EDUCATION AND HEALTH STANDING COMMITTEE

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

INQUIRY INTO THE ADEQUACY AND APPROPRIATENESS OF PREVENTION AND TREATMENT SERVICES FOR ALCOHOL AND ILLICIT DRUG PROBLEMS IN WESTERN AUSTRALIA

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
WEDNESDAY, 23 SEPTEMBER 2009

SESSION THREE

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 10.27 am

MOTT, MR PETER ROBERT
Chief Executive Officer, St John of God Hospital Murdoch, examined:

The CHAIRMAN: On behalf of the Education and Health Standing Committee I thank you for your interest and your appearance before us today. The purpose of this hearing is to assist the committee in gathering evidence for its inquiry into a review of WA's current and future hospital and community healthcare services and its inquiry into the adequacy and appropriateness of prevention and treatment services for alcohol and illicit drug problems. You have been provided with a copy of the committee's specific terms of reference. At this stage I will introduce myself, Janet Woollard; the other members of the committee who are here today, Mr Peter Abetz, Mr Ian Blayney, Mr Peter Watson and Ms Lisa Baker; our principal research officer, David Worth; research officer Renee Gould; and Liam Coffey from Hansard.

The Education and Health Standing Committee is a committee of the Legislative Assembly of the Parliament of Western Australia. This hearing is a formal procedure of Parliament and therefore commands the same respect given to proceedings in the house. 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 with Hansard making 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 the questions we have for you today, I need to ask you a series of questions. Have you completed the "Details of Witness" form?

Mr Mott: Yes.

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

Mr Mott: Yes.

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

Mr Mott: Yes.

The CHAIRMAN: Do you have any questions in relation to being a witness at today's hearing?

Mr Mott: No.

The CHAIRMAN: Peter, thank you very much for joining us today. As you are aware from the review documents that we sent to you, we are looking to identify needs and gaps in hospital and community healthcare services. Obviously, some of those needs and gaps can be fulfilled by joint relationships with private healthcare providers. Thank you for providing the number of staff and the number of beds. We have heard from other private healthcare providers some things that I certainly was not aware of such as the fact that if people have a workers' compensation claim or a motor vehicle accident, they can actually go straight into a private hospital because there is no gap and it is all covered by the insurance companies. I do not think that has been explained to the general community. If there are any other examples of that other than those two, we certainly would like to know what they are. You obviously have some arrangements now in terms of public provider ventures, but what future ventures would be possible to I guess take some of the load off the public healthcare system? There are concerns that people may, because of some of the changes that the federal government is introducing and maybe not in the next few years, but down the track, drop

their health insurance so there will be a greater burden on the public healthcare system. Therefore, what strategies do you see that can be used to take off that burden? What other assistance can you give to try to help where there are needs and gaps? Just solve all the problems for us and you have so many minutes to do it!

Mr Mott: Thanks for the opportunity to speak today. I guess I bring a certain perspective having spent about 20 years working in the public system and the last 10 years in the private system, with a couple of years mixed in between at the AMA—they are very key drivers I think in terms of the medical profession. Janet mentioned the issues of MVIT and workers' compensation and that certainly is something that has not been fully explored with the private sector and I think could be and it could take some pressure off the public system. Every year statistics are produced by a company called Hardes that detail the number of patients treated across the state in public and private hospitals. From my perspective, I am always interested to see —

The CHAIRMAN: What is Hardes?

Mr Mott: It is a statistics company that gathers all the statistical information regarding hospital admissions.

As a private hospital operator, we are interested to see not only how much of the local market, if you like, in terms of private health insurance we might be capturing but also what proportion of private patients are being treated in public hospitals, and there are a lot. In 2007-08, according to the information I have, 13 per cent of what are called chargeable day patients were admitted to public hospitals; that equates to about 25 000 patients. If you look at overnight patients, 20 percent of chargeable overnight patients were admitted to public hospitals, which equated to 29 000 patients. Some of those patients will be the compensable workers' comp MVIT patients, some of them will be patients who will be admitted as private patients in public hospitals because private hospitals do not provide that particular service, and some of them will be in specialised areas of care—burns, motor trauma—where really you get the patient in there and get them treated. But outside of that, there would be a big number of those patients who could be treated in private hospitals. I do not have any detail on the breakdown, but I think those figures themselves sort of speak volumes for what could possibly be done by better utilising the private system to take the pressure off the public hospital system. Of course, there is self-interest in that for me because I run a private hospital and in running a private hospital we are there to try to run at maximum capacity.

Mr P.B. WATSON: What is your capacity at the moment?

Mr Mott: Generally speaking, Peter, once a private hospital gets to about 85 per cent occupancy it is considered full—that is 85 per cent over seven days of the week. We are pretty much running at that at Murdoch, so we are planning future capacity growth now. To a public hospital, 85 per cent occupancy would be a dream because it would take a lot of pressure off.

Mr P. ABETZ: They are at about 98 per cent.

Mr Mott: Yes. But even at 85 per cent over seven days a week, we are pretty much 90 per cent-plus during the week and we drop to 70 per cent to 75 per cent on weekends. We are probably a bit busier than other private hospitals on weekends because of our emergency department, which probably then leads into the role we have with respect to having the only private emergency department in Perth; in the eastern states they are a bit more common. But the reason that private hospital operators generally do not have emergency departments is because they lose money. They provide some downstream business, if you like, from the certain percentage of those patients who will end up as inpatients in the hospital. Running a busy hospital like Murdoch, to be quite honest, we do not need an emergency department to capture those patients. In fact, to some extent having an emergency department impedes the amount of elective surgery or medical admissions that we can perform but it provides for a really important community need at the moment. We see about 25 000 people in our emergency department every year and —

Mr P.B. WATSON: Are they all private?

Mr Mott: No, the health insurance funds say that they cannot under the current federal health legislation care for people attending emergency departments, Peter. We wrote to the previous state health minister asking for that to be addressed and I am not sure that anything came of it.

The CHAIRMAN: So, they are all private, Peter.

Mr Mott: They are all private; they pay a fee for attending our emergency department.

Mr P.B. WATSON: Say someone has a serious accident just up the road from yours and is brought in as a public patient, do you stabilise them and then take them to another hospital?

Mr Mott: Stabilise them and send them onto to a public hospital, if they are uninsured. However, if their injuries are life threatening we treat them at the hospital. In fact it is probably important to note that for what we call triage category 1 patients, we do not charge any out of pocket at all because we figure that if they are that ill that is about the last thing they need. However, for patients from what they call triage category 2 to triage category 5, which is a range of illness severity, which is the same as all public hospitals as well, we have a fee ranging from $165 through to about $360, and that is to support a department that has well-trained emergency physicians, nurses and very good equipment that runs 24/7.

The CHAIRMAN: Peter, you are aware that the government with the AMA several months ago went to the UK and are attempting to introduce a four-hour law within public hospital emergency departments. What currently happens within your emergency department; and, without having a rule, would your department probably function within those guidelines?

Mr Mott: When we review the performance of our emergency department compared with public hospital emergency departments, we are better in some triage categories. The college for emergency medicine has guidelines for the time in which a patient who attends an emergency department will be seen. For triage category 1 it is virtually straightaway and for triage category 5 it is reasonable to wait—I cannot remember but I think it might be up to a couple of hours.

[10.40 am]

The CHAIRMAN: A couple of hours? We know of people sometimes staying at emergency departments for a couple of days.

Mr Mott: Yes. As we are running a busy hospital, we can have difficulties ourselves at Murdoch, and we do. The busier we are with elective surgery, the more difficult it is to try to keep a promise that we can see people and provide them a bed as quickly as we would otherwise like. We tripled the size of our emergency department in 2005, but we are unlikely to make it any bigger than what it currently is unless the government talks to us about that. We do sometimes have difficulties. We sometimes have waiting times that are a lot longer than what we would otherwise like. It just depends on the time of the attendance. It is more difficult for us in the afternoon and evenings, and sometimes because we rely very heavily on the goodwill of our surgeons and our physicians and our cardiologists and others to hold themselves on call, we sometimes do not have the back-up support that we would like. A teaching hospital has surgeons and registrars covering and on staff 24/7; we do not. All the doctors that work at our hospital, or the vast majority of them, will agree to be on a roster and they will, on an honorary basis, service our emergency department after hours. I should add that at the moment we receive a small grant from the Department of Health every year, which helps to pay for some of, but only a very small percentage of, the cost of the running the emergency department.

The CHAIRMAN: Do you anticipate there being any difference to that grant and your emergency services when Fiona Stanley Hospital opens?

Mr Mott: No, that is something we need to talk to the Health Department about. As a non-profit provider of care—the point there is that we, as in our hospitals, do try to make commercial profits.

It is what we do with that profit that is different, I guess, in terms of providing an emergency department or palliative care or whatever, or putting it into good works in the community. But we will look at the impact of the Fiona Stanley Hospital's emergency department—I think 60 000 or 70 000 attendances a year is what is proposed. If we find that our emergency department figures reduce by half, then we might need to look at its future. Because if the community need is being addressed in another way, the question for me as the CEO is: could that money that is currently being used to pay for the emergency department service be better used in other areas of the community? We have a never-ending range of things that we could divert that money to. My own view is that I think with the projections for the demand for emergency department care into the future, with an older, more crumblier population, that our emergency department would serve the community well a long way into the future. We will have to wait to see the impact of the Fiona Stanley Hospital.

Mr I.C. BLAYNEY: They had an emergency department at St John of God at Geraldton, but they closed it.

Mr Mott: Yes, they did, yes.

Mr I.C. BLAYNEY: They were in to see me the other day because they are doing their five-year planning exercise at the moment. We spent quite a bit of time talking about it. From what you have said and what they said to me, the difference, to a fair degree, was the attitude of the doctors.

Mr Mott: The attitude of the doctors?

Mr I.C. BLAYNEY: Yes.

Mr Mott: In respect of what; wanting to start one up?

Mr I.C. BLAYNEY: No, it had just gotten harder and harder to get the doctors. It is partly because they do not have doctors on site all the time and that put them in contravention of the rules or something; but also that local doctors are just getting harder and harder to get on with and they could not get them on the weekends.

Mr Mott: Yes, you are right there. That is, to some extent, what I have noticed. Having been in the health industry for about 30 years, one of the things that is changing to some extent is that the new generation of doctors are very busy during the day and a lot of them have young families, and to try to get them to commit to an after-hours roster is increasingly difficult.

Mr I.C. BLAYNEY: The one that interested me —

Mr P.B. WATSON: Especially in regional areas.

Mr Mott: Yes, absolutely.

Mr I.C. BLAYNEY: We have 36 doctors in Geraldton, and over Christmas, from, I think, 22 December to 3 January, they had to bring in locums because the doctors will not agree amongst themselves about who should be on call.

Mr Mott: It is increasingly difficult to get a locum, too, over that time.

Ms L.L. BAKER: Peter, I have some questions about mental health—not yours, personally! What kind of service do you offer for mental health either outpatients or admissions; and also, as a corollary to that, have your admissions or outpatient figures risen or changed in, say, the past 12 months or two years?

Mr Mott: We provide a range of services, Lisa. Firstly, through our emergency department we have psychiatrists on call who not only will attend people who might need care coming in through the emergency department, but who also might, through being referred from other doctors, attend inpatients in the hospital. Those people might have co-morbidities. One of the things we do at Murdoch, through what we call our social outreach program, is run a counselling centre for

outpatients in Fremantle—the Fremantle Counselling Centre—which sees outpatient and attendances for people suffering, largely, depression and anxiety.

The CHAIRMAN: Are they from your patient admissions and then you refer them?

Mr Mott: No.

The CHAIRMAN: How do they come to attend that centre?

Mr Mott: As an outpatient we largely target those people who are on low incomes; people who would otherwise find it difficult to attend, say, the Alma Street clinic because of the waiting time for Alma Street.

The CHAIRMAN: So you get your clients through advertising that the service is there.

Mr Mott: Yes, and lots of referrals from other agencies as well, Janet. It opened about five years ago and, probably not surprisingly, it has been overwhelmed. We plan to continue to grow and expand that service to meet, unfortunately, an ever-increasing community need. That is one of the things, if you like, that St John of God does with the profits it makes from its acute hospitals. That is just one small example of the services we run there. We also, at Murdoch, Lisa, run a satellite service for Lifeline, which is a telephone counselling centre. We set that up a couple of years ago at our Subiaco and Murdoch hospitals, whereby counsellors can come in after hours in a safe environment—because we run 24/7—and provide much-needed telephone counselling services. That has been a real success and it is providing a really important gap in need in the community.

Ms L.L. BAKER: So you do not take patients in for mental health reasons per se?

Mr Mott: No, we do not have psychiatrists who admit, generally speaking, to the hospital. That is not to say that we are not looking at the possibility of an inpatient private mental health service some time down the track. That is one of the things we want to talk to government about with respect to its planning for the Fiona Stanley Hospital. Mental health is certainly on our radar in the future. There are no private mental health facilities, really, south of the river at the moment.

Mr I.C. BLAYNEY: Would it be a fair assumption to think that most people who have got mental health problems probably have not got private insurance?

Mr Mott: No.

Mr I.C. BLAYNEY: It is not?

Mr Mott: In terms of the correlation between income and demographics, that is probably the case for those clients who visit our Fremantle counselling centre. But it is not generally, as I understand it, necessarily something that would be a truism across the spectrum. Anxiety and depression is something that seems to afflict all sectors of society.

Mr P. ABETZ: I guess the very poor, lower socioeconomic strata, such as drug addicts with psychosis, tend to get taken to Graylands.

Mr Mott: Yes.

Mr P. ABETZ: Graylands has told us about that 40 per cent of their emergency presentations are drug related.

Mr Mott: Yes.

Mr P. ABETZ: I guess at St John of God it would be somewhat different.

Mr Mott: Yes, absolutely—in terms of our emergency department.

Mr P. ABETZ: Graylands is a mental health facility anyway, so if you were to run a mental health section you probably would not get that percentage.

Mr Mott: It would be a different patient cohort—some people would say the worried well. But there would still be people with, largely, anxiety, depression-type illnesses, which seem to be on the rise. A lot of those people do have private health insurances.

Mr P.B. WATSON: Can I just ask, in comparison with public hospitals, what is your security set up? Do you have staff doing the security or do you have a security service coming in? Because the security side of things has been an issue in the public hospitals we have been to. I am just wondering how you work it in your system.

Mr Mott: Peter, we run our own security service. One of the things that we are finding is that as the Fiona Stanley Hospital starts to take shape, we have lots more uninvited visitors to the hospital coming through the backdoor at night and an increased security risk. One of the things we are looking at increasing is our security presence on the campus at the moment. Generally speaking, for a 350-odd bed hospital we run a pretty lean security service. We generally have one, perhaps two, people on each shift.

[10.50 am]

Mr P.B. WATSON: Are they trained?

Mr Mott: Yes.

Mr P.B. WATSON: This is a problem. In the public health system they have got orderlies; down in Albany they have an orderly, a boilermaker and one nurse.

Mr Mott: They are very multi-skilled then!

Mr P.B. WATSON: It is alright if you are six foot four, but if you are four foot six and have no biceps you are in real strife!

Mr Mott: If our security people come to us without prior experience, then we put them through a training program.

The CHAIRMAN: Peter, I know St John of God down at Bunbury has now moved so they are co-located with the public hospital. We certainly do not want you to reveal the discussions that you are having currently with the health department, if it is confidential in terms of what services each may provide. I guess that you are in discussions in terms of what resources each might be able to provide so that you are not spending millions of dollars on new equipment at St John of God that the government will then pay similar funds at Fiona Stanley. I am sure that those discussions are occurring. Are you aware of the benefits from the co-location at Bunbury in terms of that public-private relationship?

Mr Mott: Yes, I am. I am obviously in discussions with my colleague Mark Grime who runs that Bunbury hospital. It is a different model down there. The building is pretty much joined at the hip through the operating theatres. The Murdoch co-location will be different. It will be divided by Main Street, which I think is four lanes. It is going to be pretty big. We have spent the last couple of years negotiating with government that road access and what it will mean for our campus because we will have to change our entrance. At the moment we have taken all of our time to sort that out, and now we are starting to have some discussions with government about the provision of clinical and non-clinical services. My own view is that to some extent we will pretty much run our own race. These are going to be two massive hospitals. When the Fiona Stanley gets to 650 beds, going possibly up to 1 000, and with our own growth to hopefully around 500 beds over the next decade, they will be big enough to support their own infrastructure. The benefit will be that it will bring doctors in droves to south of the river, from a self-interest point of view, and doctors who will have the convenience of seeing their public and private patients without having to get into their cars. We certainly want to talk to the government. We are keen to understand better what the clinical service mix is.

For example, the government is looking at putting radiation bunkers in on the campus. That is a great thing. This might sound a bit trivial to members from non-metropolitan areas, but certainly in Perth there are no cancer services for people south of the river for radiation therapy. People have to go to Charles Gairdner Hospital or Subiaco. We will leverage off that government infrastructure to ramp up our cancer services. We will recruit more oncologists, we will make a stronger commitment to day chemotherapy services, a stronger commitment to palliative care and to cancer surgery generally, which, unfortunately, all the indicators are that is going to massively increase in the next few years. To answer your question, we are interested in talking to the government and saying, "Based on what they are doing clinically, what then might we do?" Going back to Lisa's question about mental health, understanding what the government are doing with mental health—if what they are doing with an in-patient mental health unit will then help to attract psychiatrists to that campus, then we might look at psychiatry. We are really driven by the clinical services planning to then decide what we want to do. But independently of Fiona Stanley, we will pretty much surge ahead and continue to grow because we are in the enviable position, I guess, of not really much competition south of the river. We plan to grow a fair bit of our own volition.

The CHAIRMAN: You have said that four lanes of traffic will separate the hospitals. Recently, when the committee were in Melbourne, we met with the CEO and the director from Melbourne Private Hospital. I believe there it is almost a tunnel between the public and the private. Before the plans get too advanced, have you considered something like that? What they do there is when a private patient goes into the emergency department, there is someone there checking whether they have private insurance. Once the initial things are sorted out, "Do you want to have a bed in this hospital?" or, "Because you have got private insurance, would you like to go to Melbourne Private?", whilst some private health care providers might be willing to pay the cost of transportation from a public hospital to a private hospital, it probably would be a lot easier if it was a case of once someone was stabilised, if there was a direct route from one to the other —

Mr P.B. WATSON: I think in Melbourne they went up a couple of floors and then went across on a walkway sort of a thing.

The CHAIRMAN: But one way or the other, have you looked at some kind of linkage?

Mr Mott: We are looking at it. That is one of the things we want to talk to government about in terms of once we understand the clinical services planning, the size of the ED and where the ED is going to be located—and all of that has generally been announced recently—then we can start to look at what practically we might be able to do in containing our facility. At the moment we are looking at, subject to our governing board approval, a substantial capital injection and thinking about turning parts of our hospital around so that it faces Main Street. At the moment it faces Murdoch Drive. It creates a bit of a logistical challenge for us, but one of the things we can do, for example, is build another medical suite, a medical clinic, for doctors' rooms, and have that face Main Street. There is a five-metre drop between our campus and the Fiona Stanley, so there will need to be escalators or something that will connect both campuses. We are looking at those things. We would very much like to come to an arrangement with government where a patient who came up through the public hospital emergency department was given the choice of whether they wanted to be treated there or whisked over to Murdoch.

Mr P. ABETZ: In terms of the ageing of the population and therefore presumably a significant increase in medical needs, somebody told this committee that 40 per cent of a person's total medical expenditure during their lifetime, on average, is spent in the last two years of their life. That would indicate that with the ageing of the population there is going to be a massive need for increased medical services. Have you looked at, with all the new developments in the south, increased housing, population predictions and so on? My personal assessment is that even with the Fiona Stanley Hospital being built there is still going to be a pretty massive shortage of beds. To what extent can St John of God create extra beds to help the overall system cope so that Fiona Stanley

will predominantly take the public patients and those who have private insurance can then be funnelled into your hospital? Even with the growth of the population, there may be pressures on your hospital in terms of going from 85 per cent occupancy perhaps to 95 per cent and that sort of thing.

Mr Mott: In terms of our planning for the future, it is largely based, as I said earlier, on this Hardes population data modelling that also predicts what health insurance numbers might be into the future as well as population growth. Certainly what we are seeing at the moment is that the southern corridor is just going to go gangbusters. I said Murdoch might go to about 500 beds over a period of time. That will service private patients; not all of them. I see in fact there was a new private hospital in Mandurah that was announced the other day as well. All through that corridor, that area will grow. I guess the question is whether as a private hospital operator there is something we might be able to do in terms of helping the government out in terms of our infrastructure. Our predominant aim is to provide private hospital services, but I mentioned earlier that ambulatory care and emergency department care projections for that sort of need in the community are going to skyrocket in the next few years. The government can talk to us about emergency department care and convincing us that we ought to perhaps have a more extensive contract than we currently do to keep that going. It would seem a bit silly for us to contemplate at some stage in the future perhaps closing that down when the infrastructure is already there and the government is going off building other emergency departments, if it gets to that stage.

There are some areas of hospital care where we are more likely to be amenable to provide public contracted services like palliative care, which we currently do on our campus. The rate-limiting step for us is providing acute public work in our hospital for a range of reasons. There are medico-political issues with that. It is seen by some people to devalue private medicine if the community becomes accustomed to be able to be treated in a private hospital as a public patient. That is what I would call the real acute care work. From time to time we get requests from government to help them out in areas of elective surgery. In my seven years at Murdoch, that has happened on three or four occasions in some specialty areas. Because we are a busy hospital, we have not done that. Because there are some philosophical differences about whether we should do that, we have not. We do, however, from time to time—and it has happened recently in our intensive care unit over busy winter periods—we accept public patients on behalf of the government, because if people need to be in an ICU they need to be in an ICU. If we have got a bed, we will help them out. We would continue to do that into the future. We would continue also to see that we might have a role in providing a public palliative care contract for government.

[11.00 am]

The CHAIRMAN: Peter, what is your relationship with the Royal Flying Doctor Service? We have just been made aware that workers' compensation and motor vehicle accident patients can be cared for in private hospitals, which would lessen the load on the public hospital system. We have also been made aware that the new jets that the RFDS is bringing on board through additional funding can land at Jandakot in an emergency situation. At the moment Jandakot does not have the runway or facilities for that to be a daily occurrence and those new jets must use Perth airport.

Mr P. ABETZ: It is only one new jet.

The CHAIRMAN: Hopefully, in future, there will be more jets.

Mr Mott: No, because they cannot land in the right places.

The CHAIRMAN: That is what I am saying: they cannot land without permission at Jandakot. I know that the RFDS is involved with the airport development plan. As a private hospital, are you in formal negotiations about the airport—because we are looking at health care needs south of the river—or with the Minister for Health?

Mr Mott: No, we have not had any discussions with the RFDS. However, given what you have said, and I know the CEO of the RFDS fairly well, I shall have a chat with him about it.

Mr P. ABETZ: Part of the issue, which we were made aware of, is that ambulance drivers, when they pick up somebody from the RFDS at Jandakot, automatically go to a public hospital, and they do not ask whether the person has private insurance. They virtually drive past St John of God Hospital Murdoch to go to Royal Perth Hospital or to Charlie Gairdners.

Mr I.C. BLAYNEY: It is the doctor who makes the decision.

Mr Mott: Which doctor is that, Ian—the RFDS doctor?

Mr I.C. BLAYNEY: No, their own doctor.

Mr Mott: Their GP?

The CHAIRMAN: It is not always their GP. Sometimes, as you know, the GPs are involved in patient transfers and sometimes it is an emergency call. When it is an emergency call-out, it is very much left to St John Ambulance, when they pick up the patient.

Mr Mott: As Peter indicated, there is an issue with the St John Ambulance drivers, who are almost on automatic pilot to take those patients through to public hospitals. They will do that because they know it is a fairly reliable system; notwithstanding the stacking and ramping that occurs. Sometimes they feel that if they bring them through to our hospital we might be on bypass—not that we go on bypass very often—or there might not be an orthopod on call, so they take the safest route for them. We are trying to change that. We have had discussions with the CEO of St John Ambulance to try to provide a more reliable service so they can bring those ambulances to Murdoch. But the culture is such, and they have been operating that way for so many years, it does not matter what the CEO and management might say, the drivers will do what they have always done. That has been our experience, even with staff at the hospital, who have tried, through St John Ambulance, to bring their own family members to the hospital and have had resistance. Part of the problem is that our hospital also has to be able to deliver on its promise.

Mr I.C. BLAYNEY: I remember asking an ambulance driver in Geraldton whether he would ever take an emergency case to St John of God Hospital, and he said not unless they specifically said to him, "I want to go to St John".

Mr Mott: Yes. We would like the ambos to ask the patients, if they are able to articulate a response, whether they would like to go to a private hospital or to the public hospital.

Mr P.B. WATSON: If you are really crook you say, "Get me to the closest one!"

Mr Mott: And if you are really crook, the ambulance driver will not ask; they pretty instinctively know that they need to get someone to a public hospital pretty quickly.

Mr P. ABETZ: I was a pastor in Willetton from 1991, and I saw the St John of God Murdoch Hospital being built. I have probably spent more time in that hospital than anybody else here, visiting in many different contexts: maternity, terminal illness, palliative care, the whole lot. I compliment the hospital in that never once has anybody complained to me about the level of care or support given to them as patients. Given that kind of quality of service that you provide, and with the ageing of the population and with more aged people needing that kind of moral support as well as medical treatment, have you envisaged that the reputation of your hospital with its emphasis on holistic care, including spiritual care, will mean a lot more people want to go there? Is that something you have considered with the ageing of the population and the pressures that might be put on your hospital? I am not suggesting that you decrease the level of care to cater for that.

Mr Mott: It would be good pressure, if people wanted to come to us, and our reputation is everything. Thank you for the feedback, Peter. If I think about my time in the public system and the private system and any distinctive differences, we do put a big emphasis on pastoral care; and we

have a big pastoral care unit. But our reputation is everything. The Sisters of St John of God have been around for a hundred years, and they are a pretty smart bunch of women and you would not see too many companies that were around a hundred years ago that are still around today. They are still around today; and we are probably stronger than we have ever been. That is largely because of their focus on their mission. CEOs, like me, who have come from the public sector get it belted into us pretty early about the importance of mission. We do try and live that out in everything that we do. We have a strong set of values. We have a fairly low tolerance of behaviour that is contrary to those values. But we realise that not everyone who comes to work for us, comes necessarily from a religious background. We try and have a set of values that say, regardless of where your spiritual beliefs are, these values ought to be generally subscribed to.

We survey our staff every year through an independent third party, Press Ganey Associates, across the St John of God group, and we compare our staff survey results with over a hundred hospitals around the country. We survey our patients every year, a snapshot in time. We survey our day patients every year. We survey our emergency department patients every year; and that is happening at the moment. And we survey our doctors every year. Part of my role is to try making everybody happy, I guess. That is a pretty hard ask, but we get very good information back and that helps us to continue to find out what we are doing well and what we need to do better. Sometimes we get a result that we do not like, but it allows us to do something about it. I think all of those things help us in terms of the population saying, if I had my choice I would go to a St John of God hospital, rather than somewhere else. I guess that is what we like to hear. People are at their most vulnerable when they come into hospital. We find that through pastoral services and other things, people really enjoy and embrace that part of our mission.

Mr P.B. WATSON: Peter, can I ask about retention of staff? Do you have enough staff capacity? Do you have trouble recruiting?

[11.10 am]

Mr Mott: Not at the moment. We are in the enviable position of having more staff than we need, which is very different to our situation of two years ago. We put a big effort into recruitment and retention, acknowledgement and professional development programs for staff. To me, it is about the acknowledgement of people and providing them with professional development opportunities. People in private hospitals work pretty hard. I could almost be bold enough to say that they sometimes probably work a bit harder than those in the public hospital system where you can get a bit lost. Certainly on the support services side of things in the private hospital system, we work a bit more efficiently.

The other thing we have done is look at our workforce mix. We had a fairly high reliance on agency staff a few years ago, like most private hospitals. We have a very, very low reliance on agency staff now. Only occasionally in our operating theatres and occasionally in our ICU and occasionally in midwifery do we have to call in staff because of peaks in activity. Other than that, we do not have a need for agency staff. Whilst they provide an important stopgap measure, we do not want to have to return to them. We are putting a big emphasis on postgraduate training programs at the moment, for nurses in particular, and for what we call patient care assistants, third-tier workers. We have also broken a bit of new ground recently by introducing a 12-month enrolled nurse program. To be quite frank, that should be the sort of stuff that the health department is doing. The enrolled nurse program is normally run over 18 months. Without diminishing the quality of that program at all, we were able to condense it to 12 months by running the program over five days a week instead of three or four days a week, reducing the length of semester breaks and providing all of the training, both clinical and academic, on the hospital grounds. We have just had 17 enrolled nurses graduate and they are fantastic. They can go on and do transition courses to reach the nursing programs. It is a combination of investment in postgraduate programs, an investment in the undergraduate programs—particularly for us it is the University of Notre Dame, where we get a lot of our nurses,

as well as Edith Cowan University and Curtin University of Technology—and a commitment to their ongoing professional education.

Mr P.B. WATSON: Do you have any nurse practitioners?

Mr Mott: No. It is something that I am interested to explore but it is a sensitive issue, as my former comrades at the AMA would tell me.

The CHAIRMAN: But it will be supported by some members of this committee, as you well know.

Mr Mott: There may well be a role for a nurse practitioner in our emergency department. We certainly have a heavy reliance on senior nursing staff at the hospital after hours. There may well be a role there in the future. We are having a good think about it at the moment.

The CHAIRMAN: I can understand the position that you are in in relation to that.

Mr I.C. BLAYNEY: What is the relative cost to you of having a nurse practitioner versus a doctor?

Mr Mott: Because we have not employed a nurse practitioner to date, I am not 100 per cent sure but I would imagine a nurse practitioner —

Mr I.C. BLAYNEY: I think it is $110 000 a year.

Mr Mott: A doctor in our emergency department, rolled up with all the entitlements, might cost over $250 000 a year. That is not the base salary; that is with all the entitlements rolled up. That is one of the reasons we would be looking at it. If we are getting a bit of pressure at the moment and we are at that cusp of whether we put on another emergency position or whether we might look at another model, particularly when a lot of the issues we have are about streamlining the care, it might be more cost effective, provided it does not diminish patient care at all, for us to look at that nurse practitioner model. It has happened at the Joondalup Health Campus. We will have a look at that.

The CHAIRMAN: Peter, I have previously congratulated you on the EN course that you have just run because there is a need for more registered and enrolled nurses. It is good that you are helping to fill that gap. You mentioned that the statistics show that there is now and there will continue to be a massive growth in population in the south metropolitan area. We all accept the number of people who are ageing and the need for aged care beds, both acute and chronic. You have said that you might build a new medical clinic facing onto the main street. I think you said a couple of years ago that you opened 30 additional medical beds. Are you looking either at Murdoch or possibly somewhere else in the south metropolitan area to bring on board another St John of God hospital because there is a need in many areas?

Mr Mott: We are always looking to see where the population growth might be. We have a look at the take-up of private health insurance, obviously, and we do a bit of investigative work from time to time to see where we might put future hospitals. We also look at where the government is locating hospitals. For example, Midland is an area that has been mooted and more work is being done in Mandurah and Rockingham et cetera. We have an interest in all those areas. We think, increasingly, that where a public hospital will be built, it makes good sense to look at a private hospital close by simply because it is easier to potentially share services and attract doctors. That has been the step we have taken in more recent times. If we think about psychiatry, it is hard to get a private psychiatrist south of the river. Up until now, they have not been all that interested. That will continue in the future.

The CHAIRMAN: Until Fiona Stanley Hospital opens and there are mental beds there.

Mr Mott: Yes, and that will be an absolute magnet. I get calls from doctors from around Australia who have heard about Fiona Stanley Hospital and who are interested in establishing their public and private practice on that campus. I think it will be fantastic.

The CHAIRMAN: This is my last question to you. We are running late, so I am sure members will keep their questions to a minimum. St John's run a drug and alcohol withdrawal network. I believe it is a free program that is supported by nurses and general practitioners. Could you tell us a little more about that program? We do have our other inquiry into problems with alcohol and other illicit drug abuse.

Mr Mott: Unfortunately, I cannot tell you much about the program because it is run through our Subiaco hospital. Dr Shane Kelly would be able to provide a better understanding of it. All I know is that our social outreach program provides funds for that service. I think a similar service is run through Bunbury Regional Hospital.

The CHAIRMAN: Could you ask Shane to give us a summary of that service so that when we are looking at our other review, we have some details?

Mr Mott: I would be more than happy to do that.

The CHAIRMAN: As there are no further questions, is there anything you would like to flag with us before I formally close the session? We appreciate you coming here today.

Mr Mott: The only point that I might make to this committee is that we touched a bit on what is happening with the medical and nursing workforce now and into the future. One of the things that is a bit frustrating at the moment is that we provide opportunities for training of junior doctors, largely interns, and there seems to be an inconsistent approach in Western Australia to the funding of those intern positions.

[11.20 am]

The CHAIRMAN: Do you mean clinical placements?

Mr Mott: Yes, clinical placements. We built facilities at Murdoch based on discussions with successive governments to try to help with the training of interns. Sixty-four per cent of all elective surgery happens in private hospitals. Interns—junior doctors—get a breadth of experience in a private hospital that they otherwise would not get in a public hospital. In more recent times, the public hospital system has started to charge us for having those interns on our campus. We provide the facility. In 2005 we spent $2.5 million on an education and training centre—auditorium, meeting rooms, lecture theatres et cetera. Our doctors provide their time to supervise those doctors free of charge. There is an inconsistent approach in Western Australia at the moment, which I understand is different from other parts of Australia, where the private system is being asked to fund those intern places. It is a service that we are happy to provide and we would like to provide into the future. But between 2002 and 2012, through medical schools throughout Australia, there will be a huge increase in the number of medical students graduating—something like 3 000. I do not think the public system will be able to cope with the demand of providing suitable training for all those junior staff.

One of the things that we certainly like to see is a consistent government approach. My guess is that because of the pressure that the public hospital CEOs might find themselves under with respect to budgets, perhaps they are looking at us paying for those positions. We have just advised Fremantle Hospital that we will not be accepting an intern place from here on if we are expected to both pay for the position that the hospital should be funding—and I think that comes from the federal government—and provide all of the infrastructure support, which we have been happy to do until now. We do this because it is in our best interests, from a self-interest point of view, to help doctors come through the system in the future. The extent to which we are being asked to subsidise those services is beyond what is reasonable. It might be worth having a look at what happens in other parts of Australia. From the contacts I have in other parts of Australia, the private system is not expected to fund the salaries of those interns while they are being supervised in the private system.

The CHAIRMAN: Who at Notre Dame has overall responsibility for that area if we wanted to find out some more information?

Mr Mott: It is not from Notre Dame.

The CHAIRMAN: Notre Dame is trying to find clinical placements, so it would have all the statistics of what is happening if we wanted to follow up on that.

Mr Mott: We accept second and third-year students from Notre Dame through the postgraduate medical program. That works very well. We have 15 students at any one time. These are interns who have finished their medical training who are in the public hospital system in their internship and being rotated through the system.

The CHAIRMAN: Does that funding come through the health department?

Mr Mott: It comes through Fremantle.

The CHAIRMAN: It comes through Fremantle for you?

Mr Mott: The medical administration unit at Fremantle Hospital organises the rotations. It is saying to us that we will have to pay for these interns in the future.

Mr P. ABETZ: So you have to pay their salaries while they are with you?

Mr Mott: On rotation from the public hospital to us. We are providing the service. Our surgeons and others often work between Fremantle and Murdoch. It would be the same between Royal Perth and Subiaco hospitals. They enjoy the fact that they can provide some tuition, guidance and supervision for students. It is in their interests as well. It is only a recent phenomenon that we have been asked to pay their salaries.

The CHAIRMAN: This is across the board. If some of Royal Perth's junior doctors are going to St John of God Subiaco, are they also asking for the same —

Mr Mott: My understanding is that a few years ago Subiaco refused to continue taking interns on that basis.

The CHAIRMAN: So it is no longer taking interns?

Mr Mott: No. Subiaco employs a few registered medical officers rather than take the interns. The interns provide some service coverage for those consultants in rounds et cetera. I can see the pendulum swinging one way. The government needs to be a little careful. If it comes back in the future and says to the private hospitals, "We'd like you to take some students", with the massive influx of medical students graduating in the next three years, it would be a bit short-sighted in a difficult budget year to be saying, "You've got to pay for them but we'd like a bit of goodwill down the track."

The CHAIRMAN: Thank you for making us aware of that issue. Thank you for your evidence before 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 added 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. Thank you once again. I am sorry we kept you waiting at the start.

Hearing concluded at 11.25 am