THE LEGISLATIVE COUNCIL GOVERNMENT ADMINISTRATION COMMITTEE A MET AT OATLANDS COUNCIL CHAMBERS, 71 HIGH STREET, OATLANDS, ON TUESDAY, 21 FEBRUARY 2012.

COST REDUCTION STRATEGIES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr ROBERT SIMPSON, GP, OATLANDS, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Ms Forrest) - Thank you. As you are aware we are looking into the health cuts, which I know by extension talks about the health system as such, but we are trying to focus on the cuts and their impact. Everything that you say today will be recorded and potentially form part of our report, which will be prepared at some later stage. Everything you say while you are here is covered by parliamentary privilege, but anything you say outside may not be. If you wanted to give us any information in confidence or in camera you can make that request and the committee can consider that request, but otherwise we are happy for you to speak freely. We would particularly like to hear about the impacts for the rural GP that you see in the patients that you are caring for as a result of the cuts. The cuts are probably only just starting to take real effect because of the implementation just before Christmas and with the slowdown generally of elective surgery over Christmas, it may not be as evidenced as it might be in the future. So if you would like to make an opening statement and then the committee will probably have some questions for you.

Dr SIMPSON - I have drawn up a few bullet points which I will talk around, but if that doesn't suit people here that is fine.

CHAIR - That is fine.

Dr SIMPSON - It is called an agenda. My background is as a rural GP at Oatlands for 34 years and I would like to advocate on behalf of rural people obviously. Rural people consume 30 per cent less Medicare resources per person than urban people and just for a start that is a lot. I think before we look at these health cuts, their implications and everything else we should look at the cultural change that has occurred in health delivery and recreation and family time. It is not confined to the medical and health people, it is everywhere. People are more inclined to be focusing on that and as a result we see practitioners who are doing more and more part-time work rather than full-time work.

We see the impact in medicine of corporate general practice, which is taking over more and more of the traditional general practices. In fact I guess now traditional general practices are well in the minority and with that is the culture of corporate general practice. These corporate general practices are business ventures, purely and simply. We have patients with a sick kid who wait for three days to see the doctor. In the meantime the corporate general practices or other practices are generating what we call 'care plans', which are quite lucrative. You might get $140 to refer someone on a care plan to have their toenails done. There is a change in the style of practice. After hours

has become a thing of the past. I don't know how many practices in southern Tasmania do after-hours; you could count them on one hand. We have this cultural change and emergency departments are completely overwhelmed. Part of that is a result of this cultural change in practice.

CHAIR - Just on that point, Oatlands is a reasonable distance away from the nearest DEM, which would be the Royal Hobart Hospital. Do people have to go to the DEM?

Dr SIMPSON - No, we provide our own after-hours.

CHAIR - So it's not an issue here as such?

Dr SIMPSON - It is not an issue here, but it is not discretionary. We have a rural hospital we are supposed to run and with that goes the responsibility of providing after-hours service, which they have had for more than 34 years. If I were living in lower Sandy Bay and working in a boutique 9-5 practice, I would probably be doing what they do; I wouldn't be doing after-hours. We are not martyrs, but for rural practitioners it's not a discretionary thing. Most rural practitioners who work from a rural hospital do their own after-hours. That is just the cultural change.

There is another significant issue here, and that is to do with leadership. I think that is fairly critical and central to some of the problems we see in health delivery. I am not in the habit of writing letters to the *Mercury*. The last time I did it was about 10 years ago, and I got a bit of a hammering for what I said. I was having a go at my urban contemporaries, which didn't endear me.

CHAIR - There's more of them than you - you have to remember that!

Dr SIMPSON - I know, but we can handle it.

Laughter.

Dr SIMPSON - I am talking about leadership and one of the points I made in this letter is that we're looking at the Peter principle where there are quite a number of people who are promoted to a level of incompetence. I mentioned that a retired secretary for Health told me that this was his biggest single issue - and that was off the record. I said this in the letter; I would normally never repeat that, but these are most abnormal circumstances, the situation we're in now. When you get the senior bureaucrat in the Health department addressing his biggest concern, which is the lack of leadership, I think you have to think that there's some truth in the matter.

Mr HALL - Do you think that's endemic right throughout the DHHS?

Dr SIMPSON - There are some very fine people but there are also some very mediocre people. If you go back and look at honoraries, when I was a medical students - 35-40 years ago - we had honoraries. They were people who were paid a pittance; they were respected and very good clinicians. They embraced teaching and there was a completely different ethos. There are still consultants these days who are like that, but they are more in the minority than in the old days. We had clinical leadership and some wonderful clinical leaders. Now, with subspecialisation, more procedural emphasis and, in a

number of cases, I think a lack of departmental leadership, particularly clinical leadership, we have seen a drift of many of our fine consultants to the private sector - and that has an effect. We have had final year medical students rotating in our hospital and practice for 10 years and the message we hear again and again and again is the comparison between the Royal Hobart Hospital and the LGH. There is a lack of leadership at the Royal, not just clinical leadership but the lack of passion with teaching - and this is not across the board, there are people down at the Royal who do a wonderful job - but as a generalisation almost without exception these medical students say the same thing. At the LGH you have the leadership of Berni Einoder and Scottie Parkes and the late Peter Hewitt, and the morale is better. Fiscally they have the same problems as the Royal probably, but I think they embrace their teaching more passionately and thus have better morale and better leadership.

CHAIR - We are now hearing the same about the north-west - the clinical school there - and the north-west is where everyone wants to go.

Dr SIMPSON - Yes, I think the north-west is not too bad but the Royal definitely has a problem and I say that after 10 years of listening to the final year medical students telling me this.

Mr HARRISS - You said you were reluctant to quote the sorts of things from the bureaucrats -

Dr SIMPSON - From the secretary?

Mr HARRISS - Yes, a former secretary. If his concern was the lack of leadership within his department, he was in a position of leadership at one stage.

Dr SIMPSON - He was the leader.

Mr HARRISS - Is he being critical of his own performance?

Dr SIMPSON - Yes. I guess he is saying, 'I'm the captain of the ship but, man, I've got some pretty average subordinates, how am I going get through this?' I think actually he did a pretty good job but the material he had wasn't that flash.

CHAIR - But wasn't he in the position to change that?

Dr SIMPSON - Yes, he was but it is not simple -

CHAIR - I am not saying it is.

Dr SIMPSON - when you are surrounded by mediocrity. There are some good value people but there is a lot of mediocrity and it is very difficult. It is not the sort of thing that you can change overnight but, of course, if by the time he finishes his term not a lot has improved then I think he has to wear some of that himself.

Mr HARRISS - Except that if there is a need for a cultural change within that structure and it is not being supported politically and if he is the secretary of the department do I

conclude then that there is the lack of political support for the desired change because if he is the head he can call the shots?

Dr SIMPSON - I think the inference I got from this person was that it was higher up the food chain, it wasn't too far down and if you have quite a lot of people up the food chain who you have to get around and get a change of culture it is not necessarily easy.

CHAIR - Are we talking at a clinical level or are we talking at a bureaucratic level?

Dr SIMPSON - A bureaucratic level.

CHAIR - So you are talking about deputy secretaries, you are talking about people in charge -

Dr SIMPSON - I am a bit confused about the level of it. My understanding is there is executive level 1 and 2 but that is Federal. When we talk about Senior Executive Service, we have SES levels 1, 2, 3 and 4. From my understanding an SES level 1 is equivalent to a brigadier and my limited experience encountering people in the civilian sector - and I guess it is probably not just health - is that these people don't rate next to them. The brigadiers I have met in my life - and you have met plenty, Greg - are articulate, intelligent, visionary, very smart people with enormous serious delegation and I can't help but make the comparison. They are a commensurate rank but they are chalk and cheese and that shouldn't be the case. Are you with me?

Mr HARRISS - I think so.

Dr SIMPSON - I could think of a few classic examples and I am not going to be specific but I tried to find out what their structure is - is it SES 1 or 2 or is it executive level 1 or 2 and I am sure executive level 1 and 2 is purely Federal, it doesn't exist in Tasmania. I think we have Senior Executive Service levels and my experience is that this is the Peter principle well at work. If you make a comparison with the military, which I think is a fair comparison, they are commensurate structure. SES level 1 is the equivalent of brigadier.

CHAIR - We did have one former secretary who was from the military and that did not go particularly well either.

Dr SIMPSON - He did get out of the military, so he cannot have been too smart. At a local level, I will give you an example. Eighteen months ago we had a director of nursing appointed and we had been warned from previous facility she worked at that there may be issues, and it was an absolute disaster. This person alienated the community completely. We made a representation to then Minister for Health, Lara Giddings, and to give her due and in 48 hours this person was gone. You do not see people make a gutsy decision and force it like that these days. This person was redirected into the Health department and, yes, six months later she was redeployed to another DON position with the same leadership requirements and it was another catastrophe. It took that community - your community, I think - six months of lobbying and public meetings to get that person redeployed elsewhere.

CHAIR - Why do we redeploy these people?

Dr SIMPSON - It is a very good point. If you have someone with a proven lack of leadership capability and they might be good people and they might have good organisation skills, but if they have no leadership they should not be redeployed to another leadership position. They should be made a project officer or put somewhere else where they are not creating big problems, particularly in small, rural communities.

They advertise now for a director of nursing instead of a site manager in these rural facilities and I think the nursing groups like to see career progression, and that is understandable. But you will get one application, the quality of which is not always that flash. If you advertise for a site manger which includes nurses and non-nurses, you may get four or five applicants. All things being equal, you would probably give preference to the nurse. But if someone has significantly superior leadership capability or runs on the board compared to maybe a nurse, that person should get the job. If you were looking for a technical conduit, a technical link, you have a clinical nurse manager on site who can provide all the nursing technical side.

Bear in mind, even though the nursing organisations feel that this career progression they should also make allowance for the fact if you appoint the wrong nurse as a director of nursing it is the 10 or 14 nurses who are subordinate to that person who suffer. So they really should look at the totality of that. I think we should go back and reconsider nurse managers as apart from director of nursing. The site manager may well be a nurse but it should be opened up to non-nurses as well as nurses.

I am married to a nurse and I have a daughter who is a nurse; I respect the profession. I think it is a fantastic profession. But the reality is, you are really confining yourself to a limited number of applicants.

CHAIR - I hear what you are saying but that, again, comes back to the expectations of that role. Sure, put a nurse in there who has the acquired clinical experience and other requirements as far as that role goes. If that person does not have the required management skills then you ensure that they get them before they get the job or they are put through them.

Dr SIMPSON - You cannot teach people to be leaders.

CHAIR - But you can teach them management skills at least.

Dr SIMPSON - You can teach them management skills but I think leadership is an intrinsic thing. You can fine-tune it a bit but you cannot go to leadership school and that is a fact. You can improve their performance and, I agree, their management skills and you can teach them all the nuances of their new position and nurture and mentor them maybe, but it still gets back, I think, that it is an intrinsic trait. We are in a position now where we have a director of nursing who - can this be off the record?

CHAIR - If you wanted something to be kept confidential you need to make a request and the committee can consider that, otherwise it is part of the public record.

Dr SIMPSON - Okay. Well I request the committee consider this and if they choose not to then that it is fair enough.

CHAIR - We just need to hear about why you want to make it confidential.

Dr SIMPSON - Because it is addressing a specific person.

CHAIR - Can we leave this to the end, then? We need to focus on the health cuts issues. You are giving us a broad issue.

Dr SIMPSON - When you get leadership which is in my opinion abysmal then that effects the whole of morale and structure and retention of staff, which is becoming a real issue.

CHAIR - We will come back to that at the end if you like. We can discuss it then but we really want to focus on the impact of the health cuts, particularly in a rural setting.

Dr SIMPSON - Health management: if you look at it strategically I do not know any thinking person who would disagree with the suggestion that there should be one layer of health management and it should be federal. We have cost-shifting and we have duplication and there is no question about that. The State says that their public hospitals are underfunded. The Federals say that the State are poorly managing these public hospitals. There is a little bit of both. I certainly think that teaching hospitals definitely need more federal funding but this duplication and cost-shifting is an issue and it is so wasteful - absolutely wasteful

CHAIR - Are you talking about federal management or federal funding because they are two very different things.

Dr SIMPSON - Regarding the public hospitals, the funding.

CHAIR - So are you talking about a single funder, not necessarily federal management because the Federal Government does not have any runs on the board for managing health.

Dr SIMPSON - I think it has to be funded from one source and there should be one management group rather than having two management groups. So I guess if it is State and then federally funded they are going to sort of link between the two. I do not think we need two completely separate structures of funding and management. Is that the message you are getting elsewhere?

CHAIR - There are a lot of people saying one funder particularly.

Dr SIMPSON - There is duplication and there is all this cost-shifting which is so wasteful. If you look at the local level, I will give you an example. We have 7 300 people on my books and there are 10 000 commuters going past this highway every day. We have a hospital, we have an ambulance. We have our acute side; our nurses are run off their feet. Then we have rural health prevention or promotion that is federal money. We are down 1.5 full-time equivalent positions - nursing. Our ambulance system uses nurses when we go out. It is the only model in the State where we actually go out with nurses.

CHAIR - We used to do it up the north-west. That is many years ago.

Dr SIMPSON - Not now, though. I think we are the last model to retain it and we are having big problems staffing our ambulance because retention and staff issues et cetera.

When we are looking at health promotion, the rural health promotion group, which is the department of unaccountability which is adjacent to the hospital over here, they had the federal bag of gold. They have got to burn off $120 000 in the next four months in health promotion and activities such as pampering massages and trips to town or trips to the beach. It sounds cynical but there seems to be a great disparity. Here on the one side you have the acute and the State-funded money which we have not got enough of and we have not got the staffing and resources to hold our head above water. On the other hand we have rural health promotion. I think the concept is okay but it seems to be so wasteful by comparison. That is why it is called the department of unaccountability. They are just advertising for a second health promotion officer for $70 000 a year. They already have one and now they are advertising for another one. It is this disparity in access to funds. That $120 000 would pay two full-time equivalent nurses. That would make us viable; we could handle our ambulance service and it would make a lot of difference.

Health promotion is important. Let us take the classic example of diabetes, which everyone talks about. We are putting more money into dieticians, diabetic nurses and nurse educators et cetera. That does not make a dent compared to addressing the issue of physical inertia in our youth and the thousands of hours of junk adverts that our youth are subjected to over the years. If you are going to be really serious about this - we are not going to change this, it would be impossible, it is money-driven anyway. Doesn't it seem a bit crazy that we sanitise junk food with all these thousands of hours of advertisements and we do not address the inertia of our youth, yet we think we will put in some dieticians and some diabetic nurse educators and that will address the issue. I do not wish to be cynical about health promotion and health prevention, I think it is critical, but I think we are really not addressing the big issue, and I do not think we will.

Paperwork: I will not go on about paperwork except to say in the acute, in hospital situations and in residential care nursing the paperwork for accreditation et cetera is breathtaking. Fifty per cent of our level 2 registered nurse's time is sitting just doing paperwork, which is no surprise.

Briefly on Tas Ambulance Service, there are three models. You have a volunteer model, which a lot of particularly rural places have; you have our model, which is the only one in the State where a level 2, VAO 2-trained nurse goes out with the ambulance. When you take the context of this highway and what goes on, the acuity of our clinical cases, I think you need one step higher than a volunteer model. Then you have the paramedic model. If you want to establish a paramedic station at Oatlands that would cost $500 000. So the model we have is appropriate and good.

People tend to treat the ambulance as a taxi service and the policy with Tas Ambulance is a 000 call, so you deploy and respond to it. In our situation, because we have local knowledge we will often ring up and have a chat and say, 'Look, can't you get Fred next door to bring him into the hospital'. We have to be satisfied that that is appropriate of course, but we have local knowledge. When people ring 000 and it goes through to the radio room they don't have any local knowledge like we do, so obviously their philosophy is 'we have to respond'. You only have to have one adverse outcome by not responding and there is trouble.

A price signal is appropriate and it doesn't have to be $500. I remember years and years ago we had a person who made repeated calls for the ambulance, frivolous calls, until one day I said to send her a bill for $20 and we did. We never got another call. It was completely out of order, we had no right to send a bill for $20, it was just to stop her abusing the system. Now $20, even though it is nothing and really anyone can afford that, even that is just the slightest of price signals. I think there needs to be a price signal. Politically it is not palatable -

CHAIR - Should that be across the board?

Dr SIMPSON - Yes.

CHAIR - So everyone who turns up at a DEM -

Dr SIMPSON - I'm talking about ambulances.

CHAIR - I am talking about the health system; should we look at a user-pays system?

Dr SIMPSON - You mean in the DEM? Say $10 or $20, I wouldn't argue with that, but I think you will have a bit of fun.

CHAIR - I am not saying it is easy; is that something the Government should consider?

Dr SIMPSON - I think you have to look at why they are all in the emergency department - because they cannot get into their general practitioner and then you are going to clobber them for $20.

CHAIR - And because DEM is free.

Dr SIMPSON - Yes, but I think you will find in Tasmania that more than half the GPs bulk-bill. So even if you go to a bulk-billing practice it is still very difficult to get in. I think it is reasonable. I think you ought to consider that.

CHAIR - I would probably question those figures on your number of GPs that bulk-bill because even in the GP Super Clinics they are not bulk-billing.

Dr SIMPSON - Okay, I take your word on that. It was roughly 50 per cent at one stage.

CHAIR - You may be right. I am just saying that I know there are lot that don't and that is one of the comments that has been given to the committee, that people tend to go to the DEMs because they have trouble getting into a GP but also the DEM is free.

Dr SIMPSON - Will it make much saving and will it be an administrative nightmare? There is a possibility.

The other thing about ambulance is ramping. If we have a level 2 nurse who goes out with the ambulance it is normally two hours and 30 minutes maybe to get there and get back, but if they are ramped it might be five hours. So once again that has implications on our staffing. We have got other staff. They get five hours of double time instead of

two-and-a-half hours double time. This all impacts on our budget. Addressing ramping, I do not know quite what you do. If you go back 30 years you would go to the emergency department, you would be assessed and the decision would be made that you are a medical admission or you are a surgical admission. You would go to the board - that is if you have a bed - and you would be admitted by the medical or surgical admitting officer. They would do the work-ups and do the imaging and pathology. Nowadays everything is handled in the emergency department from start to finish until the whole job is done. I am sure there is clinical rationale for that.

CHAIR - Cost, particularly.

Dr SIMPSON - Yes, but it does have an impact. That is where the big obstruction is, in the emergency departments.

CHAIR - What of the move then to develop these 23-hour stay units attached to the DEM for people that do need monitoring for a period, a head injury for example, or someone whose blood sugar levels are a bit dodgy and they come in and they just need to be sure they are right before they send them home? They are pretty sure they are going home. You do not want to put them in a hospital bed.

Dr SIMPSON - No way. I am talking more of if you have someone who is obviously going to be admitted and be in hospital for a week.

CHAIR - That is pretty clear, isn't it?

Dr SIMPSON - Yes, but my understanding is they get completely worked up in the emergency department before they are deployed to the bed. I am sure several of these people could be put in a ward because they are going to be admitted. The medical admitting officer can do all that and it decompresses the emergency department.

CHAIR - That is when you have beds to put them in.

Dr SIMPSON - That is right. It is difficult.

Mr HARRISS - I am looking at the document produced by the department in terms of its expected savings. They have suggested here under ambulance that they are going to increase revenue by billing doctors on compensable medical retrievals. How would that affect what you do in this ?

Dr SIMPSON - I guess they are talking about workers comp, MAIB and stuff like that but are not billing the doctor. They are billing the company. That is my take on that. In other words if you have an MAIB case, a workers comp, if they are DVA positive - gold card - they get billed, obviously. But I do not think if Joe Blow sees me as a doctor and I ring the ambulance I do not think they are going to bill me for anything. I think they are just talking about normal compensable cases and I think they already bill them.

CHAIR - There are probably some slipping through the gaps.

Mr HARRISS - It suggests there are.

CHAIR - We heard about that last hearing.

Dr SIMPSON - I think that is what they mean.

Private health rebate: the rebate is another issue and I do not think we need talk about that. That is either going to be on or not on but people are opting out of it and one of the reasons is you get battlers - and I see it time and time again - who really cannot afford medical benefits. They pay their medical benefits, they go down with a problem to the private emergency department and then the first one says, 'No, we don't have a physician on call' - and now Rob Nightingale has gone this will happen more and more - or 'There's no surgeon on call here. The surgeon on call is at the Royal', or 'Yesterday Hobart Private was "code green" and we're not taking any more patients. We're full'. The Royal does a wonderful job when you take everything into account, but these people are paying a lot of money for private medical benefits and again and again they are being redirected to the Royal. When they're battlers and make the sacrifice to pay for private medical cover, I can understand why people are opting out of the system. I think it is going to get worse and then it's bypass - you go to Calvary or Hobart Private and they say, 'Sorry, we're on bypass' - so they all end up at that emergency department with everyone else. I think we have some issues with private health, and that's probably way out of the ballpark of what this committee is all about, but it is still going to impact on health delivery.

CHAIR - It is and it isn't, because some of the discussions have been around utilising the under-usage of certain sections of the private health system with elective surgery. I hear what you're saying about emergency care. I think it's always going to be a problem for the north-west coast. If you take out private cover, you take it out so you can have elective surgery when you want, because there is generally no choice anyway. I think people have to understand why they're taking it out, if they take it out. There is spare capacity, as I hear it, in some of our private systems for elective surgery. Is there capacity for the public sector to work with the private sector to facilitate the use of those?

Dr SIMPSON - I think so, probably.

CHAIR - Do you think that creates other problems?

Dr SIMPSON - I am really not quite sure, but I think it is a consideration.

The other thing I was going to talk about, just to pick one example at the Royal, and that is cardiology. We had three level 4 cardiologists. Two of them, Kilpatrick and Nicholson, were asked to resign. They are level 4s, they get $200 000 a year, which is probably what a GP earns. Their replacement appointments were level 1 and level 2, $150 000 each, so they have saved $100 000 between them. We are talking about interventional cardiologists at the top of their game and just one adverse event with an angioplasty, for example, could be fatal, but it's more likely that they will end up as cardiac invalids. Just one adverse outcome would put a hole in $100 000. There does not seem to be any logic in making these decisions. I think cardiology has been dealt a fairly tough hand, whereas there has been generous support for other areas. There are seven consultants in ICU, seven respiratory physicians, seven infectious disease physicians and here we are with dramatically escalating interventional cardiology cases. There just doesn't seem any logic in some of this decision making. If they think they're

saving $100 000 by getting rid of the two level 4s and appointing a level 1 and a level 2 - and it has nothing to do with the calibre of the people they are replacing them with - you only need one adverse event and there's the $100 000 gone.

CHAIR - It's fair to say that a level 4 could have an adverse event, too, though?

Dr SIMPSON - Yes, sure, but doesn't it strike you that maybe that level 4s, at the top of their game, are possibly less likely to have an adverse event. They will have them, everyone has them, but I can't see the logic for the saving of $100 000.

CHAIR - So do the two level 4s now work in the private sector?

Dr SIMPSON - One is in the private sector pretty much full time and the other one is just coming back from Western Australia. He said the culture of working with the State Government over there is completely and utterly different.

CHAIR - In what way?

Dr SIMPSON - He said they're more supportive and helpful. He said the feeling in the place is different. He is a good man, he has been in the system for years over here.

The director of nursing: we should be advertising for site managers, not a director of nursing. All things being equal, give it to the nurse. But I think we need more applicants. We need more than one applicant for a job and I will give you an example. I was sitting in the surgery and the Director of Nursing had come in, I received a phone call from the Holman Clinic - would you -

Mr HARRISS - Is this the confidential matter that you are going go to?

CHAIR - We will come right to the end of that and we will have to change the format for that.

Dr SIMPSON - Yes, that is all right. The only other thing I was going to say is, I think Lara Giddings, as Premier, has been I think in some ways misdirected about the force of her cut-backs on the front line compared to some ranks a little bit further up the food chain. But I think history will judge her very favourably, notwithstanding that.

CHAIR - Do you think that there could have been cuts made in other areas?

Dr SIMPSON - I think maybe. Do not ask me for lots of examples but it gets back to me looking at mediocrity higher up in the system.

CHAIR - I think we need to be very clear here that we are talking about mediocrity higher up in the system. Are we talking about the hospital system or are we talking about the bureaucracy? What roles are we talking about in the bureaucracy?

Dr SIMPSON - Mainly the bureaucracy but it is also departmental clinical leadership and I will not say that across the board -rehab and aged care run a good show. There are some that run a good show.

CHAIR - Where are the areas that we really need look at? The committee is focusing on the health cuts. We have seen where the decisions have been made and I think they are going to get worse. The mid-years would clearly tell you that more is going to happen and so that is the reality and we will talk more about that with the relevant people later. But what we are looking at is, how these cuts are affecting patients and people in Tasmania, where else potential cuts could be made from people who work in and live and breath health services and that is what we are trying to get to.

Dr SIMPSON - I think if we get a higher standard of leadership, clinically and in the bureaucratic administrative side we will see a more efficient system. We will see fewer specialists leaving the public system and going into the private system. We will see greater morale.

CHAIR - It does not cut costs though. How do we cut costs?

Dr SIMPSON - I think it does cut costs. I think if you have sound leadership it does have an impact. It is not a tangible thing but if you have good morale and people who are motivated it has to have an effect. Do we need as many layers of bureaucracy as we have?

Mr HALL - Given the cuts to elective surgery in the State at the moment with some people getting bumped off the lists or put back, does that have an impact on you, as a rural GP, that those people are then coming back to see you to try to get some relief from whatever their condition might be before they get back on those lists? Has that been an issue?

Dr SIMPSON - It is almost like perverse cost shifting. They end up going backwards and forwards to their GPs again and again with their problems while they are waiting for a surgical solution.

CHAIR - Are you seeing that? That is the question.

Dr SIMPSON - I think all GPs are seeing it. They come in and they say, 'I cannot walk with this knee, I will have to stop working.' There are genuine people out there. I will say, it is going to be a few years. I guess you could find out factually, but my impression is that the waiting lists, even though they are bad in both hospitals, the movement seems to be a little bit quicker, the through-put in the LGH than the Royal. I have orthopods, for example, who say, you would get the job done quicker if you referred this patient up to the LGH instead of the Royal.

CHAIR - Do you do that?

Dr SIMPSON - Yes.

CHAIR - What about referring them to the North West Regional Hospital and the Mersey for their arthroscopies and things like that because there is no waiting list?

Dr SIMPSON - The Mason-Dixon line is in Tunbridge, they do not mind going north or south. But when you start to talk about the north-west, it is a different matter. I think it is a good point. I think the North West Regional Hospital is a great hospital, it has gone ahead in leaps and bounds.

CHAIR - If you look at the Mersey, where they are the days for the arthroscopies and all that, there is no waiting time on some lists. So why aren't we using it?

Dr SIMPSON - Are the outcomes the same?

CHAIR - Yes, as I understand it.

Dr SIMPSON - I am quite happy to refer them anywhere but I am not thinking outside the box because I had never even thought of the Mersey or the North West General Hospital. I thought I was being adventurous sending them to Launceston.

Mr HALL - The simple answer to the question is since those elective surgery cuts have been announced that is your assessment right across the whole board that GPs, and particularly country GPs, are seeing -

Dr SIMPSON - Not just country GPs, everyone, but we have a bigger volume. This has been basically a one-person practice functioning as one but now I have a Canadian doctor in who is very good but we have 7 300 people on the books. I thought I had about 5 000 but accreditation came and they said that I actually had 7 300, so it is a very busy practice. The busier it is the more you see of what you are talking about - people who just keep coming back again and again and they want their pain killers. The last thing you want to give someone with orthopaedic pain is opiates and they are gobbling down Panadeine Forte and it is not touching the sides with bad hips and bad knees - I am not talking about a young fellow with a sore back, I am talking about very genuine cases - but it is the same across the board, it is not just rural GPs.

CHAIR - If those people are coming back you would assume if they had had their surgery they would not be back as often, if at all, not for that complaint anyway.

Dr SIMPSON - No.

CHAIR - Have you noticed that the surgery is actually busier in the last few months or is it pretty much the same?

Dr SIMPSON - The last couple of years, I would say. I don't think it is just the last couple of months. The waiting list has slowly been getting worse and worse.

CHAIR - So you haven't seen a sudden influx at this stage?

Dr SIMPSON - Yes, I would say it is worse, it has been worse in the last few months. It has been gradually getting worse but it is exponential now.

Dr GOODWIN - Where is the nearest GP from here? Obviously, you are the closest but where is the next one?

Dr SIMPSON - Boothie and he is at Kempton.

Dr GOODWIN - What about going the other way?

Dr SIMPSON - Campbell Town. We cover Campbell Town and Dr Myrle Gray covers Campbell Town.

Dr GOODWIN - I must say that 7 300 patients seems like a lot.

Dr SIMPSON - Our geographical catchment is way beyond what you would expect and I think part of the reason for that is - and again we are not martyrs - that we provide an after-hours service 24/7. Because our nurses are so good and they are 24/7 and can handle nearly anything, so people tend to come to us rather than go to the Royal and wait five hours. If they are coming from Sorell, for example - not the whole of Sorell doesn't come but we get lots of people coming from Brighton and Bagdad and up at Miena and out at Levendale - it is because, I guess, of availability and I think the credit for that goes more to the nurses than the doctors.

Dr GOODWIN - But given you have that quite wide catchment area and the pressures on the Royal and with the budget cuts that may well increase quite significantly.

Dr SIMPSON - Yes.

CHAIR - Before we go into that other matter, are there any other comments you want to make?

Dr SIMPSON - No, but just to reinforce what I said about Lara Giddings. I think she does a pretty good job. I think she is a bit wrong with her emphasis on frontline services but, as I have said, history will judge her favourably.

Mr HARRISS - Chair, can I just go back to one matter on the ambulance? We have been aware of the ramping issues and the claims that it doesn't occur and so on, are you able in this area to provide some statistical evidence, if you like, as to the impact on your budget, for instance? Do you map that?

Dr SIMPSON - It might be a little bit difficult but I am sure that because this is becoming a major issue with the viability of our ambulance model as it exists at the moment and it is becoming untenable so that is one of the areas we are addressing - the staffing issues and the cost and of course one of the central problems we have with that is ramping. I don't think that would be an issue. I think that could be done.

Mr HARRISS - Have you mapped that?

Dr SIMPSON - I think it is being mapped. We are going to have a meeting with Tas Ambulance because we can barely maintain the staffing to keep the ambulance viable with the model it is now.

Mr HARRISS - We might have a look at that because of the impact on this area on that budget of a five-hour round trip compared to a two-and-a-half, in the instance of ramping, and how that belts the budget here.

CHAIR - As far as the budget goes here, do you have your own budget or are you run out of the Southern Area Health Service?

Dr SIMPSON - We have our own budget but the Southern Area Health Service oversees it. We have our own budget allocation and like everyone else we are going over it, mainly from staffing issues.

CHAIR - Why is that? Is it overtime?

Dr SIMPSON - It is not cheap to run an ambulance service when you have VAO 2, level 2 nurses going out, who do a wonderful job. They cost half the price of a paramedic totally, but it is still probably $160 000 - $170 000. That is probably the biggest single issue, maintaining our ambulance.

CHAIR - Your budget is managed out of the Southern Area Health Service, you are provided with a bucket of money or are you provided with a bucket for your ambulance service, for your hospital -

Dr SIMPSON - I think they are compartmentalised.

CHAIR - If you had a surplus available in the hospital -

Dr SIMPSON - We never do.

CHAIR - If you had surplus could you use it to fund the ambulance?

Dr SIMPSON - I will pass on that one. With ambulance there are other resources that can be used. The council contributes to the ambulance service here. They actually pay the drivers. They are volunteer drivers but they get a nominal fee for being drivers. Our nurses are paid from the department and I think the department make an allocation of what they see as an appropriate figure to pay the nurses.

CHAIR - For that service?

Dr SIMPSON - Yes.

CHAIR - So that is separately allocated then?

Dr SIMPSON - Yes, but I think the trouble is that it is blowing out.

CHAIR - Because of some of the ramping issues.

Dr SIMPSON - Yes. The other thing is we have with the new pay structures and awards for nurses, which have come through in the last one to two years. If you call a nurse in at 8 o'clock at night to cover the ambulance, even if that person does not go out in the ambulance - the other nurse goes out - even if that nurse is there for two hours then it is four hours double time. We have all this double time. They might come in for 15 minutes and they pick up someone who is having a seizure, bring them back to the hospital, we decide we will manage this patient overnight here, and that is 15 minutes, four hours double time, so eight hours. There are all sorts of issues with maintaining adequate staffing and the award is one of them, unfortunately.

Evidence taken in camera.