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, 15 JUNE 2005

Secretary to the committee:
Ms R Jaffray (Ph: 6205 0136)

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 2.05 pm.

TU THI THANH PHAM and

GRAHAM JOHN SMITH

were called.

THE CHAIR: We will formally commence proceedings. I will make a statement for the benefit of the witnesses. 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 like to welcome my fellow committee members and welcome back Ms MacDonald from her inclement condition. Today we're looking at the inquiry into the Auditor-General's report, No 8 of 2004, the subject being waiting lists for elective surgery and medical treatment. As I am sure the witnesses are aware, when you first have cause to speak, it would be appreciated if you could assist Hansard and the committee by stating your name and the capacity in which you appear. I now invite Ms Tu Pham, the Auditor-General, to say a few words in relation to this report. Although there have been private meetings with the Auditor-General we will need to take those into account in a public hearing sense. Would you like to provide some information on the report for the record initially, Ms Tu Pham?

Ms Tu Pham: If I may, I will make some brief comments. Firstly, I am very pleased that ACT Health and Minister Corbell have responded very positively to the report and that the department has issued the new policy on management of waiting lists, which I believe will address a number of concerns we had during the audit. There are two recommendations that the government did not agree to, and I would like the opportunity to quickly address those. The first is recommendation No 7. We recommended that ACT Health should seek to equalise category 3 waiting times by two means. The first is to discourage category 3 requests for admission from surgeons with long waiting lists. We also recommended that the department encourage pooling of category 3 patients.

The government did not agree to these recommendations, saying that it is unable to discourage category 3 requests for admission. We believe that this is animportant issue, given our evidence on category 3. The waiting lists vary, say for a cataract removal, from 30 days for one surgeon to 520 days for another surgeon. We believe there should be scope for the department to put effort into providing more information regarding the long waiting lists of the surgeons to GPs and patients, hence encouraging a patient or a GP not to choose a surgeon with a long waiting list, so that we could hopefully equalise the waiting time for category 3. The department will publish some information on the web, I believe, during this year. That will help surgeons and also the practitioners and the patients to choose a surgeon with, hopefully, a shorter waiting list.

The other recommendation is recommendation 10 which deals with the "not ready for

care" status. The government did not agree to that and I am not 100 per cent sure of the reason behind it. In this recommendation it is important to us that the patient should know what will happen to them. Hence, if a decision is made to put them onto the "not ready for care" list, they should be informed of that decision.

Although the department will tighten the way they manage and reviewthe people in this "not ready for care" category, it doesn't address our concern that patients are still left in the dark about whether or not they are taken off the normal waiting list and when they will be back on it. In the evidence given to the committee, Dr Sherbon mentioned that it would be administratively cumbersome to obtain two or three signatures. That is not what we are recommending. We are recommending that documentation, or some record, should be kept to justify the decision of the hospital to put people on the "not ready for care" list. An example is that Mr Smith called me on Saturday saying that he was not available for surgery within the next six months, so we record the reason to put him to a NRFClist.

THE CHAIR: I assume that "Mr Smith" is a generic use of the term!

Ms Pham: So it is not an issue of chasing two or three signatures at all. That decision could be triggered by a patient's request or the surgeon's request. There does not have to be consent from both parties, so we still believe there is merit for the department to consider this recommendation again. That is all I have to say at this stage. I would be happy to take questions.

THE CHAIR: Perhaps I could firstly explore the second issue, which is the one I am struggling with. I believe, from our earlier examination of the issue, the view was advanced that you could have a situation where, for example, a quite elderly patient, who may consider the time offered for an operation to be somewhat inconvenient and seeks to vacate that occasion, doesn't necessarily fully understand that that may put them well down the queue. The real issue is ensuring that that is understood and having some paper trail to support that view. That is what I believe you identified. We did explore this but I am also struggling with it. You can't identify what the real impediment is to that being implemented? You don't see that as a major administrative challenge?

Ms Pham: No, not at all.

Mr Smith: Graham Smith, Performance Audit Manager at the ACT Audit Office. I agree with what the Auditor-General has just said. We are not saying it is necessarily cumbersome but if someone were to phone up and say, "I can't go on the list because of a personal commitment", they would say, "Fine. Do you understand that that means you are now on the 'not ready for care list' and that you will be for a period of" whatever the precise time is. They would be informed of that. It is a good safety measure that the department of health are now putting in place their review process, but the patient doesn't know when that review process will come about whereby they might be put back on the active waiting list.

THE CHAIR: I have a second question. We will be hearing from Dr Hughes later, who is one of the VMOs. Could you indicate, again, the basis of the objection to changing the category 3 issue that you spoke about where you have this sort of disproportionate waiting on waiting lists for some surgeons? Is the issue with the hospital administration

or the surgeons themselves wanting to change the system? Was that clear to you?

Ms Pham: I think the government is now more willing to add a few more categories to make clearer the level of urgency within category 2 and category 3. They are now talking about category -2, 2A, 3A and 3B. At the earlier stage the department's response was not to agree to it, citing that it would add complexity to the waiting list category rather than simplifying it. We maintain that the current categories do not assist the management of the list because people in category 3 can be waiting forever. A number of surgeons believe that, if they put their patient on category 3 it may take years, hence they upgrade them to category 2 without good medical reasons, just because they are worried about the waiting time.

Mr Smith: There is one issue which I must admit I never fully comprehended, whereby patients are put onto the list under the care of a particular surgeon but they are, nevertheless, theoretically public patients without choice of doctor. What we were getting at here is alluded to in our paragraph 4.12, which lays out the 30 days for one surgeon and 520 days for another. The one possible means is that, if a surgeon calls and says, "I'd like to add one more patient to the list," if the hospital were to say, "Do you realise this patient will not be dealt with in two years?—surely you would prefer to recommend him to one of your colleagues—the doctor could then say, "No; I want to keep that patient"—or, "I see what you mean; perhaps I should refer the patient." We recognise that that situation could go either way, but we are suggesting that there be that sort of communication.

THE CHAIR: Could you help me understand? Is there some sensitivity here on the relationship between the specialist and the referring doctor?

Mr Smith: I believe there is. That is something I am not fully abreast of.

THE CHAIR: Has any reason been explained to you? I struggle to get clarification on this.

Mr Smith: No. The only reason put was that a doctor does have the right, as I certainly comprehend, to say, "I want to enter this patient for public treatment." They can certainly do so, and obviously we don't argue.

THE CHAIR: No; the practicality. I am just wondering about other issues that might be of concern on that.

Mr Smith: I think there is a degree of sensitivity. Doctors obviously build up a relationship with a patient and prefer to keep that—and the patients likewise.

THE CHAIR: Let us look at all of your other recommendations, Ms Tu Pham. Aside from the problems you have cited on these two, with the successful adoption of your other recommendations, do you believe the end effect of all of this will be to see the waiting list growth for elective surgery stemmed or stabilised, or do you expect it will still continue to go out based on the scenario? If it will, why do you still think that will happen?

Mr Smith: We were careful not to say anything about global resourcing. That is

probably a political measure beyond our realm, and it is really sort of global resources to global demand. Most of the report was about equity, or making the lists as equal or as fair as possible, both across categories and across types of patients, and general efficiencies of operation. There are one or two recommendations that are addressed towards efficiency of surgical procedures. That is more along the lines of continuing with the sorts of reviews they had been doing, which might increase overall efficiency and therefore reduce waiting lists. But, really, we can't say anything about the amount of resources that should be addressed to this issue as opposed to any other.

THE CHAIR: I understand that.

Ms Pham: I understand that the minister and also Dr Sherbon provided a lot of information to the committee regarding the increase in demand and the level of throughput that goes through the hospital. So the impact on the waiting list is a function of supply and demand and of course the resources to deal with the increase in demand. We believe there are sufficient grounds for action to be taken to improve efficiency in the use of theatre, make an improvement in same-day surgery admissions, and perhaps use theatres for surgery during weekends or in the evenings. But the department at the moment considers that not to be economically effective. We do not have sufficient information and we did not look into this issue to see whether or not that is the case. So we trust that the department has looked into the efficiency or better use of theatre during evenings or weekends, for example, and on other measures to reduce the waiting list.

Mr Smith: We had a relatively short section in chapter 6, paragraph 6.5, on the next page or two, that was talking about efficiency of surgery and some other measures that Ms Pham has already alluded to. That wound up with recommendation 25, which says that, "ACT Health should consider the cost-effectiveness of means" et cetera, but I must admit that that wasn't really the main focus of the audit.

THE CHAIR: At the risk of paraphrasing, even if the government implements all of these recommendations, including the earlier inquiry—the standing committee inquiry of 1999—whilst you expect that we would see some improvements in efficiency, it may not be the panacea to the growing waiting list problem. Would that be a reasonable summation?

Mr Smith: The 1999 inquiry gave a little more address to some of the efficiency things. That is part of the reason we picked up on this. That had more efficiency of surgery et cetera—and number of beds too—which was beyond our scope.

DR FOSKEY: I am interested in whether, when you made the list of recommendations, you put some thought into assessing whether you thought these recommendations were doable without too much reorganisation of the way things already occur. Perhaps you could give me a sense of whether you had a priority listing in terms of how easy they were to introduce and implement. Have a go at that and then I'll ask you something else.

Ms Pham: In conducting our audit and in coming up with the recommendations, we consulted widely and talked to a number of professional groups. I think the lists of the people we consulted in the opening session were listed in the report. We also had assistance from Dr Ramsey, who used to work with the Canberra Hospital, who gave us some feedback concerning the implementation of these recommendations. So in our

minds we are quite convinced that all our recommendations would be easy to implement, are quite practical, and can be done within the short or medium term.

Mr Smith: If I may add, as the Auditor-General said at the start, we were encouraged by ACT Health's acceptance of most of the recommendations and indeed their very quick implementation of some of them. There are some that are difficult in the sense of requiring negotiation and consideration with the medical profession that will take some time and sensitivity, but we didn't see any significant use of monetary resources.

DR FOSKEY: So, in a sense, you could say that the Auditor-General performs the function of being an outside investigator with very clear terms of reference and a mandate and that that perhaps then gives the government the opportunity to present something that is seemingly outside the usual politics of bureaucracy, government and all the other players in there. That is certainly perhaps a reason why, after all these years of people complaining about waiting lists, there has been some action. Would you feel that your report had anything to do with that?

Ms Pham: We do believe that our report brings the issues to the attention of the Assembly and the community—and reported widely in the media. These issues are not new. I think they have been identified, and ACT Health is definitely aware of these problems. The report often provides an opportunity for these issues to be debated more widely in the community and in the Assembly. In the process of doing the audit, we talked to the department very often. Before we finalised the report, there were a number of draft recommendations that we discussed with the department concerning implementation and the practicality of it. By the time it comes to the final report, we are convinced that we have obtained sufficient information to be convinced that the recommendations are sound and properly based on evidence and information in ourreports.

DR FOSKEY: I could not find, by the way, a list of groups and people you consulted.

Ms Pham: That is at page 3 of the report.

DR FOSKEY: Okay. The 1991 inquiry was a select committee on hospital bed numbers. It is interesting that this makes a strong recommendation about increasing the number of beds, and of course that hasn't happened yet. Does that have any bearing, do you think, on the issue that you were investigating?

Mr Smith: I think it is beyond our expertise. There are different ways of treating people now than necessarily admitting them.

DR FOSKEY: Indeed. Finally, I wanted to ask you about another recommendation that was not agreed by the government—recommendation 2. I was wondering if you feel that not accepting that recommendation may have a bearing on the success or otherwise of other measures that the government has agreed to do.

Ms Pham: To clarify the issue, the response to the report is the departmental response. At the time of the audit the departmental response was "not agreed", but the government response, which was then submitted to the committee, was "agreed in principle". Hence, ACT Health is now investigating options of changing the categories to add additional

groups like 2A, 3A and 3B. That has been agreed to by the government. That is a positive thing.

DR FOSKEY: You should be feeling very successful; influential.

Ms Pham: Thank you.

MS MacDONALD: I note on page 3 that you particularly thank a number of the external parties who provided assistance. I note that you have mentioned Dr Wayne Ramsey, the AMA, the Royal Australasian College of Surgeons, Health Care Consumers Association of the ACT and the ACT Health Services Complaints Commissioner. Did you consult with the ACT VMO association as well?

Mr Smith: No. In the course of various discussions more along the lines of different clinical areas, I'm sure we spoke to a number of individual visiting medical officers, but we didn't consult with the association as such.

MS MacDONALD: Was there a reason for that?

Mr Smith: No. It was just that we thought the other groups would have captured the views we were looking at, together with consulting the individual medical officers.

MS MacDONALD: I suppose the only reason I make note of it is because they have put in a submission to us, but the other groups have not. I'm wondering whether, had they had an opportunity to participate, that would have made a difference. I can ask them when they come up in a second.

THE CHAIR: On the last issue that Ms MacDonald raised, was there any prevailing view from the health professionals, the surgeons, the AMA and the like that came through in your discussions? Did they see a solution to these issues, or were they more or less going along the lines of those you finally reported on?

Mr Smith: It is very hard to generalise, but I think the recommendation that has changed about more increase in the precision of the different categories was supported by a number of practitioners. We recognise that that is a difficult one because there is an Australia-wide standard of one, two and three. So we were a little bit reluctant to say that, but we did have a few views there from doctors and from our observations in the hospital, as we said in the text, about high priority in fact being used by some doctors as category 1+. Other doctors were commenting about the difficulty of getting category 3 patients through at any degree of timeliness at all. They could not guarantee getting category 3 patients in within a year. Therefore they asked, "Is there some other way of dealing with those patients who do need to be dealt with in less than 365 days?"

THE CHAIR: Were the professional groups you consulted with generally critical of efficiencies, or not?

Mr Smith: It's very hard to generalise. I don't think I could say that. There would have been the odd comment but, again, because we spoke to each of them in confidence, I don't want to go too far.

THE CHAIR: Thank you for your assistance again today.

Ms Pham: Thank you.

DR PETER HUGHES,

DR GEOFFREY STUBBS and

DR JAMES LIM

were called.

THE CHAIR: Thank you, gentlemen, for making yourselves available today to meet with the committee. I am required to formally advise you that you need to 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. Dr Hughes, you sent in a submission. Would you like to make an opening statement to this inquiry?

Dr Hughes: My name is Peter Hughes. I am president of the ACT Visiting Medical Officers Association. The two other people with me as part of the ACT Visiting Medical Officers Association delegation are Dr Geoff Stubbs, who is an orthopaedic surgeon, and Dr James Lim, who is a general surgeon.

You have our submission of 31 March and we have read the Auditor-General's report. Our particular submissions is that the only thing that will reduce waiting lists is to have more operating sessions and the necessary nursing staff for those operations and for the post-operative care of those patients. There are surgeons currently working in Canberra who are willing to take up more elective operating sessions if the government decides to fund those extra operating sessions. What the government is doing is rationing public hospital services by keeping waiting lists long in the ACT. That is our opening statement.

THE CHAIR: Thank you, Dr Hughes. Is it correct that operations cannot be started after 4 o'clock in the afternoon? Is that a practice that is employed?

Dr Hughes: That applies at Canberra Hospital, and it is one of only two hospitals in the whole of Australia that stop their operating lists at 4.00 pm. In every other hospital it is 5.00 pm or later.

THE CHAIR: Has any plausible reason been advanced to you beyond the issue that you mentioned earlier of funds provision for health care?

Dr Hughes: We have been told by the department of health that it is a problem getting the nurses to do what they want.

THE CHAIR: Is that in terms of their willingness to work or the availability of personnel?

Dr Hughes: It is a rostering problem, they keep saying, which they do not seem to be able to control.

THE CHAIR: It seems extraordinary, doesn't it?

Dr Hughes: Yes. Dr Stubbs?

THE CHAIR: Please state your name and the capacity in which you appear.

Dr Stubbs: My name is Geoff Stubbs. I am an orthopaedic surgeon practising at the Canberra Hospital. It is actually worse than that. They will not start a case that will not finish before 4 o'clock in the afternoon, so there is no capacity for the list to run over time at all. So the effective finishing time for those lists may be as early as 2:30.

THE CHAIR: It does seem to be an extraordinary underutilisation of those resources, Dr Stubbs. That is a view you obviously share.

Dr Stubbs: Yes, that is my view. The elective operating lists are strongly underutilised. They are now going into a situation where some of the morning operating lists will not commence until 9.00 am. Again, that reduces those operating lists by 30 per cent, with the same problem of being reluctant to start any case that will not finish before midday.

THE CHAIR: Dr Stubbs, would specialists such as you be quite happy to work outside those time frames that are being utilised?

Dr Stubbs: Yes. At no other hospital in Canberra do those restrictions apply. It is just normal practice at all the other hospitals for the lists to go on until they are finished. If the lists are seriously overbooked, the particular surgeon making the bookings will be instructed to be less ambitious with how many cases he can do. But normally we will finish every case that is booked on those lists, and that may mean going until 6:30 or 7 o'clock some nights.

THE CHAIR: Do you practise at John James, for example?

Dr Stubbs: Yes, I do.

THE CHAIR: They probably do not deal with the same level of emergency cases, but I imagine that the operations conducted there in terms of elective cases would be comparable. Would that be a reasonable assumption?

Dr Stubbs: That is the case, yes.

THE CHAIR: What sorts of hours have you experienced in working at their theatres?

Dr Stubbs: It would be fairly typical for the lunch hour to be shortened to 20 minutes or so because the morning list had gone on a bit longer and it would be quite reasonable for a list with a scheduled finishing time of 5.00 pm to finish between 5.30 and 6.00 pm.

THE CHAIR: Would they ever initiate an operation at, say, 3.00 pm or 4.00 pm? Is that something that is avoided?

Dr Stubbs: The lists tend to be better structured, or the lists are well structured in that

sense. But yes, they would do. I know of cases where the operating lists have gone on until 8 or 9 o'clock at night with the same staff just being held back on overtime until the work is completed.

THE CHAIR: Has your information paralleled Dr Hughes's advice that the hospital's inability to secure rostering with nursing staff is the fundamental objection to it, or are there other factors that you have heard of?

Dr Stubbs: I am never quite sure what the explanation for anything is at the Canberra Hospital. Basically, it seems to be an industrial issue, that people work at the Canberra Hospital because they finish at a particular time and they can be confident of finishing on time, and it seems to be the administration's policy to enforce that.

THE CHAIR: I turn to the issue that the Auditor-General raised about some surgeons—I think the Auditor-General said "surgeons", but there could be a range of specialisations; I may be jumping here in regard to terms—having waiting lists of 30 days and some of 520 days. Would you be in a position to help the committee understand the central issues there?

Dr Stubbs: I think so. First of all, there are some variations in what are regarded as indications for particular operations, so some surgeons are more inclined to treat particular conditions surgically rather than non-surgically. There are certainly differences in how many patients a surgeon will see and, generally speaking, the more patients you see the more cases will come forward for surgery. Fairly uniformly, the waiting time is as long as two years for lots of procedures, particularly joint replacement procedures.

High-cost procedures have a much longer waiting time than low-cost procedures irrespective of the classification I give them. If a patient is a day patient, they will get their surgery done very promptly. It is easy to schedule day patients, it is easier to know how long they will be in hospital, the case is generally shorter and so forth. If I schedule somebody who is going to make a major demand on hospital resources, such as a joint replacement, particularly a complicated one, then you will know that their surgery will take place much later in that time bracket that the category number would characterise.

The other thing about it is that category 3 is not a particularly useful category for people who need surgery. In terms of orthopaedic patients, they are having their surgery because they are in pain, they are disabled and generally they are not working. So for most of them they are going to be at least category 2. Only a modest collection of patients could be treated as category 3, that is, on an essential indefinite waiting time.

THE CHAIR: Is there any explanation, though, in terms of the disparity between different specialists in regard to their waiting lists? Is there anything you can advise the committee that might work towards a solution to the problem there that has been identified by the Auditor-General?

Dr Stubbs: Dr Lim, would you like to say something on that one?

THE CHAIR: Dr Lim, please state your name and position.

Dr Lim: My name is James Lim. I am a newly appointed general surgeon in Canberra.

A point that I would like to raise, if I could, is related not just to the Canberra Hospital but to Calvary Hospital as well, which also provides a significant amount of public caseload work. Calvary Hospital is contracted by ACT Health to perform a certain amount of public work in an attempt to reduce some of the load on the Canberra Hospital.

A problem I have seen arise that causes a lot of dissatisfaction amongst many of the surgeons is the practice of cost weight limitations. This is a system where, because there is only a certain amount of public work allocated to a hospital, the administration then delegates that limit to individual clinicians in the sense that Dr A will have 130 cost weights allocated for that year and Dr B will have 200 cost weights. If you use up that number of cost weights, you are prevented from operating on any public patients, unless they are category 1 or emergencies, for the rest of the financial year, which in effect means that surgeons like me and a few others will have two months or three months of theatre time prevented. Theatres will lie fallow, unused, and we will not be in a position to help shorten the waiting lists whilst there are actually some resources available.

So, in terms of looking for solutions, one issue that I would strongly encourage for consideration is that ACT Health take full advantage of a hospital like Calvary that can take on a lot of this public work by allocating the appropriate funding for them to be able to do the public cases without the cost weight limitations that put clinicians in the difficult position of having to postpone a lot of their elective work. Every time an emergency case comes in, more cost weights are deducted and another elective case gets put on the backburner. That is one issue that perhaps could be very easily addressed.

DR FOSKEY: Dr Lim, I wonder if you could have a go at explaining the government's rationale for putting cost weight limitations on the work of surgeons.

Dr Lim: ACT Health places a certain amount of funding into Calvary Hospital. The decision to use cost weights is not the government's; nor is it of ACT Health. It is the administration within the Calvary Hospital that then sees a technique of working to a budget by transposing the responsibility for cost cutting onto the clinicians in the sense that we then have to limit the number of elective cases coming through. Many orthopaedic surgeons, gastroenterologists and general surgeons are subject to stopping public work and it galls us to see that waiting lists are extending whilst we've got our hands tied and unable to assist.

Dr Hughes: Can I just add to that? What Dr Lim has described is in fact in breach of the contracts that the VMOs have with the department of health. Our association has taken it up with the department and their initial response is that, yes, it does seem to be contrary and they are going to take it up with Calvary Hospital. But it has resulted in some people stopping operating months before the end of the financial year.

Dr Stubbs: I would like to elaborate on that. My understanding is that ACT Health purchase services from Calvary Health Inc and they purchase cost weights in particular areas of surgery and medicine. In orthopaedics, there are two classes of cost weights, one concerning joint replacement surgery and the other concerning the rest of the orthopaedic surgery.

Calvary Hospital are funded to the limit of the cost weights purchased. It is within

Calvary Hospital's facility to do more cases, but they will not be paid for them. So there is a limitation on the total volume of work provided by the cost weight purchases. You can do more, but you don't get any funding for it. Likewise, if you don't use up your cost weights, you don't get funded for the unused cost weights. So for the hospital administration it becomes an exercise in trying to reach the end of 30 June having used exactly those cost weights purchased, no more, no less.

The impact on the waiting list that ACT Health have by changing the cost weight purchases is quite marked. Three years ago or four years ago—I'm not sure, but some years ago—we felt that there were roughly 350 public joint replacements being added to the Calvary Hospital waiting list every year. At that time, something like 350 joint replacements were being funded under the cost weight basis. At that time, we were working extra lists in May and June to make sure that all the cost weights were used up. So the waiting list was at a steady state and the hospital was very active.

In the last two years at least the number of cost weights allocated by ACT Health to Calvary Health Inc has been roughly half that for joint replacement. The effect is that the joint replacement cost weights will only provide about half as many joint replacements as they did some years ago. So, instead of some 350 being done, roughly 200 are done, with two effects: the patients are being added at the old rate of about 350 and they are being taken off at the rate of about 200. Effectively, the waiting list is doubling every seven months for joint replacement surgery.

Of course, the rationing of the cost weights is such that by April often a particular surgeon has used up all the cost weights allocated to him for that section. If he has unused cost weights in non-joint replacement surgery, then the waiting list for non-joint replacement surgery will start to come down as these cases are added until the total funding is exhausted and the joint replacement waiting list will correspondingly increase. They are basically just underfunded for the work going on.

THE CHAIR: Has any explanation been given to you or is it reasonable to assume that this is all about dollars at the end of the day?

Dr Stubbs: I think it is all about dollars. It is about the funding. ACT Health purchases a certain value of services.

THE CHAIR: Have you pressed them on the reduction? We have heard in evidence before this committee that the problem in the hospital is because we are getting an upsurge in demand as the population ages and more people are coming in from interstate. Have you, as a specialist, raised with the hospital why they are reducing the joint replacement cost weights from 350 to 200?

Dr Stubbs: Again, these are just approximate figures.

THE CHAIR: Yes, I accept that.

Dr Stubbs: I know all of the orthopaedic surgeons have raised the matter personally. The answer you get from the hospital is, "That is how many cost weight fundings you have got and we cannot do any more unless we self-fund them; that is, we have to find that from some other part of our budget." They can do more joint replacements, but they are

not funded for it and, therefore, that has to come from somewhere else.

MS MacDONALD: Have you initiated any conversations with the department or the minister in regard to this issue?

Dr Stubbs: Bear in mind that these are people who are being added to a waiting list because they are elderly, they are infirm and, perhaps most important of all, their independence is threatened. They are on walking aids. They can no longer use public transport. We are now getting letters and calls from general practitioners or from the patients themselves on almost a weekly basis saying that a joint, hip, knee, shoulder or whatever has become much worse. Some of these patients are now going into institutional care because they are no longer able to manage at home. For others of them it means going onto narcotic medication.

MS MacDONALD: You have just talked about a whole lot of systemic problems, but have you actually initiated a meeting with the department or the minister, or both, in regard to these concerns?

Dr Stubbs: My unit has met with the minister on a number of occasions, I believe. I was not present. The present situation is that we simply ask the patients to write to the minister, because we are not getting any action on it.

THE CHAIR: Obviously, there is always the argument that there is no end to how much funding can go into health. That is a debate that is had in this place in terms of what is the appropriate spend. But within the framework of current funding, in addition to the industrial relations issues that Dr Hughes and Dr Stubbs have flagged in terms of being able to get these theatres at Canberra Hospital operating beyond 4 o'clock, are there any other measures you would take within the funding framework that you think would significantly improve the challenge of getting these waiting lists down? I guess I am looking at efficiencies that you think could be applied.

Dr Hughes: The health budget as far as hospitals are concerned is divided into various categories, including administration and clinical services. So long as the money for clinical services is fixed, we do not see any way that you can improve the amount of throughput in terms of reducing public hospital waiting lists. So it is a funding matter, unless the others have views on it.

Dr Stubbs: No. At Calvary it is more directly a funding matter. At the Canberra Hospital there is the additional problem that they do almost all of the emergency orthopaedic surgery and the biggest problem there is getting those patients to theatre expeditiously. You can well image the situation We have many patients whose stay in hospital is principally made up by the time they wait for their operations. That immediately produces a problem of bed block. So, in some sense, Canberra Hospital need to address their problem with being able to deal with their emergency cases expeditiously. The issue there becomes: at what level do you staff for a variable workload? At the present stage, their staffing level and their resources allocated to that do not meet the workload on an average day.

DR FOSKEY: Are you saying that, because they don't manage to do all the emergency surgery required, that adds to the waiting list, or do they reschedule and do those as soon

as possible, which pushes the waiting list along?

Dr Stubbs: The waiting list gets pushed back because the elective lists are being earmarked and turned into non-elective lists. So, for a lot of the elective cases at Canberra Hospital, the lists are being taken out of the elective category and made into non-elective lists in some sort of effort to cope with the problems from the trauma load. The other issue is that the theatres run late, that it is normal for cases that should be performed in the daytime to be taking place at midnight or later, with effects on the efficiency of all of the people to perform the case.

DR FOSKEY: I have a few broad questions. A lot of them are just seeking information as I am not really around this issue as much as you are. I took it from something you said, Dr Stubbs, that surgeons practise in a number of hospitals. Is that in all three hospitals?

Dr Stubbs: Yes, in all four.

DR FOSKEY: Four, including the private one.

Dr Stubbs: Yes.

DR FOSKEY: Is there any ability to deal with patients in a hospital where waiting times would be shorter?

Dr Stubbs: One of the issues that have been around for a long time is the subcontracting of elective surgery at the public hospitals to the private hospitals.

DR FOSKEY: Does the surgeon arrange that or does the hospital arrange it?

Dr Stubbs: Nobody arranges it because there is no facility to do so, but it is a suggestion that keeps popping up from all sides of the argument.

DR FOSKEY: Has it been popping up for some years?

Dr Stubbs: As long as I have been here, I think.

DR FOSKEY: How long is that?

Dr Stubbs: For 26 years.

DR FOSKEY: You must be feeling that you have been here before. Recommendation 14 of the Auditor-General's report states that ACT Health should investigate the possibility of better integrating hospital and ACT Health databases in order to produce a more flexible, reliable and faster analysis of waiting times. ACT Health has agreed to that. I am not sure whether that recommendation offers any solutions from your perspective. I suspect that there could be political issues around having integrated waiting lists or databases, but it could be a way of dealing with the problem. What do you think?

Dr Stubbs: It is a way of sweeping it under the carpet. One of the suggestions mooted at

the Canberra Hospital was that every patient who had been on the waiting list for 12 months should have a clinical review of their condition performed because it may have changed in that time.

DR FOSKEY: It might have got better.

Dr Stubbs: It might have, but most of them don't. But the intention was that patients who had waited for more than 12 months would be taken off the waiting list automatically because 12 months had elapsed and then directed back to the people who had put them on the waiting list so that they could have their conditions reassessed.

DR FOSKEY: And perhaps move up the waiting list.

Dr Stubbs: Perhaps move up the waiting list, but in any case it takes weeks or months to get your condition reassessed if you are looking for a routine appointment. I really think it is just a way of sweeping the problem under the carpet.

DR FOSKEY: Is there any difference between public and private patients when it comes to having elective surgery done?

Dr Hughes: In the public hospitals, no. They are categorised on clinical need and it is irrelevant whether they are private or public.

DR FOSKEY: But if they were a public patient they would not have access to John James.

Dr Hughes: A public patient wouldn't, unless they were prepared to pay, no.

DR FOSKEY: But they could to Calvary.

Dr Stubbs: No. I would think more than 90 per cent of the patients that go through the Canberra Hospital are public patients.

DR FOSKEY: I am just wondering if that has got anything to do with it.

Dr Stubbs: They have no subsidised access to Calvary Private Hospital, John James hospital, or National Capital Private Hospital. If they go there, they have to fund themselves and it is pretty hard to get a bill for less than $5,000. For joint replacement it is more like $20,000.

THE CHAIR: That is effectively the delineation between the insured and the non-insured to a large extent, excluding emergency people and so on, I would imagine.

Dr Stubbs: To a large extent, yes.

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THE CHAIR: I think the people that Dr Foskey is talking about who are electing for private treatment will obviously be able to be progressed much more quickly in the private system if they have got either the funds or the insurance to pay for it. Is that

really the point you are getting at?

DR FOSKEY: Yes. I am interested because the clogging up appears to be very much at Canberra Hospital.

THE CHAIR: I think Calvary—am I correct, Dr Lim—has also got the same difficulties?

Dr Lim: Yes, that is correct. The division between the private and the public is immense. There is literally virtually very short, if any, waiting time in the private system. I assumed the issues we are discussing are really in the public?

THE CHAIR: Yes. That is the framework of our inquiry essentially.

DR FOSKEY: That is very interesting.

THE CHAIR: Do you have any more questions? Ms MacDonald, do you have some questions?

MS MacDONALD: Yes. Dr Hughes, I have read the submission and at the very end you have made the point that, unless the government is prepared to spend more money on allocating surgery time, the problem with waiting lists will not be dealt with. Then your final comment is that the association has come to the conclusion that the government is comfortable with the number on the public hospital waiting list and has no intention of spending more money to reduce the public hospital waiting list. Can you tell me how you have come to that conclusion?

Professor Hughes: The Visiting Medical Officers Association and the AMA in the ACT have made numerous submissions to the government for more money for regular elective sessions and additional sessions to reduce the waiting time and these sessions have not come, have not appeared.

MS MacDONALD: Sorry, have not?

Dr Hughes: More sessions have not been made available. So nothing has happened.

MS MacDONALD: And has the government or the department responded to your concerns about there not being enough operating sessions?

Dr Hughes: They have said they cannot allocate any more in the foreseeable future.

MS MacDONALD: And have they given you a reason?

Dr Hughes: No, but it is pretty obvious.

MS MacDONALD: Well, it may be obvious to you, but for somebody who does not work in the area it is not necessarily obvious.

Dr Hughes: Extra sessions can be provided if the government puts up the funding for that, and they are not prepared to put up the funding. They have not increased the

funding for this purpose and it has not happened.

THE CHAIR: Dr Lim, it sounds like you practice fairly regularly at Calvary. Is that right?

Dr Lim: I do, yes.

THE CHAIR: There were media reports, and I think the *Canberra Times* carried reports of theatres being shut down somewhere around about the third quarter of the financial year. That, I take it, is not because you have all gone on holidays? It is simply a matter that you are ready and able to deliver the health care, but the cost weights are no longer available and have been used up early in the financial year. Is that what we should conclude from your evidence?

Dr Lim: Yes. I think that issue arose as a result of cost-weight limits. Although I did not see that program, it was relayed to me by my colleagues. I think that the broader principle here, to support my colleagues, is that there is manpower, there are surgeons and there is a capacity from the doctors' point of view to still increase the workload to reduce the waiting lists. Putting more surgeons on in a system where we are already limited in the amount of time we have to shorten the public waiting list does not sound to me like it would be the most sensible answer.

To put on more nursing staff would be a huge help. All of these problems with late starts, early finishes and not enough sessions are often in a setting where the physical theatre is available, the surgeon is available and the anaesthetist is available but there is no nursing staff available to open that theatre. Although I am not right in the midst of the nursing staff, the overall impression of many of us working in theatres is that the rate-limiting step in being able to open up theatres is largely lack of nursing staff, more than lack of surgeons, for example.

THE CHAIR: I might be stepping out of your field of specialisation, but is the method now of recruiting and training nurses moving more towards a tertiary approach, rather than an applied on-the-job approach that I think used to be the case? Do you think that has compounded the problem in getting nursing staff for the hospitals?

Dr Lim: I think each speciality would have concerns about providing a high quality staff and if, within the nursing profession, that is deemed the best method, it is really not for me to dispute that that is their method of producing the best quality staff. But obviously it would limit the number going through and the college of surgeons are currently deeply embroiled in this issue of wanting more to come through but maintaining quality. So it is not really in my field to say that that is the right or wrong thing.

THE CHAIR: Is ACT Health recruiting outside surgeons? Given that you say there is under capacity with the available specialists in Canberra, are you aware if they are recruiting specialists, rather than addressing current capacity issues?

Dr Lim: Well, I am one of several surgeons that have been appointed in these last four years. This year one surgeon was appointed. The previous year I was appointed, a year and a half ago, and the two years prior to that, again two further surgeons. So within the last five years there have been four new surgeons as part of a recruitment drive, largely

driven by the local surgeons because of the lack of staff to fill an emergency roster. The surgeons that are here have to work far more hours than would be acceptable to cover the emergency work. So that was what fuelled the drive to recruit new surgeons, of which I am one of the new ones in Canberra. So to answer your question, yes, there has been a drive in the last few years, resulting in four new surgeons in the last five years.

THE CHAIR: But the issue now seems to be that there are sufficient surgeons. There are just not enough dollars being employed to utilise the external specialists or salaried specialists. Is that correct, Dr Hughes?

Dr Hughes: Yes. Could I just respond a bit more in detail to Ms MacDonald's question? The Visiting Medical Officers Association did write a submission to the minister in January of this year, and in his response of 17 January he says, in part, "The ACT government acknowledges the need for additional beds and as a 2004 election promise committed to 20 additional public medical beds, funding for elective surgical growth and the provision of a 60 bed sub-acute facility in the ACT." But we are yet to see these additional sessions.

THE CHAIR: The Auditor-General has addressed this issue of patients not ready for care and feels there is a compelling case for some better documentation. Dr Stubbs talked about elderly people who may be on his list for orthopaedic work. If they are shunted back down the queue, they should understand what a decision to defer might mean. There was concern by the Auditor-General that there is insufficient documentation to confirm that people are fully aware of what a deferral might mean in terms of their place. Have you seen cases where people have been, if you like, unfairly put to the back of the line, not realising a decline?

Dr Stubbs: Worse, Mr Mulcahy.

THE CHAIR: Worse, did you say?

Dr Stubbs: Worse.

THE CHAIR: Could you please share that with the committee?

Dr Stubbs: If I could. I would also like to elaborate at the end on our comments concerning the appointment of surgeons.

I certainly have a patient who this year was to come to the pre-admitting clinic at the Canberra Hospital. She was rung the day before by someone from the admissions office at the hospital and told that she need not come to the pre-admitting clinic because her surgery had been deferred. I did not find out that that was the case until four months later when I discovered her admission papers, with a note saying that, because she had not attended the pre-admitting clinic, she was taken off the waiting list.

Now, no one had ever spoken to that lady about what had happened to her, why her surgery was not going ahead and no one had spoken to me. It was simply a question of putting a note on the admission papers and shoving them in an envelope, which somehow went around the hospital until I eventually came across it. So I think there is a serious problem with treating these clients as actual people.

The second issue is this comment by Dr Sherbon that we need more doctors. We do not. There is an atlas maintained in New England called the Dartmouth Atlas of Medical Procedures. It applies to the United States and basically lists the incidence rate of operative procedures based on geography. There are variations in the rate at which particular operations are done that are some six or seven-fold. The predictor of what the variations will be is simply the number of doctors about.

So for ACT Health their problem is not that they do not have enough orthopaedic surgeons. Our numbers have increased by a net three in the last eighteen months. But there are not facilities available for the ones here who want to work. Appointing more orthopaedic surgeons makes the problems worse. There would be an increase in demand because idle hands find things to do and they have not got the resources to give surgeons proper facilities at the public hospitals. No one is going to get up night after night and go back and work at those hospitals on their after hours and emergency rosters if they do not do any work there in the daytime because they are either not allowed to have an elective theatre list or, if they have one, it is constantly being cancelled.

THE CHAIR: Just on your first issue, the one I raised about the not ready for care and the disturbing case you have outlined to the committee, can you see any plausible reason why there is a resistance to carrying out the Auditor-General's recommendations? Is there some practical obstacle that you think that they may have to overcome or is it just a cultural attitude?

Dr Stubbs: I think it is a cultural attitude. The right hand never knows what the left is doing. There is also a bit of stamp the paper and move it on. At the Calvary Hospital, if patients do not attend the pre-admitting clinic, they are rung to find out why they have not come. They are certainly rung again, or at least an effort is made to contact them to find out the particular reason why they have not followed through the path set for them.

THE CHAIR: I see. So it can be done?

Dr Stubbs: It can be done.

THE CHAIR: I have no further questions. Dr Foskey or Ms MacDonald, do either of you have any more?

DR FOSKEY: I was just going to ask Dr Hughes, and please feel entirely free to say no because I am not sure about protocol, but I thought it would be an interesting appendix to your submission if you could attach the letter and response that you wrote and received from Minister Corbell.

Dr Hughes: Yes. I am sure it is not a private document. It has gone from the minister to an association. Yes, I would I would be happy to submit out letter to him and his response, together.

THE CHAIR: We will resolve to take that as an exhibit and authorise its publication under standing order 243.

I would like to thank you all for making yourselves available. I realise you are all very

busy. We do not want to tie you up from trying to deal with the problem that is the subject of our inquiry.

DR FOSKEY: We should have done this after four.

THE CHAIR: Yes, indeed. Thank you for making your time available. I am sure your evidence will be important for the guidance of this committee. I think we might have a break.

Meeting adjourned from 3.18 to 3.32 pm.

PAUL FLINT was called.

THE CHAIR: Mr Flint and committee members, I will formally resume proceedings. I will just read for your benefit, Mr Flint, some advice that the committee provides to witnesses. It is as follows.

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.

Our inquiry relates to Auditor-General's Report No. 8 entitled *Waiting lists for elective surgery and medical treatment*. Mr Flint, would you like to make a statement to the committee of the particular views of your membership and organisation?

Mr Flint: I would like to give our perspective of a brief summary of the document and then our response.

In general terms we would see the document saying that the statistics are fairly reliable, although not totally reliable. In broad terms they are used appropriately and then they bring in a number of recommendations for additional reporting and information structures. The difficulty that we have with it is that the recommendations primarily are for institutionalising information, and there is a broad range of recommendations along those lines.

The report does not appear to recognise some of the factors that actually cause differences in waiting periods, and these can include historical relationships with doctors, choice of doctors or other factors, such as booking and timeliness from a patient's perspective. Conversely, when it comes to surgery, filling the gap even with a patient of a lower priority is considered by us to be preferable to leaving a vacancy. That, of course, has caused some of the difference in treatment of different priority cases.

Overall there is this formal structure that is recommended. We have concerns about that in that we would see it as legitimising long waiting lists and we see that as a totally undesirable outcome, particularly from the patient's viewpoint. It may be all right as far as capacity for the system is concerned, but from a patient's viewpoint we see that as a very poor outcome. Our recommendations therefore would be to use the sorts of resources that they are talking about to actually influence the length of the waiting list because reducing the waiting list would reduce the subsequent problems that they are trying to address.

We do note that, out of the 29 recommendations, there are only three or possibly four that you could say are actually addressing the waiting list. That is where we see the real need and the need to focus resources. We find it particularly difficult where people, in effect, have to put their life on hold for extended periods while they are waiting for surgery, and we see that as totally unacceptable. So that is a broad perspective of the COTA National Seniors View.

THE CHAIR: Thank you, Mr Flint. By way of preamble, I commend you and the work your organisation on behalf of seniors. A number of members saw your work in Seniors Week. You make a great contribution to your members and those who benefit from your work.

Could ask you this? We had some specialists here a moment ago. One of them was reasonably critical about people being bumped off waiting lists. He felt that people were not being treated as people with the level of compassion that would be appropriate. Have you had complaints from your members about their handling in terms of those who do seek elective surgery?

Mr Flint: Most definitely, and that is why we have taken the particular thrust that we have, that reducing the length of waiting would address the problem. There are inequities and the inequities are exacerbated by the length of time you wait. The longer you wait, the more people are concerned about those inequities.

THE CHAIR: Tell me if I am wrong in my interpretation, but when you said there are factors that were not taken into account such as relationships and the like, you were alluding, I guess, to the fact that there are people who feel comfortable with a particular specialist; therefore that is inevitably going to mean that some specialists have much longer lists than others and that ought to be taken into account rather than just saying, "Well, we can shift people here and there." Is that the message that I should assume from those remarks?

Mr Flint: It varies around that sort of theme. There are some people that have had historical relationships with a doctor so they will continue to go to that doctor. Some will choose particular doctors maybe more appropriate to their particular case, even though they are within the broad range of surgeons. So there are all sorts of choices like that that are involved.

Again, if the waiting list is not as long, then that is not as big an issue. People may be treated differently but it may be a function of their own choice, at least part of it, so it is not necessarily an appropriate analysis just to say that because category 2 or 3 was treated before the other, that is wrong.

THE CHAIR: Dr Foskey, do you have any questions of Mr Flint?

DR FOSKEY: Unfortunately, Mr Flint, although I have read your submission, I could not find it just now. If I could have a little look at a copy?

MS MacDONALD: Do you want to borrow mine, Dr Foskey? I do not have any questions at the moment, Mr Flint, I am sorry. I suppose I would note that the major thrust of your submission is that you do not have problems with the individual submissions, as such, but with them as a whole in terms of the impact that this report will actually have overall on waiting lists generally. I am paraphrasing from recollection, but I think you said; "Are we asking the right questions?" That is pretty much what you have just said as well. What questions do you think we should be asking?

Mr Flint: Well, the fundamental issue that we have is that the more structures that you give that support the waiting list, then the more a long waiting list is justified. These

recommendations are bringing in quite a lot of structures to try and bring equity within a waiting list. So it justifies a long waiting list. That is our substantive criticism of it overall. Giving people more information is generally good. We question whether they do not have that information at the moment because we believe a lot of it is actually given by the doctors themselves, not through a formal structure. So the addition of information is rather marginal. There are some people that would miss out under the current arrangements, but we are not convinced that a whole structure will actually make it that much better for them.

So that is the problem that we have. We do not believe that it is in any way appropriate to say to a person, and to validate it, that they are number 433 in the queue; therefore they wait 12 months or 18 months for a knee replacement. In the interim that person is living a very painful existence and a very limited lifestyle. We do not see that as being an appropriate thing, even though it may give some consolation that they know when they change from 429 to 428. It really does nothing for the individual. So that is the basis of our complaint, that we are producing a system that is quite good in its own right but it is a de facto justification for long waiting times.

MS MACDONALD: This is a system that operates in varying, similar forms around the country and, I presume, around the world. I have not looked into the issue of waiting times, waiting lists in other countries. I am by no means an expert in this issue. So what you are suggesting is fairly radical in a way, or are you suggesting that the system be maintained as it is but that we have a separate focus on the patients?

Mr Flint: We are not saying that we justify a system of reduced information to patients. The broad analysis of the system is that information flows are fairly reasonable and used in a reasonable way and not particularly distorted, although not perfect, and there are significant problems. What we say is that the causality of the problems is the length of the waiting list.

So, while we would encourage more information and greater transparency, and that is a natural thing for consumers, if we had a significantly reduced waiting list, then the cost of those things would be significantly reduced, too. We are concerned that a large number of resources will be used to upgrade the information and that is all they are doing. They are not actually helping to reduce the time that people wait and so the burden of the problem on the general population.

THE CHAIR: Mr Flint, we were told by specialists that in fact there are periods of the year where, because of funds not being available, they were basically available to do the surgery but there were no resources there for them to be able to proceed. Does that come as a surprise to you?

Mr Flint: No. There are people with conditions that are described as elective for whom, as I said, we would generally regard surgery as essential for people to live a normal lifestyle. They have those waits of a year or 18 months. Yes, we get those reports.

DR FOSKEY: Who puts them in the category of elective in those instances? It is their doctor, I assume?

Mr Flint: There is a whole medical process of determining the condition, and the doctors

do that. The categories are basically determined on the degree to which they are life threatening. Once they are not life threatening, they change your lifestyle significantly, but they do not get high priority.

DR FOSKEY: This is joint replacements and—

Mr Flint: Those sorts of issues that are particularly important for older people. They are generally not life threatening. They are not emergency situations. So they are in those long wait periods. That is the focus of our concern. This system is providing more information and therefore providing a justification for longer waiting.

DR FOSKEY: Yes. It did seem to me from the Auditor-General and her colleagues who were here before that really the aim of the report was to make recommendations that did not cost very much, if anything.

THE CHAIR: To improve efficiency without addressing global resources I think was the way it was expressed.

DR FOSKEY: That was the way it was expressed. I suppose they were, in that sense, constrained. Also there was reference to—and I am sure you have had a look at this—the report on the inquiry into public hospital waiting lists of the Standing Committee on Health and Community Care in 1999. Probably an awful lot of those recommendations still stand. You have had a look at those?

Mr Flint: Yes, that is right. There are quite a few of them that have not been met. Our concern there is that there does not seem to have been the analysis of why they have not been met. That comes back to that issue that does not deal with causality of the problems. Basically the report has assumed that there will be a waiting list and looked at trying to trim the process to deal with it in a bit better manner. That is the nature of the report. So our concerns are maintained from a decade ago.

DR FOSKEY: Yes. Do you have some suggestions of how we could shorten waiting lists?

Mr Flint: There are a couple of issues in there, such as like contracting out services to other hospitals. They disregarded it as being uneconomic to use the surgeries for longer hours. It seems a bit peculiar that we have so much capital invested in our hospitals and surgery and yet we do not use them because we think more than one or two shifts is too difficult to manage. The other issue that we come back to is they say there is not the capacity in the hospital. We look there, of course, at residential aged care facilities and the number of people that are in hospitals in an inappropriate way. We see it really as going right through the acute care and post acute care and residential care systems. There are all those issues that we have rallied on for a long period that do influence the capacity of the hospital system.

THE CHAIR: More, Dr Foskey?

DR FOSKEY: No. I think your point is well made.

THE CHAIR: Mr Flint, I would like to thank you for appearing today and for your

contribution to our deliberations.

Mr Flint: Thank you very much.

THE CHAIR: We will now conclude.

The committee adjourned at 3.50 pm.