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, 1 SEPTEMBER 2009

SESSION EIGHT

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 4.11 pm

ENGLAND, MR GARRY DAMIAN
Chief Executive, Mercy Hospital Mount Lawley
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 the review of Western Australia's current and future hospital and community healthcare services. You have been provided with a copy of the committee's specific terms of reference.

At this stage I will introduce myself, Janet Woollard, and the other members of the committee present today: Mr Peter Abetz, Ms Lisa Baker and Mr Ian Blayney.

This committee is a committee of the Legislative Assembly and 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. As a public hearing, Hansard staff are 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 questions we have for you today, I need to ask you a series of questions.

Have you completed the "Details of Witness" form?
Mr England: Yes, I have.

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

Mr England: Yes, I do.

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

Mr England: Yes.

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

Mr England: No.

The CHAIRMAN: Would you please state your full name and the capacity in which you appear before the committee today?

Mr England: Garry Damian England, and I am a chief executive of Mercy Hospital Mount Lawley.

[4.15 pm]

The CHAIRMAN: This committee is looking for compliance with the Reid report and identifying any needs and gaps in services both in acute care, secondary level and community care services, and then considering the ramifications of the Royal Perth Hospital Protection Bill 2008. The committee is particularly interested in concerns that have been expressed that people are taking up funding, through private health insurance, in the public hospital system and the ramifications of that; and, if you identify any gaps, whether there are any future public-private partnerships. The committee would be happy, as you give your presentation, if we can interject and clarify points.

Mr England: It is over to me then. I was hoping that you would not do that! I will start by giving the committee an understanding of my background. I have just left the public health system after something like 33 years. I am not sure of actual numbers, but probably 23 or 24 years at Royal

Perth Hospital, and then I went out to the secondary hospitals of Perth and have been the general manager of Kalamunda, Rockingham, Bentley, Swan Districts and Rockingham.

The CHAIRMAN: You really can give us an overview.

Mr England: I have done the rounds. Three years ago I left the public sector and took up the appointment at Mercy Hospital. On the issue of the Reid report, I will start by saying that significant progress is being made but the timelines that have been set in the plan are falling well behind. There is still significant debate about whether some of the plans or proposals in the Reid report have been concluded or whether a lot remains to be resolved. I have a particular interest in that the Mercy Hospital has a government contract for the provision of rehabilitation and restorative care and it also has a contract for elderly mental health inpatient services. We have a very good relationship with Royal Perth Hospital. Although the contract is with the Department of Health and the government, we actually operationalise through Royal Perth Hospital. The very obvious issue to us is that the occupancy of our units is something like 99.5 per cent all the time —

Mr P. ABETZ: In your private hospital?

Mr England: — for the restorative patients that we have belonging to Royal Perth Hospital. The elderly mental health secure unit and the restorative care unit both operate at 99 per cent occupancy.

The CHAIRMAN: The presentation that was made by the Australian Medical Association to this committee last week indicated that the ideal bed capacity is 85 per cent and that our tertiary and secondary hospitals are way over that bed capacity, and that is why they are struggling.

Mr England: The point I am making is that occupancy is good for us, because we get paid based on that occupancy. From a private hospital's perspective that does not give us any concern. As soon as a patient is discharged, it is back to another patient. The obvious thing that comes out of that is what about the patients that cannot get admitted to the restorative unit? That is because the length of stay for those restorative patients would be on average 30 days and in our view a significant number of patients who are sitting in the public system are crying out for rehabilitation in a rehabilitation environment and they cannot get it. They are sitting in an acute bed and missing out on that opportunity. In my view, if a patient who has had an acute episode does not get into the rehabilitation phase within a certain time parameter they lose the capacity to rehabilitate that patient back into the community, so the effect is detrimental to the patient.

The CHAIRMAN: Is that mainly rehabilitation from stroke?

Mr England: There are be a number of morbidities, but that would be a good example, whereby they have had an acute stroke episode—or there are any number of complications requiring rehabilitation.

The CHAIRMAN: In that case, all the evidence points to the fact that rehabilitation is meant to start from day one or day two for those patients, and the sooner it is introduced the more likely their chance of regaining some of their previous bodily functions.

[4.20 pm]

Mr England: And get them back into the community, not into a nursing home. If you can rehabilitate them, you have got a higher chance of getting them back into their previous place of residence; but if you cannot, that makes the job much harder. Then, of course, if they are not able to be rehabilitated because you have missed that window of opportunity, you have another set of issues of trying to find a placement in a nursing home. I am sure you have had other presenters talk about the issues of getting into a nursing home.

The North Metropolitan Area Health Service's "Clinical Services Plan" makes reference to constructing an additional 12 beds at Mercy Hospital by about 2015, from memory. We have not had a single discussion about that to date. It is written in their —

The CHAIRMAN: Is that with the old and the new government?

Mr England: I am only aware of a clinical plan for the north metropolitan area. Regardless of government, it was a plan that was produced 18 months ago. It said where beds were to be built within the north metro. Discussions have not taken place. The funny complication in all this is that our relationship is with Royal Perth Hospital, which is in the South Metropolitan Area Health Service, but the North Metropolitan Area Health Service is the one that is developing the plan for our future. It is a little bit disjointed, from our perspective.

The CHAIRMAN: There have been several questions as to why Royal Perth fits under the south metropolitan region rather than under the north metropolitan region.

Mr England: That has been challenged since day one. I understand that the reason for that is all about wanting to link it to Fiona Stanley and making sure that if it was sitting in another region—the opportunity to get discussions going and shift the planning and shift the resources would be harder to achieve if they were in a different region, so coming under the same parent makes it easier to achieve.

The CHAIRMAN: It is going to assist the transition.

Mr England: Correct.

The CHAIRMAN: In relation to the report that you just mentioned from the north metropolitan region, is that available on the internet, or are you able to provide us, by way of supplementary information, with a copy of that review?

Mr England: Certainly at our hospital, we received a copy of it from the planning people in the north metropolitan area.

The CHAIRMAN: Can you provide us with a copy of that by way of supplementary information?

Mr England: Certainly. My view is that, from a rehabilitation perspective, there are patients sitting inside Royal Perth Hospital who would be better served in a rehabilitation environment rather than an acute environment. The limitations are the clinical doctors—not enough specialist geriatricians to provide that care—and the financial aspects.

The CHAIRMAN: Also, are those patients not on isolated wards and therefore the staff are not focused on rehabilitation, whereas in a dedicated rehabilitation unit the focus is on rehabilitation?

Mr England: Last year Mercy Hospital was approached by Royal Perth Hospital. Because Royal Perth Hospital was under significant stress, Royal Perth approached us to buy some beds in our private hospital for the purpose of providing restorative care. Basically, it would be an overflow from our existing restorative unit, managed by the same specialists. We established that service and it operated for approximately five months. Then, for financial reasons, it was ceased. Even though there was a contract in place, it was seen as something that could no longer be —

The CHAIRMAN: This was before the three per cent efficiency dividend?

Mr England: It was part of it.

The CHAIRMAN: Part of the three per cent?

Mr England: Yes. It was not presented to us in any shape of saying that it was part of the three per cent dividend; it was just presented to us "for financial reasons". The plan was that we would start off with six patients, increase to 10, increase to 15, and that would be connected to our restorative unit. What it demonstrated to us in evidence was that there were patients there who needed that care. We were required to turn those patients over quite well.

The point that I probably have not made clearly is that the doctors who service our restorative unit and our mental health unit are actually government doctors; they are Royal Perth Hospital doctors. We provide everything else; they provide the doctors. There is very much continuity of care. We experienced that as saying that we put out our ability to assist in that for mutual benefit, but it was withdrawn—frustrating.

Mr P. ABETZ: So it was not for lack of demand?

Mr England: The demand is there. My view is that if you had a look at the patient profile in Royal Perth Hospital now, or even Sir Charles Gairdner and Fremantle, you would find a number of elderly patients who would be suitable for a rehabilitation environment and who cannot get into the rehabilitation environment.

The CHAIRMAN: Not just in those hospitals, but also in many of the other secondary hospitals there are patients who really need to be transferred to a rehabilitative environment.

Mr England: Yes. The other issue that we find very frustrating, I suppose, is that one of the objectives of the Reid report was to increase private patient revenue, but that comes at the expense of private hospitals, because many of those patients would otherwise be treated in a private hospital environment. While they are sitting in a government-funded bed and the hospital is collecting revenue for those patients, they could just as well be treated in a private hospital. There are two reasons for that. One is that it is seen as revenue raising for the government hospital, but actually it is in conflict. There are a number of objectives that are in conflict. Delivering patient care and putting as many patients as possible through the hospital, delivering on waiting lists, removing ED blockages et cetera, but then, on the other hand, encouraging private patient admissions is a little bit contradictory, and one that certainly the private health insurance funds are not happy with. Certainly, we see that that is a market that could potentially be transferred to the private sector.

The CHAIRMAN: You are saying that some of the tertiary hospitals are billing the private health funds for the patients who have private health insurance and who would otherwise be cared for in the private hospitals if they had not been admitted?

Mr England: Could otherwise be treated.

The CHAIRMAN: Who could otherwise be treated.

Mr England: Yes, that is correct.

The CHAIRMAN: Do you have any idea, in terms of the statistics, of the figures for those?

Mr England: It would be wrong of me to say that, but I will say it is fairly significant—the revenue is fairly significant. That does not mean that every patient would go to a private hospital. A lot of the private hospitals are unable to provide certain types of tertiary care, but there are other types of care so that the patients could easily be treated in a private hospital environment.

The CHAIRMAN: We have actually discussed this with earlier people who presented to the committee. We are aware that there are many patients who have private health insurance and who are very upset that they are within the public hospital system receiving care, and have great difficulty trying to get out of the public hospital system, but they are not given that opportunity. With the increasing pressures on the public hospital system, we are looking to see what strategies can be used to encourage those people who have private health insurance, wherever possible, to use the private healthcare providers.

[4.30 pm]

Mr England: As I said, the Reid report encourages the collection of private patient revenue. So while it is good for the government, it is not necessarily good for the system. I am sure HBF could very easily tell you the amount of money that it is paying over to the government for that. The other thing is that the health funds will pay—I will use these rough figures—$250 a day to a privately insured government patient.

The CHAIRMAN: In tertiary or secondary?

Mr England: It is the same fee. But they would be paying a lot higher fee if that patient was in a private hospital.

The CHAIRMAN: Double or quadruple?

Mr England: Probably two and a half times.

Mr P. ABETZ: The health funds would be paying two and a half times as much?

The CHAIRMAN: If the patient was in a private hospital.

Mr England: Because their figures are set, you see.

Mr P. ABETZ: I understood you to say before that the health funds are unhappy —

Mr England: They are.

Mr P. ABETZ: — about private patients being in the public hospital system, yet it is actually cheaper for the health fund.

Mr England: Yes, that is correct.

Mr P. ABETZ: That is interesting.

Mr England: Because people pay to get private health insurance for the opportunity of using that private health insurance in a private environment—private room and all the facilities, doctor of choice, et cetera—but in the tertiary system they are paid far less, and certainly the health funds are not happy about that.

The CHAIRMAN: The difference is that if they are admitted to the public hospital system, even though they have private health insurance, they do not have their choice of specialist caring for them—it is whoever they are admitted to under the system—whereas if they go to a private hospital, they are involved in the choice.

Mr England: That is correct. So there are contradictory objectives, in my view, because the tertiary hospitals are under so much pressure to address waiting lists, ED blockages, et cetera, yet there is an incentive to bring in privately insured patients when those patients could be treated in another environment.

The CHAIRMAN: The Under Treasurer, Tim Marney, was not able to come to a committee hearing last week, but hopefully he will be coming to a committee hearing in the near future. It would be interesting to ask him for the statistics about how much of the income of the various public hospitals is derived from private patients. There has been some discussion as well, in terms of the clinical services framework, about what services are going to be provided at Royal Perth and whether these services are going to be public or whether there is going to be a public-private mix. We will certainly need to look at that very carefully when that framework is tabled.

Mr England: Perhaps the first part of that question is revenue, and the second is numbers, because the revenue will not give you a good indication of the numbers.

The CHAIRMAN: Right. So for beds, the average number of patients over the year —

Mr P. ABETZ: Bed days.

Mr England: Bed days of patients using private health insurance in public hospitals.

The CHAIRMAN: So total bed days in public hospitals and total bed days in private hospitals?

Mr England: Yes, and the revenue that that generates.

The CHAIRMAN: And the total of those bed days for the public versus private mix, and then the revenue that is generated from the private bed occupancy?

Mr England: Yes. You possibly do not even need to explore too deeply the ratio of public to private. It is just the fact of how many private bed days are in a public hospital setting. From that, you can get a good feel of the potential opportunity to shift some of that. As I said, that does not mean you can shift all of it, but there is some that can certainly be shifted.

Mr P. ABETZ: One of the earlier submissions talked about the fact that it would be beneficial to shift—to actually divert—as many of the privately insured people as possible from the public

hospitals. So the ambulance would take them directly to a private hospital, if they had private health insurance and if that was an appropriate clinical place for them to go, so that they did not clog up the system. It seems crazy that we have the ramping at public hospitals and spare capacity in the private hospital sector, when some of the people who are being ramped are privately insured and could be at these private hospitals. It just seems to be a crazy lack of coordination.

The CHAIRMAN: Yes, or even if not at that level, at the level where they are assessed to ensure that if they do not require a specific service that is available only at that tertiary hospital, they are not admitted to that public hospital but are transferred to a private hospital.

Mr England: Even if there was a triaging system at the public hospital, and they could then be immediately directed to a private hospital. You need to remember, however, that not all private hospitals have emergency departments; there is only one. Many private hospitals have doctors on call 24 hours a day to receive patients under their respective specialities, and there is not a problem in doing that.

We also see that there is opportunity for other parts of the public sector to be serviced in a private hospital environment at no expense. That relates to motor vehicle accident patients and workers' compensation patients. They also could be very easily managed in a private hospital setting, but, again, they are managed generally in a tertiary setting. Private hospitals readily take those patients without any concern whatsoever.

The CHAIRMAN: Sorry. Could you clarify that again?

Mr England: I am talking about motor vehicle accident and workers' compensation patients. For example, a person may have suffered an injury—whether it be orthopaedic, plastics, or whatever—in a mining accident, and that patient will come to Royal Perth Hospital and be treated in that public hospital. That patient could be treated in a private hospital setting in exactly the same way.

The CHAIRMAN: So are you saying that for the services that are provided by the Royal Flying Doctor Service, there could be some sort of triage or assessment when the patient arrives in Perth, and then a determination could be made as to whether the patient has private health insurance —

Mr England: The patient does not need to have private health insurance. It comes under workers' compensation. In my view, that is another opportunity whereby the cooperation between the public and private hospitals could be enhanced.

Mr I.C. BLAYNEY: If the injury is pretty serious, obviously the person is going to be admitted straight to RPH, or whatever. However, if the person has private health insurance and is treated in a private hospital, is there not the problem that the private fund may have placed a cap on the amount of money the person is allowed to claim, and also that there may be gap payments for specialists and things like that?

Mr England: I was referring to workers' compensation in the example I just gave, where the patient incurs no cost. It is the insurer that incurs the cost.

Mr I.C. BLAYNEY: So the insurers would be happy enough about that?

Mr England: Absolutely.

The CHAIRMAN: So it should be up to the patients to choose where they go?

Mr England: Not necessarily. With workers' compensation I do not think is up to the patients.

The CHAIRMAN: No. I am saying for motor vehicle accidents, if the person has private health insurance —

Mr P. ABETZ: It does not matter, because the motor vehicle compensation insurance would cut in—the third party insurance. It has nothing to do with whether the person has private insurance or not. That is the point Garry is making.

The CHAIRMAN: So in both those cases they do not need to have private insurance—they could still go to the private hospital sector?

Mr England: That is right.

Mr I.C. BLAYNEY: But would the bills to the insurance company be the same?

[4.40 pm]

Mr England: No. The bills would be different. The bills to the insurer for the workers' comp would be greater in a private hospital setting.

The one with MVIT—it is not call MVIT now; it has another name—has a contract with the government at a set price, but it does not have contracts with the private hospitals. I am saying they could have contracts under MVIT. We trialled it at Mercy with plastic surgeons at Royal Perth Hospital, and we received an in-principle agreement for that to happen, and it did happen for a short period. One of the problems is, particularly on weekends—I will use Royal Perth Hospital—it is hard to get into surgery because accident trauma is the priority. When a person comes in with a wound that requires going into a theatre or requires plastic surgery, it is put very much at the back of the priority, so that patient is generally not likely to get into theatre on the weekend and will have to wait until later to get into theatre. I am saying that those patients can be —

The CHAIRMAN: Can go to theatre straight away if they go to a private hospital.

Mr England: Correct. Most of the private hospitals have theatre staff on call 24/7. Generally a specialist at Royal Perth Hospital works in the private setting as well. All he or she has to do is take that patient to the private hospital and perform that same surgery at the private hospital.

The CHAIRMAN: The number of patients who had their surgery cancelled repeatedly may decrease if the waiting lists —

Mr P. ABETZ: There would be a cost saving would there not? Rather than taking up a hospital bed for two days waiting for surgery they would be operated on straightaway?

Mr England: Correct.

Mr P. ABETZ: Plus there would be some clinically better outcomes for being dealt with immediately.

Mr England: Correct.

Mr P. ABETZ: They seem to be silly for not doing it.

Mr England: There are competing forces in health. I am sure you will recognise them as we continue. What I said about workers compensation can be easily done. What I said about motor vehicle is a bit more complex, but can be done. Certainly, with private health insurance patients there is no reason it cannot be done.

The CHAIRMAN: I am hoping that possibly some of the obstacles that may have been there in the past may not be there. I think the current minister is very keen on decreasing the waiting lists. Again, as we said earlier, whilst the former government was keen on that also, as a committee we are becoming aware of many problems?

Mr England: It is very complex.

The CHAIRMAN: Merely this presentation and possibly recommendations flagging where the issues are and where some cost savings can be met will, hopefully, be taken up by the minister.

Mr England: There is certainly capacity in a number of private hospitals in Perth. Specifically, Mercy Hospital, which has large capacity, is an underutilised hospital. It was referenced earlier that, the potential changes in private health insurance rebates will impact on the number of people continuing to use their private health insurance. If the change in rebate comes into effect, it is our understanding that its impact will probably not really occur until the following tax year when

people complete their tax returns and realise they will no longer get their rebate. They will say, "Hang on, I might reconsider my private health insurance." Of course, with the economy as it is at the moment, there are also stresses which, in our view, make people think seriously about the continuation of their private health insurance. That is having an impact on private hospitals. Capacity for growth will not happen under the private market at this point.

Mr I.C. BLAYNEY: Our private hospital in Geraldton closed its emergency department because it brought in a rule that it literally had to have a doctor on the premises 24 hours a day to have an emergency department. Would that be the case?

Mr England: I would say that would be sound management.

Mr I.C. BLAYNEY: It is a town. There is probably a doctor five minutes away at all times. But as a result of that rule, it shut its emergency department. It had to pay to use it anyway. There is a section of the population that is quite happy to pay. Because of that technicality it had to close it. That has pushed everybody into the emergency department of the government hospital, which does not really make a lot of sense does it?

Mr England: There are all these forces that occur in health. It is very complex.

The other thing that occurs is that health very much dictates a lot of what occurs in the private sector without reference to the private sector. I will use wages and conditions of employment as a classic example. A decision will be made to pay the nurses an increase of X amount. If the private hospitals do not match that X amount, the nurses will say, "I can get better conditions elsewhere and I'm leaving." Many times the private hospitals cannot afford those increases, particularly the not-for-profit hospitals. I stress that it is a knock-on effect, without due consideration for the consequences. If we look at health beyond just public health, its effect is significant. We suffer with that greatly.

The CHAIRMAN: I, for one, certainly would not support no increase in wages. I would support instead that we invest more in healthcare services. If we do not pay the staff salaries we will not attract staff here. We are already poaching nurses, doctors allied health professionals from other countries. Some of those other countries cannot afford to lose those healthcare professionals.

Mr England: That is correct. I have no qualms whatsoever about what you are saying. The point I am making is that state determinations have a ripple effect without due consideration for the consequences in the private market. If there was a mechanism for that consultation to occur, recognising the wider ramifications certainly would enhance the system.

The next issue I would like to mention is Royal Perth Hospital and its future. Royal Perth Hospital is located something like three kilometres from Mercy Hospital in Mt Lawley. Many of its doctors work at both Royal Perth Hospital and Swan District Hospital. We are stuck in the middle. Again, the impact of what will happen in the public sector will determine our future, if we have a future. It may determine that Mercy Hospital does not have a future under one of those changes. If the new Midland health campus is determined to have private beds or is a co-located facility, and another private hospital organisation goes out there, because its tender is successful, in effect that will see Mercy Hospital no longer being viable.

The reason is that Mercy Hospital's catchment is drained from the east. So if private beds are to be built out there, that is the potential risk that will occur. The likelihood of a private hospital being built is in my view very slim, but an arrangement where there would be private beds out there in whatever shape will force or have a flow-on effect, a rippling effect, also.

[4.50 pm]

The CHAIRMAN: But I do not think that was a recommendation from Reid, that there be a public-private mix.

Mr England: No, but that is where it is heading.

The CHAIRMAN: That is where you think it is heading at the moment.

Mr England: Correct; that is where I think it is heading. It is a bit like, if you could use the example of a balloon, there are only so many private patients in Perth, and you push one area in and you blow the other area out. You are not adding to the balloon, and that is the effect. So it will only cause patients to move there, with the consequence of this having an effect here. So we are very concerned about that, from a provider's perspective, and to date we have seen a number of different scenarios being floated. We are not sure where it is heading.

Mr P. ABETZ: How many beds does Mercy Hospital have? Excuse my ignorance.

Mr England: We are licensed for 244 private beds, and the occupancy in some areas is as low as 50; and, as I have said, in the public aspects it is up to nearly 100. We also provide community services for the government as well, community restorative care, and I think it is 6 500, or a number like that

Mr P. ABETZ: Those are ones that are fully utilised all the time.

Mr England: Yes, the beds are there. I am not sure whether that is all.

Mr P. ABETZ: Coming back to the restorative care—I am not sure whether I have it jotted down—there are X number of beds. Royal Perth Hospital or the government contracts you to provide them for 99.5 per cent of the time. Royal Perth Hospital has major accommodation problems, and until Fiona Stanley Hospital is up and running, that is going to continue to be the case. How many beds could be freed up in Royal Perth if more restorative beds were purchased out of your spare capacity at Mercy?

Mr England: I suppose we would be in a position without any stress to lease something like 25 beds.

Mr P. ABETZ: Which would make a significant difference to bed availability in Royal Perth.

Mr England: Correct.

Ms L.L. BAKER: Very interesting; thank you again.

The CHAIRMAN: Garry, thank you for giving us a very comprehensive picture of not so much the needs and the gaps, but I guess the consequences of the decisions that are being made in terms of the structure of healthcare services over the next few years. You have given us suggestions as to recommendations that we could make to relieve some of the pressures that we currently have on the public hospital system. It has been very useful for us as committee members. We will be sending you a copy of the transcript. If, when you get that copy and you have a chance to look through it, you think you did not mention such and such, then we are quite happy to receive that with your transcript by way of supplementary information, because it has been very useful. So we 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 by 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. Once again, thank you very much.

Mr England: Thank you.

Hearing concluded at 4.55 pm