and I do think the issue that the public system is giving a free service, which means somebody else pays for it, rather than it being free, is a component for some people -

Ms FORREST - So should we charge a nominal fee for everyone who comes through the door of the DEM?

Dr WATSON - That is right. That would be an option.

Ms MALE - I do not think you are allowed to under the Health Care Act.

Ms FORREST - No, but nothing is set in concrete forever.

Dr WATSON - I would agree with that because if you could have a general practice on one side of casualty and casualty on the other side and say, 'There is a $15' or whatever 'fee to go there or you can sit here for four or five hours for free', then at least there would be

a bit of an option and the general practitioners in our community would be happy to be involved with an after-hours service that involved most of the GPs in the community.

Mrs SMITH - Do you think if, in the new building in the new emergency service in Launceston, the State Health department gave an offer to GP North, we will call them, of rooms to facilitate after hours, so when people came in there was that choice, that there is a GP there or you sit and wait up to five hours, the GPs would pick up that proposal and take it on?

Dr WATSON - I think we would seriously look at the proposal. We would have to take it our members; we would have to consider the incumbent service that already exists. A number of years ago we investigated a cooperative type of after-hours service and it was rejected by our membership because of the concerns that we would be encroaching on the incumbent after-hours service that does exist within our community.

Mrs SMITH - If the State Health department decided to put their own GP in the new DEM in Launceston and people could be told, 'There is the GP there' - and this is the emergency, after hours - do you see that as something that would speed up the true emergency situation?

Dr WATSON - We are a member organisation. General Practice North represents about 140 GPs in the northern region of Tasmania and we would certainly put it to our members. Obviously we have to be careful because some GPs like to look after their own patients after hours. Some of our general practitioners provide a seamless service for their patients whereas others are less connected. But it certainly would be an option. If we could reduce the waits in casualty, that would be good for everybody.

Mrs SMITH - The sorts of numbers going to casualty, particularly in Launceston, show that there needs to be something done. Some of it may be just the psychological aspect of people who go to emergency because they can do everything, particularly after-hours when there are not lots of options. If they had that specially facilitated GP-type doctor within there so that somebody directed them -

Dr WATSON - The benefits would be that the general practice would potentially have access to, as you say, some of those services that are currently not available within a general practice setting - for instance, laboratory testing. So that would be an ideal position.

Ms FORREST - Currently they are only available for emergency call-ins. As far as having 24-hour service, even having a GP in there, if the person sees the GP and if they need to have medication prescribed, unless they are prepared to wait until the morning to go to the pharmacy down the street and get the medication then they are still going to sit around in there until the hospital pharmacy opens or pathology opens. Go away and come back the next morning for it. You might be able to dispatch them out the door, only for them to come back.

Dr WATSON - I would have hoped there would be ways of providing patients with enough medication to tide them over until the next day.

Ms FORREST - And give them a private script?

Dr WATSON - Yes.

Mr WING - The waiting time is one of the two problems at the LGH accident and emergency. The other is when the patients are not even seen by a nurse or a doctor for an hour or two. Is your association able to exert any influence to have that changed?

Dr WATSON - No. We have a memorandum of understanding with the Launceston General Hospital. We have a GP liaison officer who does her utmost to keep reminding the hospital that GPs exist, what a useful resource they are and how they could interact and interweave with the hospital to the benefit of the patients. But we do not have any direct influence. The director of accident and emergency, for many years, has denied that there were any category 4 or 5 patients coming through his doors. That has been a bone of contention with us. Category 4 and 5 would be the sprained ankles and the finger jammed in the door level of injury.

Mr WING - Is that the existing director?

Dr WATSON - I believe he is still the director.

Mr WING - There used to be an after-hours surgery. I think one of our former members, Dr David Crean, worked there at times. I thought it was at Elphin Road. Has that been replaced by Dr Tredennick's after-hours surgery or are they separate?

Dr WATSON - Dr Tredennick is the only current after-hours service apart from the general practices that provide their own. I am aware of another service that will be opening, all going according to plan, at Elphin Road later this year.

Mr WING - After-hours?

Dr WATSON - An after-hours service, yes.

CHAIR - Is there a national benchmark for waiting times in the hospital system?

Dr WATSON - There is, yes.

CHAIR - Where are we with that?

Dr WATSON - You will find that the State releases a state of public hospitals report on a regular basis.

Mr WING - I know some medical practices have closed books, but we heard evidence this morning that there is one practice in Launceston that has been advertising that it is able to take more patients. Are you able to tell us which practice?

Dr WATSON - I can do. They have had two doctors who left, and two doctors have arrived. So as a consequence they have space for more patients. It is the Esk Family Health Service on the corner of Brisbane and Tamar streets.

Mr WING - Dr Alex Thomson?

Dr WATSON - Yes. He has been lucky enough to recruit two.

Ms FORREST - Where did he get them from?

Dr WATSON - One of them is Scottish and I think the other one might be from Western Australia.

CHAIR - Are there any issues you would like to sum up with?

Ms MALE - No, I think we have covered all the points that we raised in the submission. We would be happy to provide you with follow-up information data if you were interested in that because we maintain information around GP numbers by local government area and nurses.

Ms FORREST - What would be good would be to have the breakdown by FTEs. On a regional basis would be helpful.

CHAIR - We thank you very much for your attendance here today.

THE WITNESSES WITHDREW.