LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON PUBLIC ACCOUNTS

(Reference: Auditor-General's report No 8 of 2004: waiting lists for elective surgery and medical treatment)

Members:

MR R MULCAHY (The Chair)
DR D FOSKEY (The Deputy Chair)
MS K MACDONALD

TRANSCRIPT OF EVIDENCE

CANBERRA

WEDNESDAY, 27 APRIL 2005

Acting Secretary to the committee:
Ms R Jaffray (Ph: 6205 0199)

By authority of the Legislative Assembly for the Australian Capital Territory

Submissions, answers to questions on notice and other documents relevant to this inquiry which have been authorised for publication by the committee may be obtained from the committee office of the Legislative Assembly (Ph: 6205 0127).

The committee met at 2.02 pm.

SIMON CORBELL,

TONY SHERBON and

MARK CORMACK

were called.

THE CHAIR: I commence proceedings by welcoming the members of the committee and the witnesses to these proceedings. By way of formal commencement, I advise you that you should understand that these hearings are legal proceedings of the Legislative Assembly, protected by parliamentary privilege. That gives you certain protections but also certain responsibilities. It means that you are protected from certain legal action, such as being sued for defamation, for what you say at this public hearing. It also means that you have a responsibility to tell the committee the truth. Giving false or misleading evidence will be treated by the Assembly as a serious matter. I would ask witnesses, when first giving evidence, to state their name and the capacity in which they appear for the purpose of assisting Hansard.

I welcome to this inquiry the Minister for Health, his officials, other members of the committee and Mr Smyth. Minister, before we invite questions in relation to the Auditor-General's report, I formally propose that we authorise for publication, pursuant to standing order 243, the government's response in relation to the Auditor-General's report No 8. There being no objection, that is approved and considered to be so authorised. Minister, would you like to make some opening remarks in relation to this particular inquiry before we invite questions?

Mr Corbell: Yes, thank you, Mr Chairman and thank you for the opportunity to be here today. I will only make some brief comments because I think our time is probably best served through questions and discussion around that. But I would like to make some general comments and observations about the performance of elective surgery activity in Canberra's public hospital systems.

The first point I would make is that the level of demand that we continue to see for elective surgery is unprecedented and significant levels of growth have occurred in a whole range of areas. Our system continues to work hard to address those areas but clearly, as with all other public hospitals around the country, access to elective surgery and management of elective surgery is a key area where all systems are facing considerable pressure. The ACT is no different in that regard.

It is, I think, worth putting on the record what the government has done in terms of funding to improve access to elective surgery since it has been in office. If we look at each of the financial years from 2002 onwards, the government has consistently increased the level of funding which is available for elective surgery. In 2002, the government applied an additional $500,000 to additional joint surgery. In 2003-04, an additional $2 million was put into the budget and there was an additional special funding of another $1 million in the same financial year. In 2004-05, the budget appropriated an additional $2,050,000, additional special funding of $1,025,000, and then a new

appropriation of another $1 million. That has continued through 2005-06 and will continue through 2006-07 and 2007-08.

If you look at the total that the government has committed for additional elective surgery in terms of resources, it comes to over $20 million extra put into funding for elective surgery. That is a significant level of commitment in terms of resourcing. That said, we have continued to focus on areas where we do see long waits in categories 2 and 3. Our performances with category 1 patients are, I believe, very strong. Whilst they are not perfect, we do see our system responding in a timely and effective way in dealing with category 1 cases.

Category 2 and category 3 long waits remain an area of considerable concern and the government and the department will be continuing to work closely on targeting those areas. As I have already highlighted, some of the additional appropriations that have been made have focused on long waits in particular specialities, particularly eye surgery and joint surgery, where we know there are particularly high levels of long waits.

To give the committee an idea of the total surgical activity to 31 March this year, 75 per cent of the current financial year, let us look at a range of groups. In ophthalmology, our targeted throughput in cost-weighted separations is 525. We are 73 per cent completed three-quarters of the way through the financial year. Orthopaedics, 1,804 cost-weighted separations; we are 69 per cent completed. Urology, 305 cost-weighted separations; we are 87 per cent completed. Ear, nose and throat surgery, 90 cost-weighted separations; we are 73 per cent completed. General surgery, 1,468 cost-weighted separations; we are 85 per cent completed. Gynaecology, 402 cost-weighted separations; we are 81 per cent completed. That gives you a bit of an idea of how we are tracking this financial year in terms of the key areas of surgical activity and what steps we are taking to make sure we are on target to meet our targeted throughputs.

The government will be continuing to focus strongly on elective surgery. That is a matter which has been subject to budget deliberation and I am sure members will see the outcomes of that when the budget is released next week. I can also flag that the government will also be focusing on other areas of systems within public hospitals to make sure that operation of our theatres is as efficient as it can be to ensure that we are able to maximise the throughput in our public hospitals. Mr Chairman, that is really just a very general overview statement, but I am very happy to take questions and I and all my officials are happy to tackle those as best we can.

THE CHAIR: Thanks, minister, I appreciate the outline you have provided. I will commence the questions, if I may. On the broader issue of waiting lists, the March 2005 list would have been due out on 21 April, as the custom and practice. Could you indicate where they are or what has been the delay this month?

Mr Corbell: There is no set date for the release of waiting lists. Waiting lists are released on a monthly basis and that is no different this month; they will be released.

THE CHAIR: Do you have any idea when, minister?

Mr Corbell: I haven't yet seen the documentation. Once I see the documentation and

sign it off, I release it. But I want to put to bed a bit of a myth that is perpetuated around the place that there is a set date on which waiting list figures are released for the month. There is no set date, but the government releases them on a monthly basis. That is what I have done since I have been the minister and that is the approach we are currently adopting.

MR SMYTH: Minister, at the health annual report hearings last week, if I remember rightly, you told the committee that it was on your desk. Has it not progressed off your desk in the last week?

Mr Corbell: I don't think I said that, Mr Smyth. I am happy to check *Hansard*, but I think I said, if I recall correctly, that I hadn't seen them. I haven't seen them. Once I have seen that brief, read it and signed it off, it will be released in the normal way.

THE CHAIR: There is no indication Dr Sherbon could give us in terms of when they might be forthcoming?

Mr Corbell: The figures will be released on a monthly basis. That is what happens; they are released on a monthly basis and that is what we will do.

THE CHAIR: Just looking at the monthly average for patients treated, minister, in your opening remarks you spoke about significant growth in a number of areas. I think your words were that there were significant levels of growth in a number of areas, which you cited as pressures on the system. If you look at the monthly average for patients treated, defined as patients removed from lists after admission for elective surgery, to reflect back over the past five years, there were 714 in 2000, 689 in 2001, 646 in 2002, 658 in 2003, 706 in 2004 and 674 in February 2005. It seems to be virtually a static performance, minister. I was just wondering whether there is a reason why these figures which have come from your monthly waiting list data sets remain in such a state?

Mr Corbell: I think the point that needs to be made on this, Mr Chairman, is that, whilst the number of people is decreasing, the complexity and therefore the time taken to complete operations is going up. So the acuity or the complexity of conditions is increasing. That means procedures take longer, they take more time, and that is what is driving that change.

THE CHAIR: Are you saying that, even though these figures have remained virtually unchanged and the waiting lists have grown, really it is because the patients coming in are requiring more complex procedures, minister? Is that the explanation that you are offering?

Mr Corbell: Yes, that is what I am saying, and that is the case across all parts of our health system. It is not unique to the ACT, either. We are seeing increased acuity and complexity of cases in our public health system, whether that is in elective surgery or that is in people who are presenting through our emergency departments. There is an increase in the number of older people with more complex conditions presenting in our health system and that, quite frankly, is driven by the demographic change in our community. With a rapidly ageing population, we are seeing more older people presenting to our health system with a need for care and the management of their conditions is more complex and more time-consuming. It is also worth making the point

that endoscopy procedures have moved from inpatient to outpatient in terms of their categorisation, and that also affects the figures that you are quoting, Mr Chairman, as well.

THE CHAIR: If you look at the waiting lists as they have tracked—I am going right back to 2000, when the figure was, according to the records here, 4,002—by and large the figure has continued to climb up to 5,057. Obviously, we will be watching with interest the March figures. It seems that, as those lists grow, the number of patients treated is static. You speak in terms of $20 million being spent over a period of time. What are you projecting as going to be the scenario from here on out? It seems to me that, if we continue on this basis, we are going to continue to get larger and larger lists of patients waiting for treatment without actually making any further headway. What do you project is going to happen for the remainder of 2005 in the Canberra community?

Mr Corbell: For the remainder of 2005, it will depend very much on the range of measures which the government is putting in place. As I have indicated, there is a range of additional resources being applied. We will also be focusing, as I have indicated, on system improvements in terms of the management of theatres and other systems within the hospitals to make sure that they work as efficiently as possible. My view, though, would have to be that we will probably see a reasonably stable position in terms of waiting lists in the foreseeable future, certainly for the remainder of the 2004-05 financial year. I do not expect to see any dramatic change in the position of the waiting lists in 2004-05.

Can I just take you through the change in the waiting lists in each of the years from 2000-01 to 2004-05. This, I think, highlights my point that, despite extra resources, the complexity of cases and the change in some of the ways that people are receiving treatment—that is, as outpatients rather than inpatients—is seeing the figures remain relatively constant. For example, in 2000-01 the net change in the waiting list was an additional 430 people. In 2001-02 there was a real decrease of 263 people. In 2002-03 there was a net increase of 234 people. In 2003-04 there was a net increase of 198 people. In 2004-05, up until the end of March, there has been a net increase of 314 people.

As you can see, the additions and the overall growth in the list are remaining reasonably constant. That, to me, sends a signal that it is the increasing complexity of cases that is leading to a need for additional resources in terms of costs without necessarily seeing a real decrease in the total number of people on the lists. Perhaps it is worth making the point that in 2001-02, 7,946 people were removed from the list because they had their surgery undertaken; in 2002-03, 7,488 people were removed from the list because they had their surgery undertaken; and in 2003-04, 8,435 people were removed from the list because they had their surgery undertaken. So far this financial year, 5,932 people have been removed from the list because they had their surgery undertaken.

When you take into account removals for other reasons—that is, surgery undertaken elsewhere, no longer required, not fit for surgery, or a range of other reasons—you are looking at a significant level of turnover in terms of the number of people who are either getting their surgery or being removed from the list for other reasons, but the net change in the total number of people is relatively small when you look at it year by year.

THE CHAIR: But if you look at the number of new people being added over those average years, according to my data, which is sourced from material you released, there has been an average of new patients added to waiting lists per month that ranges from 932 in 2000 to about 855 in February 2005. It seems to me that, if you are only dealing with or resolving somewhere around, on average, 680 cases per month and you are adding these extras to the lists, the net effect will be that your waiting lists must continue to grow; so you would have to increase the number of patients treated to make any serious headway with these waiting lists, whether they are more complex or not, if the objective is to shorten the waiting lists.

Mr Corbell: Mr Chairman, the objective is to make sure people get their surgery within the clinical time frames. The list can be 10,000 people and, as long as everyone gets their surgery within the clinically desirable time frames, then—

THE CHAIR: I accept that that is the objective, yes.

Mr Corbell: If I can just answer your question, then that is fine. The point that needs to be made is that, as long as people get surgery within the time frames that are clinically desirable, the total number of people on the list is largely irrelevant. It only becomes relevant when we do have people waiting longer than is clinically desirable. That is the situation we do have at the moment in a number of areas. But I make the point that the net change in the list is actually relatively small.

Let me make two points. The first one is that the net change in the list is quite small. If you look at the net change in the waiting lists across the ACT, in the 2000-01 financial year there was a net increase of 430 people. In 2001-02 there was a net decrease of 263 people. In 2002-03 and 2003-04 we saw a net increase of approximately 200 to 230 people and in 2004-05 we have seen a net increase of 314 people. So the net increase in the total number of people on the list is quite small when you are talking of, say, 5,000 people—only about a 300 or so net increase each year, or less than that, between 200 and 300 net increase each year.

But let me put on the table another figure which I think is very important, because it can address a lot of the issues. The total number of people removed for surgery in 2003-04 was 8,435. That was the highest figure since 2000-01. It was higher than the figure in 2000-01, which was 8,300. So the government is paying for more surgery, more surgery is being done, but at the same time the additions to the list continue to grow. It is probably worth reminding the committee of the increase in growth from New South Wales patients. Let me just run you through a few specialities to give you an appreciation of the issues we are facing here. In ophthalmology, the change in the number of New South Wales residents who were seeking ophthalmology procedures—

THE CHAIR: In Canberra hospitals?

Mr Corbell: In Canberra public hospitals, in Calvary public and the Canberra Hospital, it was 99 per cent. There was a 99 per cent increase in the number of New South Wales residents seeking ophthalmology procedures.

THE CHAIR: How many patients?

Mr Corbell: I will get those figures for you. In contrast, there was a net decrease in the number of ACT residents seeking the same procedures of three per cent. Another example is vascular surgery. The change in the number of New South Wales residents seeking vascular surgery was 55 per cent. There was a 55 per cent increase. In the same time, there was only a 10 per cent increase in the number of ACT residents seeking the same types of procedures or needing the same types of procedures.

In another one, orthopaedics, there was a 27 per cent increase in the total number of New South Wales residents needing orthopaedic procedures in Canberra hospitals, compared with only a nine per cent growth in terms of ACT residents. That just gives you a bit of a feel for where the pressures are coming from in our system. Overall, there has been a growth in the number of New South Wales patients added to the list of 40 per cent—40 per cent—during 2002-03 and 2003-04. ACT patients increased by zero per cent during the same period.

THE CHAIR: Minister, did you say you have the actual figures?

Mr Corbell: I am sorry, we do not have them available, but I am happy to provide them.

THE CHAIR: Could they be provided to the committee? Thank you. Mr Smyth, just on the theme I was on, did you say that you had something supplementary to that?

MR SMYTH: Yes, I certainly did. Would that be in the form of the entire report, Dr Sherbon, or would it just be those three specialities that the minister just mentioned. because I think the public is quite interested—I am certainly interested—in seeing the entire report that you have quoted from?

Mr Corbell: Sorry, the entire what?

MR SMYTH: Is this the report that validates the New South Wales numbers on the ACT list that you are quoting from?

Mr Corbell: I am just referring to data provided to me by the department.

MR SMYTH: Dr Sherbon, is this data being drawn from the report that was commissioned by your department?

Mr Corbell: No, no. Can I make clear that the department did not commission a particular report. The department did an analysis of the waiting list and provided those figures to me and it is that data which I am drawing on today. If there are particular specialities that you are interested in, Mr Smyth, I am happy to provide figures on those for you.

MR SMYTH: I would be interested in seeing all of them, minister.

Mr Corbell: In all specialities?

MR SMYTH: In all specialities, yes, please, minister.

Mr Corbell: I am happy to take that on notice and provide that to you, Mr Smyth.

MR SMYTH: Thank you, minister. On the question of numbers going on and the list growing, you actually did say in your introduction—I wrote it down—that the level of demand has been unprecedented, but then you seemed to change and say that it was actually the acuity that was causing the trouble. Which is it? Is it the level of demand or is it the acuity?

Mr Corbell: The answer is that it is both.

MR SMYTH: It is both. But the average number of patients added to the list over the last four years has been static or has declined and it is still not as great as the average number that were added to the list per month when we were last in office.

Mr Corbell: That is simply not the case. The figures I have already provided to you outline that quite clearly. The net change in the waiting list over the past four years has been, with the exception of 2001-02, in the positive. So there have been net increases in the number of people added to the waiting list in all of the financial years from 2000-01 except for 2001-02, where there was a net decrease of 263.

MR SMYTH: All right. Maybe my calculator is broken. Perhaps you could provide that analysis in the breakdown that proves what you have just said.

Mr Corbell: I am happy for Dr Sherbon to explain it to you now, Mr Smyth, because it is not that complicated.

MR SMYTH: The numbers I have say that under the previous Liberal government 913 patients were added per month to the list. The average for the Labor Party for the last 3½ years is only 878 per month.

Mr Corbell: The figures I am referring to are the total net gain or loss on the list for each year. So, when you look at each year, the number of people taken off, removed for surgery or removed for other reasons, and then: has there been a net increase or a net decrease? The figures speak for themselves. Let me just give you some examples. Total additions in 2003-04, the last full financial year, 10,911. Total removals, 10,713. Of those, 8,435 were removed because they had their surgery undertaken and 2,278 were removed for other reasons, that is, a net increase of 198 people.

MR SMYTH: All right. Are we allowed a copy of the chart that you are quoting from?

Mr Corbell: I am happy to provide the figures for you if you want to know what they are for a particular year.

MR SMYTH: That would be helpful.

Mr Corbell: Which year? I am happy to provide the figures. I have just provided you the figures for that financial year. I am not sure whether there are other financial years you are interested in seeing.

MR SMYTH: I would be interested in seeing your figures for all financial years, minister.

Mr Corbell: I will read them out now. In 2000-01 there were 10,920 additions. There were 10,490 removals. Of those removals, 8,300 were removed because they had their surgery undertaken and 2,190 were removed for other reasons, a net gain of 430. In 2001-02, total additions, 10,205; total removals, 10,468. Of those, the people removed for surgery, 7,946; removed for other reasons, 2,522—a net decrease in that year of 263. In 2002-03, 9,849 additions; 9,615 removals. Of those, 7,488 were removed because they had their surgery undertaken and 2,127 were removed for other reasons—a net change in the waiting list, an increase, of 234. In the last full financial year, the figures I have just quoted to you, there were 10,911 additions and 10,713 removals. Of those, 8,435 were removed because they had their surgery undertaken and 2,278 were removed for other reasons—a net change in the waiting list of an increase of 198. I can provide you figures up until the end of March for this financial year.

THE CHAIR: Thank you.

Mr Corbell: Additions, 7,974; removals, 7,660. Of those, removed for surgery, 5,932; removed for other reasons, 1,728—a net change in the waiting list at this time for 2004-05 of 314.

THE CHAIR: Thank you, minister. I might come back to some things in there in a moment, but I would like to give Dr Foskey an opportunity to ask a couple of questions now.

DR FOSKEY: I would like to look at the chief executive's overall response and recommendation 1 for my first little bracket of questions.

MS MacDONALD: Dr Foskey, are you actually looking at the Auditor-General's report No 8?

DR FOSKEY: Yes. Goodness gracious, I thought you were going to tell me that it was another inquiry altogether.

MS MacDONALD: No. There was just a question to my left.

DR FOSKEY: I am not sure whether it is in the report and I did not see it, but I am interested in ascertaining what percentage of ACT residents are on the waiting lists, compared with people from outside the ACT.

Mr Corbell: What is the break-up?

DR FOSKEY: Yes.

Mr Corbell: I think we have that.

Dr Sherbon: I can get an accurate figure for you, but the last time I saw the figure, which was a month ago, there were 3,100 ACT residents and about 1,600 New South Wales residents. I will confirm that on notice, if possible. We do have a percentage; it is 36 per cent for New South Wales and, obviously, 64 per cent for the ACT.

DR FOSKEY: That is adequate.

Dr Sherbon: But, as the minister made the point earlier, the growth is entirely in the New South Wales population. The ACT resident figures on the waiting list are stable.

DR FOSKEY: Are referring medical practitioners outside the ACT able to work in with our methods of categorisation? I am not sure about our relationship with Queanbeyan hospital. I gather that it is more a country hospital rather than a regional central hospital. Does the ACT government work with Queanbeyan hospital?

Mr Corbell: I will ask Dr Sherbon to give you a bit more detail, Dr Foskey, but perhaps I can give you a bit of a brief overview. We work with Greater Southern Area Health Service, which is the New South Wales entity responsible for health services in the surrounding New South Wales area. The New South Wales government has committed to a significant upgrade of the Queanbeyan District Hospital. That upgrade is currently being planned and ACT Health is closely involved in providing advice and feedback on what Greater Southern Area Health Service is contemplating for Queanbeyan hospital.

We have identified what is called reversing patient flows, or trying to get patients from New South Wales to utilise, wherever possible, services in New South Wales, as a key strategy. We are doing that in a range of areas. At the moment, I am advised, Greater Southern Area Health Service is looking at data from the ACT elective surgery waiting list on New South Wales patients, particularly in the areas of gynaecology, ophthalmology and general surgery procedures, to identify what can be done to enable those people to get those procedures in their local area, rather than coming to the ACT.

Greater Southern recently appointed an ACT liaison nurse, who is assisting with their flow reversal strategy, and Greater Southern are highlighting areas where they can offer New South Wales patients surgery in their area. This was first done in January this year. An offer was made to 18 Queanbeyan area patients waiting for an arthroscopy and four patients accepted this offer to have their surgery done at Queanbeyan. A further 21 patients from the Queanbeyan and South Coast area waiting for the same procedure were sent a letter of offer to have it done in their area rather than in Canberra on 23 March this year. That is an example of some of the strategies that are being engaged in.

It is important to make the point that, under the Australian health care agreements, all public hospitals around the country, including ours, are obliged to accept people without fear or favour if they indicate that they wish to have surgery performed at one of those hospitals, and we are compensated, obviously, through bilateral agreements, in particular between ourselves and the New South Wales government, for that. The quantum is always a matter of some dispute. The territory believes that we are not adequately compensated for the costs of providing care for those New South Wales residents. However, we are obliged to take them and we do take them.

We cannot compel people who are New South Wales residents to have their procedures performed in New South Wales if they would prefer to have them performed here. In terms of other flow reversals, I will ask Dr Sherbon to give you a bit more detail, and also on what is happening with Queanbeyan.

Dr Sherbon: There is probably not much more to add to the minister's detailed answer, except to point out that we do enjoy a productive relationship with Greater Southern Area Health Service. We meet regularly. As the minister pointed out, we recently instituted endoscopy services at Queanbeyan hospital using ACT doctors, ACT specialists, to provide that care at Queanbeyan for New South Wales residents. We are examining other opportunities in orthopaedics. It is proving a bit more difficult, given that capacity, particularly of Bega hospital, is actually full at the moment, there is no theatre time, and in ophthalmology at Moruya hospital.

As the minister outlined, our relationship with Queanbeyan is strategically very important. The relevance of your question, Dr Foskey, is noted in that Queanbeyan hospital is about to expand to the extent of a $35 million redevelopment which the New South Wales government announced two years ago, and the planning is progressing. We are a member of that planning committee and I can advise the committee, without necessarily foreshadowing the final formulation of that plan, which is obviously a matter for New South Wales, that the planning does involve considerable investment in what is called secondary level care—that is district/suburban hospital care—and that will significantly improve the chances of reversing flows from New South Wales to the ACT.

DR FOSKEY: Does the Victorian government provide any funds to support patients from over the border that probably come here through New South Wales doctors, being the nearest to those patients in northern parts of East Gippsland?

Mr Corbell: I would imagine that we would have some funding arrangement agreement with that. It is reflected in the Australia health care agreements which we have signed with the commonwealth, basically the Medicare agreements as they were previously known. They recognise that if you have someone from another state who ends up in your hospital that state is billed for that occasion of service at a set rate.

DR FOSKEY: Even if they come through a New South Wales doctor.

Mr Corbell: I think the point is that it is where they live. So, wherever they live, the funding comes from that state or territory government.

DR FOSKEY: Just finally in relation to this area of the report, there is a more detailed discussion on page 25 of the social factors in setting priorities. I am interested in how that is actually done. Our policy in 1995 about the ACT waiting list says that social and geographic circumstances should be considered. The Auditor-General actually says that our system uses the basis of medical need for prioritising patients, but I noticed in the government's response or the chief executive's overview—I can't remember exactly where I read it—that the government says that it does take social factors into account. Could you explain that to me?

Mr Corbell: Sure. I will ask Mr Cormack to give you some information on that. Before I do, it is probably worth making the point, Dr Foskey, that the Auditor-General found that the system of categorising patients into different levels of priority was fundamentally sound, but did identify some areas for improvement. Fundamentally, the Auditor-General said that the system of prioritisation categorisation was sound. I will ask Mr Cormack to provide you with some further context around how social and other geographic factors are taken into account.

Mr Cormack: I am Mark Cormack, Deputy Chief Executive, ACT Health. Yes, Mr Chairman, through you, as the minister stated, clinical need is the overriding criteria for determining access to care in the public hospital system and, in this instance, elective surgery. There are other factors that we need to take into account. So when all other things are equal, we look at factors such as the geographical location of the patient. We look at factors such as whether they may have experienced a previous cancellation. We also need to bear in mind their social situation such as whether they have got special childcare needs. So we need to take that into account when offering them the next available appointment. The clinical need is the overriding criteria and, when all other things are equal, we look to other factors such as those that I have just outlined.

MS MacDONALD: Following on from Dr Foskey's questions in relation to the first recommendation: the government response was that recommendation one was agreed and that it would be raised at appropriate national leadership forums. I appreciate that the Auditor-General's report came down in December; so that is not much time in terms of raising the issue. Presumably there has been some discussion going on between the Auditor-General's office and Health in the first place, so this isn't a surprise. I am just curious as to how that is progressing, what forums it will be raised in, et cetera.

Mr Corbell: Sorry, this is in the context of the recommendation around better clinical guidelines to improve categorisation, recommendation one?

MS MacDONALD: Yes.

Mr Corbell: Okay. There is work that we can do both within our own jurisdiction as well as work that can be done in and across the jurisdictional way. Our strategy to date is to develop clinical priority assessment criteria in consultation with surgeons so that surgeons adopt a consistent approach to how they categorise patients, because each surgeon does do it a little differently. At the end of the day these are subjective professional judgments that are being made by the individual specialists.

But it is possible to get a greater level of consistency, particularly within individual specialities. Ophthalmology is planned to trial and implement a clinical priority assessment criteria process. We would do this in a way that hopefully takes account of the thinking of that speciality in other jurisdictions.

From talking with the colleges of the relevant specialities and looking at the experience in other jurisdictions as well, the objective would be to ensure that patients with the most severe conditions and social circumstances be treated in priority order. So that work is under way at this time. We will be adopting a speciality-by-speciality approach. Obviously it is easier to get, in some respects, all the specialists within one speciality to agree to a uniform approach rather than try to do it across all specialities simultaneously.

I am advised by Dr Sherbon that we are in discussions with other jurisdictions, in particular Western Australia who is also looking at this issue.

MS MacDONALD: Yes, I saw that in relation to recommendation five.

Mr Corbell: New Zealand also, I am advised.

MS MacDONALD: Sorry?

Mr Corbell: Dr Sherbon has just advised me also that New Zealand has done a lot of work in this area and we have looked at their experience as well.

MS MacDONALD: Okay. My question sort of follows on from recommendation one and what you have just said. You have talked about the fact, which I understand, that you can't conduct surveys without surgeon and GP approval. I know that this is an issue across the states. I am just curious to know what work is actually being done nationally in terms of getting some sort of common agreement. It is interesting.

I was having a discussion with somebody yesterday about the issue of coordinated care. We were talking about lack of communication between GPs and specialists and referring things back to GPs who may have originally referred on, et cetera. It is an area fraught with difficulty, which doesn't have a simple solution, in my opinion. But I am curious to know what work is being done nationally to actually try to address these issues.

Mr Corbell: There are two issues, I think, Ms MacDonald. The first is the issue of waiting times for specialist consultation. Then there is also the issue, once you have had the consultation with the specialist, of what is their wait time before they can perform the procedure.

We are focusing first and foremost on the latter in that we are trying to get together elective surgery waiting list data from both TCH and Calvary so that we can publish on the web accurate and relevant data on waiting times for individual surgeons so that patients and GPs can see who is busy and what the average wait is so that when they are referring someone to a specialist they might look at how the specialists are tracking in terms of how busy they are and then say, "Look, I would recommend x, y or z specialist and, for your information, this is how long you would expect to wait, once you have had a consult with them, to get the procedure done, depending on clinical priority and so on."

On the issue of the waiting time for how long it takes to see the specialist or indeed to see the GP or to see the GP again, some specialists and GPs are willing to look at that; others aren't.

The advice I have from the department is that at this stage the focus should be on reporting the waiting times from the consultation to the procedure by a specialist rather than immediately go to the issue of how long you have to wait to see the specialist, but that is certainly something which, at a later stage, we contemplate addressing.

THE CHAIR: Can I just, relating to that, Ms MacDonald, as a supplementary, ask: is there a reason they advise you why they don't want to provide that assistance?

Mr Corbell: Some see it as intrusive; they don't see it as the government's business how long it takes for them to see an individual. Others cite patient confidentiality reasons, but Dr Sherbon can elaborate a bit more.

Dr Sherbon: Those are the primary reasons cited but also the fact that there is no measurement tool; we don't have urgency categorisations like we have for admission to

hospital—urgency one, two, three that you are all familiar with from reading the briefs and the information published by the minister for waiting times to get into hospital. There is no such system for waiting times for consultation, and the practice for consultation is slightly different to admission to hospital.

There is a broader group of patients that need to see a surgeon, many of whom may not come anywhere near a hospital—they have been treated in the rooms—or not even require any operative intervention whatsoever.

There is no actual system to, say, start recording against this yet and there is no national action that I am aware of to progress such a system. It is essentially a commonwealth government issue as to how long people wait to see a specialist.

Until there is such a system, my advice to the minister, as the minister has just outlined, is: we secure information for consumers on wait times for admission to public hospital through negotiation with surgeons and GPs—and we are about to present a model to surgeons and GPs for publication on the web—before we start a more intrusive and less scientifically formatted process of negotiating measurement of waiting times for consultation which will require commonwealth and GP and specialist cooperation.

MS MacDONALD: What you have just said, Dr Sherbon, I think, partially if not fully, answers my initial question of what work has been done nationally with regard to the issue. I accept that they are two separate areas that we are talking about, the waiting times until you get the consultation and then the waiting times from consultation to procedure, but there is no work being done nationally to actually get some sort of data and some ways of actually flowing it through better?

Dr Sherbon: There is no work been advised to health officials through the Australian Health Ministers Advisory Council of which I am a member. There may be work within the commonwealth that I am not aware of, but no work has been advised to the joint jurisdictional fora that I am aware of.

MS MacDONALD: Thank you.

MR SMYTH: Minister, you and the departmental officers have mentioned that it is clinical need rather than how many people are on the list that is the overwhelming priority.

Mr Corbell: It is waiting time rather than numbers of people waiting, yes.

MR SMYTH: Sure. At the end of March this year, what percentage of the list is overdue for treatment?

Mr Corbell: I will see if I can provide it for you, Mr Smyth.

THE CHAIR: How are you travelling, minister?

Mr Corbell: I am just getting some clarification from my department. I can work through them for you. In cardiothoracic—these are figures indicative as of 28 February—the percentage of long waits is 6 per cent.

MR SMYTH: Sorry, this is the end of February?

Mr Corbell: These are indicative of the end of February, conscious that the actual figures for the end of March have not yet been reported. This is an extrapolation of that.

MR SMYTH: It is just that twice now during the hearings you have actually been able to quote end-of-March figures. I was just wondering what figures you actually have with you for the end of March.

Mr Corbell: I have these for 31 March. These are ones for 31 March: cardiothoracic, 6 per cent overdue; ENT, 50 per cent overdue. Those are long waits, sorry. In general surgery, 54 per cent are long wait; gynaecology, 27 per cent; neurosurgery, 59 per cent; ophthalmology 22 pert cent; orthopaedics, 62 per cent; paediatrics, 54 per cent; plastics, 67 per cent, thoracic, zero; urology, 32 per cent; and vascular, 62 per cent.

THE CHAIR: Minister, all these are beyond the appropriate clinical time for the operation. I think earlier in these proceedings you made some focus on the fact that the waiting list weren't so critical if they were within the appropriate clinical times, but in fact the figures you are giving us here show that quite a lot of these are in substantial periods beyond the appropriate time.

Mr Corbell: The point I was making, Mr Chairman, is that if you had a long waiting list and everyone was getting their surgery within the clinically appropriate times it wouldn't matter how long the list was because everyone was getting access within the clinically appropriate times. But I also said, if you recall, that that is not the situation we have and we do have long waits in a whole series of categories of specialities.

MR SMYTH: Minister, you were asked at the start whether you had the number that were on the waiting lists available and you said no. You seem to have an awful lot of other data though. Minister, do you have before you or do you know what the number of people on the elective surgery waiting lists at the end of March 2005 is?

Mr Corbell: No, I don't because I haven't read the brief yet.

MR SMYTH: But it is not in the documents in front of you?

Mr Corbell: I haven't seen it in these documents, no.

MR SMYTH: Dr Sherbon, do you have in your documents what the end of March waiting list, the total figure, is? Somebody must know. It must be in the documents. I can't believe you have come here—

Mr Corbell: The department, Mr Smyth, is aware of what the figures are. The procedure is that I sign off on those figures before I release them. I haven't read the brief on the waiting lists and I haven't signed off on them; so they haven't been released.

MR SMYTH: And you haven't got the figure there in the documents in front of you?

Mr Corbell: I haven't looked fully through this folder, but I am not aware that I do, no.

MR SMYTH: Are you willing to have a look at the moment and see what the figure is?

Mr Corbell: Mr Smyth, the figures will be released when I have read the brief and signed off on the brief.

MR SMYTH: It is just that at the start of this hearing you said you didn't have the figures for the end of March—

Mr Corbell: I don't.

MR SMYTH:—yet we have had three or four instances where you actually do have the figures for the end of March, Mr Corbell.

Mr Corbell: Mr Smyth, I have already answered your question. You want to know when the figures will be released. I have told you they will be released when I have read the brief and digested the information in that brief. Then they will be released.

MR SMYTH: So you are not withholding the figures from the committee?

Mr Corbell: No, I am not withholding the figures from the committee. I genuinely have not read the brief. I genuinely have not seen the data, the complete data for the month, and, until I see that data and have signed off the brief and agreed to its release, it won't be released. And that is very standard procedure.

MR SMYTH: But you haven't got an end-of-month figure there in your documents?

Mr Corbell: I have already answered your question, Mr Smyth.

THE CHAIR: Minister, I just want to ask you something on recommendation 10, which relates to the not-ready-for-care status of patients. From our discussion with the Auditor-General and looking at this report, one of the things that I was troubled by was the suggestion that people may find themselves dropped off the waiting list or bumped back considerably without understanding the consequence of not being available for a particular procedure.

You have rejected the recommendation here that requires written or verbal assent of either the patient or their specialist to ensure that the patient is clearly informed that they have been placed in the not-ready-for-care category. The response that the government has provided certainly is not persuasive, from my review, in addressing that very real concern that exists.

Have you got any comments you would like to make, or Dr Sherbon?

Mr Corbell: I will ask Dr Sherbon to provide you with some information on that question, Mr Chairman.

Dr Sherbon: This was an issue on which we agreed with the Auditor-General that there needed to be tighter control of the not-ready-for-care list, and we published a waiting list policy in November, as the Auditor-General's recommendations were being made known

to us. We structured a policy that dealt with a lot of the issues that were raised in this report. One of those elements of the policy is the need for a more structured arrangement that allows the clerical staff to evaluate the appropriate mechanism to place people on not-ready-for-care; what are the criteria; and what review mechanisms are available for people on that arrangement, such that they are returned to the waiting list at an appropriate time. So that policy has been devised.

There is a process by which patients are given a series of offers. Just quoting from the policy:

> Patients may be removed from the waiting list if they decline admission on two occasions or indicate they are not available for treatment for personal reasons for a period of 6 months or more.

We do err on the side of keeping patients on the list. We do allow them the opportunity to point out their own circumstances. Obviously, if they have a high clinical urgency, in a 1 or 2 category, particularly in the 1 category, we are very reluctant to change them to not ready for care.

The question that you asked is: why don't we get written permission from the patient and the specialist before we make that change? The simple answer is that the waiting list is an organic creature in a way in that there are people coming in and out of the waiting list by the dozens every day. And the waiting list management process is complex enough as it is without waiting for two or three signatures before the patient is re-categorised.

What we have built into our new policy is a mechanism to ensure people are reviewed. There was no mechanism previously, and people, quite rightly, were pointing out that they did not wish to remain on the not-ready-for-care list forever; they still wished to have their operation even if they weren't available to have it now or in the near future. So, we built in a review mechanism to deal with that. There now is a requirement that a date for review be installed on every occasion that a patient is classified as not ready for care. It is simply administratively extremely cumbersome to chase two signatures on every occasion.

THE CHAIR: Dr Sherbon, I am not sure, though, that you have really addressed the point I have raised. You have talked about what you do and the pressures and the difficulties. But what I put to you was that one or the other consent could be obtained, either the patient or the specialist. And I put it to you that there are instances, as emerged from our preliminary inquiry, of people who may not understand the consequence of making themselves unavailable.

To say, "Well, we give them two shots at it, unless it is a category 1," is fine from the point of view of the health administration, but I am concerned about people who may not fully appreciate what the change of their status might mean, particularly older people who might say, "Well, it's not convenient next Tuesday to have this surgery because I have got some personal engagement," not understanding the consequence of what that decision would mean in terms of changing their status.

Is there not a mechanism where you can provide some greater measure of confidence that people will not be put into that status without understanding the full consequence of

their own healthcare?

Mr Corbell: The department is developing a planning list guide to the department's waiting list policy that explains how the waiting list works in layman's terms and also will explain these issues around not ready for care and what options people have if they decline an offer for surgery. I think it is very important to stress that in the context where people are pushing hard to get access to surgery, where someone is offered surgery and says, "I'm too busy that day; I can't do it," that can only be done on a limited number of occasions because the pressure on the list is such that that really puts all the onus on the hospitals and the administration of the hospitals and no responsibility on the part of the patient to accept the offer when it is made.

I accept there may be extenuating circumstances from time to time, which means someone cannot take up the offer of surgery, and that is why the policy permits a couple of goes at it before they are not made another offer. I think there is a balance to be struck here between the effective management of the list and the reasonable—

THE CHAIR: I have got no problem with that, minister.

Mr Corbell:—management of the list so that all people get access to surgery in as timely a way as possible.

THE CHAIR: I am not suggesting that.

Mr Corbell: As Dr Sherbon says, it is administratively a real headache. It is not a trivial thing; you are talking about thousands and thousands of people being managed every single year. And to add another layer of bureaucracy in terms of the management of the list, what is it going to add to the overall management of the elective surgery waiting list? My view is that it is not going to add very much at all; it is not going to add very much at all to the way the list works, to the effective management of the list, to make sure as many people get access to surgery when they need it.

It might be a courtesy, but it doesn't really add a lot to the overall efficacy of the list, of the management of the list. And that has got to be the key priority. It has got to be the key priority, managing the list effectively, so that as many people get access to surgery as they need, as we can manage.

THE CHAIR: I don't think anyone has got an issue with that, minister, but the fact that the Auditor-General took the view that it was warranting a recommendation was based upon the very real issue not of you having to make umpteen attempts to approach them but to ensure that patients understood the consequence of vacating that opportunity. And my point is that surely you could have a mechanism in place to ensure that people, particularly older people who may not realise that that means that their surgery could be deferred for a very long period of time, know that.

You have already acknowledged that a large number of procedures are well beyond their appropriate clinical times. I would have thought it would be pretty simple to ask their specialist to say, "Well, sign off on this at least so that the patient understands that, if they're on this category, then this is the consequence of not accepting the opportunity provided." I wouldn't have thought that that was difficult to do.

Mr Corbell: As I have already indicated, we are developing a planning list guide to the waiting list policy which will outline to people how the system works, what their expectations of it are or should be, and, equally, what happens in the sorts of circumstances that you have outlined so that it is made clear up front when they are added to the list on the first occasion.

THE CHAIR: Dr Foskey asked about a copy of the waiting list policy, which I think Dr Sherbon mentioned had been published in November. Would you be able to provide a copy of that for the benefit of the committee?

Mr Corbell: Yes.

THE CHAIR: Thank you.

DR FOSKEY: I have a similar concern to the one Mr Mulcahy was expressing in relation to the actual procedure of yours that the Auditor-General agrees with, which is the removal of people from the waiting list after they have rejected a spot twice, I think it is. I am just wondering is there any right of appeal, because there can be very genuine reasons why this happens.

Are people aware, when they reject a spot in the surgery or in the theatre, that they might be losing their spot or that they might be relegated? I am just wondering whether, if they come in again if their appeal is successful, they get back on the list. Where are they on the list?

Mr Corbell: If they are successful, yes. I will ask Mr Cormack to outline to you how that process currently works.

Mr Cormack: Through you, Mr Chairman, the answer to your first question is: there is a right of appeal if a patient is removed from the list. That is documented at 6.9 in the waiting list policy that we have agreed to make available to you.

DR FOSKEY: Which we eagerly await, yes.

Mr Cormack: Your second question was in relation to the consequences. There is a second point. If I could just quote one short paragraph, Mr Chairman. For patients who decline treatment and ask to be removed, there must be evidence that the patient has been informed of the potential risk to his or her health by not receiving treatment, depending on the patient diagnosis—for example, notes of discussions. So we require a document that we have discussed this issue with the patient, we have informed them of the consequences of being not ready for care or being not available.

But one of the overriding principles of the policy is that we do not penalise people because of their social circumstances or health circumstances, for that matter, which may make them temporarily unavailable.

We take into account their clinical need—as I said before, the overriding imperative of access and clinical need—and we also take into account social factors such as where they are and whether they have been cancelled in the past. So we do not necessarily think that

they should go back to the end of the queue again. It is not quite as straightforward as that.

DR FOSKEY: In recommendation 14 regarding investigating the possibility of better integration of hospital and ACT Health databases, I have got a couple of questions. Currently how are the hospital and ACT Health databases meshed or not meshed? How are they interconnected? And how is that investigation proceeding?

Mr Corbell: I will ask Dr Sherbon or Mr Cormack to answer that. This is an important piece of work and it is, I understand, progressing.

Mr Cormack: The present situation is that there are two separate waiting lists maintained by Calvary and TCH. We have waiting list liaison officers at both hospitals, plus we have one for the department who oversees the management of those lists. At the present time they are two separate lists that we pull together and check for reporting purposes. There is a regular process of audit whereby we are able to identify any duplicate entries or any issues relating to the quality and the management of that information.

We have commenced a process of work whereby we will have a tighter central database which will—I do not wish to sound too technical—take a direct data feed from two separate databases and effectively integrate it at a central level, and that will enable us to avoid some of the double handling and will also enable us to avoid any potential risks, such as inadvertent change of status or duplication on the list. That work is proceeding well. In fact, we are doing a lot of development work on our information management systems and that will be progressively rectified over the next two to three months so that we will have a much more up-to-date and robust data set.

I stress that, in the interim, we do have good manual systems and we have clear lines of responsibility for the officers that are involved in maintaining the separate lists in the consolidation process that I described before.

DR FOSKEY: Will this system have the capacity to implement recommendation 21 of the Auditor-General's report, page 13, which enables the publishing of the number of patients in NRFC category as a supplement to waiting list statistics and ideally, as the recommendation says, split into their former category, for instance, that they used to be category 1? In your response, minister, you say that new hospital systems will report the patient's current clinical priority as 1, 2 or 3, and whether they are ready for care or not ready for care. I am not sure whether this happens yet, but could you indicate when this will happen?

Mr Corbell: I am advised that the progress to date, Dr Foskey, is that not-ready-for-care patient numbers will be reported on the ACT Health web page from July 2005. I am unclear as to whether they will be reported by their previous category and I will ask if my officials can assist me with that. But, certainly, the numbers of people who are not ready for care will be reported from July 2005.

In terms of what category they previously were: I am advised it probably would be wise to take that on notice and get some further information for you on that. But, certainly, our intention is to report not-ready-for-care people publicly.

DR FOSKEY: While we are on page 13, something that comes up a fair bit in the government response is that it will be covered in the reporting review of this year. That is, for instance, your response to recommendation 24. But what I am interested in is how this review is being conducted and, once it has been conducted, how action can be taken to implement whatever comes out of it.

Mr Corbell: It will be an incremental process, Dr Foskey. The department and the two hospitals collectively are continuing to work to refine the waiting list data and to develop more meaningful reporting of that data. It is certainly the intention, in relation to recommendation 24, that we will work towards including reporting on elective medical procedures in regular reports and medical services such as endoscopy and angiography. Waiting lists will be published on the waiting times web page from July this year.

We will be continually refining the list. It is a result of the refining of the data and our interpretation of that data that has led us to get a much better handle on where the growth is coming from in our system and the fact that a lot of that is coming from New South Wales residents. It is a result of the work the department is doing that we are getting a better handle on that and, in the same way, we will be continuing to refine the list, refine our interpretation of it, and report in more meaningful ways on a whole range of indicators that that work discloses.

THE CHAIR: Minister, ladies and gentlemen, we are going to take a five-minute break and resume at 3.25 if you would rejoin is then.

Short adjournment

THE CHAIR: We will formally resume proceedings. I now invite Ms MacDonald to commence with some questions.

MS MacDONALD: Thank you, Chair. My question relates to Auditor-General's recommendation 2, which has been agreed in principle, in relation to intermediate categories between categories 2 and 3. In the government's response, you are investigating some options at the moment. It says—

Mr Corbell: Sorry, Ms MacDonald. Which recommendation is this?

MS MacDONALD: Recommendation 2.

Mr Corbell: Thank you. Yes.

MS MacDONALD: You are recommending some additional categories, such as 2A, 3A and 3B. Obviously the work being done on it would be in an early stage, but I would just be curious to know how you envisage that working and what sorts of categories would go into the intermediary categories of A and B, 2A, 2B, 3A, 3B, that sort of thing.

Mr Cormack: It is relatively simple to redesign a request for admission form to incorporate new categories. That is the easy bit. What we do need to undertake is the development of an urgency rating system that is a bit more sensitive than the 1, 2, 3 that we have got at the moment. But we also need to work with the individual specialty

groups because the categories 1, 2 and 3 apply across neurosurgery, ophthalmology, orthopaedics, general surgery, et cetera. So there will be a bit of work required.

We are engaging the services of an obstetrician/gynaecologist who does this sort of work in a consulting sense. He will be working with us to look at the way we are codifying the levels of urgency, but we will need to do that on a speciality-by-speciality basis. Once that is complete, we think that will further refine the decision making in terms of the next patient off the list to get the next slot in a surgical session. So it is work in progress and will take some time to fully refine.

MS MacDONALD: Do you have a ballpark figure of about how long you think it will take to actually work that out?

Mr Cormack: Well, we are starting with the higher priority, the longer wait groups, such as ophthalmology. In fact, the person who is assisting us will be out in the second week of May and the ophthalmologist will then be following that up with the orthopaedic surgeons, who also have a similar issue. So we envisage that the big chunks of that work will be completed within the next three to four months to be able to convert that into a refined RFA.

MS MacDONALD: RFA, what is that?

Mr Cormack: An RFA is a request for admission. That is the form that admitting medical officers submit when they want to actually admit a patient for a procedure in a hospital or for any admission to a hospital.

MS MacDONALD: Even when I know the acronyms, I often forget them.

MR SMYTH: Minister, in the response to the Auditor-General's report on page 7 the head of your department says that it is for this reason that the government will provide more than $20 million over four years, 2003-04 to 2006-07, for additional elective procedures. How many additional elective procedures in total do you plan to conduct with that extra funding?

Mr Corbell: In terms of the funding already announced, you mean?

MR SMYTH: Well, if there is more funding announced, then I would be interested in the total.

Mr Corbell: I do not want to pre-empt the budget, Mr Smyth. We will need to take that question on notice, but I am happy to provide you with that information.

Dr Sherbon: Just by way of explanation, we will have to go back through the previous announcements to determine the targeted procedures. As the minister alluded to earlier, our additional funding for 2003-04 and 2004-05 has been utilised and the current year funding for 2004-05 is on target for utilisation, complete utilisation, of our elective surgery funding. But we will have to come back to the committee with an exact figure on those.

THE CHAIR: If I could just clarify. I missed the part of your question. Did you ask how

many more procedures would arise on that?

MR SMYTH: Yes, that was the question. He is going to find out.

THE CHAIR: Sorry. I got distracted.

MR SMYTH: Minister, then, in the 2004-05 budget, the government announced it was going to spend $17 million over four years to recruit general surgeons to reduce waiting lists. I notice you have only talked about $20 million today, so is that $17 million part of the $20 million?

Mr Corbell: No.

MR SMYTH: So is there, in fact, $37 million?

Mr Corbell: No, they are different things. Employing additional staff specialists is different from paying for occasions of surgery.

MR SMYTH: Sure, I understand that.

Mr Corbell: So it is a different thing.

MR SMYTH: All right. Of the $17 million, how many surgeons have been recruited for that money so far?

Mr Corbell: General surgeons?

MR SMYTH: Yes.

Dr Sherbon: Two additional general surgeons, one of whom has recently started. We were hopeful of securing a third, but we have been unable to complete those negotiations. We expect that in the coming months we will be able to secure that third surgeon.

MR SMYTH: All right. When did the first two surgeons begin work in the hospital?

Dr Sherbon: The first additional surgeon is actually a returning surgeon. He resigned in, I think, either 1999 or 2000. He has returned because he is more comfortable with the arrangements that we have proposed. He returned in November. I will have to check that, but it was either October or November. The second surgeon is a new colorectal surgeon. He commenced in March.

MR SMYTH: How much of the $17 million has therefore been spent so far?

Dr Sherbon: There has been a significant expenditure of that money in the surgical stream. Basically, at this point in time, most of it is being spent on category 1 and emergency patients. That general surgical money was not only for elective surgical patients. As I think you understand, the additional surgeons were to assist in the after hours roster, as well as to complete elective surgery work. So that funding has been utilised for additional case weighted separations in surgery, predominantly emergency at

this point in time, although, with the arrival of the second surgeon, we are hopeful that he is now in a position to do a lot more elective cases and, in fact, is assisting other surgeons with their waiting lists.

MR SMYTH: Do we know what the planned cost per procedure is that they will conduct? Has there been a number worked out on what each of their separations will cost?

Dr Sherbon: Well, in the ACT the average cost weighted separation in 2003-04, which is the latest published figure, was around the $4,100 mark. We generally use that as a basis to plan forward and we take a portion off that for the marginal effect. I cannot give an exact figure, but our planning was based on a figure of around that mark.

MR SMYTH: On average, then, what percentage of that $4,100 are administrative costs?

Dr Sherbon: You have asked that on notice in another forum, I think. I will have to take that on notice.

MR SMYTH: The answer was somewhat unclear.

Mr Corbell: We are happy to revisit what was provided to you, Mr Smyth, and see if there is anything that can be done to elaborate, but the breakdown of a cost weighted separation is a fairly complex process, as I am sure you would appreciate.

THE CHAIR: In terms of recruiting your surgeons, where are you recruiting those from, minister?

Mr Corbell: As Dr Sherbon just indicated, one of them is a surgeon already—

THE CHAIR: Reassigned, rejoined?

Mr Corbell: here in the ACT who is willing to come back and work in our system. The other I am not sure of.

Dr Sherbon: The other is an Australian who has recently returned from a post-fellowship stint in the US where he gained a specialist expertise in colorectal surgery. So he is a new set of skills to the territory.

THE CHAIR: Do you have surgeons who are in Canberra that are not able or whatever to work in the public hospital system?

Mr Corbell: We have a whole range of specialists who choose not to work as VMOs.

THE CHAIR: Yes.

Mr Corbell: That is entirely their choice. Some choose it for lifestyle reasons. Some choose it because that is the way they conduct their business as surgeons. Every individual is different.

THE CHAIR: Sure. I am just thinking in terms of this recruitment process, whether there may be prospects for achieving arrangements locally that might solve your problems here in a number of specialisations, rather than having to go further afield?

Mr Corbell: Look, we explore all options, Mr Chairman. The VMO package that the government negotiated is a very attractive package. It is one in which, I am very pleased to say, this government achieved a first without any industrial disputation or disruption to services. Unlike other occasions where territory governments have sought to renegotiate VMO contracts, where there has been protracted disruption to the system and impact on patients, this government achieved that without any disruption to services and without any impact on care. The payments to VMOs are extremely attractive and competitive and we have certainly utilised the terms of the general bargaining arrangement for VMOs to attract additional staff to the territory.

I think it is worth making the point, however, that basic workforce shortages means that, even if you have got the best package in the world, if there are not enough people to go around, you are still in a fight to get people. That is unfortunately the case in a range of specialities. The government has long-term, as well as short-term strategies, to address workforce shortages in both the medical area as well as in the nursing area and allied health areas. That is everything from investing in the ANU medical school, investing in the nursing facilities at UC to investing in a new allied health training facility at UC.

It is really about trying to create, as much as possible, a source of medical workforce and nursing workforce, allied health workforce into the future, about recruitment, interstate and overseas and about training up our own. That is particularly the case in nursing, where we are unable to attract sufficient nursing staff to work in critical areas, such as ICU or emergency departments, or in surgical nursing roles. We are undertaking training of existing nursing staff to upskill them so that they can do that work, rather than simply relying on recruitment from outside. So we do a very broad range of things to try and address the workforce shortage.

Ultimately a range of issues to do with workforce shortage will have to be addressed with workforce redesign so that the types of jobs that, say, nurses do now will change over time and potentially new types of positions will be created to do some of the other work that currently we rely on nurses to do. That is ultimately another part of addressing workforce shortage.

THE CHAIR: Mr Smyth, I interposed with a question about surgeons. Have you anything further on that theme?

MR SMYTH: Yes. If I remember the initiative line in the initiatives budget paper No 3 from this year, it said that it was for elective surgery and for emergency surgery. What percentage are they doing as elective and what percentage are they doing as emergency surgery?

Mr Corbell: Sorry. Are you referring to general surgeons?

MR SMYTH: To two of the three general surgeons that you have recruited.

Mr Corbell: I do not think that we have that exact break-up now but, as Dr Sherbon has

already indicated, the first traditional general surgeon that has been recruited has focused on a lot of emergency work as a significant part of his work. The second surgeon is doing more elective work.

Dr Sherbon: Yes, that is correct. Both have elective theatre time.

MR SMYTH: Sure.

Dr Sherbon: Canberra Hospital is one of the few hospitals I have ever observed that managed to recruit surgeons in the late 1990s without giving them elective surgery theatre time, and that is why they left. Both are doing elective surgery theatre time but, as the minister mentioned, the first surgeon was recruited to assist us in the roster to expand the general surgical roster from, I think, six to seven general surgeons, and now were at eight with this further addition. But as the second person has come on line, we have been in a position to provide more surgery.

MR SMYTH: Right.

Dr Sherbon: More elective surgery.

MR SMYTH: Yes. Can we get a breakdown on how much elective surgery we are actually doing?

Mr Corbell: I am happy to take that on notice and try and provide that data to you.

THE CHAIR: Dr Foskey, did you have some questions?

DR FOSKEY: Yes, thank you. Recommendation 28 of the Auditor General's report on waiting lists for elective surgery suggests that ACT Health should complete implementation of agreed recommendations of the Standing Committee on Health and Community Care's 1999 inquiry into waiting lists. I have here, as well as the 1999 report on the inquiry into public hospital waiting lists, a report from the select committee on hospital bed numbers, which was conducted in the Assembly in 1991.

Mr Corbell: And you are about to produce another one.

DR FOSKEY: Yes, that is right.

THE CHAIR: Because the problem continues.

DR FOSKEY: To see some progress would be really good.

THE CHAIR: It would be a great achievement.

DR FOSKEY: I have to say there has been progress since 1991, so I commend all governments for that. One of the things that are proposed is that the number of public beds is a problem. It was actually estimated that 1,000 public beds is conservative in terms of ensuring sufficient beds for a growing and ageing population. That is 1,000. By the time of report No. 3 of the Standing Committee on Health and Community Care in 1999, they offer statistics that the number of beds wavers between 563 and a high of 591.

Forgive me for not knowing, but I am hoping that you will tell me the current bed numbers. Recommendation 2 of the 1999 report recommends that government "ensure that increased patient throughput is not jeopardised by excessive reductions in bed numbers". Recommendation 3 recommends that the government "examine ways of improving theatre utilisation", which is an issue that we have had raised with us from another submission.

There are a number of recommendations, and I do commend them to you. Recommendation 1 suggests that there be a trial for pooling public patients by specialists. I realise there are all kinds of political problems around that and there I do not mean party political, but they are issues that have been recognised for quite a while.

THE CHAIR: Maybe we could give the minister a question.

DR FOSKEY: Well, I am interested. I thought it was necessary to give that historical background—

MS MacDONALD: You were asking about bed numbers.

DR FOSKEY: but the response—actually, that was just one instance.

MS MacDONALD: Okay.

DR FOSKEY: I just wanted to go through those recommendations because the Auditor-General says that ACT Health should complete implementation of agreed recommendations. Sadly, I do not have the government response to this report in front of me, so I do not know which recommendations the government—

MS MacDONALD: They say that they have been implementing over time.

DR FOSKEY: Yes, "has progressively implemented responses". I want to know what those responses are. You may be able to find me an actual version of your response and that would be really handy.

THE CHAIR: I think the secretariat, Dr Foskey, will be able to retrieve that for us. So that could be considered as part of our deliberations.

DR FOSKEY: Good. I do think that would be very helpful to us. Perhaps meanwhile the minister or Mr Sherbon or Mr Cormack could indicate which of these recommendations you feel you have adequately addressed of those that you agreed to address.

THE CHAIR: It is a very broad question, Dr Foskey.

DR FOSKEY: Well, there are actually only nine recommendations here and because the government response is that they are being implemented—

THE CHAIR: All right. Well, minister, I do not know whether that is one you would want to take on notice because it would involve a fairly long response. Would it be something you would be happy to take on notice?

Mr Corbell: I am happy to, Mr Chairman. Perhaps I could make some general comments. Dr Foskey has raised a range of issues there. I think I could probably give you an indication of what the government has done to address a range of those issues. First up, in terms of the recommendations of that standing committee report, that was obviously done some time ago and it was under a different government.

DR FOSKEY: Which one, 1991 or 1999?

Mr Corbell: In 1999 in the first instance, obviously done under a different government and a different Assembly. I read that report shortly after becoming minister and generally familiarised myself with it. Most of the recommendations in that report were adopted by the government of the day. It did make a range of recommendations for improvements in management of elective surgery, which were agreed to and implemented. Equally, the recommendations of the 1991 report, as you have outlined, Dr Foskey, were generally accepted by the government of the day and agreed for implementation.

You make a couple of points that would probably be worth highlighting. You talk about bed numbers. There was throughout the 1990s a reduction in the number of beds in our public hospital system, and that was consistent with a practice that occurred right around the country at that time of reducing overall the number of beds in public hospitals in Australia.

Since 1999 the figure has remained quite constant. This government has not closed any beds, unlike the previous Liberal government. We at the moment, I am advised, have approximately 490 beds at the Canberra Hospital and approximately—not exact numbers but approximately—120 at Calvary. The government is on the record as committing to an additional 20 medical beds, and that was a commitment we made at the last election and a commitment that we will be honouring, obviously.

We also have capital works money right now to build an additional 60-bed subacute and psychogeriatric facility at Calvary Hospital. That project is in the detailed design stage and we will shortly be seeking development approval. So this government will be the first government since the late 1990s, indeed for some time, to actually increase overall bed numbers.

You raise also the issue of pooling—pooling of patients within specialities. This is a difficult issue. Some specialities and surgeons are prepared to consider this and contemplate it. Others are not. The approach ACT Health is adopting is, wherever possible, where there is agreement between surgeons within specialities or groups of surgeons within specialities, to pool patients. Pooling is already occurring, I am advised, in relation to general surgery at the Canberra Hospital amongst some general surgeons and also in relation to the ophthalmology speciality at Calvary Hospital. So pooling is a desirable practice, wherever possible. It is certainly my view that we should pursue that. That is the department's approach. But it does rely on the consent and the agreement of individual surgeons and their preparedness to see other surgeons' patients. Some surgeons are prepared to do that and some are not.

DR FOSKEY: I just want to check that we have agreed that you will, if possible, respond to the recommendations here as a question on notice.

THE CHAIR: You are looking for more detail of the government's implementation of recommendation 28?

Mr Corbell: I will give you as much as I reasonably can. I think it is worth making the point that I do not think the government can go back and review and commit to everything that previous governments have committed to.

DR FOSKEY: No, but you can indicate why that is—

THE CHAIR: No, except that you are on the record, though.

Mr Corbell: I can give you a general summary of the key issues and what is being done in relation to those key issues and I am very happy to do that.

THE CHAIR: Because it is in here under the recommendation—

Mr Corbell: Yes, it is.

THE CHAIR: that you have progressively implemented these matters.

Mr Corbell: I do not want to go back to tors and revisit every single recommendation of previous reports.

THE CHAIR: I understand.

Mr Corbell: The response of the government of the day is—

DR FOSKEY: Except they are helpful. The reports are helpful.

Mr Corbell: Yes, they are, absolutely.

THE CHAIR: Ms MacDonald, do you have a question?

MS MacDONALD: Yes, I do. It is not a particularly long one. It relates to recommendation 5 in relation to the posting of waiting times on the web.

Mr Corbell: Yes.

MS MacDONALD: I read this before. You have said that the elective surgery waiting list management policy that was adopted in 2004 supports the publication of surgeon waiting times procedure on the web and that action is expected this year. I am just curious about the progress of that and when that is likely to occur or if it already has started to occur.

THE CHAIR: Did the minister answer that earlier on when he talked about New Zealand and WA?

MS MacDONALD: He may well have. I am sorry.

Mr Corbell: No. It was a separate issue, Mr Chairman.

MS MacDONALD: No, that was a different issue.

THE CHAIR: Was it?

Mr Corbell: The time frame for that particular project is, I am advised at this point, August 2005 for completion of that project, which would allow us to publish accurate and relevant data on waiting times for individual surgeons on the ACT Health web page.

MR SMYTH: Just with respect to the overdues, in October 2001 Canberra Hospital, 29.8 per cent of their list was overdue. At Calvary it was 35 per cent. In the February 2005 figures for the Canberra Hospital elective surgery waiting list, 53.3 per cent of patients were overdue and 40.1 per cent were overdue at Calvary. Given you have said the important thing is the need to see people inside their time frame, why are almost 48 per cent of the list now overdue as compared to, say, 31 per cent of the list when you came to office?

Mr Corbell: Well, again, Mr Smyth, it comes down to the issue I highlighted at the beginning of these hearings—the increasing demand from particularly New South Wales residents and the increasing complexity of the procedures that are required. So the issue is to do with the overall pressures on the list.

MR SMYTH: But the number of overdue patients has increased by almost 50 per cent. Are you saying that the number or the acuity has gone up by 50 per cent in that time? I have seen the chart that you provided when I last asked this question and it does not go anywhere near the 50 per cent more acuity or higher acuity.

Mr Corbell: I do not think that is a reasonable comparison. You are not comparing apples with apples. The percentage increase in acuity does not necessarily correlate with a commensurate increase, with a same level increase in terms of numbers of people overdue. It depends on which specialities it is occurring in and the availability of surgeons in those specialities. Obviously, if there is an increase in, for example, the number of people requiring neurosurgery, we have a very limited number of neurosurgeons in this town. Even a slight increase in the total number of people requiring neurosurgery will result in a more significant increase in the number of long waits simply because of the number of neurosurgeons. So I think it is not a valid argument that you make.

THE CHAIR: But not in absolute numbers, minister? It would not in absolute numbers. It is not as though there are armies of people requiring neurosurgery, surely?

Mr Corbell: My view on this, and the data I have from the department is that it is very much down to what is occurring in the individual specialities where those demands are, how many people, how many surgeons we have got to actually do that work. So I do not think your argument is a valid one.

MR SMYTH: Well, except the information you provided last time said that between 2003-04 and 2004-05 the variance was only 2.3 per cent.

Mr Corbell: The variance in what, Mr Smyth?

MR SMYTH: Surgical activity. In answer to your question, I stated that we are doing more complex surgery and the answer you provided is that it has only gone up 2.3 per cent. I can give you back your answer if you like, but that does not correspond to a 50 per cent increase in the number of overdue patients.

Mr Corbell: I am sorry, Mr Smyth. I am not clear on what statistic you are quoting and without understanding that, I really cannot give you a reasonable answer.

MR SMYTH: It was your answer to my question earlier. I am happy to give it back to you.

Mr Corbell: Yes, please do provide it.

MR SMYTH: The problem is your answer initially was more people were going on the list, but we have debunked that because in fact there are not as many people going on the list as previously used to.

Mr Corbell: No, that is not the case.

MR SMYTH: You then swapped to; "It's more acute. We're doing more. The acuity is getting higher and higher." At the same time your own data says that the variance is only 2.3 per cent, yet something like 48 per cent of patients are now overdue on the elective surgery list. That is a 50 per cent increase since you have come to office. Why is that so?

Mr Corbell: For the reasons I have already told you, and I know you do not agree—

MR SMYTH: But the reasons do not hold up. By your own that you have signed off on, the reasons do not hold up.

Mr Corbell: No, that is simply not the case. There is an increase in acuity. There is an increase in the number of people being added to the list.

MR SMYTH: By your own chart—

Mr Corbell: The growth is quite clear.

MR SMYTH: there is a—

Mr Corbell: If I could answer the question, Mr Smyth. You have had the opportunity to make your statement. For the same reasons that I have provided to the committee previously, there is an increase in acuity, there is an increase in the number of people being added to the list, particularly people from NSW, and those figures do speak for themselves. The number of ACT residents on the list is remaining pretty much the same. The number of NSW residents on the list is going up. Those figures are very clear. At the same time—

MR SMYTH: They are only clear because you have got the report or the analysis, which you have refused to release.

Mr Corbell: Mr Smyth, I have told you. There is no report. There is an analysis and I have provided the data to the committee. I have provided the data to the Assembly. I do not know what else you want me to do, to create a report that does not exist? The issue is acuity is increasing, particularly category 1 and category 2, and the number of people being added to the list is increasing. I know Mr Smyth tries to make some other arguments here, but that is the bottom line on the waiting list. I can go through the figures again for you, if you like, from NSW.

MR SMYTH: What, the end of March figures?

Mr Corbell: Look at the change the number of NSW residents for the 18-month period from July 2003 to December 2004. The change in the number of patients on the waiting list by state of residence and specialty is as follows: ophthalmology, 99 per cent increase.

MR SMYTH: But how many people is that? Ninety-nine per cent could be two people.

Mr Corbell: We have taken that on notice, Mr Smyth.

THE CHAIR: You have agreed to provide the data, have you not?

Mr Corbell: At the same time a decrease, a real decrease in the number of ACT residents on the list. Neurosurgery, a 31 per cent increase in the number of NSW residents, only a nine per cent increase in the number of ACT residents. Gynaecology, a 27 per cent increase in the number of NSW residents.

THE CHAIR: Minister, I think you have already put this in *Hansard*.

Mr Corbell: Mr Smyth has raised this issue again and I am entitled to respond.

THE CHAIR: I am conscious, minister, that we have now exceeded the time for this hearing. Would you conclude?

Mr Corbell: I will conclude very quickly, Mr Chairman. There was an eight per cent increase in the number of ACT residents. Orthopaedics, a 27 per cent increase in the number of New South Wales residents, with only a nine per cent increase in the number of ACT residents. Ear, nose and throat, a 25 per cent increase in the number of NSW residents, with a three per cent increase in the number of ACT residents in those specialities. Those figures speak for themselves. You can see where the growth is. You can see where the growth is coming from and that, combined with the increase in acuity, is creating the pressures that our lists face today.

THE CHAIR: Thank you, minister, and members of the committee and Mr Smyth and the officials.

Mr Corbell: Mr Chairman, before you conclude, if I can just clarify an issue that Mr Smyth raised earlier today? Mr Smyth indicated to me that I said I had the brief on my desk and I had not signed it yet in relation to elective surgery waiting lists for this coming month.

THE CHAIR: He asked if you had that.

MR CORBELL: Yes. I have checked *Hansard* for the annual reports hearing. Mr Smyth asked me if I had the waiting list numbers available and if I would share them with member here at the committee on that day, 21 April. I said, "I have a very large pile of briefs on my desk and I've not looked through them all yet." Mr Smyth said, "So you've not seen the waiting list numbers for last month?" I replied, "I have not seen them." Mr Chairman, that remains the case. I have not yet seen those figures. When I see those figures, I will sign off the brief and make that information available in the usual way.

THE CHAIR: We will be looking forward to seeing them, minister. Thank you to all for your participation. I will now adjourn this hearing.

The committee adjourned at 4.03 pm.