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

THURSDAY, 1 SEPTEMBER 2005

Secretary to the committee:
Ms A Cullen (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 3.18 pm.

PHILIP GRAHAM LOWEN was called**.**

THE CHAIR: Thank you and welcome to these proceedings. Before we commence, I need to advise the witness of the following: Mr Lowen, 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 actions 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.

We are resuming this public hearing into Auditor-General's Report No 8 of 2004, waiting lists for elective surgery and medical treatment. Mr Lowen, for the record, would you state your name and the capacity in which you appear?

Mr Lowen: Philip Graham Lowen, CEO, John James Memorial Hospital.

THE CHAIR: For the record, would you like to say anything in relation to the report on the matter of waiting lists, before we open up for questions?

Mr Lowen: Thank you, if I might. I just wanted to summarise, under a few headings, what I intend to say and then go into more detail. Firstly, it is our position that there is no shortage of beds in the ACT. There is an issue with labour appropriately skilled to staff more beds. There are fundamental inefficiencies in the ACT public health system. There are perverse incentives that create pressures on public waiting lists. There is a fundamental advantage to public administrators in having solid waiting lists. There would be immediate relief on the system by utilising private hospitals as the primary vehicle for private and DVA patient care. I would also say that there are a no quick fixes but a need for sustained effort to achieve a long-term solution.

On the first point that there is no shortage of beds in the ACT: today nearly half of the National Capital Private Hospital beds are empty. That would be approximately 30 to 40 beds. I have my Deakin ward closed, which is 24 beds. TCH has 6 per cent of its beds with private patients and possibly up to 5 per cent more with DVA-funded patients.

There is, of course, an issue with labour appropriately skilled to staff more beds. If we all had all the beds open, there would not be adequate labour. There have been known and emerging skills shortages for many years. There has been rhetoric more than there has been action.

The ACT produces fewer nurses through training than it expects to lose by attrition, by nearly 30 per cent. And this territory relies on net inflows of labour. The average age of nurses is 43 at John James, and 45 for midwives. We are approaching an ageing crisis within nursing as well. The ACT is the slowest on the up-take of labour substitution and upskilling. An example is EN medication courses where private community sectors have trained approximately 30 or 40 nursing staff to dispense medications. To my knowledge, two have been trained by TCH. There is no theatre technician training outside of nursing

in the ACT and there is not the provision of aides to nursing which are common to nearly all other states.

ACT workforce planning is public only and across the whole of the sector, including private facility aged care and community medicine within the public sector. That does not involve the private sector, which employs almost as many people in care. ACT Health and its hospitals do not seem to have any interest in joint appointments across public and private sectors to attract quality surgeons to town.

There are fundamental inefficiencies in the ACT public health system as perceived from the private sector operating in parallel. I also point out that I am a customer of the ACT public sector as much as anyone else in this room, having used emergency services previously. The ACT has a disproportionate infrastructure running a de facto area health service at the level of a state department of health. There is over $1 million spent on salaries alone in CHIP—not as in cheap, low cost, but CHIP as in the name of their quality peer review unit; yet Calvary and TCH community health could only achieve two-year quality accreditation. We feel that there are inappropriately allocated resources for the wrong sorts of things within ACT Health.

The ACT constantly tries to re-invent the wheel instead of adopting what works elsewhere. The best-practice approach should suffice for a 330,000 population centre by adopting others' learning. Its industrial practices are such that there is fundamental inefficiency in the utilisation of capital infrastructure and strong resistance to change. At times there would appear to be a lack of political will to support management in dealing with the necessary changes. My view is that the focus is on building buildings, new theatres and announcing new centres, not on measurable health outcomes and existing effective use of capital stock, which would be appropriate for a small territory.

The public operating theatres are fundamentally less efficient than the private sector. They have afternoon sessions at TCH that go for only three instead of four hours; few theatres have the flexibility of working late on demand; they do not do as many operations in the time available; and there is no elective weekend operating. The scheduling of emergency cases, I will admit, often leads to cancellation and re-booking of elective cases, most of which then form part of the ongoing waiting list numbers.

There is stronger competition between public hospitals in the ACT than between the public and private sector. It is our view that that competition is not always healthy and is not focused on outcomes and efficiencies. The private sector is much better geared for elective surgery; it is our core business. JJMH does more surgical procedures than the Canberra Hospital. Shortly you will be asked to vote money for two high-tech theatres in the public system. You do not need them; you just need more efficient theatres; and you need retro-fitting of some of the ageing infrastructure.

On my assertion that there are perverse incentives that create pressure on waiting lists: the public sector funding structure encourages chasing private patient and DVA revenue as cream on top of the public funding, even if it does not meet the real cost of the care. The public sector offers incentives to get patients to self-identify as private patients so that private revenue can be collected. However, it goes well beyond that. There is considerable evidence to suggest that they are actively encouraging VMOs to bring more patients to the public hospital and funding and equipping areas such as pathology and

radiology, which is where the real money is in health care, to compete with the private diagnostic companies. We think it has gone far beyond just identifying private patients to actually pursuing private patients because it is seen as core, cream on top of the existing funding.

Veterans affairs patients are fully funded and are the prize in the system, despite the demographic units of ACT Health's own study that demonstrates that chronic, co-morbid cases are the main systemic blocker of beds in their system. There are veteran lounges, liaison officers and DVA transport coordinators funded by public money in the pursuit of the veteran patient.

National Capital Private Hospital and John James both report privately on those being approached to bring more private patients to the public sector at a time of high waiting lists. National Capital reports its previous referrals and transfers from the emergency department of TCH have all but ceased. Yet, at the same time as ACT Health chases private patients, it issues a tender for 212 public waiting list cases to the private sector for consideration. We will no doubt submit a tender but it does seem a bit bizarre, if not unethical, that they treat the private patients and then tender out public work.

We also ask whether anyone has done a full study, including infrastructure and replacement cost, to test the public sector logic of blindly following the New South Wales practice and spending public moneys chasing private patients, where other states seem to have backed away from that position. There is a fundamental advantage to public administrators having solid waiting lists. I speak from having worked in the public and private systems. If I were in the position of administering a public hospital, it would be very tempting to have big waiting lists. The reasons are:

- it is a great distraction from systemic inefficiencies;
- it leads to top-up funding whenever budgets are exceeded;
- it allows for constant, near-full occupancy which allows you to regulate your staffing levels without the peaks and troughs, which are routine in the public sector—if you have always got people waiting, it makes management of the patient flow easier;
- it keeps pressure on governments to pour more cash into the system without strong outcome measures;
- it can be readily manipulated; and
- it is easy to distract politicians with *Yes, Minister*-like behaviour and plausible solutions and explanations, with lots of committees and study groups.

Waiting lists in the public sector are like death and taxes; they are not going to go away. I have not seen any solutions that have ever removed them. The thing is to manage them effectively and ensure the best patient outcomes possible within the resources available. If I were a public official and empire builder, I would welcome waiting lists rather than their abolition, because it makes life easier. In fairness, though, there is progress on many of the issues that have been identified. But are there tangible results? Progress seems to be very slow—a bit like the issue of skills shortages, being well known as an issue but what is really achieved, apart from a lot of investigations, committees, study trips and tours?

There would be immediate relief, in our view, to the system by utilising private hospitals as the primary vehicle for private and DVA patients. But there are no quick fixes, and

there has to be a sustained systemic reform and cultural change to alleviate the extent of the waiting list problems.

THE CHAIR: Thanks, Mr Lowen. You have certainly covered a lot of areas. I will be keen to look through the transcript to assist in our deliberations down the track, as well as what we discuss with you in the time we have available. I might start things off with a question. A matter that was raised by the VMOs in evidence related particularly to the theatres, and you touched on that. It seemed they were suggesting that there were different times applied and different levels of efficiency between the public hospitals and the private sector. Can you explain to the committee what your view is as to the reasons why they work differently and illustrate the practices that you have in your hospital, compared to those that might exist elsewhere in Canberra?

Mr Lowen: We are an elective surgical hospital, and there are some difficulties when you starting mixing emergency lists with elective lists, because you can have unpredictable lengths of operations. Often the work is not as extensive; so you do not always know what to fully expect. That can throw the tail end of your list out and then you have rollover or re-bookings, which is a common problem in the public system.

I believe there have been efforts to try to have some exclusive elective lists, but a number of doctors who have had those comment to me that often they are lucky to get only one or two patients booked on the list, despite the long waiting lists. So there certainly are some problems with their booking systems.

We have got fairly sophisticated computerised booking systems, very similar to the ones that the ACT will be adopting shortly with their new software. We have everything focused on fast turnover. We are not best practice; we have got a long way to go ourselves; but we do know that we pack a lot more into a session than public sector facilities do. One of the drivers is that the basis of our economic sustainability is the ability to put people through theatres with everything in place quickly. We have a lot of flexibility in our theatres. Quite a number of our theatres will go quite late into the evenings and we have got some flexible staff built around that to respond to those demands.

Afternoon lists are a known problem with TCH. They run an hour shorter than the standard session times of the other hospitals, including Calvary, and it obviously has an overall impact. If you multiply 10 theatres by an hour a day, there is 10 hours a day less operating time available.

THE CHAIR: Do you know why they have those shorter hours?

Mr Lowen: It is an historic artefact and one that I believe is now more industrial than anything else in trying to overcome it.

THE CHAIR: Is it by agreement rather than by any industrial award provision?

Mr Lowen: It is not something that I would do as an administrator. Three-hour sessions are very difficult, given a lot of operations run for two hours, and you have got to have fill-in operations for 20 or 30 minutes. There is a reported tendency of the operating sessions to cut off fairly sharply if the patient is not going to be ready to go in before

5 o'clock, so they would not put them in at 4 o'clock.

THE CHAIR: We were told in evidence that it was if an operation was going to go beyond 4 o'clock. I understand that at your hospital you are happy to run beyond 6 o'clock and later. Is that correct?

Mr Lowen: Not all our lists. We have eight theatres in our main complex, and probably three of those are scheduled each night to be staffed to about 7; one, to 9; and we have a call-in team who are always there for 24 hours a day on immediate call. We anticipate that there are going to be one or two lists that will go later due to complexities, and that is why you staff according to that demand.

THE CHAIR: Could I just follow up on another point you made. You said there was reluctance to, or an unwillingness to, consider joint appointments. Have you got any examples you can give the committee of where this has been illustrated?

Mr Lowen: I have got a current one. We have an acute shortage of paediatricians at John James. We have got one paediatrician who has taken the entire after-hours workload. We have been recruiting in Australia and internationally for a paediatrician. We approached the state to see whether or not they could offer some sessional hours, because we have got a paediatrician from Sydney who will come up and take an appointment if some sessional hours are offered. That was declined, and two weeks later they advertised a full-time position in exactly the same area.

We made an approach back in January for joint advertising to try to attract a wider group to Canberra by advertising for positions that would involve public and private appointments so they can get a better income stream; they have a foot in both camps, for research and teaching. There are one or two divisions at TCH who have been making some approaches to try to change that, but on the whole it has been disappointing that there is not a territory-wide approach to dealing with specialist appointments.

THE CHAIR: What is the reason offered to you why they will not cooperate on those key points?

Mr Lowen: No reason has been given.

THE CHAIR: I have got a few others, but I might ask Dr Foskey if she would like to take up the questioning.

DR FOSKEY: I, too, am going to have to go back to *Hansard* to get the detail of what you said because there was an enormous amount in it, and it was very interesting. I am not an administrator; I have no background in that. A lot of my questions are likely to sound ignorant because they are. I was just wondering how, in general, you would describe your ability to communicate with ACT Health. Do you have to seek meetings; do you have regular conversations; do you routinely receive circulars; are you kept in the loop; do you have to fight to get an appointment at all? Do you get the idea of what I am asking?

Mr Lowen: Prior to 2001 there was almost no communication between the two sectors. We made representations at the political level, and that has certainly improved. Whether

there have been benefits from the communication process—our board is currently making that evaluation of whether the dialogue is even worth continuing—we feel that the dialogue—

DR FOSKEY: Whether the dialogue is worth continuing?

Mr Lowen: Yes. We do get information flows, but we tend to find that our opinions are rarely acted upon. We get acknowledgment, but it is a bit like community consultations at times within the health sector. There almost appear to be predetermined outcomes that have been formulated and we would have been no more than told what is happening. On some key issues, especially post bushfire, it has taken three years for some very important issues, from our point of view in the private sector, to have been resolved.

DR FOSKEY: Do you want to go into detail about that?

Mr Lowen: An example was—and it was resolved in the end—simple things like insurance. Because we took a lot of evacuated patients from nursing homes and put them in a ward that was under renovation at the time of the bushfires, technically we were in breach of all forms of legislation and could have been sued by those patients. We asked that they issue insurance for them and that doctors who volunteered and came in and staff who were volunteers be covered in an emergency when it is declared. It took from the bushfires until early this year for that to finally be effected with the insurer. But that is just red tape; it is such a simple thing that needed to be fixed. There are numerous kinds of examples like that.

We have been harping about the need to get cross-territory approvals around the quality of medical practitioners and their appointment processes. We pointed out very early in the piece that there was a fundamental flaw in their legislation that prevented us really participating in that in a meaningful way.

THE CHAIR: Could you explain for the committee what you mean by that?

Mr Lowen: This committee has the protection, like all committees, to discuss issues on peer review—it cannot be used in legal proceedings—so that we can get the doctors to talk openly about their peers and deal with issues. The information that flows from one committee to another is not protected.

THE CHAIR: Could that mean patients are at risk because the full stories about poorly performing medical practitioners cannot be communicated?

Mr Lowen: It does. Even when I write to other institutions, knowing that there may have been an incident there, there are some institutions that decline to comment, on the basis that it would not be protected; whereas if there were a channel between the various committees for that information to flow under privilege, we would then get a clearer picture of individual doctors across the territory as a whole because a number practise in multiple hospitals. But we are not seeing the data collected at one level.

THE CHAIR: I do not want to stop Dr Foskey but just to pursue this: are there tangible examples of where you believe patient care has not been of the standard required but you are not in a position to communicate that as fully and frankly as you would think

appropriate?

Mr Lowen: Yes. We rely upon feedback from individual doctors who are on the committee, who are in the know, rather than on formal documentation flowing back across the system.

DR FOSKEY: You are confirming something I have heard anecdotally as well. I think Mr Mulcahy has got more specific questions. In general, if your suggestion is taken up—and it does not sound like it is going to be—how would public hospitals remain viable? That is part one. Part two is: what do you see as the role of the public health services in your ideal model of the health world?

Mr Lowen: On the first question: I do not think someone has done a proper economic examination, including all subcosts, like your cost of capital and your long-term cost of capital replacement, as to whether in fact chasing private revenue, which is the cream on the top, actually is a benefit financially or not. It certainly is for the incentives from the hospital administrators' point of view because they are already being funded for the members of the public once; then, on top of that, if they can pick anything else up, it is an advantage. Has that been properly costed? I did a submission that suggests that, on the back-of-envelope figures, from what we can glean, it may in fact be less cost effective to do it in the public sector than in the private. That is an area that we think should be looked at but not looked at by ACT Health itself.

DR FOSKEY: The Auditor-General?

Mr Lowen: We have asked several times that that sort of thing be looked at by the Auditor-General. Is it sensible or not sensible to be chasing those dollars? At the moment what we have got is that my biggest competitor in the ACT is not National Capital Private Hospital, not Calvary Hospital, but TCH. And that is a bit bizarre. I do not mind that if we have an open competition model and they are funded in the same way we are and they compete on an open market basis. But they do not because they cross-subsidise, using public money to pursue the private patients.

DR FOSKEY: Is that not what Calvary has been doing?

Mr Lowen: There is a little technicality in funding which I do not understand the difference of. Calvary Hospital has a private wing. It is kind of unique in that it has a private wing but it has public theatres. The private side of Calvary then pays the public side of Calvary for the use of the public infrastructure. We have long argued that the formulas for that are not necessarily correct, but that is a whole other argument.

Where the private patient goes into Calvary and goes into the private wing is part of the recent scandal in the papers—whether they are in a public wing being charged as a private patient or the private wing as a private patient. There are two different rates of payment. The health insurer pays the private sector at higher rates than they pay a private patient in the public sector, because it is a default benefit arrangement formulated by the commonwealth and the states, recognising they have been funded once and they get a top-up of about half the pay that we would get to treat the same patient, because we are wholly funded by a health fund.

The money you get from a health fund for a private patient in Canberra Hospital can never fully cover the cost of that patient because it is set at a default rate, and it is a per-day paid payment and does not even pay for theatre. They rely on the funding they get for them as a public patient and top it up with the private income that seems to be the cream. Veterans affairs is different in that they fully fund everything to do with their patient, and it is open market competition between us and the hospital.

DR FOSKEY: Veterans affairs being returned soldiers?

Mr Lowen: And war widows, yes.

DR FOSKEY: And the family.

Mr Lowen: They would represent about 10 per cent of the total health care demand in most of Australia—slightly less, maybe closer to 8 per cent in the ACT. But on the South Coast, which is the catchment area too, it is probably getting close to 15 per cent or more.

THE CHAIR: If we understand your evidence correctly, Mr Lowen—if I look at data provided to me, it shows that, at the end of 2004-05, 50.1 per cent of patients at the Canberra Hospital were overdue for surgery, about 1,409 patients, which was a record for that hospital in both percentage and actual numbers, and that, at the end of 2004-05, 37 per cent of patients at Calvary were overdue for surgery, which is a record also for that hospital—you are suggesting to us that a significant reason why the patients are overdue for all surgical treatment is that the hospitals are busy chasing down the dollars they can get from DVA or from private patients and that, potentially, our public patients, who are a less profitable customer group, if you like, are in fact losing out on this equation in the quest to get the dollars and compete.

Mr Lowen: Absolutely. And it is also the position of the Australian Private Hospitals Association, which has published a lot of material on this very issue.

THE CHAIR: If you were in a position to change the arrangements—and this committee will obviously be making recommendations to the government as part of its response to the Auditor-General's report—what would be two or three measures that you would strongly advocate that would ensure we get improved patient care to address this issue of waiting lists?

DR FOSKEY: And don't forget my second question, will you?

Mr Lowen: Okay, the role of the public hospital. I would need a lot more information that I am not privy to to be able to answer the question; otherwise I would be guessing a bit. Certainly our view is that a lot of the patients who are privately insured, particularly DVA patients, could be removed from the system tomorrow and that would clearly unblock those chronic co-morbid beds because most veterans present with co-morbidities; they are an older age group generally than the rest of the patient population. Their own data shows that within TCH; so there would be some relief. It will only ever be part of the solution; so it is a short-term solution to take pressure off. There will have to be other systemic reforms in the efficiency and deployment of the resources.

As to the role that I perceive that public hospitals play—

DR FOSKEY: No, I really mean public health services, because hospitals are only one part.

Mr Lowen: I am ex-DVA and I was brought up on the tenets of health care being access, equity and need really; and that is what the public sector is there for. If the private sector can allow people to access, using their own resources, and it relieves pressure on the public sector, then that is a good thing too. But the bottom line is: the public sector is there to provide equity of access based upon clinical need for its citizens.

We have Medicare legislation that also gives them the choice of electing to be a public patient or a private patient when admitted to a public hospital. That same choice is not applied by the ACT in things like aged care and step-down areas. In fact, the Burrangiri decision very recently has done just the opposite and said that private patients do not go in there without the private sector paying for them. But, on the whole, something we are saddled with is the view that they make the election. There is some truth to the need to get people in the ACT to elect to be a private patient, because they want to get more money for them from the health funds, even though they might not get a different doctor or different Treatment. Our concern is that, at the same time, there is an active pursuit of more private patients as a fund-raising source for the hospitals, which itself could be a fallacy.

THE CHAIR: You mentioned, earlier, incentives in relation to people electing to be private patients. Obviously, the financial incentive to the institution is evident. But what goes on in this respect?

Mr Lowen: They do things like try to get them to waive gaps. The diagnostic services do not charge the same gaps that would be charged elsewhere. The aim is to try to reduce out-of-pockets. Pressure has been put on doctors to charge at rates where there are no out-of-pocket payments. There have even been suggestions at times that there might be gaps paid for by the public sector. That has been reported back to us by doctors, but we have not been able to obtain clear evidence that it occurred. But it certainly has been suggested.

THE CHAIR: That is, if the doctors were to admit their patients to TCH?

Mr Lowen: Yes, because in admitting a patient privately to TCH they would be accepting a lower fee, if they are on fee-for-service rates. There are some negotiations there that occur from time to time about what those rates might be because it is an incentive to do so. And certainly there are resources deployed to do it, because at the end of the day you need to be able to offer some differentiation to a patient who is private from public. We have heard discussions quite openly in the area of maternity, where they have suggested looking at trying to differentiate the care delivered so that there is a higher standard of amenity for private patients than public patients as well. That does not sit well with me because I do not think that is what a public health care system is about. I suppose that part of my answer to Dr Foskey is that I do not think it is an appropriate role for the public sector to be competing.

THE CHAIR: And there are instances that involve the patient, too, in this exercise, by

the sound of it, through the removal of out-of-pockets?

Mr Lowen: There are strong pressures on patients to identify themselves as private; whereas in the past a lot of private patients who identified at accident and emergency used to be transferred to private hospitals after stabilisation. Once they have identified them as an income source, they very rarely leave those hospitals unless they run out of beds. About the only time I see transfers now is if the patient regularly demands it or when their doctor insists, when they get resistance to being moved or when there are things like no ICU beds left in the territory. Then, on those occasions, I accept public patients into my ICU and bill the public sector.

MS MacDONALD: Mr Lowen, you have talked a lot about the system in general. It certainly was interesting. I will also go back and have a look at the transcript. But I would also mention that this is the public accounts committee, not the health and disability committee, which I chair. You might like to write to the health and disability committee and raise some of these issues. In fact, I would be happy to hear from you about some of these issues.

With regard to the way the public system works in the ACT, specifically with regard to waiting lists: how do you believe it compares when you contrast it with not only a place the size of Sydney but also a town like Wagga or a catchment area like the Hunter region, the Newcastle area, in terms of the waiting list times and the way the system works, with private and public assisting each other in places like that?

Mr Lowen: Having worked in the Hunter, I found that the Hunter public and private areas tended to work much more closely. That is not to say they did not have lots of incentives; they gave free newspapers and free parking to private patients in public hospitals as well. But their ability to reduce waiting lists was fast-tracked and we would quite often assist as a private hospital in the Hunter Valley. Their waiting list seemed to be reasonably well managed. I do not think the ACT's waiting lists are any worse than some of the other major cities. I travelled to Adelaide recently and it was all over the front pages there as well.

As to regional centres: it is problematic to make the comparisons because a lot of regional Australians have already opted out of health care in the local environment and put themselves onto the waiting list in Sydney and, to some extent, even Canberra, because that is the tertiary referral centre closest to them. But, equally, I would have to say too, though, that, while the ACT perhaps is not that much worse, that does not necessarily excuse the issue. I would also suggest that the ACT is probably better resourced than any other health system in Australia as well.

MS MacDONALD: You mean per capita?

Mr Lowen: I think so and as to how it is actually deployed. And that goes to whole issues of community disability as well. I think there is some underfunding in community disability and probably overfunding in hospitalisation in the ACT, despite the very issue today being about waiting lists in hospitals.

MS MacDONALD: Concentration on the tertiary rather than the primary care?

Mr Lowen: And part of that may be because it is attempting to run itself as a health department, and it should not be. It is not that big a territory to have huge health promotional campaigns, to have all the ministerial, nice, glossy openings, brochures and special centres and things. Yes, you have them to the point where they help attract a labour force, but do you really need to reinvent the wheel and spend so many resources? There is $1 million alone of salaries in that CHIP unit. I wonder what it really achieves now.

MS MacDONALD: Sorry, which unit?

Mr Lowen: It is a unit called CHIP.

THE CHAIR: It is the peer review unit.

Mr Lowen: Yes.

THE CHAIR: Could you tell us a bit about that?

Mr Lowen: I do not really understand its functions, but I have lost a couple of my staff to it.

THE CHAIR: So they pay well.

Mr Lowen: Because it pays much better. We do accreditation and peer review on a shoestring and have got full four-year accreditation and very few problems in our system. So I question whether throwing resources at a problem is the actual solution. It is how you use resources smartly. I think that part of the whole issue going forward with the waiting lists is that the resources are there; it is how they are prioritised and managed.

THE CHAIR: Could I just ask you about the waiting lists. Notwithstanding that we had an inquiry under way, there seems to have been some pronounced improvement in May and June of the number of people on the list for elective surgery. A lot of people were removed—"for other reasons" was the report—they are off the list. Do you have any knowledge of how that might have been achieved?

Mr Lowen: I will not directly comment but I can comment on broader experience in my career as a public health administrator and suggest that one would need to be wary of consistency of definition and of purging of the lists. It is very easy to purge a waiting list at a moment's notice, basically. You can ring around; you can knock waiting lists back very quickly when you want to. You can also let a waiting list build up when you want to. I am not suggesting, however, that I have got any evidence that would suggest that someone might purposely manipulate the list, but there would be incentives to do so.

THE CHAIR: It was put to us that, despite a recommendation from the Auditor-General, it was not practical to ask people to sign off on not-ready-for-surgery consent. I guess that would be an issue if you were purging them fairly aggressively.

Mr Lowen: Yes. In all fairness, too, in the Hunter, where the hospital I was running was doing waiting list reduction surgery for the public sector, we were extraordinarily disappointed at the quality of waiting lists there, in that we would get patients that we

would offer an operation to on Saturday morning and they would say, "No, I'm going to bowls" and not turn up. You would offer them twice and then you would have problems when you would suggest they then be removed from the waiting lists, and they were not, and things like that. I got a phone call one day from a businessman, "I've got a business meeting; I'm going to be late to surgery; reschedule me to 2 o'clock, please," instead of the 12 o'clock slot we had him in. We were appalled at some of the attitudes of public members who were on the waiting lists and their expectations of the system too. So it is not entirely a one-way street.

THE CHAIR: Sure. One of the issues the Auditor-General raised with us in this report is that there were people who did not find the time convenient—and you talked about some of those—but did not appreciate the consequence that they may be jettisoned out for another year or so. They assumed it was a more simple process of moving people back and forth on the list.

Mr Lowen: There is an issue between clinically ready for surgery and emotionally ready and also then being socially ready for surgery. I do not think the latter really is justifiable perhaps after you have had a couple of offers. It would suggest that there is not the unmitigated pain and suffering that would necessitate a higher offer than some other person on the list.

THE CHAIR: Going on to the issue of skills shortages, which you identified at the commencement of your remarks as a major factor: people tell me that in the hospital one of the critical issues is the shortage of nurses. I have looked at the pay scales and what we are offering in the public hospitals is now competitive with New South Wales. Have the proper methods of training or the tertiary-based reliance on training for nursing staff exacerbated this problem? Would on-the-job training, or whatever the appropriate term is—applied training—be an answer to addressing this shortage? You talk about an average age of 42 for nursing staff. It is a bit worrying in that a lot of those people would be looking to retire within the decade, potentially.

Mr Lowen: That is correct. There is not an easy answer. There are very split views about the benefits of the move to tertiary education versus on-the-job training. My personal view is there should be a blended solution. I think we miss out on some very suitable nurses who are vocationally orientated, who are quite appropriately vocationally leaning towards nursing and do not enter because of the tertiary barrier and could have benefited from on-the-job training as a method.

I think there are also a number of nurses who come through the tertiary system, as do doctors, who find they do not like patients and end up working in other sectors. I think there has been a huge growth in what I call clipboard nursing, which is non-direct patient care using the nursing qualification, and that probably has been encouraged a bit. How many people want to come out of a tertiary education and find they are still handling bedpans and making beds and things, which in many other jurisdictions are being done by support staff who underpin nursing? In the ACT it has been very much kept by the ANF within the nursing purview.

It is areas of reform like that that are probably more useful in the short term—getting theatre technicians, anaesthetic technicians, who are non-nursing based, trained up and appropriately skilled and getting aides to nurses who can underpin the nurses, getting

enrolled nurses medication trained so that they can take on a greater role. Those things are all on the agenda nationally. The ACT certainly lags behind the other states in implementing changes in the workforce.

THE CHAIR: So work practices are working against people staying in the profession?

Mr Lowen: It is, and it is like trying to stretch nursing too much. On the one hand, we are saying we want to start looking at nurse practitioners becoming doctors because of the doctor shortage; at the other end, we are still asking them to do bedpans, change beds and shower patients. There needs to be a different way of approaching that vocational skills mix than relying on expensive, tertiary-educated nurses to do it all hands on.

THE CHAIR: Is there any overflow exchange between yourselves and Canberra Hospital, given you are a three-minute run, almost, between hospitals?

MS MacDONALD: How fast are you driving?

THE CHAIR: Well, whatever. Five minutes, maybe. Obviously if they have critical bed shortages, are you likely to be in the same predicament on those occasions, or is there opportunity there for far more toing and froing?

Mr Lowen: In areas such as ICU we argued two or three years ago quite forcibly for a collective approach to both doctors and nurses in ICUs across the territory. My personal view is that it fell upon empire builders; there was too much tension between Calvary and TCH over ICU anyway, such that there was no likely resolution because they could not talk. Why did we expect to be involved in a network solution?

THE CHAIR: Dr Foskey has a question, but in terms of, say, elective surgery, our main focus, is there a method where you could help them relieve their lists by maybe accepting some of those patients or not?

Mr Lowen: There is going to be reluctance in the private sector to accept public patients in with private patients because it undermines the very product on which our sector is based, which is private insurance. If the private insurance does not have value in differentiating, it is going to be difficult.

THE CHAIR: Private patients on their list, you would be happy to assist, obviously?

Mr Lowen: Yes, more than happy to take private, and we have offered to take public patients in and say, "We've got an auxiliary hospital, if it's day surgery, at Lidia Perin." I am quite happy to sell blocks of time and blocks of staff to the public sector to assist them. There could be better flows. But, in fairness, there is a fair degree of labour flow between the public and private sector anyway. A lot of the labour force in the private sector are casual, a much bigger proportion are permanent part-time, and it is quite common for nurses to have multiple jobs across multiple hospitals. So they are far more connected at the real nursing level than the administration and the planning are.

DR FOSKEY: Could you go back to the statement you made earlier that your board, or some entity related to your hospital, is considering looking into the value of dialogue with ACT Health. Is that right? Tell me more. What does that mean?

Mr Lowen: Our board set out, as one of my early objectives, to improve networking and dialogue with the ACT. Some of the reasons were: we felt that there needed to be appropriate cross-sector dialogue on labour force shortages, on planning of capital infrastructure and stock, because we were looking to develop new buildings and new facilities and things. We wanted to be sure there were not conflicts and that we could work together. We have had a lot of dialogue. I do not know that it has really achieved anything of great value to us. There have been some information flows, but we are not satisfied that it is necessarily a worthwhile investment.

DR FOSKEY: So you think it is worth while for ACT Health?

Mr Lowen: Perhaps, in that they are getting information on our intentions earlier than they might have done. I do not see a great deal of responsiveness to the suggestions we make. I feel sometimes that we are told and not consulted, and I feel that great opportunities are lost for cooperation across the sectors.

THE CHAIR: We are past time. Mr Lowen, I have been quite interested in and fascinated by your evidence. I know both my colleagues will read through your evidence. It may be that we may want to ask you a little more down the track. I know how busy you are. We appreciate the time you have made available, but we will see how we go on that score. Thank you for coming here today and sharing your thoughts with us. I am sure they will form an important part of our deliberations. I will now formally adjourn this hearing.

The committee adjourned at 4.03 pm.