EDUCATION AND HEALTH STANDING COMMITTEE

REVIEW OF WA'S CURRENT AND FUTURE HOSPITAL AND COMMUNITY HEALTH CARE SERVICES

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
TUESDAY, 25 AUGUST 2009

SESSION TWO

Members

Dr J.M. Woollard (Chairman)
Ms L.L. Baker (Deputy Chairman)
Mr P.B. Watson
Mr I.C. Blayney
Mr P. Abetz

Hearing commenced at 12.56 pm

GEELHOED, PROFESSOR GARY CORNELIS
Medical Practitioner; Australian Medical Association,
C/- Emergency Department,
Princess Margaret Hospital for Children,
examined:

JENNINGS, MR PETER LYNNE
Deputy Executive Director, Australian Medical Association,
examined:

The CHAIRMAN: I will start with our opening statement. On behalf of the committee I thank you for your interest and appearance before us today. The purpose of the hearing is to assist the committee in gathering evidence for the inquiry into the review of Western Australia's current and future services. You have been provided with a copy of the committee's specific terms of reference. This committee is a committee of the Legislative Assembly of the Parliament of Western Australia. The hearing is a formal procedure of the Parliament and therefore commands the same respect given to proceedings in the house itself. Even though the committee is not asking you to provide evidence on oath or affirmation, it is important that you understand that any deliberate misleading of the committee may be regarded as a contempt of Parliament. This is a public hearing and Hansard will be taking a transcript of the proceedings for the public record. If you refer to any document or documents during your evidence, it would assist Hansard if you could provide the full title for the record. Before we proceed to your presentation and the questions that we have for you today, I need to ask you a series of questions.

Have you completed the "Details of Witness" form?

The Witnesses: Yes.

The CHAIRMAN: Do you understand the notes at the bottom of the form about giving evidence to a parliamentary committee?

The Witnesses: Yes.

The CHAIRMAN: Did you receive and read the "Information for Witnesses" briefing sheet provided with the "Details of Witness" form today?

The Witnesses: Yes.

The CHAIRMAN: Do you have any questions in relation to being a witness?

The Witnesses: No.

The CHAIRMAN: The way we might proceed is to ask if you would both make a presentation to the committee. We are obviously very interested in discussing particularly some of the AMA's recent media releases, and we are aware that you have been following funding and staffing numbers, and problems, in both the hospital and community sector for some time. Perhaps you would start with the presentation, Gary, and would you mind if committee members interjected as you went along? Is that okay with you both?

Prof. Geelhoed: Not at all.

I might start and make a bit of an opening statement, and then I will have Mr Jennings fill in a lot more of the detail. First of all, thank you very much for giving us this opportunity to come and talk

on this important subject. Certainly health in WA is in a period of change, but that is what health is about. Certainly, particularly this state with so much of the population being in Perth, a generation ago we had three tertiary hospitals as well as the children's and the women's hospitals that were a long way apart. Fremantle was a long way from Royal Perth Hospital, I would think. But times change, and if one looks at a map now greater Perth stretches from north of Two Rocks down past Mandurah. Our tertiary hospitals were right in the middle of the city and we clearly needed to change. I guess that mainly started through the Reid report and then with modifications through the clinical services framework. We are now in a period, as committee members know, of moving to a model that is much more akin to a bigger city like Melbourne, Sydney or London, rather than a small city, and we are building up our hospitals in the peripheries. That is well under way with the general hospitals at Joondalup, and around the peripheries with Swan Districts, Armadale, Rockingham, Peel and so on, and there is rationalisation of tertiary hospitals as well. A southern tertiary hospital is being built, which is well overdue of course, and we are moving the children's hospital, and so on. There are very big changes going on. It is a very expensive business, of course, and everybody is worried about it taking an increasing amount of money out of the public purse. If the committee asked the person in the street about the problems in health at the moment in WA, they could say many things, but I think there are three recurrent themes. The first is emergency departments' access to the hospitals. Clearly, this has been an ongoing problem in Western Australia. I am sure all committee members are aware of the term "access block", which although essentially a way of measuring overcrowding in emergency is now more a measure of overcrowding in hospitals because it is the percentage of people who can be admitted to hospital within eight hours of that decision being made in emergency departments. That has gone up in a step-wise fashion over the past 10 years or so, and we now have the highest access block in the country. That means that our hospital are incredibly overcrowded, and probably we have the worst overcrowding in Australia based on that measurement. The second point is that people want to be able to get elective surgery—as well as emergency surgery, of course—in a reasonable period of time. Again, there has been pressure on that system. Although there have been gains, often it is through throwing money at the problem in the short term and applying a bandaid effect, as it were. Those two things are intimately related because that is what hospitals do. The two core functions of our hospitals are to treat the sick and injured as they arrive and also to do the elective surgery. Generally we have a system that should be able to accommodate both of those things. At the moment we do not because we do not have the capacity in the system. Probably the third point is access to general practitioners. Certainly, in my job working in an emergency department, I often hear from people that they are there because they could not get in to see a general practitioner. To some extent, of course, that is a much broader problem and probably the federal government has responsibilities there—but just to make an important point—that is due to bureaucratic decisions made something like 15 years ago when the number of medical students was cut.

What I am saying here is that there are not enough beds in the system. This is an ongoing mantra for the Australian Medical Association. Certainly, this has been acknowledged in the sense that some time ago now the federal government said Australia was 4000 beds short, meaning there were about 400 beds short in Western Australia. The federal government came out with that figure, which we certainly agreed with here. In different ways this state government said the same thing before it came to power, when it was talking about the need for close on 1 000 nurses. Again, the implication was that nurses would mean beds, as beds do not mean much without the nurses, of course. Why should we have got to this particular point in time, if you like, with not having enough beds? We would refer the committee to the paper titled "Why Public Hospitals Are Overcrowded" by Jeremy Sammut from the Centre for Independent Studies. I am sure the committee has a copy of that. I will take a few facts and figures from that paper, a lot of which is referring to Australia, but a lot translates to Western Australia as well, and where appropriate I will mention Western Australia. Jeremy Sammut's report points out that over the past quarter of a century the number of public hospital beds in Australia has decreased by 60 per cent. That has been adjusted for population, but it

has decreased actually 60 per cent from something like 4.8 beds per 1 000 population down to 2.5 beds for Australia. In a shorter period of time, when the rest of Australia shut down about 10 per cent or 11 per cent of their beds, Western Australia shut down 19 per cent of its beds. When I say "shut down" I mean lost them in the sense of being available to —

The CHAIRMAN: It had not kept up with population.

Prof. Geelhoed: — a thousand population. It is a combination of the population growing—remember WA has been the fastest-growing state in recent years ahead of Queensland, and sometimes behind Queensland. We dropped down to where we have something like 2.4 beds now per thousand population. We had 4.8 beds per thousand population in 1983. In OECD countries that are comparable in a lot of ways, the average tends to be over four beds per thousand population, so we are way beyond that. It is certainly true that beds by themselves are not the answer. Often one hears people say that beds are not the answer and it is about prevention and managing chronic illness in the community. But certainly we have to have enough beds. It is true that we have been able to close down a lot of beds over the years simply because the average length of stay in hospital has come down, so we do not need as many beds, and we do a lot of things outside the hospital where before we did not, and all sorts of other advances. But we have to have enough beds. How much is enough? Certainly, we are not just saying beds, we need to use those beds as cleverly and efficiently as possible. But prevention is not the answer either, in the sense that will not fix things overnight, even though it is important to put these things in place. There is also the school of thought that prevention just delays the problem and we will still have a problem. It seems paradoxical, but we know that we spend most of our money on people who die within the year. In years gone by, people who, say, would have died at 55 years of age from heart attacks, or at 47 from lung cancer from cigarette smoking—those same people, whom we are preventing these things with—go on into their 60s and 70s to get more chronic illnesses, and although we can keep them out of hospital, eventually everyone, sadly, is going to die, and everyone will go through that.

Mr P.B. WATSON: Would it be better if we educated them earlier? You are saying that instead of dying at 47 people go on to 60 and 65 years of age, but what if we educated them earlier, say, in the school system or in early childhood?

Prof. Geelhoed: I am sure the member has read the recent report of the National Health and Hospitals Reform Commission that covers all of this; that is, the sorts of things that we are looking at. Health is so expensive these days that we have to look at all these things and at prevention, but we need evidence. It is very easy to see when we treat patients with pneumonia with penicillin that those who are treated will live; but without treatment half of them would die of something, But when we talk about putting something in place and expecting to see the benefits in five, 10 or 15 years, firstly, that is difficult to measure and, secondly, it is difficult, if we get it wrong, to wait all that time.

[1.10 pm]

So all these things are very important, but there needs to be a balance. In some ways what I am arguing here is that we need to do all those things. We need to get in early. We need to put resources into our children when they are very young—the families—because that is shown to be very cost effective in terms of avoiding social problems later on. But at the same time I think to some extent people have become absolutely blinded, where if you do mention beds, they just glaze over and say that is not the answer. What we are saying is we have gone too far—we have cut too many beds, and people are suffering. The AMA is on record certainly as showing that it is not just an academic thing—that there is overcrowding in our hospitals, and there is access block. It is not just about inconvenience. This is killing people. People who are in that chaotic system will do much worse—their medical outcomes will be much worse.

Mr P.B. WATSON: With the beds, we have a situation where a lot of seniors are taking up beds when they should be in aged care homes. Would that alleviate the problem somewhat?

Prof. Geelhoed: Yes, certainly. There are two ways of looking at it. One is that we cannot get people into hospitals, because people are occupying the beds. However, we also have to look at the way in which we can use those beds more efficiently. There is no doubt that at the moment—part of this is the National Health and Hospitals Reform Commission again—we do have this split between commonwealth and state, and we do have a lot of older people in our hospitals who are taking up those beds and who could be looked after in other facilities, but because of the funding et cetera, that is not happening; so that is certainly true. One way of looking at this, rather than just saying we need more beds, is to look at occupancy rates in hospitals. Now what that says is that you need an 85 per cent occupancy rate. No-one argues with this. Again, the state governments and the commonwealth government are on record as agreeing with this. It is more or less saying that if you are 85 per cent full, you are efficient, in the sense that 50 per cent is not very good, but at 85 per cent you are efficient enough to be cost effective, but you also have the capacity to respond to swine flu or seasonal variations, and you can do all the things you want—you can keep doing your elective surgery, and you can keep adjusting to the people coming through the door. Once you start getting up into 90 per cent—our hospitals run well into 90 per cent; in fact close to 100 per cent—not only does it become chaos, but also you get poorer outcomes. So if we had the same number of beds that we have now, but we had 85 per cent occupancy, that would be enough beds. I will mention here at this time the so-called four-hour rule. This is an attempt by the government to take on board what we are saying—that you cannot artificially corral people into emergency departments and keep the rest of the hospital ticking over, where they can say once they are full, they cannot take any more patients. This is an attempt to spread that efficiency throughout the whole hospital. Certainly from the trip I went on to the UK, this has been very successful there in getting people to become much more efficient about how they use their hospital beds. So this is a very good initiative to try to make better use of the beds that we have. My question is, though, will that make up for the 400 beds that we do not have? It is somewhere in between.

The CHAIRMAN: So that 400 makes up the balance between that 85 per cent occupancy and the 95 per cent or 100 per cent occupancy? We need 400 additional beds now?

Prof. Geelhoed: If nothing changed, we would need 400 needs to try to get 85 per cent occupancy, but if we take initiatives like the four-hour rule and various other things, it may be that we can have fewer beds. So in some ways, rather than say we need 400 beds, we need to aim—whether that is through being smarter and having initiatives like the four-hour rule and so on, or adding some beds—for that 85 per cent occupancy. I just make the point, too, that if we have shut down all these beds, is it cheaper to run health and the hospitals? The answer is clearly a no. Again, to quote Jeremy Sammut, he makes the point that in Australia generally, over the past 10 years recurrent expenditure on public hospitals has gone up by 64 per cent. But he also points out that between 2002 and 2005—this is Australia-wide—hospital administrators increased by 70 per cent. There was a report some months ago—it was headlined in the *Sunday Times*—basically making the point that Western Australia would seem to have the worst non-clinical to clinical ratio in the nation. So Australia has increased 70 per cent with hospital administrators, but Western Australia seems to be the leading light there.

Mr P.B. WATSON: Would that be because there is now more transparency, and because of litigation you need to have more people to check things and stuff like that, or is it just total over-indulgence?

Prof. Geelhoed: Certainly life has become much more complex and you do need support for IT systems and all sorts of things that we did not have in the past, so a lot of that will be appropriate. But at the same time it is an extraordinary thing that while we have shut down 60 per cent of our beds over 25 years, we have increased over a much shorter period of time the non-clinical people by 70 per cent. What we are saying is we think that is a bit overdone both ways. Sure, you probably need some people, and, sure, we could have cut some of the beds. But we think the proof is in the eating. At the moment, a lot of the time people cannot get their elective surgery done when they

want, and the sick and injured just cannot get into hospital in a timely fashion when they want. We would suggest that part of that may be because of the governance model that we have, and we should be looking at that. Is this centralised system that we have the best? I mean, in other areas where they have looked at this—certainly in New South Wales with the Garling report and so on, which I am sure you have looked at—a lot of that is talking about their chaotic system there, where they think there has been a disconnect between the people on the ground doing the jobs, the clinical people and the people in the hospitals, and a distant bureaucracy that is just not hearing, is just interested in numbers and so on, and they are not talking to each other, and also you get a demoralised workforce as well.

The CHAIRMAN: Does WA have more of a centralised structure than the other states, which perhaps do not have the same problems in terms of bed occupancy and inadequate funding of health?

Prof. Geelhoed: Certainly, we have had a centralisation here that has gone on for many, many years. At one stage we had autonomous boards, but more and more it has become concentrated, and it has also become politicised, because the minister has become the board, basically. A lot of what is done in health now is because of the political imperative rather than because of what might be considered the best. So certainly there is always the argument about economies of scale and about everyone speaking the same language and so on. That is clear. But at other times it can be a disaster. One particular example to mention is the Health Corporate Network. That was set up to support the hospitals. Prior to this, each of the hospitals had their own divisions, which were acquiring equipment et cetera, were hiring and firing staff, and were arranging for the staff to be paid. The idea behind that was that instead of having all these different systems, we would centralise the system and have the same system for all hospitals, and we would have economies of scale, we would have uniformity, we would have a much better system, and we would save money.

That is a grand theory, but the reality is that it has been an unmitigated disaster. It has been going on now for years and years and years, and it is way past the time when you can say it is just teething problems—because up to a certain point clearly such a big change was going to have teething problems. We have situation now where—this has been highlighted at my hospital just in this past week or so—junior doctors have literally just not been paid. They have been in the system for a long time—years—and they have got their records there, and they just have not been paid. Some of them do not know about it until their bank is calling them to tell them they are overdrawn and so on. They are a minority, obviously—thankfully—but for the majority of them, their pays are never right. They never get paid for what they actually work. We have had the flu season lately and we have really been under pressure, and my department has gone up almost 50 per cent on what we usually see this time of the year because of swine flu, and suddenly junior doctors—who have been very good about helping out and working extra shifts—are saying, "I have no confidence at all that if I do this I will ever get paid for it; you are asking me to work for nothing." We have had other situations in the past where we have had to pay for certain things and for equipment and so on. In genetics, for instance, which is a very specialised area, they often have to send a test overseas to investigate families here in Western Australia. They were threatened recently with not being able to have these tests done in the future—that was by the company that was doing the tests, in the United States or Europe, or whatever—because they never pay; that is, HCN could not get its act together.

So that is just one example of where I am saying the theory is good, but the practice has been shocking. I am sure there is a compromise there, where you could still in this day and age, for instance—this is what we have suggested—move a lot of those people back to the hospitals. You could still have a small corporate area centrally that would make sure that there were uniform standards et cetera, and that they were using the same systems, but you would still get that human context and the face-to-face communication that has been missing. It is very inefficient, because the people in the hospitals are having to do all their work. They are actually doing the same work that is supposed to be done centrally, but because they get it wrong so often, the people left behind in the

hospital—the skeleton staff—are having to second-guess them and are trying to do that work for them so that when the mistakes come they can tell them where they have gone wrong. That is just one example.

[1.20 pm]

The CHAIRMAN: You mentioned earlier the boards. If we look at what is happening in Education, there are similarities. The government is now planning to give schools and principals more autonomy. I personally think that when we had boards for the hospitals, there was someone actually going in and batting for that local community. We all know how, traditionally, people south of the river have missed out on services. I was disappointed to see those boards go, because we lost that lobby group. Do you believe that it might be an idea to consider not only devolving the empire, but also possibly reinstating those boards? How do you think we can ensure that the services go where the population needs those services?

Prof. Geelhoed: Yes, I think we would support re-examining that. Again, what the actual model would be would need to be looked at. In this day and age, you do need to have certain communication. You cannot have absolute silos any more just ignoring each other and so on. We believe that somewhere in between there should be some sort of a workable compromise—for instance, area boards. Certainly, in the past the AMA has been on record as saying that perhaps with three area boards in the metropolitan area, there should be one for children, because it is a statewide service. The country probably could be broken up again. Therefore, you would devolve this. They would need to talk to each other, but you could put it down to a local area, and also get input again from the community, and get it from the sorts of people who have served on boards in the past, with their expertise. That is certainly something we would support. Peter, do you have a comment on that?

Mr Jennings: I think we have advocated in the past for regional boards. The Health Administrative Review Committee reported in 2001 to Bob Kucera. We put that forward, and I think they accepted the premise that there should be three general boards within Perth—north, south and east—with the women's and children's separate, and also, obviously, rural. There is that need for a balancing between the political dynamics and community input, so we would have no argument against that at all—quite the reverse; we would strongly support it.

Prof. Geelhoed: I might stop there. I know that we are talking about tertiary and secondary, and even into the community and so on. I do a zeroing in on what I see as the great stumbling block at the moment, as I see it. The average person wants to be able to get into those hospitals. There are lots of other things too. I think Peter will go through some of these things in a bit more detail, and a bit more broadly also, but I wanted to concentrate just on that very thing: the ability to have hospitals at 85 per cent occupancy.

The CHAIRMAN: Peter, I have noticed recently that there have been some comments from the AMA in relation to the funding cuts. I wonder whether you have any more evidence that you might like to give to this committee in relation to those funding cuts.

Mr Jennings: It is fairly controversial, I think. I will come to that, if I might, and put it into context. There are significant concerns and there are significant rumours. Not a lot has been put in writing, but a lot is being said in corridors, and I will obviously take that on board and come to it at the appropriate time. I have tabled a document that really tabulates the various references that I will be referring to. I looked at this, and I would really start from the premise, if you do not mind, of a quote from Warren Zevon in *Fistful of Rain*: "You've heard all the answers but the questions remain." That really underpins the fact that the AMA is here for the long term. We have seen more reports, more reviews, more examinations, more commitments, more press releases, but we have seen very little action in many respects.

Your terms of reference really go to the Reid review itself. From our point of view, we argued long and hard for that review, and we essentially supported the thrust of it. It really went to the cornerstone recognition that over the previous decades there had been a massive underinvestment in Health, and capital, in particular, had been left to deteriorate. Indeed, even now, the capital allocation in the state budget relative to Health's use of the state budget is fairly minor. Really, Reid was all about a catch-up reinvestment phase, and now, of course, we have met difficult economic times. It is about providing efficient capacity and getting the balance right.

The first document—these are all taken from official government documents, I should say—is entitled "Table 1: Budget — Recurrent and capital proportions" and simply details the macro recurrent state budget for 2008-09 actual, and the 2009-10 budget. The recurrent allocation for Health, which is around 25 per cent for 2009-10, is slightly down on the previous year as a proportion, but is consistent with about 25 per cent of the recurrent budget over many years. Then it details the capital allocation of the state government and the capital allocation in particular to Health. You will note that while Health consumes 25 per cent of the recurrent budget, it accounts for only some six to seven per cent of the capital budget, and we are in a reinvestment phase in Health—in other words, a very low level of investment in Health relative to its use on the recurrent side of things.

The second table is entitled "Table 2: Capital Forward Estimate Changes: Health". That is taken from last year's forward estimates and this year's forward estimates, and it shows the capital allocation. I should say that before the parliamentary committee looking at the three per cent cuts and so-called productivity dividend, which we simply regard as a cut, we argued strongly that as the global financial crisis was feeding through, we needed to bring forward capital investment in Health to prime the economy and maintain employment and so on and so forth. These forward estimates—official documents—at this point in time demonstrate that in fact to 2012-2012, some $350 million less is being put forward in capital compared with the previous forward estimates, which is obviously a concern. We do recognise that there are other things in the fire. Perhaps Mr Marney, who was due to appear this morning, might have articulated that somewhat. Again, it is a relevant setting to the implementation of Reid.

The CHAIRMAN: Actually, we are very interested in your comments. Unfortunately, Mr Marney was not able to join us this morning due to sickness, but we hope he will join us next week. Therefore, we would be pleased to hear about any particular areas that you would like to highlight to us.

Mr Jennings: I hope he has a good doctor! The third document is titled "Table 3: Health recurrent and capital proportions". That shows in a schematic format the proportion of the recurrent budget and the proportion of the capital budget. Again, they are taken from budget papers and budget summary papers tabled by government in Parliament. Of course, Reid was about modernising the system and providing the capacity to meet demand efficiently and qualitatively—I emphasise "qualitatively"—for a recapitalisation and other reform improvements. Currently, the equipment budget in Health is extremely poor and a matter of major concern amongst clinicians. I think $13 million was allocated in 2009-10 for equipment. In 2010-11, there is only $2 million. You might have seen previous press reports, including statements by the AMA, expressing concern about the state of equipment and, indeed, the government's own analysis of that through what was called the Monash review. That established that there was some $200 million deficit in equipment placement across Health. I understand that this year it was considered by the department as necessary to replace at least $43 million worth of equipment, but the budgetary allocation is $13 million. So there is an obvious gap, which of course is consistent with your terms of reference. If we want a modern, efficient health service, we have to have the tools to increase throughput and increase the quality to facilitate earlier diagnosis, treatment and intervention. There is major concern about that, notwithstanding past promises that Monash would be implemented. We do

believe that submissions have gone to Treasury, and, obviously, you might wish to ask the Under Treasurer about that next week.

In terms of system obligations, in addition to service and capital refurbishment, including equipment, obligations in the system also include the need for continuous investment over the short, medium and long term. We emphasise that from our point of view. On quality services, I instance Queensland, where they put an emphasis on capital, but they had Dr Death because there was not an emphasis on quality. They include training, workforce, research and innovation, and leadership through initiatives such as the clinical networks, which has been established but which we understand is under some pressure from the budgetary point of view, and that raises some concerns as well. Thirdly, as Professor Geelhoed has indicated, there is prevention. They are all part of the health matrix in trying to get the balance right in the short, medium and long term.

The current focus appears to be on short-term budgetary management. Some of these issues are therefore suffering. I would say that obviously there is also a major difference between health-care efficiency and budget management. The two do not necessarily correlate. That is a concern when we are trying to trim budgets. That is understandable in these economic times, but it is causing concern from the professionals' point of view in terms of access and so on. If we are going to minimise recurrent costs in terms of best practice, we have to have the tools to do so. We have had massive increases in productivity in Health. Professor Geelhoed has referred to length of stays going down, down and down, and the reduction in beds.

[1.30 pm]

We believe that is overshot well and truly and that there is actually virtually no further, or very limited capacity, to decrease length of stay further given the ageing of the population and comorbidities on the medical side of the equation.

The other issue of major concern to clinicians is the lack of an integrated, efficient computer platform. Systems are still currently paper-based in many areas. There are some exceptions. There has been some very good progress in, say, radiology with what is called the PACS system, which works very well. But in the generality, the technology platform is very poor. We know that some $350 million was allocated, I think about five years ago, to try to put in place a new computer platform system. It has not occurred.

The CHAIRMAN: Would the AMA support the health initiative where the patient's data is shared between general practice surgeries and the hospitals?

Mr Jennings: Yes, as a general premise. Obviously there are a lot of problems to work through privacy-wise, security-wise and the like. I think again that has been highlighted in the national health reform commission report as well. I do not think there is any argument about that from a health point of view. There are a lot of benefits to be gained from that. It is complex.

Mr P. ABETZ: There will also be a lot of cost savings, I would assume, in the sense that a patient forgets what has already been done—which might be on record—but then is repeated, an investigation or whatever did not take place. I think it has an enormous savings potential.

Mr Jennings: Absolutely. The new doctors and nurses are all extraordinarily computer literate compared with someone like myself. My son just shines and I just bumble along likes a dinosaur. That is where we have got to go. We are lagging behind. Clinicians go overseas and see other systems that are far, far superior to ours and they facilitate greater efficiency and actually also facilitate quality in that you minimise the risks because the contraindications can be flagged up there and so on, rather than lost in paperwork. It is very, very important from that point of view.

Mr P. ABETZ: You mentioned $350 million set aside. Where is that program up to?

Mr Jennings: I suggest you ask the Under Treasurer.

Mr P. ABETZ: I shall do.

Mr Jennings: We have raised it with him previously. We have had a very good meeting with him on that. I think there is a degree of frustration that that has not been progressed. That will probably become evident in —

Mr P. ABETZ: It seems an enormous amount of money to be invested if you have not seen anything from it yet.

Mr Jennings: We have seen no evidence that it has been invested. It has just been sitting there—it was allocated. We do not think it has been generally invested.

The other side of this is where the public system sits relative to the private sector—the push-pull equation. The turnaround in plummeting health insurance levels in the late 1990s provided immense relief to the public system. There is a risk now that the demand balance will change again with some of the federal initiatives where they are actually undermining private health insurance through the threshold legislation, the levy legislation before Parliament currently. I think it is true to say as well that the health department is similarly concerned. They gave evidence before a federal committee in June or July last year. I gave evidence the same day. Their modelling post-Reid was predicated on retaining the balance between public and private and no adverse decline in private health insurance levels. They gave evidence to the effect that would have had a significant effect on the state government if they did decline, and necessarily they would have to increase bed numbers beyond that which they have calculated post-Reid. Again, there is a potential gap there.

The CHAIRMAN: When Peter Flett addresses the committee in a few weeks' time, we are hoping to get some further information from him in relation to that federal-state funding arrangement. Again, I will flag that that is on the agenda. If there are areas that you have previously identified, please let us know.

Mr Jennings: On 15 July last year, the acting director general, Robyn Lawrence, stated that the activity demand and capacity modelling that underpins the health reform agenda assumes that the private-public mix of patients in our public hospitals will not change.

She gave further evidence that the calculated effect of the change by the federal government at that point of time would require 100-odd beds above and beyond what the other reports had already indicated. That is a concern.

In the meantime of course unrelenting pressure on the public system continues. Professor Geelhoed has indicated the federal government itself has acknowledged that we are probably 400 beds short. He has referred to the report by Mr Jeremy Sammut entitled "Why Public Hospitals Are Overcrowded: Ten Points for Policymakers" by the Centre for Independent Studies, which is the fourth item in the papers I have supplied. I certainly would recommend reading it because it has a very succinct summary of the situation.

The CHAIRMAN: We are hoping to catch up with Dr Sammut at some point.

Mr Jennings: The Reid review itself—and it is interesting to reflect now—was appointed in March 2003; six and a half years ago. It reported in March 2004—five and a half years ago. What have we got to show? That is the big question. What have we actually got to show? Central to its recommendations, adopted by government with the then exception of recommendation 87 effectively; the PMH one, which was subsequently accepted—was a 10 year recapitalisation plan to about 2014—four and a half to five years from now. It recognised this disinvestment in capital over decades, and also the need to adopt an 85 per cent occupancy level if they want to provide quality care and have surge capacity for things like swine flu et cetera... We accepted and supported the Reid review in concept, in its generality in terms of recapitalisation. We argued matters of detail very, very vigorously. For example, its population projection was 2.3 per cent increase per annum—about 25.5 per cent increase cumulative to 2014. Its demand projections were 4 per cent per annum based on ageing, comorbidities and other factors—a 48 per cent increase to 2014. It only recommended an 11 per cent increase in the number of beds—369 extra beds to 2014. So a major

gap in terms of productivity expectation between a 48 per cent increase in demand and an 11 per cent increase in capacity. We questioned their ability to bridge that gap. I argued vociferously that the proposed bed numbers were insufficient to deal with that, notwithstanding our ongoing commitment to increase efficiency. We thought that was just too big an ask.

Mr P. ABETZ: Did Mr Reid offer an explanation for that gap?

Prof. Geelhoed: There were a lot of assumptions that trends to bring down length of stay and advances would just follow. There were a lot of projections that subsequently just have not eventuated.

Mr Jennings: The clinical facilities framework effectively revises that figure substantially; more in line with what we were arguing for. Table 5 effectively, in graphical form, summarises Reid in terms of demand growth, population growth and bed growth. It illustrates it fairly graphically. That is taken directly from that report. That is entitled "Reid Review Findings/Proposals 2004-2014". Table 6 is an interesting document entitled "Metropolitan —

The CHAIRMAN: Sorry, if you could just go back to "Reid Review Findings". You were saying that this one shows increased demand of 45 per cent.

Mr Jennings: About 48 per cent versus 25.5 per cent increase in population versus an 11 per cent increase in beds to 2014 proposed by Reid. It graphically demonstrates the gap, which is obviously a matter within your terms of reference.

Prof. Geelhoed: Those projections for population went wrong not long after that because we had a boom—the baby boom and the boom up north.

Mr Jennings: And immigration. Table 6 is entitled "Metropolitan Public Hospitals — Overnight Beds" for 1990-2014. That again graphically illustrates why we believe we have got capacity problems. To the extent you can measure longitudinally beds across time having regard to statistical changes, this is as accurate as I can get it. The 1990 figure is taken from the then $1.2 million Deloittes report, which the Chair and others might recall. The health department report is a public document. In 2004, again government figures; 2014, Reid figures. In other words, what Reid was advocating is that we should have less beds in 2014 than what we had in 1990 against a backdrop of their proposed 48 per cent increase in population post-Reid; not post-1990. As Professor Geelhoed has said, fertility rates changed markedly and our traditional 25 000 babies a year went up to 30 000 with the baby bonus and other factors. Immigration went up and so on.

[1.40 pm]

The other thing I will briefly refer to is the National Health Hospital Reform Commission report. That report has recently gone to the Rudd government. It recommends —

> … the overall balance of spending through taxation, private health insurance, and out-of-pocket contribution maintained over the next decade.

That is on page 92 of the report. That contradicts the federal government's tax on private health insurance.

The CHAIRMAN: I could not hear you very well. Could you repeat that?

Mr Jennings: That contradicts the federal government's tax on private health insurance, which could result in reductions in private health insurance and added pressure on the state government. There are some contradictions in issues from that point of view.

Mr P. ABETZ: It was anticipated that the threshold and all that would reduce the number of people taking up health insurance. I read recently in the newspaper that that does not appear to have eventuated this year; that there is actually an increase.

Mr Jennings: As of yet—I think those are the operative words. Again, there is legislation before the federal Parliament currently to actually means test the rebate very, very significantly indeed.

Again, the AMA (WA) appeared before that inquiry, as did insurers, as did some from hospitals and so on. When you take a combination of those two factors and you do it over time, then obviously there is major concern. If you look at the private health industry advisory committee, which reports directly to the federal government and is an independent body, that demonstrates the changes in private health insurance over the past 25 years. You will see the lag effect, for example, and the effect that particular interventions have, and how quickly or slowly they have a cumulative impact. Private health insurance pre-Medicare agreement of 1984, for example, was up to 60 or 70 per cent. It slid down to about 32 per cent into the late 1990s before the lifetime community rating and the 30 per cent rebate came in. Then it picked up to the now 49 to 50 per cent mark. Given the fact that basically, I think, 40 per cent of elective surgeries are undertaken in private hospitals and 50 per cent of separations, not acuity weighted, are undertaken in private hospitals. If there is a diminution in private hospital activities as a consequence of a reduction in private health insurance, then the back-flow impact on public hospitals is going to be significant. As I quoted earlier, the Department of Health's projects and modelling post Reid are all predicated upon retaining the existing balance, which the National Health Hospital Reform Commission also advocates is necessary, but which the federal government does not appear to be adopting. So there are major potential problems from that point of view. In any event, Reid advocated that. Our position in broad terms with the Reid review —

The CHAIRMAN: Before you move on to that, we are having a presentation from St John of God, but it might be worth our thinking about having a presentation from the health insurance providers, because they would have picked up any changes already.

Mr Jennings: Yes. Obviously, post Reid, it reported in March 2004. The Health Reform Implementation Taskforce was established in August 2004 to implement Reid's recommendations. That resulted in the Clinical Services Consultation in 2005, which is a detailed document really re-evaluating the projected bed numbers and testing the ability or otherwise of the assumptions underpinning Reid and then doing some demand model based on what was an undisclosed methodology using consultants Hardes and Associates from the eastern States. The document also set out clinical roles in tertiary, general, secondary hospitals et cetera, the consultation and finalisation leading to the Clinical Services Framework that you referred to in the terms of reference. That process, rather than recommending the 300-odd beds that Reid did, recommended an extra 1 165 beds by 2014, a 32 per cent increase in beds, compared with, say, the 48 per cent population projection at the time.

Mr P. ABETZ: That is virtually adding the completed Fiona Stanley Hospital into the existing system.

Mr Jennings: Stage 2 plus a little bit of the stage 2 to 1 000 beds, so with that it became effectively in the metropolitan context 4 772 compared with Reid's 3 796.

The CHAIRMAN: Did they base those figures on a specific methodology?

Mr Jennings: They did, but they would not disclose it. I understand it is a commercial, proprietorial, analytical system and it was subject to in confidence, as I understand it. I may be corrected on that. That is what they told us, and they would not disclose the assumptions. We were relatively happy with the outcome but we could not test the assumptions.

The CHAIRMAN: it would be useful, if we could get hold of that, to look at the methodology used for those extra beds in comparison with the methodology of the current clinical services review.

Mr Jennings: The interesting thing is that post that, the consultative document is not the final point in the bed argument. The clinical services framework actually increased beds further up to 2015-16 to 4 981 beds. In terms of where we sat, one of the aspects of that was that Reid had advocated, I think, 700 general medical and surgical beds on the QEII site, with the Sir Charles Gairdner Hospital as the major tenant of that site. At the clinical services framework outcome, they were

advocating 1 100 general medical and surgical beds on that site. The government was not moving or relocating PMH and King Edward et cetera. We argued, and it is illustrated in the seventh document, which is an extract from the AMA WA's publication in *Medicus*, "AMA's plan for solving the CSF jigsaw". We argued that it should be reconfigured and rather than QEII site general medical and surgical capacity increasing from the 550 mark currently, it should confine itself to Reid and be increased to 700. PMH and King Edward should be brought on to the QEII site to facilitate economies of scale, whether it is in cleaning, parking and so on and so forth, and decrease marginal costs from an economic point of view, and that the 400 beds should be decanted north, south and east, closer to home.

The CHAIRMAN: Joondalup, Rockingham and Armadale?

Mr Jennings: Yes, and also Fiona Stanley Hospital.

Mr P.B. WATSON: And down south?

Mr Jennings: Yes, down south. That is set out there. We had a meeting with the minister and the then director general, Neale Fong, and chief executives and so on, and work was undertaken to analyse that and ultimately indeed they did accept that after reanalysis and looking at the arguments and so on. But it has not been implemented of course.

The CHAIRMAN: That was the previous minister.

Mr Jennings: Yes. I should emphasise that in that period—2004-5-6—the recognition of incapacity, the commitment to investment and so on, generated an awful lot of enthusiasm amongst the profession. They have been under the hammer, looking to see the wood for the trees, the light at the end of the tunnel et cetera. They put in a huge effort volunteering on committees, often out of hours and in their own time, to provide the input necessary to design, facilitate and so on and so forth. The effluxion of time and the lack of action in many respects have dissipated that enthusiasm and there is a degree of alienation creeping back into the system that you should be aware of. In September 2005—this is the eighth document, entitled "Boom delivers and extra $890 million for WA hospitals", a press release was made by the then minister, Jim McGinty, on 29 September. That press release indicates, amongst other things, an additional $322 million for the Fiona Stanley Hospital. On the second page, which is marked —

> the hospital is scheduled to open its doors as a 600-bed facility by 2011 and upgrade to 1,000 beds by 2015-16. The funding includes investment for a new research facility in conjunction with university and research bodies.

There are other matters there. It is now 2009. It is now scheduled to open in 2014, stage 1; stage 2, we am not sure. So a lot of time has gone through. The profession, as I said, is somewhat disillusioned and suffering what I would characterise as not RSI but RES—either reform exhaustion syndrome or restructuring exhaustion syndrome, whatever you want to characterise it as. It is a bureaucratic disease. They put in a huge amount of work and are seeing only a limited progress in some areas, more in others, and some good things have occurred, but some long-term investment seems to have been pulled back. We would argue that health is a major investment in the community and in society and it also has economic dividends. If we are thinking about reducing recurrent costs per episode, then we need to be retooled et cetera.

[1.50 pm]

It is the truth, as Professor Geelhoed has illustrated with HCN, that the bureaucracy is driving some in the profession to disillusionment. We had a meeting the other night to talk about Fiona Stanley Hospital planning, internally in the AMA, and the comment was made by a clinician that more bureaucrats are involved in planning hospitals that do not exist than those that do exist and there are too many bureaucrats generally. Okay? That probably summarises the sentiment amongst clinicians whose interest is in providing quality care as soon as possible to people and relieving suffering.

The CHAIRMAN: Was there a discussion at that meeting—and I have heard rumours—about contracts and the seeming delay in awarding contracts for tenders to get the hospital moving?

Mr Jennings: I have not heard that so I cannot verify that rumour: I have not heard that rumour or otherwise. Presumably that question could be asked of the director general or the Under Treasurer. The focus of that was the concern about the indecision, the lack of implementation on these things, and the fact that it is almost yo-yo politics for want of a better expression—that is, things are committed to and then they back off. If you are designing a department, it is complex to try to design a service of fifty years as a service and not just a factory. Previously agreed changes were changed because they did not want to change the costings. It came down to having a quality institution rather than just simply having a factory.

The CHAIRMAN: Are there concerns about what services will be provided at Fiona Stanley Hospital stage one?

Mr Jennings: Services to be provided include the capacity for teaching and things of that nature; sufficient space for the discussion of clinical cases—that is for doctors to be able to confer in confidence and so on and other things of that nature; and the size of departments to ensure they are both functional in the short term and will also provide for capacity in the future.

Ms L.L. BAKER: Following up that point: it is rumours and scuttlebutt but I think that some of the concerns that I hear mentioned when talking to people in the community is that it has taken quite a long time to get Fiona Stanley Hospital up and running and that now we are looking at an even further length of time before it is up and running and that it is pretty much going to be a little bit out of date by the time that it actually gets up and running. Have you heard that? What you were saying just then is a bit indicative of that: if it is not funded and well-resourced when it opens, there will be further gaps.

Mr Jennings: Yes. Look, our argument on the capital side is that if you look at over a ten-year period something like $50 billion is expended by the state government on capital. As illustrated earlier, currently, at a time of recapitalisation, we are only spending seven per cent of the cap budgeted on health, yet health consumes 25 per cent of the recurrent expenditure for this state. If we are to achieve efficiencies in health to the extent that we can, or deal with demand better and provide higher-quality care, they have got to invest. We do not believe that they are investing fast enough or enough. If you are designing an institution to provide a foundation for at least the next 50 years and beyond, it has got to be well designed to cover both what is foreseeable in the short term and yet have the flexibility to adapt to design best practise in the future as well. We are not convinced at this point in time and clearly there have been an awful lot of delays and there will probably be further delays. That is causing immense frustration and disillusionment. You know, the enthusiasm was there. It was captured. It was provided voluntarily. But the bureaucracy has got in and it is going around in circles a little bit—that is a concern.

Mr P.B. WATSON: Peter, what is the AMA's take on private-public partnerships?

Mr Jennings: We have not really got a formal position. I have looked at what they have done in Victoria, in women's health and so on. I know that the Auditor General there said that it was a line-ball outcome. There is a good report on that. I think the experience that we had with Joondalup is really the only significant capital investment in health in the past 13 years—that is, from 1996 onwards. That was very successful in terms of building quickly and building to budget by the private sector. That one did work. That is the only significant example in the Western Australia health culture. If I recall, the Auditor General found that there was a very, very small saving with the Melbourne women's hospital, but that it was marginal. It was uncontroversial in terms of the outcome of the building. There have been buildings in some states in which the lifts did not even comply and they could not get trolleys in with horizontal patients. You have got to get things right. We will, I think, leave that to the experts; however, we have not got any negative details —

Prof. Geelhoed: No; no there is no philosophical objection.

Mr P. ABETZ: Just a question about other jurisdictions where there has perhaps been better investment in health—capital-wise and so on: what is considered a reasonable proportion of recurrent to capital expenditure in terms of keeping the system, shall we say, up-to-date? Is there some sort of an indication as to what we ought to be aiming at in our long term budgeting?

Mr Jennings: I would not profess to be an expert in that area. I would argue however that clearly we have been deficient and that everybody has recognised that; the Reid process recognised that. We have argued very specifically in terms of, for example, equipment, with the Monash process. Here we are looking at CT scanners, MRIs and things of that nature. They are fairly high-cost capital items that can cost one or two million dollars et cetera. That equipment should be depreciated and replaced in accordance with its depreciation. They should look at alternative models of funding, purchasing and leasing, so that we can keep ahead of the pack. If you can increase throughput on a three or four-million-dollar machine, rather than rely on a patched up thing like the last MRI machine for which there were no spare parts left in the world, and I emphasise, in the world! That machine was kept going well and truly beyond its use-by-date. It slowed everything up. It lead to things like access-block because you could not take all the patients down in the time to have a scan to facilitate diagnosis and work out treatment and so on. There are inherent delays in having equipment that is out of date and slow, when you have got high cost of labour and so on and so forth. We have not been able to get a commitment to replace equipment commensurate with deprecation and so on. In terms of macro-capital stock—for example, hospitals—it is probably more complex again. Clearly, we have had major under-investment. We are in catch-up, but there is a lag to catch-up and the questions that beg to be asked now are: are we going to do it to requisite quality and are we then going to maintain it? The first things that suffer in an economic downturn are maintenance and prevention, longer term investments in health, health promotion and things like that.

Mr P.B. WATSON: Peter, would you prefer a hospital that was not flash but that had better equipment, or would you prefer a big flash hospital with not-so-good equipment?

Mr Jennings: I think the answer to that would be that the clinicians want the ability to treat patients to the best of their ability and that they want to operate in an institution, not a factory, that is geared towards quality improvement and continuous improvement. That would be the answer from a clinician's point of view. The outside look of it is not a big issue. If I am sick, if I am one of those 55-year-olds, as I am, mentioned earlier—I shuddered at that point—I want to be treated. I am not really going to worry too much about that. I want to know that you have got the right equipment and the capacity to treat, and that I am not going to sit in a corridor waiting for a bed. I want to be in a bed. They are the key issues: the capacity to provide quality care and the capacity to develop over time and to train the next generation. That is a critical issue, and one that I will come to in terms of the funding question in a moment.

Prof. Geelhoed: That is a difficult question in the sense that you would of course like to have both. The setting aside of a certain amount of the budget for art work was brought up. We were asked about that and I was making the point that it is not unreasonable when talking about how people will recover in hospital. There are good studies that show that people who have an outlook and who can see trees and things like that actually get better faster.

Mr Jennings: It is true.

Prof. Geelhoed: The other thing is the retention of staff and those sorts of things. Working in a well-designed, modern building is more likely to retain staff than if we have them working in a brick concrete box, as it were.

[2.00 pm]

It is not just a simple trade-off. It does have implications for the health outcome of people and staff and direct effects on people and the surroundings they are in. There is no easy answer there.

Mr P.B. WATSON: If you do not have the right equipment, they die and you cannot sue.

Mr Jennings: The other issue about this and your terms of reference and so on, is the statistical manipulation. A lot of reports and statistics are produced. The ninth document goes to illustrating the AMA's concerns over statistics. The health performance reports are now produced quarterly as a consequence of the Reid recommendations. The extracts from the WA Health Performance Report of the April to June 2007 quarter illustrate a 93.5 per cent overnight bed occupancy level, and an increase in the bed occupancy level on the previous quarter. We talked earlier about the need for 85 per cent as an internationally recognised desirable average to facilitate surge, and not have the overcrowding problems that do result as the research clearly indicates, in poor outcomes and, indeed, in some cases, deaths. The interesting thing about that report was that it identified the occupancy at 93.5. With very similar throughput in the hospital, the July to September 2007 quarterly report illustrates an 84.5 per cent occupancy level with a tiny note, which notes a changed definition. Nothing occurred at the coalface; the hospitals were still operating at full capacity.

Prof. Geelhoed: Access block rates actually got worse, meaning that, clearly, there was not more space in the hospital; in fact, there was less because they were having even more trouble getting people into that hospital, so there was a bit of fudging there.

Mr Jennings: We look at some statistics with a degree of cynicism, and that one stands out. That document, by the way, was tabled in very late December. In terms of gaps, IT is languishing. Clearly, there is funding but funding that is insufficient at the present time. The chairman asked what was happening with funding and what the concerns around the traps are.

The CHAIRMAN: Particularly in relation to front-line services. As Gary mentioned earlier, we know the value of initiatives in terms of children and various programs for cost saving later in life. We are hearing of front-line services that have gone with the introduction of the three per cent cuts.

Prof. Geelhoed: That is the difficulty. I mentioned before preventive programs and assessing them and knowing your money is being well spent. The other thing is that investing money in something like that, even if you think it is a pretty good bet, and it is for young children, but we are not seeing the benefits for many, many election cycles shall we say.

Mr Jennings: In terms of front-line services and in terms of the implementation of Reid, a good example of that is the redevelopment of Rockingham hospital. The suggestions are—this needs to be validated—that there has been no transitional funding for the redevelopment expansion of Rockingham hospital and no real provision made for the additional recurrent funding for an expanded Rockingham within the budget. We are following that up, but that appears to be the suggestion.

I referred earlier to equipment, notwithstanding the government's own reports identifying $43 million need now—$200 million that is inadequate provision within the budget.

Teaching the next generation to be qualitatively good and efficient is fundamental. We have the expansion of interns, which is welcome. But we understand the employment of those interns, which the government is committed to, is being internally funded, without additional funding. Again, they are being internally funded, and that means funding for other services is being squeezed as well.

The CHAIRMAN: So there is no additional funding for clinical staff placements?

Mr Jennings: No additional funding. Propositions were put forward as we understand—I stand to be corrected—hope to be, but that is what we understand at this point in time. Of course, it carried over the deficit from the last budget, which it has been asked to carry.

Prof. Geelhoed: You have great sympathy for people caught in the middle trying to run these hospitals because it is the magic pudding in terms of funding in the sense that they keep telling

people to take this out of your funding, "You will do this." Then when they suggest cutting some services they think maybe we cannot do this, they are told, "Well you can't do that". You are literally trying to do more with less all the time.

Mr Jennings: To illustrate the issue of capacity, the last document I tabled entitled "State Government Projected and Proposed Hospital Capacity" under the tab "Peak Capacity Table 1990 and Beyond". That is a table I put together longitudinally over time from official government documents. I preface my comments in that it is quite hard to compare bed statistics longitudinally if definitions change. But this is confined to multi-day overnight beds. It draws from all the government's own documents. The 1990 figures are from the Deloitte's report in 1991. The other figures are from the Clinical Services Consultation and Framework and Reid review documents and so on. If you look at the subtotals of south metropolitan, central and statewide—the WA public hospital activity figures that were appended to this last week's web site, which I pulled off on 18 August and which are also attached—you will see that on 18 August 2009, the government's web site indicates a total, including mental health beds, of 3 649 beds. You will notice that, in 1990 the Deloitte's report suggested there were 3 644. They have gone up by five beds in 19 years. In press comments, the previous minister used to accuse us of being a broken record on beds. We make no apologies for that—five beds in 19 years.

Prof. Geelhoed: I think the population has gone up by about a third in that time.

Mr Jennings: This tracks through the macro aggregate figures from the clinical services framework, Reid and so on, and where we should be by 2010-11—next year. Under the clinical services framework et cetera, we should have 4 522 beds compared to 3 649. On that figure, we are roughly 900 short.

The CHAIRMAN: Was that 4 522 based on the Deloitte's report?

Mr Jennings: The 3 644 in 1990 was in the Deloitte's report when Keith Wilson was the minister and looked at area management at the time and commissioned the Deloitte's review.

The CHAIRMAN: Which review gave us the methodology for the need for the increase in bed numbers?

Mr Jennings: Over Reid?

The CHAIRMAN: Yes.

Mr Jennings: It was the Clinical Services Consultation using consultants from the eastern states and then the framework built on that a fraction more after that. You can argue about the total number of beds. I know we have a capacity problem. Certainly, the federal government at present is accepting we are 400 short. The conventional view has been that we have needed somewhere between 80 and 100 beds per annum to tread water with population growth and aging, as the baby boomers come through. Despite the various promises and lots of press releases about opening beds and none about closing beds, the net change has been five—in 19 years.

The CHAIRMAN: The government would argue that the reason there has not been a change is because there has been improvement in community health-care services; therefore, more people are able to be cared for at home? What is your response to that?

Mr Jennings: Yes. We have improved immeasurably across a range of fronts. There are better treatments. There has been a lot of work at various points in time on public health measures: anti-smoking, for example, a matter close to our hearts, as you will know. That has longitudinal impacts. We started decreasing smoking rates from 1983 onwards with the first bill. Those sorts of things have changed but the issue still comes down to the lack of fit in capacity and stresses within the system. We are operating in a very stressed system.

[2.10 pm]

That has all been recognised and commitments have been made, but commitments are not being realised in actuality to the extent that has been promised. There is disillusionment occurring as a consequence, and the gaming that goes on, from a professional point of view, is disenchanting in the extreme.

Prof. Geelhoed: Can I also make the point that there is confusion at times about the problems in emergency departments, and we often hear people saying that there are people in the community who should be seen, et cetera. The problem is not the people coming through the doors of emergency departments, because the ones who could actually could have been seen by a general practitioner are very few, and they are easily dealt with by emergency departments. The problem is getting out—it is access block that is the problem.

The CHAIRMAN: Do you mean getting admitted?

Prof. Geelhoed: Yes, meaning that people who need our hospital beds. Although it is true that the government might say that it is putting things in place—prevention, community health—at the same time, we need a system in which, when people need to come into the hospital, they can get there in a timely fashion and there are enough beds.

The CHAIRMAN: So even with improvements to community health services, we should still ideally have only an 85 per cent bed occupancy to ensure that the hospitals are functioning to the standard that they should function?

Mr Jennings: Yes.

Prof. Geelhoed: That gives us the flexibility.

Mr Jennings: The other problem is that we have a community capacity problem in general practice, for example. Professor Geelhoed earlier alluded to decisions of government back in the 1990s. Some committee members may recall that around 1996, the federal government argued to decrease medical school numbers from 1 200 down to 1 000 and it was argued vociferously and repeatedly in the media that there were 5 700 too many GPs across Australia. With the wisdom of hindsight—what a joke, on both counts.

Mr P.B. WATSON: What is the AMA's opinion on nurse practitioners?

Mr Jennings: We support practice nurses working within a team environment with general practitioners. We do not support independent nurse practitioners on the premise that we think that that would result in fragmented care and duplication and, indeed, it may result in increased costs to government. One of the mantras that underpinned the position in the 1980s and 90s was supply induced demand theory within federal government. It believed, for example, that if it could suppress growth in the health workforce, it would actually suppress latent demand for health services, and commonwealth government reports were issued that extrapolated a population growth of 27 per cent from then to the turn of the century, and an increase in the number of health professionals by, I think, 43 per cent or 46 per cent; it was a report that came out in 1985 or 1986. I should explain that I have been around a while! That report concluded that that increase would result in supply induced increased commonwealth government outlays of $1 billion a year. That partly underpinned the attempt in the mid-1990s to reduce medical school numbers and the accusation of too many GPs when we are now demonstrably have too few GPs, and there is a 10 to 14-year lag time from these policy positions. That is the tragedy of it. There has been extraordinarily poor workforce planning and now, of course, we have the wonderful situation of going from 120-odd interns a year to 300 in the space of four years, and we have to provide qualitative training for them. At the same time, we have budgetary pressures.

The CHAIRMAN: In relation to that, as a nurse and former president of the Australian Nursing Federation, we do not really want to get into fisticuffs over that issue at the moment. If Peter is satisfied with that answer, I would—because of the time—certainly like to hear about the three per

cent efficiency cuts and the effect they have had on tertiary hospitals. We could sit here all day and argue the value of nurse practitioners, and we would not come to any agreement.

Mr Jennings: The fundamental issue at the present time is hospital base funding and capacity. Things like transitional funding are referred to in Rockingham and so on, and having staffed, funded beds versus beds that are not staffed or funded. As we understand it, the hospitals are being asked to fund last year's deficit within existing allocations. As the committee knows, there has been a so-called three per cent productivity dividend applied—we would argue that it is a three per cent cut, not a dividend—but the deficit is not being fully funded, and they are being asked to carry that. As a consequence, they are starting the year off really behind the eight-ball. The magnitude of that appears to be extremely significant and very concerning indeed, if what has been related to us anecdotally is true. Rockingham will get no recurrent funding expansion and no transitional funding. We believe that a $300 million shortfall across the system is being bandied around, and that has been broadly divided up as approximately $100 million in north metro, while in south metro—which incorporates Fremantle and Royal Perth—

The CHAIRMAN: Bentley, Armadale and Rockingham.

Mr Jennings: Yes, but the larger institutions are being asked to find savings in the order of $80 million for Fremantle and $110 million for Royal Perth. We were in the press the other day about the potential 10 per cent cut. That appears to correlate with those figures. The problem is that there are also cost increases, and we are told that workers' compensation has gone up and that electricity costs are having a major impact on budgets, because they have to factor in a significant increase in outlays on that account, and so on. It is very fragile, and the indications at best are that they have a zero increase in funding and a negative decrease in real funding for this year, at this point—bearing in mind that governments often provide additional funding during the course of the year and that things like equipment may be remedied. Things like funding may be remedied, but we are not necessarily holding our breath in these times.

The CHAIRMAN: In your opinion, the effect of these cuts will be what in terms of waiting lists and services?

Mr Jennings: As we said before, front-line services are inevitably being affected. I referred earlier to the disillusionment about the bureaucratisation of this planning process and the lack of implementation to the extent promised, and so on. These concerns, which senior clinicians and departmental heads are having to make decisions about to try to come in on budget, are further exacerbating the morale levels within hospitals, which are what makes institutions work; morale is a very positive factor, but lack of morale is a very negative factor in terms of recruitment, retention and productivity. We are in that difficult cycle; we understand that the government is in difficult fiscal position, but on the other hand, our responsibility is to treat patients and advocate on their behalf, and there are tensions.

Prof. Geelhoed: I also make the point that, if it is true that the state government will force these quite dramatic cuts, it is in real contrast to the federal government's approach. At the beginning of a recent report released by the federal government, it makes the point that although it is acknowledged that there is a global economic meltdown, this is not the time to be scrimping and saving on health, and that we need to invest for the future and keep Australians as healthy as possible so that when the good economic times come again, we will be best equipped to go forth and prosper. There is a real disconnect there, and underpinning that is the whole funding model and where we are going to go with that. I think it is short-sighted of the state government. Clearly, the state has tremendous pressures and we want to keep our AAA rating, but I think there are other things that could be put off instead of health. It is not only that the budget might be cut by five or 10 per cent, but for a system that is already struggling to try to effect all these reforms and do all the things we have talked about, it is like a body blow in terms of morale and so on. A lot of the goodwill and impetus that has come about over the past five years or so to try to effect all this

change and get a new tertiary hospital, will dissipate if, in fact, the department is suddenly decimated. I think it is a false economy.

Mr Jennings: We cannot afford to decrease quality. That is exactly what Queensland did.

The CHAIRMAN: We will have one last question for each member of the committee, then I will ask Professor Geelhoed and Mr Jennings to give us a final summary.

Mr P. ABETZ: In terms of escalating costs of health care, I think one of you made the comment that during the last year or two years of one's life, one spends about 40 per cent of one's total lifetime medical costs. It would seem to me, having served as a pastor and having been in hospitals for the past 25 years, that there is lot of what I would deem inappropriate or excessive medical intervention in those closing stages of life, whereas in my view palliative care would be a much more appropriate way of dealing with such patients. Has that been considered by the AMA? Even though a person may be definitely dying, there is often pressure from families to put the patient in intensive care and pumped him full of all sorts of things to keep things going for another week longer, but it does not actually cure the patient.

[2.20 pm]

Prof. Geelhoed: It is something that has to be looked at. When I was a student, you did not get into ICU if you were, say, over 70 or something. As I get older I think that maybe it would be wise if they changed that. But, honestly, it was just accepted that that was necessary if a person was of a certain age, but now that has changed. There are no simple answers to this, but it is clear that we are spending a lot of money on people who will die within a year. I think it is a much broader debate that society has to have; we cannot keep on paying out all this money. If it keeps going up, it will consume the whole budget. A broader public debate will have to be had and the AMA will have to be part of it. To some extent, what has happened in Western Australia in this last month or so is part of that debate, about how do we deal with the difficult problems. Once upon a time you were either alive and had a reasonable quality of life or you were dead. There is a very grey area now in between there. I think we have to start looking at this in a compassionate way but in a much more practical way as well. I think that as the population ages this will become a very important topic.

Mr Jennings: The other facet of that is that a lot of work has been done on models of care, not only relating to this particular facet but more generally how can we provide best practice and what are the most appropriate models of care to apply, whether it be in relation to diabetic management or asthma or end of life-type issues. That has been basically driven through the clinical networks that are partly a product of the Reid review and so on, and we support that. There is some concern, however, that that is subject to the three per cent budget cuts and other budget cuts and so on. We need to invest in those sorts of issues to try to see how we can get the best fit and get the balance right to facilitate best practice. We need to undertake the appropriate research and so on to get this right, rather than just simply this stop-start budget management. That is a real concern.

Mr P.B. WATSON: My final question is about Hospital in the Home. We did have successful Hospital in the Home projects but they seem to have drifted away. Do you think that is the way to go in the future, to try to keep more people in their homes?

Prof. Geelhoed: From my understanding, the Hospital in the Home program did not particularly save money, but it was a better model and it was well accepted by the public so it was worthwhile from that point of view. I can only assume that if there have been cutbacks in other areas, it is because they are expensive even though they may be—clearly, if they were saving a lot of money, rather than having people in hospital, they would be trumpeting them. I know I keep going on about beds, but I am trying to make the point that we have to use them as efficiently as possible and we have to keep looking at all these things that we can do in a smarter way. There may be other models of care that we can use, especially in chronic illness situations, to try to keep people out of hospital as much as possible.

Mr Jennings: Some money has been allocated to Silver Chain to be used in a sort of similar sense.

Prof. Geelhoed: It involves general practitioners.

Mr P.B. WATSON: Yes, we have one of those in Albany. It is very successful.

Mr Jennings: That is a good thing.

Mr P.B. WATSON: I do not know what the cost ratio is there.

The CHAIRMAN: Gary, would you like to sum up and give us maybe three key areas that you think the government should immediately focus on?

Prof. Geelhoed: You have probably gathered from what I was saying that there is a need to look at actual bed capacity and hospital capacity and get accurate statistics about that capacity. That must be looked at, so that when the sick and injured need a bed, they can get timely access to hospital. I think there have been some very bad outcomes for the patients and we know that, as I said before, it is not just the inconvenience, it actually causes bad outcomes. It has also had the secondary effect of, because the conditions have been so chaotic, demoralising the very workforce that is working there. Certainly that needs to be looked at. In terms of funding, times are tough, but we have Gorgon, and so on, in the future. I think it is a false economy to be just slashing and burning at the moment, because not only will it just affect frontline services, but it will also demoralise the health workforce and have implications long after the money returns again. Lastly, there is just a plea for evidence base. We need to invest more and more to see exactly what does and does not work, rather than what is fashionable and so on. In medicine we talk about evidence-based medicine, and I think we need to have a lot more rigour about the programs that we introduce.

Mr Jennings: I think the key thing, in a sense, is action, not words. That means we would argue that capital investment should try to be put back on the rails. I would have said "brought forward", but now everything has been delayed. It is the right time to invest in capital, but that investment needs to be at a qualitative level as well as a quantitative level so that we have the capacity to go in the future, provide the technological platform and provide hospitals with the recurrent capacity to function. They are struggling. Those would be the issues. The pressure politics of the current budgetary games are really unhelpful from a care point of view and in terms of short, medium-term and long-term goals. We have to be realistic and pragmatic about that. We cannot artificially withdraw funding or expect them to sustain deficits; that will be counterproductive to frontline services. Community frontline services that were not supposed to be affected are being affected. The government needs to recommit with actions, not words.

The CHAIRMAN: I would like to thank you and the AMA for the evidence given to the committee today. A transcript of this hearing will be forwarded to you for correction of minor errors. Any such corrections must be made and the transcript returned within 10 days from the date of the letter attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be introduced via these corrections and the sense of your evidence cannot be altered. Should you wish to provide additional information or elaborate on particular points, please include a supplementary submission for the committee's consideration when you return your corrected transcript of evidence. Thank you for your time today.

Hearing concluded at 2.27 pm