PUBLIC

THE LEGISLATIVE COUNCIL SESSIONAL COMMITTEE GOVERNMENT ADMINISTRATION A MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART ON WEDNESDAY, 24 OCTOBER 2018.

ACUTE HEALTH SERVICES IN TASMANIA

Dr STEPHEN DUCKETT, HEALTH PROGRAM DIRECTOR, GRATTAN INSTITUTE, WAS CALLED VIA TELECONFERENCE AND EXAMINED.

CHAIR (Mr Valentine) - Thank you very much for taking the time to present to us today; we really appreciate that. Some formalities first: we are not swearing you in today because you are not in our jurisdiction. You have received an information for witnesses card, but parliamentary privilege obviously does not apply because you are not being sworn. This is a live broadcast, so we are being filmed and the audio is live. It is also being recorded and the *Hansard* version will be published on the committee website when it becomes available.

We wrote to the Grattan Institute on 31 August with respect to a couple of matters on which we are seeking further information - patient safety from a Tasmanian perspective and also verification of some data received as a submission to the inquiry by Mr Martyn Goddard, an independent health policy analyst. We will hand over to you to present to us, if you are happy with that; please introduce yourself, and give your title and position for Hansard.

Dr DUCKETT - My name is Dr Stephen Duckett and I am the director of the health program at the Grattan Institute in Melbourne, an independent public policy think tank.

Thank you for the opportunity to speak to you this afternoon. I would like to start with a couple of points. First, with respect to comparisons with the quality of care between states, this is very difficult to do in any vigorous way. One of the indicators you might use, for example, is the rate of hospital-acquired diagnoses; that is, complications of care or issues that happen during the course of the admission, and you can try to compare that between states.

We have done major work on this issue. We have issued three reports over the last 12 months on analysing complications of care and, in particular, analysing the routine data and what you can get from the data that hospitals already report. One of the issues we noted is that there are differences in the patterns of coding between the states and, to put it at its most blunt, Victoria has much better and more detailed coding than other states. This is possibly because we have had a longer history of activity-based funding and also of use of the particular codes that help you identify whether there has been a complication compared to other states. That means when you are comparing states, you are partly comparing the coding and partly comparing the actual underlying complication rates. My view is that the data are not robust enough to enable us to disentangle those coding versus complication effects.

In our reports, we didn't do any comparisons between states because I didn't trust the data enough to stand up and say with confidence that in the differences we revealed we could see - and there are differences between the states - that those differences represented underlying quality differences.

Ms FORREST - Thank you, Stephen, I appreciate your expertise in this area. Can you elaborate a little more on what Victoria does? We know you have Safer Care Victoria and that has not been in place for very long, but I am interested in what coding method they use, how that came to be the case and is there something you would recommend that all states follow?

Dr DUCKETT - In fact you already do that in Tasmania. In Victoria about 10 to 15 years ago, maybe longer, we introduced what was called the 'condition onset flag'; that is, we forced the hospitals to ask, 'Was this condition or diagnosis present when the patient came into hospital, or is it something that arose during the course of the admission?' All states do that; it is now uniform across Australia. We have had it longer in Victoria.

I can't tell whether every state is using that code to the same level and appropriately, but we know there are other differences in coding. For example, if I can pair New South Wales and Victoria, on average the recorded complexity of patients in Victoria is higher than patients in New South Wales, and there is no demographic reason you would expect there to be a difference between New South Wales and Victoria on that issue. The same is true with Tasmania and Victoria, but there may be underlying reasons Tasmania is different because you might send your more complex patients to Victoria, so I am not confident we can always compare states appropriately. What you can do, though, is look at comparisons over time within a state and that is something that should be being done.

Turning to Safer Care Victoria, I did a report into quality and safety in Victoria a couple of years ago called *Targeting Zero*, which recommended the creation of the organisation that is now Safer Care Victoria and the creation of another organisation now called the Victorian Agency for Health Information. My inquiry was established because there was a series of potentially preventable deaths at a hospital on the outskirts of Melbourne and part of the problem was the culture within the Victorian Health department, which wasn't focused efficiently on safety and quality of care. With Safer Care Victoria we were trying to raise the profile of quality and safety but the department was more or less obsessed with finance only and, in my and the review's view, the quality and safety issues were not being addressed appropriately.

Similarly with the Victorian Agency for Health Information, the quality and safety issues weren't being addressed appropriately and the government wasn't putting information into the public domain. I am very much of the view that we should share information with the public; I see this as part of democratic accountability. The public, which is after all paying for all this, ought to know what the costs per patient are, what the complication rates are between hospitals and so on. We wanted to improve the transparency of the health system in Victoria, which is why we went in that direction.

CHAIR - Stephen, for Hansard, could you describe the capacity under which you were doing that inquiry?

Dr DUCKETT - I was appointed by the secretary of the Health department to do that inquiry. I took leave from Grattan to do it; it was a public inquiry and the government released the report and accepted in principle all our recommendations.

Mr FINCH - Dr Duckett, could you explain, for people who are watching and listening to this evidence, what you mean by coding, and does that vary from state to state, or is it uniform across Australia?

Dr DUCKETT - What I mean is this: every patient discharged from every hospital in Australia, be it a public or private hospital, has a set of procedures recorded in their notes, and all that information is then computerised. To computerise the diagnosis and the procedures, a coding framework is used and a number is ascribed according to what is called the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification. There is a standard code set that is used to summarise all diagnoses and procedures, which is then is put into computerised datasets.

Grattan has been able obtain that dataset with all hospitals and patients de-identified. We are not allowed to even attempt to identify patients or hospitals. We are able to analyse that data to compare the efficiency of hospitals, and to compare and understand what is happening with complications et cetera in Australia over time. Does that answer your question?

Mr FINCH - Yes, to a certain extent. In your report you talk about a veil of secrecy that exits. Can you trust that the coding you receive is factual?

Dr DUCKETT - In most states - and I cannot be certain about Tasmania - they do audits of the coding. That is, a sample of records is obtained and records are gone through by independent people who check the coding the hospital has registered. I am confident those audits are good enough. I say this because we use the information the hospital supplies for setting the budget they get in most states under the so-called activity-based funding. Because we are talking about money, ordinary principles of finance such as audit come into play, so you have to be sure the hospitals are being truthful about what they do. That is why you have to have an audit.

I don't know what Tasmania does. The audits by and large show that the mistakes hospitals make on the upside of it are offset by the mistakes they make on the downside. No-one is ever perfect in all this. That being said, my view is we should try to change the processes so that a lot of that coding is done independently of the hospitals to avoid any pressure and any incentive a hospital has to play with that coding.

CHAIR - Stephen, when you are doing your analysis, do you look at case mix at all in any way, shape or form?

Dr DUCKETT - Yes, we do.

CHAIR - Is it a full comparison?

Dr DUCKETT - Yes. When you are looking at the complications and the quality, we have to take into account the fact some hospitals have a more complex set of patients than any other hospital. If you don't, you are getting false results. Because we have information about the age of the patient and how many other diagnoses the patient has, we can take that information into account in working out a complication rate. When we have been comparing hospitals, we talk about the hospitals' excess risk, by which we mean that once you have taken all those things into account, is it riskier to go to hospital A than to hospital B, everything else being taken into account? We are able to do that. There are standardised ways of doing that now and you can get packages that help you do it more easily.

CHAIR - In a small state like Tasmania where few public hospitals are available, do you still see a benefit in making this information public?

Dr DUCKETT - Yes. The evidence from the United States is that patients don't use this information. The hospitals get embarrassed when the information is published and it drives the hospitals to change their performance more than it drives patients to change where they go. In Tasmania, which has three or four hospitals big enough to use for this comparative information - and in very small hospitals it is much harder to do - it is worthwhile publishing this information, if only to see whether the hospitals are improving over time. You should be able to see that and you can compare Tasmania, with some limitation, to other states. You can compare yourselves over time and you can compare yourselves within Tasmania.

Mr FINCH - For clarification, Dr Duckett, are you talking about public and private hospitals?

Dr DUCKETT - Yes, I am talking about public and private hospitals. I think what we are going to see is that health insurers will probably move faster on this than some of the governments. I think it is inevitable that governments will be publishing this information within a few years, but the health insurers might beat governments to the gun because it is very much in the health insurers' interests to encourage their members to go to hospitals with lower complication rates than to hospitals with higher complication rates.

Ms FORREST - A couple of things that flow on from this: one of the things we are particularly interested in is the rates of adverse patient outcomes and the cost of those, but also the contributing factors. Have you done any work looking at the contributing factors or is that not really an area [of interest]?

Dr DUCKETT - We've done a lot of work on the costs. We have estimated the costs of complications in Australia. We haven't so much looked at the contributing factors, for this reason: what we can tell from the routine data is just whether a complication occurred. We can't use the routine data to say why it occurred. You have to start looking at individual factors within a hospital.

Our general view is that you use the routine data to look at patterns and trends. You look at how things are changing: does this hospital have a higher rate of infections than that hospital? Then you say, 'Yes, we appear to have a higher rate of infection; why do we have a higher rate of infections? What is happening at this hospital leading to us having that?' You can only use the routine data to point your finger at where you need to be looking, but you can't interpret why. I can't say why something happened, with a couple of minor exceptions. By and large, the international evidence is that higher volumes are associated with better outcomes. You can use the data to look at that sort of thing, but, by and large, it is difficult to look at the why question using the routine data.

Ms FORREST - Are you aware of anyone who has done that work?

Dr DUCKETT - What do you mean?

Ms FORREST - Looking at the reasons for the complication rate. You talked a bit about how the hospital can compare itself against itself, for example, over time. You can also compare it with similar hospitals around the state. Then you said there may be a reason for one being more risky than another. Has any of that work been done?

Dr DUCKETT - The only work we have done is looking at a couple of different medical specialties. For example, in medical cardiology we looked at what is the relationship between efficiency and quality. Basically, there was none. Everything was all over the place. We had some hospitals that were very efficient and had high complication rates, and other hospitals that were very inefficient and had high complication rates. Every possible combination was there. We weren't able to go very far with that because it was all over the place. That is all I would like to say on that.

Ms FORREST - You mentioned you have done some work on the costs. I know that is contained within the report, but for the record, can you tell us what your estimate has been of the cost of these complications that occur in the acute health setting to the state? If you have a breakdown of public versus private figures, that would be helpful.

Dr DUCKETT - We estimated, right across Australia, the cost of complications, which we estimated to be about $12.6 billion a year from public hospitals and another billion or so from private hospitals. Not all of that is able to be saved. Even if you got the complication rate down for the best 10 per cent of hospitals in the country, you are still going to have a high rate of complications. What we estimated was that across the country you could save $1.5 billion a year if you could get the complication rate down to the level you see in the best 10 per cent of hospitals. I have no reason to believe that Tasmania isn't the same as all of the other states on this. Whatever Tasmania's proportion of the population is, that will be my estimate of the savings for Tasmania.

CHAIR - About 2.5 to 3 per cent.

Dr DUCKETT - That is still worth pursuing.

Ms FORREST - Absolutely, because that is all more health care.

Mr FINCH - The report is about safety in hospitals. You refer to hospitals that have come through the investigation as being the safest and the desire to raise up those that aren't as safe up to the standard of those that are. How do you measure that? How did you get your suggestions there?

Dr DUCKETT - We identified the 10 per cent of hospitals which had the lowest risk; that is, after you take into account the complexity of their patients, what is the 10 per cent of hospitals that are the best in the country? That is what we said were the benchmarked safest, so it is a purely comparative measure.

Mr FINCH - Are there observations that can be made by hospitals that have not made it into that 10 per cent that they could utilise to perhaps get to the benchmark they should aspire to?

Dr DUCKETT - Yes, that is exactly our point, so thank you. We are saying we want people to learn from the best. Early in my career I had a colleague who was the CEO of a hospital and every year the comparisons in Victoria came out about this, that and other, comparing various public hospitals in Victoria. If he was not the best or in the best quartile, he would establish a little team to go to another hospital that was performing much better than his so he could learn from them. It is trying to establish this collaborative culture where people feel they are able to go and learn from the best, because we're all in the business of trying to improve and trying to give the patient a better experience.

CHAIR - Dr Duckett, for Tasmania, how would you see benchmarking happening for us?

Dr DUCKETT - There are two components. One is, you only have a limited number of hospitals, but that is not to say you cannot do it. There is no particular reason why the Royal Hobart Hospital should cost more than the Launceston General Hospital, or whatever, once you take the patient mix into account and the other services being provided. Within Tasmania there is benchmarking and that is worthwhile, even if you do nothing else.

Second, you can then say, 'We ought to be comparing like with like' and, 'Can we learn from hospitals in Victoria, New South Wales or South Australia and establish relationships?' There is a private organisation called the Health Roundtable that facilitates those comparisons but you can establish bilateral arrangements to share information and learn from each other.

CHAIR - Given Tasmania's health status, the general population and the ageing population and the like, would it be easy enough to find a hospital we could benchmark with?

Dr DUCKETT - I think so.

CHAIR - Understanding the level of illness et cetera?

Dr DUCKETT - Yes. What you are interested in is asking, 'What does the orthopaedic department at the Royal Hobart Hospital look like compared to the orthopaedic department at Box Hill Hospital in Melbourne?' I think those are roughly the same size. Let's look at the cost of a hip replacement at the Royal Hobart Hospital versus the cost of a hip replacement at Box Hill Hospital or whatever. You can take into account and look at the difference in the age of the population and you would get down to specific comparisons, and I think that's what you need to do.

CHAIR - Even with more complex case mixes? If you are talking about hip replacements, there are more people with diabetes which creates complications in how you deal with those things.

Dr DUCKETT - Absolutely, and the DRG, the classification for hip replacements, divides up hip replacements into those with more complications than those with less or fewer, so you can do that.

CHAIR - That is diagnostic-related groups you are talking about?

Dr DUCKETT - Exactly, yes, and you can do that with a hospital like Box Hill. You wouldn't necessarily go to the Royal Melbourne or the Austin because they might be way more complex, but you still have quite large hospitals in Victoria that are similar to the Royal Hobart.

Ms FORREST - I don't know if you can comment on this, but over the course of this inquiry the committee has heard a lot of evidence about the higher risk of adverse outcomes with lack of continuity care where there is a high use of locums - for example, bed block or access block in the emergency department, with people waiting beyond four hours. We have a pretty high rate of that and I think some of our hospitals are the worst in the country on that measure. Do you have any evidence or have you done any research that highlights some of those perhaps not patient-related conditions but hospital-generated problems that would increase the risk of complication?

Dr DUCKETT - We haven't done any analysis of that but a fair bit of literature done in Australia shows that if you have longer waits in the emergency department, it is associated with worse outcomes. There is already Australian literature showing that, which is of course one reason you have those sorts of targets.

Mr FINCH - Dr Duckett, through compiling this report for the Grattan Institute, which of your observations caused you the most concern? Was there a particular area you think needs more attention?

Dr DUCKETT - This is probably not the answer you're looking for, but it is probably complacency - that people weren't really concerned about the level of complications. We know that complications vary from small to large, but they all add up in cost and they all impact on the patient experience, and there seems to be generally a desire to focus on a small number of complications rather than to say every complication matters because it impacts on the patient. So there was not this visceral commitment to address complications and really own it and say, 'This is a problem we have to fix, and fixing it helps both patients and the health system.' What we showed in the report is that if we could get the complications down to the lowest 10 per cent of hospitals, 250 000 patients who have a complication now would go home complication-free. The scale of the issue is one I just didn't feel there was enough ownership of.

Mr FINCH - Would you like to think that is the message perhaps hospital administrators would take most notice of?

Dr DUCKETT - Yes. If there is one thing we ought to be really serious about, it is this: doing everything we can to reduce the level of complications, not just focusing on those the government says we should focus on, but all of them, so we can get the rate down right across the board.

Ms FORREST - Also the sentinel events, those near-misses that often go unreported. Do you have a comment on that?

Dr DUCKETT - Yes. It's quite interesting you should say that because when you look at the official reporting, about 100 of those are reported across Australia every year, but when you look at the routine data we looked at, there are actually about 400 of them. It's quite funny that somehow or other the reporting isn't really capturing the extent of the problem.

CHAIR - Thank you very much for that. We probably interrupted you in delivering your -

Dr DUCKETT - That is all right. That all stems from the first issue you raised. The second issue you raised was the overall performance of the hospital and Mr Goddard's reports. I would say this: the first report, which I think is his submission, used Grants Commission data to argue Tasmania is not spending as much money as it is actually getting in.

My view is that I'm not keen to use Grants Commission data as a benchmark comparison, partly because I used to be involved in writing Victoria's submission on these sorts of things and Victoria was really in competition with New South Wales, Queensland and Western Australia. We wanted to minimise what money they got and maximise what money Victoria got, and to some extent the smaller states didn't matter. If Tasmania put up a case about *x* or *y* about its disabilities, as the phrase goes in the Grants Commission work, we weren't so fussed about it but

we were really fussed about what the other states did. I wouldn't like to say that the Grants Commission is the most scientific basis for working out what Tasmania ought to get or whatever.

That being said, the second report, which I've seen only recently, and the work we've done suggests that the performance of the Tasmanian health system is poor relative to the other states, its costs are high and a lot of improvement could be done in Tasmania for the benefit of Tasmanians. There is probably misallocation of resources in the sense of not getting good value for what has been spent already.

CHAIR - Your observation there about not necessarily using the Grants Commission data as the be-all and end-all, if I could put it in those terms -

Dr DUCKETT - That's exactly my view. I don't like the way he got to his conclusion, but I think his conclusion is right that a lot is left to be desired.

CHAIR - On the point made on page 4 of his latest submission where he talks about the health system being underfunded by about $1.6 million since March 2014, I am interested to know whether he is in the ballpark there, in your estimation.

Dr DUCKETT - I'll put it this way: Tasmania had very poor waiting time statistics. There are many more people waiting long periods in Tasmania. Whatever the reason, why is it that you have such long waiting times? It's difficult for me sitting here in Melbourne to put a number on so-called underfunding, but what we see patients experience is that they are not getting the same level of service that patients in other states get.

It is not for me to say why that is. I look at the data and there it is, in black and white, that patients are waiting longer, for example.

CHAIR - Is the basic way he works out the dollars that are underfunded and are GST calculations reasonably sound?

Dr DUCKETT - I wouldn't go to the last decimal point believing those GST and Commonwealth Grants Commission figures, but even if he is only half right, it is still significant underfunding.

Ms FORREST - On that point, you mentioned the misallocation of resources and underinvestment. I want to clarify where that sits. Is it, as Mr Goddard suggests, because of our relative disadvantage in providing services, that Tasmania gets a higher percentage of GST anyway? Because of the factors in health we get a specific additional allocation on that basis, are we -

Dr DUCKETT - His argument is that money is not flowing into the health sector to the extent it should.

Ms FORREST - Do you agree with that proposition? That's the question here, I think. If it is going somewhere else, that is not a question for you. I wonder where it is going - I think I know - but I wonder if you could expand on that notion for us.

Dr DUCKETT - My position is that I wouldn't overly rely on the Grants Commission data to say that this is money Tasmania is getting that could go into the health sector but is not going into

the health sector. Whatever the cause is, the result is that Tasmanians are waiting longer than patients in other states. However, there is a caveat I put on this and it is why I am being a bit equivocal: we also know that Tasmanian hospitals are more expensive than hospitals in other states, so there is some inefficiency at play in Tasmania, certainly in the larger hospitals.

Ms FORREST - Is that compared to similar hospitals on the mainland?

Dr DUCKETT - The comparison I am talking about is comparing the patients - that is, the cost per weighted patient. After taking into account the case mix of the patients, Tasmanian hospitals are 10 to 20 per cent - and I have some recent figures in front of me. The Tasmanian cost per weighted patient is over $5100 compared to $4700 in Victoria and $5000 in New South Wales. Even compared to New South Wales, it is $100 per patient more expensive in Tasmania than in New South Wales; this is after taking into account the type of patient. This adds up when you are talking about a lot of patients.

CHAIR - While you say you wouldn't take the Commonwealth Grants Commission data as the be-all and end-all, or the way it has been used, do you agree with the basic principles being used by Mr Goddard? He says that first it redistributes money between states so that all the jurisdictions that have different capacities to raise money themselves have an equal per capita amount to spend on services. Despite this, we have seen that the Tasmanian Government spends much less than the average on health. That is the first part.

Dr DUCKETT - Yes, I agree with that statement.

CHAIR - The second stage looks at the relative health needs of each population. In this stage, Tasmania currently receives about $260 million a year, redistributed from other states which have lower levels of need. If the state Government actually spent this money on health, per capita expenditure would be much higher than the national average, but it is much lower.

Dr DUCKETT - My concern is that I do not really trust the Grants Commission estimates of what the disabilities or needs are. If you accept that, if you believe the Grants Commission has it perfectly right, Mr Goddard's assessment is also perfectly right.

CHAIR - That does assist. I appreciate that comment in the sense of the underlying data that is being used is your question rather than the way Mr Goddard has used it.

Dr DUCKETT - He said the Grants Commission is an independent arbiter and this is what they have said, and he got that right.

Ms FORREST - Following up on that, we are trying to get to the potential underlying basis for which the Government needs to fund Health. For a bit of background - and for a number of years I have taken the minister to task on this - for many years there has always been an extra allocation toward or during the year for Health, either by way of what we call a request for additional funding, or a supplementary appropriation bill. Every year, the actual spend is much higher, about $156 million, and $161 million this last year, than what the budget was. Then the government sets the next year's budget higher than the budget from the year before, but less than the actual expenditure. This is a perpetuating thing; it has been going on for years. My argument is that they should give it a bit of a boost and start from a better starting point, at least a bit more than what they spent the previous year. Do you have any comment about that?

I accept your comments about the Commonwealth Grants Commission and using some flexibility around that. I was reading - I have forgotten exactly where it was from - some comments about the Commonwealth Grants Commission considering our own state revenue-raising capacity. Tasmania has reduced its revenue base in many ways through additional concessions for a number of taxes and things like that. Do you have any insight into whether that is perhaps impacting on the amount available to spend on health, not just the Commonwealth Grants Commission allocation?

Dr DUCKETT - The Grants Commission is a totally and completely opaque process but it takes account of the state's revenue capacity. Property values are greater in Victoria so our state government can raise more money from land tax or stamp duty than Tasmania. It takes account of both revenue capacity and the needs. For example, the Northern Territory has a higher Aboriginal population than Victoria so it gets the higher weighing for indigeneity. Both sides are taken into account, and if Tasmania has reduced its taxes for whatever reason, that is also taken into account in a different component of the Grants Commission assessment.

Ms FORREST - Does that impact on the amount the state has to spend overall? If we make a decision that erodes our tax base or our revenue base, the Commonwealth Grants Commission will say, 'Bad luck, that's your decision, Government of Tasmania, but we're only going to base it on the average', or whatever?

Dr DUCKETT - Yes. They have tables in their reports that say if Tasmania had set its taxes at the same level as all the other states, taking into account property values or whatever, this is what they could have raised. It has information in its report, in the same way Martyn Goddard has used, that this is what they should have spent on health if they spent the same as every other state. They do both sides.

As to the supplementary estimates, I have never known any government to perfectly estimate spending at the start of the year because there are always two things that happen. One is policy decisions that are made after the budget and you also might have an award or enterprise agreement variation and you didn't know precisely what was going to happen during the course of the year. Obviously, the further away you estimate, the bigger the supplementary estimate is relative to the initial budget, it is a sign of sloppy planning because you should be as close as possible and you should have taken as much as possible into account. You should have said, 'This is what we anticipate the enterprise agreement is going to be. Is it going to be $1.9 [million/billion?] or is going to be $1.95[million/billion?]?', but you shouldn't say it is going to be zero. You should be pretty close and the supplementary estimates should be unanticipated variations and it is a sign of sloppiness if they are always big and always overestimating the revenue or the expense. Grattan has published a comparison to the federal government where we have said that the projections have been historically optimistic in terms of revenue and that this is a problem of the Treasury modelling, for example.

CHAIR - Thank you for that. Moving to the private practice scheme, do you have any experience of such a scheme that operates in Tasmania?

Dr DUCKETT - I am not fully aware of the details but it does seem unusual, to put it mildly. In other states there is private practice in public hospitals and so there should be, but in the systems I am most familiar with the doctors pay some share of their revenue to the hospital depending on the nature of their specialty. For example, in pathology, laboratory medicine and biochemistry, the share might be 85 per cent or 90 per cent, because all the work is being done on

hospital-owned equipment by hospital staff, so the amount of revenue a medical biochemist would get would be very low. In surgery the share might be trivially small because basically the surgeon is doing all the work and so on. I was surprised to see that the hospitals are losing money on private patients. It does seem very unusual.

CHAIR - On average $1500.

Dr DUCKETT - The average cost of a patient is around $5100 in Tasmania so that's a lot of money to lose.

CHAIR - Moving on, there are a couple of issues with regard to emergency. I don't know whether you can verify this - it is on page 6 of Mr Goddard's -

Dr DUCKETT - I haven't looked at emergency in Tasmania in any detail so I can't make any comment.

CHAIR - That's fine.

Ms FORREST - Was there anything you wanted to say about the underinvestment and the misallocation of resources that could help us in terms of what you would do if you were the minister?

Dr DUCKETT - I really think I'm a bit far away from Tasmania.

Ms FORREST - It is helpful to get advice from far away.

CHAIR - Somebody who is standing back looking at the forest rather than being in the trees.

Dr DUCKETT - Obviously you've some issues with hospitals in the north - how many beds you have there and how many hospitals -but it is probably not something I should make any comment on.

Ms FORREST - When you say 'misallocation of resources', where do you believe the resources are being misallocated? Where should they go?

Dr DUCKETT - We have done some work and are going to be releasing a report later this week on Sunday which looks at avoidable mortality - that is, deaths from conditions the health system should be able to help with or be able to prevent. It is not necessarily about what happens in hospitals but about the general health of Tasmanians. If you compare Hobart with Melbourne, for example, and take into account the age distribution, the avoidable mortality rate is much higher in Hobart than Melbourne, with 295 per 100 000 in Melbourne versus 381 in Hobart. There is obviously something happening where either the Tasmanian Government isn't investing enough in prevention or the primary care system isn't working. There is something happening down there where Tasmanians are dying when they shouldn't be.

Ms FORREST - You mentioned primary care in your comments, and I absolutely agree. I really look forward to reading that report in terms of where the underlying potential causes may be, but in terms of primary care, which is not the focus of the committee but obviously is an important aspect of the whole health service provision, do you have any recommended reports or anything on the crossover and interaction with primary and acute health?

Dr DUCKETT - We haven't done anything on the interactions but we have done three reports on primary care over the last few years. The most recent one is called *Mapping Primary Care*. Basically what we're arguing is that the primary care system isn't doing enough and the Commonwealth and states should be working together much more closely on trying to improve the primary care system throughout Australia.

Ms FORREST - The whole problem with cost-shifting and one jurisdiction saying it is your problem -

Dr DUCKETT - Yes, exactly. It is that sort of problem, but it's also saying there is a single primary health network in Tasmania and the state should be working with that and the Commonwealth to say what are the priorities we need to work together on in Tasmania to reduce the number of people admitted to hospital who do not need to be admitted to hospital - the so-called potentially preventable hospitalisations - and all of those sorts of things, working together rather than pointing fingers at each other.

CHAIR - Page 14 of Mr Goddard's submission or addendum, the one he provided in October, refers to public hospital expenditure by funding source. Would you have any reason to doubt those figures?

Dr DUCKETT - No, not at all.

CHAIR - He makes the statement -

> Over the three years to 2016-17, the Tasmanian Government spent $123.5 million less than the national population adjusted average on its public hospitals.

He suggests -

> This is far more damaging than it seems at first sight. A great deal of Commonwealth funding is forgone. You should also remember that the Tasmanian population needs much more health care than the national average. All levels of funding should therefore be much higher than the average and not, as is the case, lower.

Dr DUCKETT - He would be right there. It is because of the age distribution. Because the Tasmanian population is older on average, you would expect a bit more hospital funding.

CHAIR - He says -

> Because of its higher GST entitlement, the state Government has the money available to meet this need; it has chosen not to do so.

Dr DUCKETT - That is a question about whether you believe the GST or not.

CHAIR - That's fine.

Mr FINCH - In his report, Mr Goddard describes Tasmanians as the oldest, the poorest and the sickest. I am wondering whether you might give us a sense of this preventive health aspect being more important for Tasmania than perhaps elsewhere in Australia. What are your suggestions about the spending that might occur, or should occur, in preventive health care?

Dr DUCKETT - I don't want to put a number on it for Tasmania, but what I would say is what I said in the answer to the previous question. The Commonwealth and the states have to work together. You have the unique advantage - not quite unique because a couple of other places are in the same boat - that there is a single primary health network for Tasmania, THN, the state Government is a single government, the Tasmanian Health Organisation or whatever it is now called, is sort of unified, so you should be able to work together jointly - the Commonwealth, state, THN, hospitals - to ask: 'What are our priorities for trying to improve the health of the population, trying to improve the quality of primary care so that people don't get sick and end up in hospitals for things that they need not come to hospitals for? Can we actually reduce the rate of diabetes? Can we improve looking after asthma in the population et cetera so that people don't end up in distress in the emergency department and are admitted?' It is about working together to improve the primary care system and to improve prevention for everybody's benefit.

The good news now is that the Commonwealth shares in the cost of hospital growth, so it is in the Commonwealth's interest to reduce hospital admissions just as much as it is in the interests of the state governments.

Ms FORREST - When we had the minister before us earlier in the week, we talked about this matter - the spending on health and whether Tasmania is perhaps spending less than what we should be - and he referred to the significant capital expenditure that is going on at the moment, I am sure you are aware, with the Royal Hobart Hospital rebuild. In your view, is it important to separate that from operational costs?

Dr DUCKETT - Absolutely. The capital expenditure is one-off. He might have been saying, 'We are putting a whole lot of capital here and that inevitably has recurrent expenditure consequences in two years' time.' If they are saying, 'We are going to expand the size of the Royal Hobart Hospital by *x* number of beds or whatever', they should know today what the consequences of that is on-spending in 2021 or whenever it is going to open. They should know that. They shouldn't say it is going to cost $500 million to do this, but he should be able to say it is also going to cost another $250 million a year to run it. That information should be known today because obviously they should not have committed to build the thing if they are not able to run it in two years' time, so they would know that information right now and should be upfront about that.

What I am saying is that I try to avoid focusing on inputs. I try to avoid focusing on how much you are spending; I would rather focus on what the experience of the patient is. The experience of the patient is that they are waiting far too long and they are sicker than they ought to be. Then what I say is, 'This is what we can actually see. I don't actually care whether you think you are putting in enough money or you are not putting in enough money. The outcomes are not good enough for Tasmanians and it is your job to fix it.'

Ms FORREST - That is a very helpful comment, thank you. Following from that, will your next report perhaps shine some light on whether Tasmanians are experiencing more adverse outcomes, more complications and more -

Dr DUCKETT - No, that comes back to what I said at the beginning: I don't trust the data enough to make those comments.

CHAIR - Thank you very much, Dr Duckett, we really appreciate your time today. We are right on time, but do you have any closing comments?

Dr DUCKETT - No, but thank you very much for the opportunity to talk to you.

THE WITNESS WITHDREW.