SUBCOMMITTEE OF THE STANDING COMMITTEE ON ESTIMATES AND FINANCIAL OPERATIONS

INQUIRY INTO PUBLIC SECTOR EXPENDITURE

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 25 FEBRUARY 2009

SESSION ONE

Members

Hon Sue Ellery (Chairman)
Hon Brian Ellis
Hon Jon Ford

Hon Ken Travers (Participating Member)

Hearing commenced at 11.33 am

GEELHOED, PROFESSOR GARY
President, Australian Medical Association (WA),
sworn and examined:

JENNINGS, MR PETER
Deputy Executive Director, Australian Medical Association (WA),
sworn and examined:

The CHAIRMAN: Before we begin, I advise that the committee has given permission for the media to come in during the proceedings to film, but they will not record any sound.

On behalf of the Legislative Council Estimates and Financial Operations Committee, I would like to welcome you to today's hearing. Before we begin, I must ask you to take either the oath or affirmation.

[Professor Geelhoed took the affirmation.]

[Mr Jennings took the oath.]

The CHAIRMAN: Both of you would have signed a document entitled "Information for Witnesses". Have you both read and understood that document?

Witnesses: Yes.

The CHAIRMAN: These proceedings are being recorded by Hansard. A transcript of your evidence will be provided to you. To assist the committee and Hansard, please quote the full title of any document you refer to during the course of this hearing for the record. Please be aware of the microphones in front of you and try to talk into them and ensure that you do not cover them with papers or make noise near them.

I remind you that your transcript will become a matter for the public record. If for some reason you wish to make a confidential statement during today's proceedings, you should request that evidence be taken in closed session. If the committee grants your request any public and media in attendance will be excluded from the hearing.

Please note that until such time as the transcript of your public evidence is finalised it should not be made public. I advise you that publication or disclosure of the uncorrected transcript of evidence may constitute a contempt of Parliament and may mean that the material published or disclosed is not subject to parliamentary privilege.

We have read your submission. I invite you now to make an opening statement or to expand on anything that is in your submission and then members will ask you questions.

Mr Jennings: Thank you very much and we would be grateful to take that opportunity.

The submission we put forward was pretty brief and at short notice. Obviously, from our point of view, this is a critical matter for the health system of Western Australia. Effectively it is about patient care-that is really the nub of the deliberations of this committee-and also maintaining and not deflating the momentum of reform that is underway in this state, which is critical as well. The three per cent so-called efficiency dividend is from our perspective simply a budget cut. It is not a single cut; it is a recurrent cut. The way it is betrayed is that over a four-year time frame approximately $450 million will be taken out of the health system and, from our perspective, that will affect health care. The other facet we have introduced into the submission is to bring forward the capital program. That is an important element in maximising efficiency, which I will come to in this presentation.

In our submission we have sought to focus on the terms of reference that go to whether particular agencies or functions should be exempt, whether the rate of the dividend should vary and whether there are alternative methods of achieving a three per cent reduction. Our submission is that health should be exempt in its entirety, that patient care is a fundamental role of government and that standards, quality and the capacity of the system to care for the escalating demand and so on warrant exemption and any increase in efficiency that can be achieved should be reinvested in health. We are a long way from achieving the goals that have been set by politicians successively over many years.

We do not believe that it is acceptable that purely frontline services should be exempt. If that is to be the case, clearly the frontline budget should be exempt, and that has not been articulated by the state government. It has stated that frontline services will not be affected. We do not believe that that would be the impact of this cut. If the government was true to its word then, logically, frontline budgets should be exempt. Similarly, we argue that capital programs should be brought forward to facilitate both efficiency and assist the economy in these difficult times and also to decrease the growth in unemployment, which such activities would assist in ameliorating. Consequently, that would reduce the potential growth in mental illness which we are likely to experience as the recession bites and which will again impact on the system, and that is a circuitous argument.

Committee members would be well aware that since at least 2001 governments have promised to fix the health system and provide a social dividend. Successive governments have stated that. We have stated, and we are on the public record, that this proposed reduction is effectively a breach of faith with the electorate at large. I will quote from a press release by Bob Kucera, the then Minister for Health, on 14 August 2002, only a few years ago, as follows —

- during the 1990s, the bed capacity of Perth's adult teaching hospitals was reduced by almost 350, including a 224-bed reduction at Royal Perth Hospital and a 124-bed reduction at Sir Charles Gardner Hospital;

In fact, we never really recovered from those reductions in the 1990s and 2000 onwards, which has been characterised by constantly trying to redress those problems. Interestingly—I draw a parallel here—some of those reductions were a consequence of the 1993 McCarrey report, which members might recall. It is a fascinating tone and I refer to volume II, which I am holding in my hand. The report led to various dividends being called upon by the state government and it resulted in the system struggling and constant deficit funding and a lack of investment in the capital stock of the health system. That may well be repeated. Today it is a fear of clinicians and the association who have a long memory.

Of course governments sought to struggle with the health system and the Reid review was commissioned in 2003 and reported in 2004. That report was a very important critical review of health on where it was at and projecting where it was going. Importantly, it concluded that the population would grow by approximately 2.3 per cent per annum and that by 2014 there would be a 25.53 per cent growth in population, which is an indictor of basic demand.

[11.40 am]

It, however, having regard for factors such as ageing and the like, projected a four per cent per annum demand growth, or 48 per cent cumulative growth, over that 10-year period, and it postulated and recommended a bed growth of only 1.1 per cent. That, just in visual terms, is encapsulated in this graph, with demand growing very, very significantly—greater than population because of ageing and other factors—and bed growth recommended under Reid —

The CHAIRMAN: Sorry, I will interrupt you for a moment. Can you just read out the title of that graph for Hansard purposes, so that we will come back and make sure we have a copy of the right thing?

Mr Jennings: Right. This is a document formulated by the AMA, based upon the data in the Reid report itself. It is entitled "Reid Review Findings/Proposals 2004-2014". I am happy to leave it with the committee if it is of interest.

Since that time, of course, the birth rate in WA has increased dramatically. The standard annual birth rate was in the order of 24 000 to 25 000 per annum in the preceding decade. Last year it reached some 31 000—a massive increase in the birth rate—and that will work through the hospital system over time. So that is an underestimation in the Reid review.

Against a declining bed base et cetera, there has had to have been a massive increase in efficiency already within the health system. That has been widely acknowledged. There have been very substantial improvements. That has been brought about and is reflected in things like reduction in the length of stay, increases in day surgery, new techniques, early discharge. People are being discharged quicker but sicker, and then being sought to be managed at home and so on. So the capacity to achieve further improvements is limited, and we are also getting into the ageing factor as well.

It has also, I think, been self-evident that the system is under huge stress. The occupancy levels are excessive. International benchmarks suggest that to have the surgical capacity to deal with the demands of emergency departments et cetera provided in hospitals, you should be operating generally at about 85 per cent occupancy levels. Recently we have been operating generally in the metropolitan context at 93 or 94 per cent, and often at 100 or 102 per cent—more than one person in a bed a day. Somebody moves out; somebody comes in et cetera. The manifestation of that problem is the emergency department experiences. They manage the patients, but they cannot get them into hospital et cetera, so that hospitals are operating at very high levels of activity and above international benchmarks.

It is also very clear that the capital stock that doctors, nurses and others are working with—the tools in the factory—is crumbling. Reid, of course, recommended a major recapitalisation and retooling of the industry, and, importantly, it premised that you could only reduce funding after that had occurred, not before. That is a critical point that I do want to emphasise. So what Reid advocated was that you need to retool, and it is going to take time. You need to invest, and as a consequence of that investment you should be able to reduce marginal recurrent costs. But that investment has not been undertaken. A small component of it has—only a small component. The rest remains, and some of it is problematic in the current climatics, of course. Compounding that with a three per cent budget cut obviously causes additional concerns.

The consequence of that is that if a three per cent budget cut is imposed, it will affect front-line services, and the only way it can be dealt with effectively, in our view, is either by reconditioning the population in terms of their demand on the public system or rationing. We have alluded to the means testing debate in the submission. It was previously raised in the 1990s and so on. The rationing, of course, is either overt—it is evident in the newspapers—or it is covert. As I said, the critical thing about the investment program that Reid advocated and was accepted by both political parties was that capital stock had deteriorated and there needed to be substantial reinvestment, not disinvestment, and not reducing funding during this critical period of time. From our point of view, if there are any efficiencies that can be gained in the interim period, they need to be reinvested as well on top of that before you reduce the budget et cetera. We have currently got problems of capital efficiency; we have got capacity overload. We also have a workforce shortage of both doctors and nurses, and probably even to a greater degree amongst nurses than doctors, and we are not going to be able to address that sort of thing by a decreasing budget and, indeed, causing morale problems within the system. This is clearly happening at the present time.

Critically, you are aware that at the outset we stated that there are real concerns about patient care. You have seen it in the press, you have seen it acknowledged throughout by both parties, and you have seen it acknowledged in international journals and the like that the problems currently of

excessive occupancy and overcrowding manifest in less than ideal care and, in fact, in deaths. Only last year the health department issued a sentinel report. I will just quote an article on 30 October 2008 headlined "Hospital errors 'kill 45 patients'" in the Western Australian health system —

> Mistakes in WA hospitals had killed 45 patients in the past year, a 50 per cent rise in deaths from the previous year, partly due to a rise in the number of suicides, a Health Department report released yesterday said.

It is not the AMA; it is the health department saying this —

> Some of the deaths and serious harm occurred because of emergency department overcrowding and staff fatigue from high workloads.

The capacity to actually increase efficiency is clearly not that great in the context of those sorts of comments and so on. We have major problems with access block. We are trying to address those, and we are trying to initiate and redesign clinical services and so on, and that requires resourcing, not a reduction in resourcing, so the timing is very important in that context as well.

You are obviously aware of waitlists and the mental health demands. Rural health demands are critical. There are clear problems with access to services in rural Western Australia, and that manifests in poorer quality health outcomes and so on. Part of that, obviously, is in terms of Aboriginal health, and attempts to close the gap are clearly going to be diminished if services are not able to expand to meet the current unmet needs in rural areas where there is major disadvantage in terms of access.

On top of that, you are probably aware that very belatedly governments have increased medical school numbers to address the workforce situation—something we have been calling for for 10 or 15 years—and that places additional training demands on the public hospital system. Traditionally, about 115 or 120 medical graduates come out of the University of WA in this state. Last year I think it was about 136 in total. By 2009 there will be 246 new doctors coming out, and by 2011 it will be 308. The critical thing for those new doctors is that they receive quality training in the system so they can maximise their efficiency in terms of not ordering inappropriate tests and increasing costs as a consequence, and develop their skills, properly mentored and properly taught and so on; yet there is no additional funding for that purpose, as we understand it currently, and we are deeply concerned that if they do not get the proper training, they will not be as efficient, and, indeed, patient care will suffer. That has been clearly articulated in the press by a number of people.

I am now going to move briefly, if I might, to a report in *The Australian* recently —

> A TOP medical specialist is demanding an "immediate overhaul" of training for junior doctors, saying hospital supervision has broken down and the lack of it is damaging patient safety and doctors' morale.

[11.50 am]

The CHAIRMAN: Just so we can identify that document, can you give us the date that it appeared in *The Australian*?

Mr Jennings: The date is slightly obscured; I am sorry. I will send it to the committee.

The CHAIRMAN: Thank you.

Mr Jennings: Equipment is also a major problem. The committee may be familiar with the Monash report, which was a critical review into equipment deficit in public hospitals and identified the need to significantly improve equipment replacement and, again, to retool the industry. There are 40-year-old operating microscopes still in use today at Royal Perth Hospital, for example. We understand that the equipment budget is paltry for major equipment. Private health insurance is under challenge. Only yesterday or the day before, the federal Treasury recommended that the rebate in fact be removed, and the consequences of that in terms of escalating demand on the public system will be fairly self-evident. We also have a recession, or hard economic times, and the likely

demand on the public system is going to increase at a greater rate than has previously been predicted. Everyone is trying to achieve maximised efficiency. If their efforts are rewarded by budget cuts, the effect on morale, commitment and recruitment will, we believe, be adverse.

I will briefly allude to the electoral platform of the current government and what it essentially stated. I will refer, if I might, to the Liberal Party policy statement, "A Plan for Better Health Services", which was released prior to the last state election. It states —

> A Liberal Government will move decisively to create stability in our public hospital system.

Proposing a budget cut does the reverse of that. It continues —

> A recent report commissioned by the Department of Health shows that Western Australia faces a massive bill to replace decrepit medical equipment, including machines needed for dialysis and cancer treatment.

The Liberal Party also promised, in a press release, better hospitals and more beds. We have insufficient beds; we are understaffed and we have excessive occupancy. We need stability and we need reinvestment; we do not need money to be taken away.

We obviously recognise that the economic climate is difficult and that tough decisions have to be made, but a recurrent cut across health is, in our view, completely inappropriate and will potentially derail where we are trying to get to in solving the problems we have in health. It should also be noted, of course, that the federal government has introduced a massive stimulus package of $42 billion; that has been widely advertised. Unfortunately, it did not contain anything for health. In fact, I think it was recently reported in *The Age* that $15 billion earmarked for education and health capital from the federal funds has, in fact, being reallocated to the stimulus package, so health will actually miss out from that point of view again.

The midyear financial projections put out by the federal Treasurer clearly indicate what I alluded to earlier: that the government is looking at taking out $60 million for the remainder of this year; next year, $126 million; the year after, $132 million; and the year after that, $134 million. On our estimation, if normal indexation were applied to health in terms of net recognition of what it requires, it would equate to some $500 million or $600 million being taken out of the health system. I think it should be noted that the state and commonwealth governments have recently concluded the Australian Health Care Agreement. The commonwealth government actually recognised that it needed to increase funding and has applied 7.3 per cent indexation to the Australian Health Care Agreement grants in this state. It would be a little bit perverse if the state took three per cent from those grants. I make the point that it is not the state's money to take off; it is designed for the hospital system. The commonwealth government is saying that we need to index an increase by 7.3 per cent.

The state government, as I said earlier, has pledged that frontline services will not be affected. As I said earlier, if that is the case, then logically, frontline budgets should be exempt. We have seen leaked documents recently in the press, indicating that chief executives of frontline services in hospitals have been required to reduce their budgets by three per cent. The odd document has fallen off the back of a truck, if I can use that term, suggesting that they will reduce staffing, the use of casual employment, the use of overtime, and a range of other initiatives—in other words, reducing patient care hours. This is very clear from the documents. There was one the other day referring to Fremantle Hospital, for example, in that regard.

In conclusion, we believe that demand is escalating and that the capacity to deliver increased efficiency is diminishing over time, as we have achieved a great deal, and that any improvements in efficiency need to be reinvested in health. The alternative is that the government needs to make decisions to ration, and that is a political decision for the government. We believe that there has been a commitment by both parties to seek to fix the health system and provide a social dividend,

and that the parties should honour that commitment and that health should be exempt. Thank you very much.

The CHAIRMAN: Thank you for that. I will now invite questions.

Hon JON FORD: Thank you very much for your submission. You have actually answered a fair whack of the questions I was going to ask you, but I would like to try to quantify some of the issues you have raised. Your submission quotes parts of the Reid review —

> Reinvest and modernise health infrastructure to facilitate increases in efficiency and dampen down growth in recurrent expenditure.

You touched on that in your opening statement. Assuming you agree with the quote, where would you see efficiency gains if the government continues to reinvest in health capital works, and do you believe that even greater investment would result in even greater efficiency gains—exponential efficiency gains?

Mr Jennings: It is hard to quantify, but as an example, hospitals are currently full of paper; we have old technology. A lot of the systems are not computerised. Some of that can actually lead to adverse effects on patient care, and I have seen first-hand examples of where the volume of paper actually hides some of the contra-indicators to particular types of treatment, whereas if you have a computer screen, it is all there. There is a lot of wastage and inefficiency from that point of view, but there have been promises to effectively retool the hospital system in terms of technology for many, many years, and with some exceptions, not a lot has happened. One very good example of where it has occurred is with what is called the PAC system in radiology, which has been a very successful example of increasing efficiency. The hospitals that are connected to PACs, anywhere in the state, can actually pull up the patient's previous radiological examinations. The PAC technology can also be used, for example, if somebody is injured in a rural hospital; they can send information down to Perth for a specialist opinion. There are obvious advantages and savings that can be achieved through that sort of example, but the general technological base and platform of the hospitals in terms of patient records and so on is still, by international standards, very lax. Money has been set aside for that purpose, but it has been set aside for quite a few years now and it still has not progressed.

Professor Geelhoed: Could I make a comment there? The three per cent cut has been brought in so that there will be no cut in clinical frontline services and so on; the minister has said that. That is being applied very quickly down through the hospitals, but I think that frontline services are being cut. When you talk about investment in the future and so on, for example, over the past few years we have had the development of health networks in this state; the committee may be aware of that. It is an attempt to take a longer-term view to look into combining preventive measures as well as balancing that with acute measures and so on. It is empowering senior clinicians, doctors, nurses and social workers, and involving them with the community to set up whole systems to actually keep people out of hospital and to have a much more efficient system. These are part of the very broad reforms that have been going on for the past four or five years. My concern is that, at the moment, everything that is not thought to be literally hands-on is at risk of being cut, and those sorts of initiatives that I think will really bear fruit over the years and are currently showing great promise are the sorts of things that could be cut, because they are not seen as dramatic. What I am getting at is that we need efficiencies, but that at the moment it is slash and burn. Managers are being told to get on with it and cut back three per cent as soon as they can, but there are limited options. You can stop the sandwiches and do all these knee-jerk reactions; you can stop agency nurses, rather than maybe taking the longer term view and saying, "Maybe there should be efficiencies; let's look at them and then let's reinvest them into areas of health that are a good investment for the future."

[12 noon]

Hon JON FORD: Thanks for that. That leads to my next question. If governments increase the investment in non-recurrent capital and capital works as you suggest, rather than making a three per cent cut, by investing more you could actually achieve better than the three per cent efficiency that is being sought in a recurrent period. Is there a potential for that?

Mr Jennings: It is hard to quantify. The Reid review certainly concluded that we basically advocate to try to maintain baseline funding other than additional electoral commitments of 5.5 per cent per annum after retooling. What you will gain from it is also qualitative. What I alluded to with the example of the computer system and the improvement of records and so on goes to some of those issues. There is both the economic dynamic and the qualitative dynamic as well, which is one of the drivers from the medical profession's point of view—high quality services and better outcomes. Some of those are hard to put in economic terms. From a personal point of view and from a community point of view, they are very significant indeed. As you know, there have been debates in the past from a rational point of view—what services do you provide, what age do you cease to provide them? They raise all sorts of ethical conundrums and so on. They have to be taken into account by society. If the government caps funding, we are effectively saying that we can only provide a certain volume of services to a certain standard. The question is: does the volume diminish, does the standard diminish, do both diminish or should both escalate?

Just coming back to the capital, if you look at the state budget figures from the capital side of the equation, over the past 15 years or so the average capital allocation towards health, whilst it consumes in the order of 24 to 25 per cent of the recurrent budget, has been in the vicinity of three to five per cent. Three to five per cent of the capital budget on health goes on roads, the rest goes on schools and everything else. Last year's figure was six point something per cent, from memory. It peaks with Fiona Stanley Hospital and so on in a couple of years' time. It still remains a very modest percentage of the total capital budget. It is surprisingly modest. Most people do not realise that. It receives an inferior level of investment. Because it only received two to three per cent on average during the 1990s, it went backwards. It is like an old factory that is inefficient. It is not competitive. It is not international best practice. Professor Geelhoed's own hospital, Princess Margaret Hospital for Children, looks nice but functionally it is not efficient and that has now been accepted. The issue is implementation, timing, whether things get shifted out again and again and again. That is our concern. There are lots of promises but, ultimately, people who work in the health industry and who want to remain in the health industry or reconsider whether they will—that is a problem with recruiting nurses, for example—judge that by what is happening on the ground, not the political promises that people make.

Hon JON FORD: You referred to the McCarrey report. There was a reinvestment for about 10 years. Are you saying that we have not caught up from that reinvestment?

Mr Jennings: No, because any money that went to health was syphoned into battling the day-to-day demands of the health system. There was no investment. The technological advancement in terms of patient records and so on, with the exception of radiology and a few other little exceptions, just did not occur. They were delayed and delayed because of the budget imperatives at the time. We are not as efficient as we could be. The Reid review was ultimately the catalyst that said we need to reinvest, we need to retool and make people more efficient. It is a very labour intensive industry. You will see that 70 per cent of the recurrent budget is roughly spent on salaries. If you are cutting three per cent, what are you cutting—people? There is not much left to cut on the other side of the ledger either. Again, those are important considerations. We think we are going into a climate now where demand is going to increase more than was projected.

Hon JON FORD: You also mentioned excessive occupancy levels. I was particularly interested in that. I did not quite see what you saw as the reasons for that. You touched on it again in your introductory statement. Would I be right to suggest that you are inferring in your submission that

poor equipment, technology and ageing infrastructure—all the things we have just been discussing—are the major contributors to that, the fact that we are tooled down?

Mr Jennings: There are two issues there—the tools and the capacity. We have long argued that the system has insufficient capacity to meet demand. The manifestation of that is the emergency department access block issue. As I said earlier, the international standards suggest that a hospital should operate at roughly 85 per cent occupancy to deal with surge demand and not to get into inefficiencies. If you are familiar with marginal cost analysis, for example, you get diseconomies of scale if you are doing too much. For example, certain sized hospitals are regarded as more efficient than others depending on their role. If the demand exceeds the specification of that hospital, you get into inefficiencies because you are running at more than 85 per cent. You are getting into that level where people are wasting their time trying to find a bed rather than caring for a patient. There are a range of examples but that is the case currently. They are not being used as they were employed to and they find it professionally unsatisfying, hence sudden problems with recruitment retention and so on. Importantly, from an efficiency point of view, it is inefficient use.

Professor Geelhoed: There is one stark statistic there. While the rest of Australia lost about 10 per cent of its public hospital beds per 1 000 population, Western Australia lost about 19 per cent, almost as much. In 1989 my hospital had over 300 beds. It is close to the 200 bed mark now, despite the fact that the population has increased. Trends change. The average length of stay by a patient and everything else comes down. I am saying that we certainly closed a lot more beds than the rest of Australia and we now have the worst overcrowding in our tertiary adult hospitals in Australia. We felt that for some time and that was measured last year in a snap poll throughout Australia on the one day. As expected, we came in the worst. In simple terms, that is why we have such overcrowding.

Hon BRIAN ELLIS: In your submission you are obviously recommending that health should be exempt. I am the first to acknowledge the importance of health to our society. You referred to the Reid review, which was done in good economic times when the state was flush with money but you also recognise the harsh economic times we have now. I notice in your submission your comment "whilst there is always a capacity to increase efficiency". You do accept that there can be efficiency cuts. I know you have mentioned this, but I am still having trouble. Could you explain why health should be exempt when other departments are going to take some of the burden of an efficiency cut in such tough economic times and when health does receive a major portion of the budget?

[12:10 pm]

Mr Jennings: Firstly, we obviously accept that and strive to maximise efficiency in its various forms. That is in economic terms and in quality of care terms. The driver from our point of view is quality of care of patient outcomes. We do not want to see quality and patient outcomes diminish.

Our tenet here is that where we are successful in further improving efficiency, those who achieve those efficiencies should be rewarded, rather than disrewarded and a disinvestment occurs. If we are truly going to solve the problems of the health system, which has been promised for so long, then we have to invest and re-invest, and not take it away.

In terms, obviously, of why health should be any different—probably, I guess—that is obviously a matter for government to make the political decision on that. But our responsibility is to the patients of Western Australia; our responsibility is to the young doctors of Western Australia and their training needs and the services they are going to provide to us in the years ahead, and to make sure they are properly trained and so on. Given the particularities of health and that it has not had investment over the decade of the nineties, its level of capital investment—that has been demonstrated, hopefully—has been extraordinarily poor and extraordinarily low compared to the current costs, and so on. We believe that to solve the problem you have to achieve efficiency now, and for the future, because a lot of this is about the really long term as well. Stop-start policies are no good for health. It has been a disaster for health. To disinvest now to derail the reform program

and so on, to deflate the gloom and the efforts of people and so on, and to undermine people's commitment to the system and to cause them to rethink moving into the health professions and working in the public system is going to be extraordinarily negative, at the same time as demand on the health system is increasing—it is not like other areas where you can turn it on and off —ageing, birth rates, demand, potential reduction of private health insurance, and so on—the demand is increasing.

It is the responsibility of government; it has made the commitment to the community. Both governments have committed to Medicare and so on, and they need to be honest. They need to be honest, and if they are going to put a cap, they need to say where. If they are going to ration, they should not hide behind, "doctors make those decisions," and so on. They have to determine, "we will provide this level of service to the population" and what the consequences are in terms of waiting lists or not addressing mental health needs, Aboriginal health needs, not training doctors for the future, not recruiting the promised number of nurses, not increasing the number of beds as promised, and so on. We believe this will be a very bad decision for health and a bad decision both for today and in the medium to long term. If we continue what's gone on in the last 15-20 years, it will not be good.

Hon BRIAN ELLIS: But you also acknowledge that you can make efficiencies?

Mr Jennings: We can make efficiencies, and we strive to do that every day; and there are some inefficiencies in the system today—there will be in any system. But the argument is that managers should be able to manage that and re-invest the outcomes, because we are struggling as a system to deal with the demands, and it will only get worse. The decision that governments can make is, is it going to decrease the capacity of the system, is it going to diminish the reform agenda, and is it, therefore, going to diminish the capacity, actually, to become more efficient in the medium term? The Reid report was profound in the sense that it said if you want to achieve genuine efficiency, as distinct from an efficiency dividend which is little more than a budget cut—that is all it is—then you do need to invest, and you do not stop investing. We have hardly started, in fact. We have hardly started.

Professor Geelhoed: I will come in on that. You described that we have a responsibility to be as efficient as possible with the money we have. You mentioned the health networks, which I think are a great investment for the future and should bear fruit; are bearing fruit. The so-called four-hour initiative that is now being planned over the next few years, again, is generally supported by medical staff. That again should make us be able to use our system much more efficiently. Having said that, the baseline that we are starting from is a long way out. The federal government acknowledges we are 400 public hospital beds short in this state. The state government says we are 800 nurses short. So we are starting a long, long way back. So, although efficiencies need to be found—should be found—what we are saying is that, even when we do that, we are still a long way back and this is not the time to start cutting three per cent out of health. The consequences of having the most overcrowded hospitals in the country are very, very real. The signs are that people suffer, and even die, unnecessarily; that is very clear and obvious. So we feel it would be a retrograde step to not exempt health.

The CHAIRMAN: I will move on, as I am conscious that we are running behind time and will hold up other people who are going to appear before us. I have two questions, if I can address them to you. In your submission and in your comments today you talked about patient care potentially being compromised if a cut is applied to the programs in place to replace outdated equipment. You gave us one example, which is using 40-year-old microscopes. I do not understand how that compromises patient care, but can you give us some examples of how you think care would be compromised if there was to be the current three per cent cut to the program to replace equipment?

Mr Jennings: Well, the classic example is things like waiting lists. If a person's surgery is delayed, in the intervening period they are receiving additional drugs, which they would not otherwise have

received; that is a waste and inefficient. They are enduring additional pain; that is the effect on the patient, and so on. And if we do not have the capacity to deal with them in a timely manner, there is also the potential for significant events to occur which can incur additional costs to the system in the event they do not die. For example, we have a debate currently. Several years ago the then minister made a commitment that all category 1 patients—very serious cancers and the like—should be operated on within 30 days. That has now dropped to 90 per cent being seen in that time period, so that is a clinically compromising situation. The guidelines say that people with these conditions should all be seen within 30 days, operated on, and their problems addressed. The consequences of failing to do so is inefficiency, additional cost, and additional suffering, and so on.

The CHAIRMAN: And how is that related to equipment?

Mr Jennings: Some of that relates to equipment; for example, there has been debate about MRIs. I think—I stand to be corrected—Royal Perth's MRI should have been replaced two or three years ago. We had the same problem at Sir Charles Gairdner Hospital. What is happening now is that some of those services are being outsourced at a greater cost, and so on. There are also delays and difficulty in reorganising patients. As a consequence, a patient who comes into an ED may require an MRI, the efficient thing is to whip them down, get it done, and so on. They are expensive machines; there is no question about that, you would recognise. But if you have the right technology you can facilitate an early diagnosis achieved by the correct treatment in a timely way, then you do not have the duplication of booking, clerking, and so on and so forth, for example, of people in ED spending an interminable amount of time trying to find the beds—as I said earlier on. There are a lot of other things with equipment—I alluded to computer technology. That is a basic tool these days. You know, all the new employees are computer smart—not like me, they are good—and the savings to the system through the release of labour hours that will deliver, and capacity to provide greater patient care, and so on, is self-evident. But we are still behind; we have not invested.

The problem with budgets is they are annual. The problem with health is it is long term. There is incompatibility. There have been strong arguments that we should have rolling budgets for health, not annual budgets for health, because it takes time and there has to be certainty and stability. There is so much energy going around now in the system trying to find a three per cent cut; that is inefficient in itself.

[12.20 pm]

Professor Geelhoed: Are you asking for a very concrete example of —

The CHAIRMAN: Yes, understanding that none of us are health professionals.

Professor Geelhoed: This is not quite current, but this is the sort of thing that can happen: at Princess Margaret hospital where I work, for instance, it was a long time before we got our own MRI machine. Prior to that, any child who needed it would have to be taken to another hospital and so on, that is obvious. But even then, our CAT scanners for a very long time were very old and could not be replaced for whatever reason. The consequences of that was that they increasingly kept breaking down and when they did break down, that child had to be taken to another hospital and that involved an anaesthetist's time, using an ambulance and so on, so it became very inefficient. We were also aware that the old machines we were using were giving more radiation than was actually necessary; with the newer machines we would use much less. We knew the newer machines, for instance, could do these things much faster. For small children, if you could do it very fast you could get away without an anaesthetic, but with the old machine, you had to have an anaesthetic so they would stay still long enough to do this. They are the sort of practical things where you can obviously see that if you can get new equipment that we will save on time and money and it is better for the child. They are the sorts of practical things that fall down, yes.

The CHAIRMAN: Thank you. I will turn to another area and move on because I am conscious of the time.

In respect to capital works, the committee has been provided with information from the Treasurer in respect to the process—the instructions that have been given to agencies for setting the next budget. This information has been made publicly available through our website. One of the things it talks about is that agencies are requested to suspend work on any new capital project with a pre-tender estimate greater in value than $20 million that is at or is in the process of going to tender. I would invite your comments on what sort of projects that will have an impact on. My recollection is that things like the new cancer centre, for example, would be impacted by that kind of direction to halt the tender process, but I am interested if you have a point of view on what that might mean.

Mr Jennings: We are not sure and I think that is one of our concerns. Obviously, we are discussing these matters with government and we will be pressing them on these issues. A lot of health investment exceeds $20 million; that is self-evident. We understand these are close to $4 billion in total and so on. We understand the Sir Charles Gairdner Hospital redevelopment proposals have been modified in light of the financial situation and that some aspects of it will not now proceed. One aspect was the proposed ambulatory surgery capability there, which they believe can be dealt with by using other institutions—that remains to be seen.

The CHAIRMAN: Just to help the committee—ambulatory surgery, are you are talking about kind of walk in, walk out day surgery?

Mr Jennings: Walk in day surgery, keyhole surgery, things of that nature. A lot of that will be diagnostics laparoscopes, knees, and it also can be eyes—cataracts—for most patients and so on, so that will not proceed. But they believe they can deal with that through increased utilisation of other sites—that remains to be seen. What we are obviously concerned about is both delay and quality, as well; whether their specifications are being rewritten to decrease the quality and hence the capability. Not all machines, for example, CT machines, MRIs, are the same. If you go for a lower model, then it can take longer, the level of resolution can be less than ideal, so the diagnostic capability might be different. For example, if you maintain old equipment, as Professor Geelhoed has indicated, the patient throughput is diminished. It is old, it is slow, it does not produce the same quality of outcomes and so on. However, in terms of the $20 million, there are probably lots of examples, potentially, when it comes down to what is the current commitment of government and what will be actually done in reality because history suggests to us that there is always a difference, unfortunately.

The CHAIRMAN: Thank you. I invite comments from Ken.

Hon KEN TRAVERS: Just one question: I think there was a mention earlier about the four-hour initiative being positive in terms of outcomes. I would agree with that so long as it is adequately being funded and the resources—I would imagine it is one of those areas where you need to invest money to get a positive outcome at the end of the process, otherwise you end up with just hiding the problem back in the wards. I think you talked about the marginal cost problems then and that would actually become more expensive and more problematic. Is the three per cent cut having any impact on ensuring that that project is adequately funded?

Professor Geelhoed: It will have an impact on hospitals generally—emergency departments—but I was on the touring group to the UK to look at what they have done there. A lot of it actually needed some resources, but a lot of it was actually changing the way you did things. At the moment we artificially corral all our overcrowding in hospitals into emergency departments. What we realise now is that what they have done in the UK, and in Canada to some extent, is actually now spreading that overcrowding throughout the rest of the hospital and getting them to become much more efficient because in some ways by artificially keeping them in the emergency department it has made the rest of the hospital less efficient than it otherwise could have been. In fact, there was an absolute disincentive, perhaps, to be discharging patients. Therefore, it will affect the efficiency of the hospitals generally, I would think, so it will impact on this. Having said that, there is $75 million worth of commonwealth money that is coming to this state, which is to go to emergency services in

a broader sense. I believe certainly part of that will be put towards facilitating the process of introducing the four-hour rule.

Mr Jennings: And we hope that $75 million is without minus three per cent of that.

The CHAIRMAN: Have you actually raised with government your concern that they might be going to take three per cent off the money that is coming from the commonwealth?

Mr Jennings: We have raised quite vigorously with government our concerns about the three per cent generally, and I think we will be probably next week, as well.

Professor Geelhoed: Yes. For a long time, as you know, we have been complaining about the split and the way the states have had to contribute more and more and the commonwealth less and less. The commonwealth now seems to be committed to some sense of redress and that balance, so it is unfortunate in some ways that as they do that the state then says, "We are going to cut that three per cent"—it is not a good look.

The CHAIRMAN: No. Thank you very much, gentlemen, I will wrap it up there because we have run out of time. I have other questions that I would like answered, if we are able to provide you with those questions in writing, would you be prepared to respond to us?

Professor Geelhoed: Certainly.

Mr Jennings: Yes, that is fine.

The CHAIRMAN: Thank you very much and thank you for your contribution today.

Hearing concluded at 12.26 pm