LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON PUBLIC ACCOUNTS

(Reference: Inquiry into 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, 28 SEPTEMBER 2006

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 that have been authorised for publication by the committee may be obtained from the committee office of the Legislative Assembly (Ph: 6205 0127).

WITNESSES

The committee met at 11.32 am.

GALLAGHER, MS KATY, Minister for Health, Minister for Disability and Community Services and Minister for Women

CORMACK, MR MARK, Acting Chief Executive, ACT Health

THE CHAIR: Good morning. Before we commence this public hearing into the Auditor-General's report No 8 of 2004, concerning waiting lists for elective surgery and medical treatment, I need to read the following for the benefit of witnesses. The committee has authorised the recording, broadcasting and rebroadcasting of these proceedings in accordance with the rules contained in the resolution agreed by the Assembly on 7 March 2002 concerning the broadcasting of Assembly and committee proceedings.

Before the committee commences taking evidence, let me place on record that all witnesses are protected by parliamentary privilege with respect to submissions made to the committee in evidence given before it. Parliamentary privilege means special rights and immunities attach to parliament, its members and others, necessary to the discharge of functions of the Assembly without obstruction and without fear of prosecution.

While the Committee prefers to hear all evidence in public, if the committee accedes to such a request, the committee will take evidence in camera and record that evidence. Should the committee take evidence in this manner, I remind the committee and those present that it is within the power of the committee at a later date to publish or present all or part of that evidence to the Assembly. I should add that any decision regarding publication of in camera evidence or confidential submissions will not be taken by the committee without prior reference to the person whose evidence the committee may consider publishing.

I also need to inform you that, as part of the webstreaming trial of Assembly proceedings, this public hearing is being webstreamed, which is a first for the public accounts committee. We will watch that with keen interest. I would like to remind witnesses, as I am sure you would be aware, that you should state your name and the capacity in which you appear when you first speak before the committee. I extend a welcome to you, minister, and Mr Cormack.

Just by way of a quick reminder for the benefit of those monitoring proceedings, we have been undertaking this public hearing for some time and we were particularly interested in inviting the current minister to review some of the material that we sourced through inquiries undertaken by the committee in Sydney, particularly in relation to the Auburn elective surgery program pilot. We felt that the material sourced from, initially, my own visit to the facility with the committee secretary and the visit subsequently by other members of the committee was of considerable interest and we thought we would like to give the minister an opportunity to review that before moving to the final stages of our report. The minister kindly acceded to that and we took the slightly unusual process of sending our report on that particular series of discussions to the minister so that she and her officers could consider it.

Minister, I invite you to make a preliminary comment or give an overview on that material, if you are in a position to do so, and then take some questions from the committee.

Ms Gallagher: Thank you, chair. I apologise for being late and thank the committee for working with me on that one. I understand that this inquiry has been going on for some time and that you had the previous minister come and speak to certain things that were going on in ACT Health in relation to elective surgery and the management of the waiting lists, and we can certainly answer questions about that.

I have had a look at the material the committee provided to me on the information it obtained from visits to Sydney in relation to the Auburn model. I will be fairly brief and then we can get into the questions. We are lucky to have Mr Mark Cormack here as the acting chief executive, as he actually worked in that area of Sydney for some time and has a deep understanding of what is going on. To be brief, there are certainly things going on in relation to the Auburn approach which are relevant to us in the ACT and there are certain parts of the model which are not.

We are already working on the areas that are relevant. We cannot replicate some areas in the ACT largely due to the fact that Auburn hospital is quite different from Calvary Public Hospital and the Canberra Hospital in the sense that of necessity, to survive, it had to change its focus to what it provided to the population around it. There are 13 hospitals across the western metropolitan area of Sydney, up to the Blue Mountains and as far as Lithgow. The fact that Auburn hospital is also a fairly small community-based, non-teaching hospital with 120 beds makes it different again from the hospitals that we have here.

In a sense, the hospital had to find a niche for itself in order to survive and it has done that very well. It has done that by concentrating on elective surgery and throughput. Certainly, in the areas that we can learn from the Auburn model, we will, but within the constraints that we have here, that is, that both of our public hospitals are teaching hospitals. Canberra Hospital is a major regional hospital and does a lot of emergency surgery and of dealing with emergencies. Therefore, our control over elective surgery on a day-to-day basis is a lot more fluid than perhaps the experience at Auburn. But everyone here is able to answer questions of the committee and also to inform you of what we are continuing to do in an attempt to improve our service to the people of Canberra in the area of elective surgery.

THE CHAIR: Thank you very much, minister. I will lead off. I have a number of questions. Whether we get through them all with depend a bit on how we go. I might put them on notice to you if we run out of time.

Ms Gallagher: Yes, sure.

THE CHAIR: I will start on the cost issue. What impact do you believe decreasing from current levels the length of stay and time taken to perform elective surgery procedures and increasing the efficiency of theatre utilisation in the ACT would have? What sort of impact do you think is, I guess, achievable?

Ms Gallagher: Is your question around the cost?

THE CHAIR: The cost impact, yes, as a result of change in the length of stay and time taken to perform elective surgery procedures, which might include efficiency of theatre utilisation.

Mr Cormack: Mark Cormack, Acting Chief Executive, ACT Health. I think the short answer is that we are providing a number of approaches to improve elective surgery throughput, and the minister will no doubt talk about some of those in response to questions, but your specific question is around theatre efficiency and scheduling.

THE CHAIR: And duration.

Mr Cormack: Yes, that is right. Certainly, there are a number of areas that we look at in theatre efficiency. One of them relates to day-of-surgery admission, which is referred to as DOSA. DOSA is a system whereby, instead of bringing a person in the day before their operation, you run outpatient clinics that are called preadmission clinics, and that is very much a part of the Auburn model. You get them all worked up, you make sure that they are fit, they are well, and then when they turn up for their operation they are ready to go.

Day-of-surgery admission is certainly well established at Canberra Hospital and Calvary Hospital, and that really involves a person turning up at 6 o'clock in the morning, rather than coming in the night before, and organising the theatre lists around that. So you save half a bed day and, when there are pressures on beds, that is a very important gain for us. That is certainly one area.

We monitor those every month and we have set targets. Calvary Hospital runs at just under 90 per cent of its admissions on a DOSA basis and TCH is now running at over 70 per cent. That is a significant improvement over the last 12 months and that has enabled us to improve the throughput of the theatres and also to reduce cancellation rates. So that is one tangible example.

THE CHAIR: If I might take up on that point, can you help the committee understand why there is quite a significant difference there as to the 70 per cent and 90 per cent factor?

Mr Cormack: Sorry, I do not understand.

Ms Gallagher: Between Calvary and TCH.

Mr Cormack: The difference there is clearly due to the types of cases that go to the two hospitals. Calvary Hospital has a more focused role in elective surgery, and that is because they do less complex work and they do a lot less emergency surgery, so their operating theatres are less prone to interruptions and those sorts of things. If you are familiar with the Auburn model, one of the key features of the Auburn model was that there were almost no interruptions to the theatre through emergency operations.

The difference between TCH and Calvary is that Calvary have less emergency surgery, less break-ins, so they are able to plan their lists a lot better, have less interruptions. Also, they tend to focus on less complex cases, and less complex cases can be planned

better. You can get more in to, say, a four or six-hour theatre session and that is why Calvary are able to get roughly 90 per cent of their patients—it varies a bit from month to month—in on the day of surgery because they know that they are unlikely to be bumped, which is the term we use, by an emergency surgical patient.

TCH is a different kettle of fish. It is a 24-hour major trauma hospital. We do cardiothoracic surgery, major vascular surgery, major hip and knee, trauma, plastics, paediatric surgery. It is a much more complicated environment. Therefore, we believe setting a target at between 70 and 80 per cent is probably about as good as it is going to get there under the current circumstances.

THE CHAIR: Okay. Turning to the operation of the theatres at TCH and Calvary—we were told in earlier evidence that John James has a different arrangement, notwithstanding all the problems besetting the hospital—what are the comparable hours of operation of the theatres under most circumstances?

Mr Cormack: I can't give you the precise detail for every day of the week, because it varies from Monday to Friday. But, looking at Monday to Friday, typically Calvary will run a little bit longer than TCH, largely due to the way they have been able to schedule their lists and organise some of their rosters. That has been part of our program for both last year and this year. Part of the government's additional allocation to elective surgery in 2005-06 and 2006-07 is about actually extending the operating hours, specifically at TCH, where some of the lists finished at four. We are progressively going to be increasing those to five and that is going to give us a good bit of additional throughput.

THE CHAIR: Will you achieve parity, do you believe, between the two hospitals?

Mr Cormack: No, I don't think we will achieve parity.

THE CHAIR: Is that because of industrial constraints?

Mr Cormack: No, not because of industrial constraints. The major difference between the two hospitals is the nature of the workload and the casemix. Calvary have six operating theatres and they can pretty much predictably run those six operating theatres all the time. Canberra Hospital have 10 and they have to set aside one theatre, sometimes up to three theatres, at any one time for what is called non-elective surgery, that is, very urgent work, or emergency surgery. So you have got a lot more balls in the air to juggle at TCH than you have at Calvary.

THE CHAIR: Do you see any merit in rationalising operating theatres to a single 6½-hour list with one shift of theatre staff?

Mr Cormack: We are looking at a whole range of options for improving the efficiency of the theatres. We are focusing this year mainly on TCH and we see some merit in extending the overall length of the operating times, and that could well include consideration of an unbroken six-hour list. So we are very open to that suggestion, but at this point in time we are doing a piece of redesign work under the access improvement program and that will give us greater guidance on how we can structure those theatre lengths and durations.

THE CHAIR: In a sense, you may have answered my next question a bit earlier, but it just needs a little expansion. What clinical pathways currently exist for day-only surgery in the ACT, and has the government considered developing these to provide more comprehensive education to limit the amount of time patients stay in hospital because of post-op nausea and vomiting? For example, in the Auburn elective surgery program pilot, patients were seen in the preadmission clinic by post-acute community care experts. Do we do the same in the ACT? If not, aren't there staff available to implement a change of this type, given that over the period of that particular project, with which I am sure you are quite familiar, the cost of post-operative inpatient care was reduced by nearly $82,000? I am just wondering if you can do that. Do you think there is scope for more efficiency?

Mr Cormack: Yes, there certainly is scope to do that and, in fact, we are doing that. Certainly, Calvary has a good, well-developed preadmission process. They have a number of clinical pathways for certain conditions that are high volume, like a laparoscopic cholecystectomy or a gall bladder removal. You see a lot of those, and for those high-volume operations you are able to build what they call a pathway. You know exactly how long the person is going to be required to come in for their work-up, exactly how much time they will be in theatre, how long they will be in recovery and when they will be ready to go home. There is scope to do that. It is better established at Calvary. We are establishing it at TCH.

The other part of your question related to preadmission clinics. They are a feature of both hospitals. That is a critical part of achieving day-of-surgery admission as opposed to admission the night before. We have those processes in place, and the redesign work that we are undertaking under the access improvement program is going to consider further expansion and development of that concept.

THE CHAIR: Given that the most popular feature of the Auburn pilot project from the patient's point of view was having a definitive day of surgery, do you believe that the absence of this level of surety is a major source of discontent in the ACT system?

Mr Cormack: I think it is fair to say that we would like to be in a position where we can guarantee a day of surgery for every elective surgery patient that we have. So one way of answering that is that, yes, if we could guarantee that, we would. But, unlike Auburn hospital, both of our hospitals have busy emergency loads. We do focus on reducing cancellation rates and reducing rescheduling rates, but it is not possible to guarantee that every person who turns up for their booked elective surgery is necessarily going to achieve that. In last year's budget papers and in this year's as well, we set targets for ourselves about getting to a target cancellation rate at each hospital down to, I think, five per cent at TCH—I will double-check that for you—and two per cent at Calvary. If we can get down to those sorts of rates, that is probably about as close as we could realistically get to a guarantee of surgery.

THE CHAIR: Notwithstanding those targets, do you actually have figures or are you able to furnish this committee with figures on the number of elective surgery procedures that have been postponed because of emergency cases over the last year?

Mr Cormack: Yes, we certainly can make that available to you.

THE CHAIR: I have other questions, but I invite Dr Foskey to take up the questioning.

DR FOSKEY: One of the things suggested to us by the Australian Health Care Reform Alliance—it has an Australian, not ACT, focus, so it is probably easier for it to say these things—was that there be better cooperation between ACT and New South Wales services, I guess as part of us being part of the southern region. I am interested in what arrangements we have with Queanbeyan hospital, especially in the light of recent developments there, and whether it can be brought into the equation along with Calvary and TCH. Also, where does John James fit in?

Ms Gallagher: I will begin and Mr Cormack can jump in if I get anything wrong or if he has things to add. I think that about 30 per cent or 28 per cent of the waiting list in the ACT is taken up by New South Wales residents. In fact, when we saw a big growth in the lists, a lot of that growth was coming from New South Wales, not the ACT. ACT additions to the list were remaining fairly static, although I understand that that growth in New South Wales has ebbed a bit.

So, in terms of cooperation, from our point of view there is enormous cooperation from the ACT in terms of providing access to elective surgery for New South Wales residents. That, of course, is dealt with through the cross-border arrangements that we have with the New South Wales government. In terms of Queanbeyan hospital, they have not had a great deal of capacity to deal with the demand or the complexity of the cases that are coming from across the border. Their redevelopment may provide greater opportunities, although it is still pretty early days. I don't know when that is due to be finished, certainly in a couple of years.

There may be more opportunity for New South Wales residents to go to Queanbeyan for particular operations, but I think it is recognised that the hospitals here are excellent. If you are coming through a specialist and the specialist decides that you need a particular type of procedure and you get put on the lists here, there are not too many complaints about that. We offer a great service through our hospitals and that is recognised through the number of New South Wales people coming here. That could be due to some extent to a lack of capacity within the New South Wales hospital system—I mean more broadly than Queanbeyan—in this area, stretching down to the coast.

DR FOSKEY: I know, because they even come from across the border with Victoria. Delegate hospital is the nearest hospital, but people from there come here, too. I am not sure whether we recover money from Victoria.

Ms Gallagher: We do, yes.

DR FOSKEY: We are surrounded by lots of small town-based hospitals.

Ms Gallagher: Yes, that is right.

DR FOSKEY: We did talk to someone from the New South Wales department of health on that—the secretary's memory might be better than mine on that; I was just looking for my notes and, naturally, I could not find them—and I think he said that Queanbeyan might focus on knee reconstructions, that it might have that ability. I do not know whether anyone else has a better memory on that.

Ms Gallagher: That would be great. It would be of benefit to the management of our lists here if that were to occur. In relation to John James, a later part of your question, we did purchase a small number of procedures from private providers, but I am not sure if John James was one.

Mr Cormack: Yes, the minister is correct. We went out to tender for a small number of procedures last year and we received bids from two of the local private hospitals.

THE CHAIR: Was that the varicose veins exercise?

Mr Cormack: That is right, yes. We received bids from two private hospitals and the winning bid was from NATCAP, and they did the work for us last year.

DR FOSKEY: Is that the National Capital Private Hospital?

Mr Cormack: Sorry, the National Capital Private Hospital. It is on campus at TCH and the minister has certainly announced and has advised of her intention for ACT Health to continue to develop that as a very good and useful way of targeted reduction in long-wait surgery. We are actually in the process as we speak of preparing for some expressions of interest from the private sector to provide some targeted procedures.

THE CHAIR: What sorts of procedures do you believe would be applicable to this option?

Mr Cormack: There are a number of procedures. We are mainly focusing on those sorts of procedures that, first of all, are in long-wait categories, that is, category 2 or category 3 that are well past the benchmark time. So the first criterion is to identify who is waiting the longest. We also need to bear in mind that we don't want to inadvertently give priority to a person who has been waiting longer over a person who may have more clinically urgent needs. So we have to balance that.

The sorts of procedures we would be looking at relate to some skin procedures; that is, plastic surgery. I stress that I am not talking about cosmetic surgery; I am talking about plastic surgery or soft-tissue surgery. We would be looking also at urology, gynaecology and some minor orthopaedic procedures. The reason we are focused on those is that we've got a lot of them, they tend to wait a longer time than other cases, they tend to be less urgent and, in the main, they can be done on a day-only basis. That is attractive for the private sector and that is attractive for us. If we can get a good price for that from the private sector, that helps us to do a lot of the reforms that we mentioned before and focus greater attention on improving the efficiencies at both TCH and Calvary.

Ms Gallagher: There may be some changes to the private providers here, as people might be aware from listening to the media over the last few days, and we will be watching how that might affect costs.

THE CHAIR: Are you talking about the ownership of John James?

Ms Gallagher: Yes. That certainly will change the mix that we've got at the moment of private providers, and that may have a flow-on impact on cost, on what people are asking

of us in terms of tendering for these. We will just keep an eye on that. I should also say, since I have made it clear that I am open to looking at and investigating ways of dealing with certain types, particularly long-wait patients, through private providers, that I have had representations from the private health insurance sector—in fact, I met with it last week—which is concerned about this. So I think it's steady as we go.

I did address their concerns by saying there were only 50 procedures last year, that we were not talking about a full-scale revolution as to how we deal with elective surgery lists, but that where there was a particular patient with a long wait and it could be done at a certain price in the private sector, then we as a responsible government should investigate that option. Certainly, we wouldn't be looking at a large-scale change because we strongly believe in public hospitals providing services to the public, but also out of just maintaining an appropriate balance there.

There was enormous concern expressed during this meeting at that coming into the private sector. It was largely around the effect it may have on people's uptake of insurance, that if a patient had gone through the public system and was sitting in a bed next to someone who was paying for private health insurance and they have got the same procedure, the same doctor and the same treatment in the same nice environment, that may have a flow-on impact on people taking up insurance. I was able to comfort them by saying that perhaps waiting two years for your surgery may be enough of an incentive for the private person to maintain their insurance.

THE CHAIR: Would I be right in assuming that the other part of their concern would have been, whilst I am sure their primary interest is in their policy holders, the fact that you would be paying a premium for work undertaken at NATCAP, that that might have been the central issue of their concern, and therefore their costs?

Ms Gallagher: That certainly wasn't part of the meeting.

THE CHAIR: I understand you pay a premium. For the varicose veins procedures, I understood that there was a premium paid for that work.

Mr Cormack: We pay market price for those procedures. The arrangements between the private health insurers and the private hospitals, as you can appreciate, are commercial contracts. We do not have access to those on a micro basis, but we go out to the marketplace and the marketplace gives us a price. If we believe that the benefits can be achieved at that price, then we buy.

THE CHAIR: I am not being critical, but you would obviously be paying more to conduct those 50 procedures there than you would be if they were conducted at TCH.

Mr Cormack: Yes, we certainly did last year, but that is not necessarily going to be the case into the future. We may take a different approach. It is not all about money, though, as I think you would appreciate. What we are trying to do, above all, is to improve timely access to elective surgery for public patients. If we do not have the capacity immediately available to us to do that, the private sector has at times got slack capacity available and we take advantage of that.

DR FOSKEY: Can I take this opportunity to correct what I said earlier about

Queanbeyan hospital as a result of looking at our conversation?

Ms Gallagher: Damn, they are not going to be doing hip and knee!

DR FOSKEY: They could be open to persuasion. In this conversation, the person concerned—Donald McClelland, whom you probably know—talked about Bega as well as Queanbeyan upgrading, so that could take some flow from the region. He talked about knee surgery as a case study as to where money could be saved in this sort of in and out arrangement, but he did not say that any particular hospital might take that up. That was just to clear that up.

MS MacDONALD: It is open to negotiation, possibly.

DR FOSKEY: I would say so.

Ms Gallagher: I think that any upgrading of the hospitals in Bega and Queanbeyan, even outside the elective surgery issue, would be of some benefit to some of the demand that we see across the system in the ACT, so we would welcome those investments.

DR FOSKEY: I think that you have given us some good reasons today why the Auburn model isn't directly applicable here, but one of the things that might be transferable is the way that they administer their waiting lists, their entries and so on. I am just wondering whether there is any potential in the ACT for streamlining, given that we have got two hospitals involved and potentially a private hospital or two, of the way that admissions are handled and the way waiting lists are surveyed. I know that there is a triage system of some kind, but I am wondering whether you could perhaps indicate any changes that might have occurred since the Auditor-General reported.

Mr Cormack: Certainly, a number of changes have been made. One of them is that we now have a clearer elective surgery waiting list policy. That is published on our website and it largely addressed the policy issues that were raised in the Auditor-General's report. A second key element of the Auditor-General's report was really the administration and management of the lists themselves. We have now established a single waiting list arrangement across the territory, whereas we had a fairly clumsy hospital-by-hospital arrangement and at times there were people on two lists at the same time, so you were getting a bit of a distortion there. We don't have that anymore. We've got a single, integrated web-based system.

Thirdly, we publish on a dynamic basis a surgeon's waiting times on the website. That has been up and running for, I think, just under a year, and general practitioners and consumers have access to it. If they have to have a hip replacement, for example, they can literally go to the website, call up the list of doctors who have public hospital admitting rights and look up the waiting times, and that can guide their choice. We encourage them to make that choice with their general practitioner, who, of course, guides patients in that choice. So we have been able to do that.

We have also concentrated on a clerical audit. Because people on the waiting lists can, unfortunately, be there for a long time, we need to make sure that we continually update their details. We need to make sure that they still need their surgery, because we do find that some people might have their name on a list here, they might have their name on a

list in New South Wales, they might have their name on a list in Victoria, and then, if they get fed up with all three, they may just use their private health insurance and get it done privately. We don't automatically know that. That is why we have a routine program of audit and the staff you see behind me are responsible for managing that process of audit. Certainly a lot of the nuts and bolts of managing the lists has improved significantly.

One of the features of the Auburn model was surgeons being paid on a fee-for-service basis. That is available to any surgeon. When their contract comes up, we offer them fee-for-service or sessional payment. That is a choice that is available to surgeons. A number of them avail themselves of that and others choose to have an hourly rate. We have already introduced that. As I mentioned earlier, one of the other features of the Auburn model is the focus on day-of-surgery admission. We have made some very substantial gains, particularly at TCH, over the last 18 months. Yes, we have adopted a number of good principles there. In fact, we will continue to look at those in our current redesign work. Chair, you mentioned before the longer list duration, and that is certainly something that we are exploring as a worthwhile initiative to pursue for some sorts of cases.

THE CHAIR: Just following on from what I raised earlier about the sorts of procedures that might be available for contracting out, one of the objectives of the ASPP project was to build proficiency in low-complexity surgical procedures, therefore increasing the types of surgical procedures that could be performed in one day. Is it possible to join these two approaches? That is, could the government manage elective procedures to allow a pool of private providers to perform low-complexity procedures within a day? I think you said you tender or invite bids and I know there are issues now with the possible ownership of one of the private hospitals, but is it possible for you to create a pooling arrangement?

Mr Cormack: Pooling of lists?

THE CHAIR: Pooling of private providers to undertake less complex procedures.

Ms Gallagher: Through a tender process, you have available 10 surgeons who are ready to go.

THE CHAIR: Yes.

Mr Cormack: It is possible within the government procurement guidelines to do that.

THE CHAIR: Is it something you would favour personally from your experience?

Mr Cormack: I haven't seen that system in place, I have to say, a pool of private providers within an area. As the minister pointed out, by virtue of the ownership change there are now only two private providers of major surgical work in the territory. There is some specialised stuff at the Canberra Eye Hospital and those sorts of things. It is possible through the government procurement guidelines for us to have a panel or a pool of providers, which in this town would be the two or three private hospitals. It is possible to do that. I am not sure, chair, whether you are also referring to the other aspect of the Auburn model, which was the pooling of patients.

THE CHAIR: That was something else that we learnt in our visit, which they seemed to believe had been surprisingly well received, after some work, as you would know, with the surgeons, which I must say would have been one of life's more interesting challenges. Is there a reason that that can't be explored or is it a battle you would rather not run?

Mr Cormack: No. We have ongoing dialogue with our surgeons on ways of improving access for public patients. For the benefit of the committee, generally speaking, when patients get onto the public hospital waiting list, they get on with a doctor's name against them. So it might be a Dr Smith who does surgery and they then wait on the list until a slot comes up on Dr Smith's list and he will either do the surgery himself or herself or his or her registrar will do that under supervision, because that is the way things work in the public system.

What does pooling involve? Within, say, the speciality of orthopaedics, there might be in this town a dozen orthopaedic surgeons. Instead of assigning a patient to a doctor, you assign the patient to a pool for the next available time in an operating theatre, so you might come in under Dr Smith but you get operated on under Dr Brown. We have that in place for a number of subspecialities. We try not to enforce it. We try to encourage the doctors to see the benefits for their patients and the benefits for the system as a whole.

Doctors are very concerned about the relationship they form with their patients and we respect that. That is a professional thing. It is part of their ethos and code of conduct, and we respect that, but we also respect the right of patients to get access to timely care. So in the case of general surgery, for example, we do have some arrangements where surgeons, if you like, share their patients amongst a group of surgeons. Just recently we relocated some ear, nose and throat patient lists from the Canberra Hospital to Calvary, and that involved a cooperative arrangement between a number of surgeons to redistribute the workload. We try to do that, I guess, through negotiation rather than forcing the issue, and we would like to encourage more of that, but I think you are alluding to the fact that those sorts of negotiations can be difficult. We encourage it but we can't enforce it.

THE CHAIR: Have you familiarised yourself with the way they got to that point at Auburn? They seemed to feel they had made quite a deal of progress in managing all that and, dare I say, herding those cows.

Mr Cormack: Dr Brooke-Cowden was probably the major driving force there. He took responsibility for setting up the model. I think he cracked heads amongst the surgeons. So it was really a clinician-led arrangement. I think he said, "Do you want to provide a better service to your patients by getting them off the lists quicker or do you just want to hang onto them until they wait three or four years for their operation?" That clinician-led model is a good way of doing it. When they come to a decision as a group of peers it is a lot easier than a bureaucrat suggesting that they do it.

THE CHAIR: That makes sense. Given the recent comments that were made by a surgeon in the ACT system—for the record, it was on 13 September on the ABC and the quote was "until you actually have the people responsible for service delivery actually involved in these decision-making processes, I think you'll always have

inefficiencies"—does the government believe the role of a surgical coordinator as used in the Auburn project would contribute to improvement of the efficiency of the ACT system?

Ms Gallagher: I will begin and Mr Cormack can fill in the detail. I missed that interview, although I've got the gist of it, I think. From my understanding, there is a range, certainly a couple, of forums where surgeons are involved in decisions around how policies and procedures are taken. I haven't got a date yet, but I am going to attend a couple of those meetings just to hear directly from them about other ideas that they have to improve access to elective surgery, in particular. If there are things they do not think we are doing and they can be specific about them and we can address them, I think that would be a good outcome for everybody.

My understanding is that they have been involved in all of the discussions to date and there have been significant improvements based on their advice. They are an important source of advice and I will take whatever they say and see what we can do with it, within the bounds of what is achievable at the time. Mr Cormack might be able to talk more about that. They have two different names. I can't recall what they are.

Mr Cormack: There are really three major opportunities that we are pursuing at the moment. The minister has very strongly encouraged us to enhance and improve the dialogue with surgeons—indeed, all clinicians—and we are kicking off what is called a surgical services task force. The minister will be attending the first meeting of that as soon as we can get diaries lined up, because surgeons and ministers are sometimes difficult to get in the same place at the same time.

The surgical services task force will be a fairly large group. There will probably be up to a dozen surgeons, a couple of anaesthetists, and obstetricians. We are asking them to work with us to roll out a surgical services plan for the ACT across both hospitals. It will also engage the private sector as well. That surgical services task force will look at overseeing the changes we want to put in place, particularly in the TCH operating theatre, so that their needs are met. They clearly are key stakeholders here. They know what works. They understand their patients' needs. We are setting up this forum for them to do that. As I mentioned, the minister will be kicking off that process in the next week or two.

The second piece of work under way is the access improvement program. The minister has referred to that on a number of occasions in the Assembly and in the public arena. We are investing a lot of work in redesigning care and administration systems in surgery at TCH. We have three groups guiding that process, and surgeons are actively involved and taking the lead in a number of those groups.

The third area is subject to some consultation at the moment and we haven't made a decision on it. It is just really looking at giving not just surgeons but other clinicians a more prominent role in the management structure of TCH. We are looking at appointing a number of clinical directors who are practising surgeons, anaesthetists, physicians, obstetricians, et cetera, to play a more active role in the management decisions of the hospital.

There have been forums like that in the past, but John Mollett, the general manager there,

is actually going through a formal consultation process to ensure that clinicians are more actively involved in the management processes of the hospital. We are confident that there are avenues there already and we are actually doing some new work that I think will give surgeons, in particular, a lot more influence and say in the way things are organised in that hospital.

THE CHAIR: It is quite interesting to hear that. It sounds like a positive initiative and it sounds as though you are wanting it to be, to an extent, government-guided and peer driven to get the outcome. I think I can safely say that we will watch that with interest. Just going back to the 6½-hour theatre shift—this might be more for the minister—if that is outside the current industrial arrangements there, would the government be willing to consider addressing that or renegotiating it and paying what may reasonably be required to take a different approach in terms of theatre utilisation?

Ms Gallagher: Through an industrial agreement?

THE CHAIR: Yes.

Ms Gallagher: I am not sure whether the industrial agreement prohibits that now.

Mr Cormack: No.

Ms Gallagher: We are about to embark on discussions with the nurses.

THE CHAIR: So I read.

Ms Gallagher: I think they are going to be difficult negotiations and we will be looking for productivity savings in terms of any additional pay increase that the nursing staff are after. We will be looking at changes to the industrial agreement. We are looking at changes to the work force arrangements as part of our other challenge, which is to bring down some of our costs across-the-board to 10 per cent above the benchmark, and some of those are going to be difficult discussions, too. Changing the mix within the nursing profession, the RNs and the ENs, and the use of direct care employees is another. All of that is being looked at in terms of providing a more efficient, less costly system and actually getting patients in and out with regard to access to elective surgery as quickly as we can. All of that is on the table. It is going to be a big year in health.

DR FOSKEY: With regard to the surgical services task force, is it the plan for that to have just as long a life as is required to set up a plan, or will there be some ongoing arrangement, and will that include representatives of the department of health or the hospital? Could you go into a little more detail about that?

Mr Cormack: The plan at this stage is to set up the task force for 12 months. The reason for doing that is embodied in the title; that is, they have a list of tasks that we want them to achieve and focus on. Those tasks include a surgical services plan, assisting us with role delineation of surgical services across the hospitals, and putting in place clinical networking so that irrespective of where a patient turns up in our system, whether it be at Calvary or TCH, they will get the same standard of care and the same pathway through to care. We have also got to look at the accreditation of our surgical training posts, because both hospitals are teaching hospitals.

So we have got, really, four major elements there for them to focus on. That will more than occupy 12 months of work by that group. We would look to guidance from that group as to how they would wish to progress after they have completed that work plan. So we will set them a work plan for 12 months. If they do all that and decide they want to pack up and go home after 12 months, that might be the end of the task force, but it might be replaced with something else at that point in time. We are not keen to set up committees that just keep on going for no good reason.

DR FOSKEY: Who will chair that committee?

Mr Cormack: I will chair that committee to start with, but the plan is to hand the chairpersonship of that over to a senior clinician. We have a similar task force for critical care. It has been operating for about 12 months. Critical care picks up on emergency department and ICU services. I have a co-chair arrangement with that, whereby I co-chair it with Dr Imogen Mitchell, who is the director of ICU at TCH. In the case of the surgical services task force, we may move to that model. The idea is, I guess, for the surgeons and the clinicians to take the lead themselves.

DR FOSKEY: Is that a successful model and is that why you are rolling it out here? I am interested in the success of that.

Mr Cormack: It has been a successful model. It has still got work to do. It is based on a piece of work that started in New South Wales in the early 2000s. The government action plan for health used a similar model of fairly large groups of clinicians working with management and working closely with government to bring about changes in the system. We trialled that with the critical care task force. We have had very good engagement. They have provided a lot of guidance to the department and also to the government in relation to planning and development of emergency department and critical care services, and the minister will be coming along to the next meeting of that group as well to give them some guidance and direction, I guess, as to where critical care services are going. Yes, we think the model is good and we think it will probably work well within surgery.

DR FOSKEY: Are you talking about allowing clinicians to have a greater role in TCH management? I am interested in your thinking behind that, whether the model that you are using here works successfully in another jurisdiction, how much it is a real kind of role in the day-to-day management of the hospital and what you think the benefits of that will be.

Ms Gallagher: Maybe I should start. I think that there is an awareness that we need to increase the participation of clinicians at key decision-making points, but there will always be a need for administrators within the health system. I guess we are trying to rebalance the mix a bit. There seems to me to be a bit of us versus them across health everywhere in the world: there are surgeons and there are hospital administrators and the two don't ever seem to get along. You just have to watch *All Saints* to learn that.

THE CHAIR: I hope that is not guiding ACT Health policy!

Ms Gallagher: No. I will wait for that media release! That was just a joke. We are trying

to make sure—it is partly why I want to attend these meetings and hear directly from surgeons and clinicians—that they can have access to me and understand that they are being listened to and that we are responding. Certainly, the evidence before me is that they have come up with some great ideas, we have responded to those and there is recognition that their involvement is critical in terms of moving the health system forward and we are going to continue to look at that. Having said that, there will always be a role for hospital administration. It is just getting the balance and making sure we have got the right forums, I think, for them to participate in, because clinicians are very busy people and they do not want to be tied up doing things that they do not have to do. I think that getting the right people at the right meetings giving the right advice across the board is the key to this, and hopefully to some more changes that are positive for the hospital, for the clinicians and for the patients.

DR FOSKEY: Do you have some targets for reducing waiting lists, or is that a meaningless objective? Also, given that the whole hospital waiting list issue is to my mind, while it is an important issue, a very handy political football because there will always be waiting lists and oppositions can always pick up on that, is there a danger of diverting resources to that problem from the more preventive health interventions at the primary level so that we can reduce the number of people seeking this surgery in the first place?

Ms Gallagher: Yes, sure, and I think there are a couple of points there. I think you are right. On the first day I took the job someone said to me, "Get used to it that there will be waiting lists in the emergency department and the focus will be on that." I thought that that could not be the case. Anyway, it has turned out like that. That was very good advice, very correct. I have thought about this long and hard. Should I be driven by ensuring that the waiting lists are coming down? My answer is that I have to be conscious of it and we have to be making sure that we are investing enough in it to deal with demand on waiting lists, but I actually think that the key for me will be the number of procedures that are being performed. That is, I think, a performance indicator which shows whether we are getting it right.

We have had record amounts of elective surgery over the past year, but our lists remain pretty constant. Even though we have removed 9,120 from the list, the list remains hovering around 4,600. It has come down quite a bit, I should say, over the last 12 months and perhaps a better measure is removals from the list and additions to the list. Maybe that gives you a better idea of what is going on than what the list is at any point in time.

Over the past month, there has been an increase of 59, I think, on June 2006 in the waiting list. That gives you a snapshot, but it doesn't actually tell you what is going on. I am conscious of it. I know I have to keep responding to it. But the issue is, yes, we need to keep investing in elective surgery and we will probably need to keep investing in it. Every government will need to keep investing. We are getting older, we are getting more expensive to fix, we are living longer and we have got a pretty knowledgeable population here. The other day I was talking to a GP who said, "People know that they don't want the $15,000 knee thing, they want the $30,000 knee thing, because they have done their reading and they know that it is better." So we are dealing with a whole range of things within that mix that make for the fact that every government is going to have to continue to invest in elective surgery.

Having said that, we did yesterday launch the primary health care strategy, which is the first time that we have actually put down on paper a focus on primary health care as a key part of meeting the expectations of our community over the next few years. That document does set out keys areas of focus, key areas of actions, what are our principles, and the need to make sure that our promotion of primary health care isn't lost in the mix of secondary and tertiary health care. For most people in Canberra, when you think about it, their dealings with the health system are at the primary level. Fortunately, it is going to your GP or going to your physio. It might be dealing with a community provider. It might be a young person going to the Junction—whatever. That is really where the bulk of the health system's work is, and people's contact with it. So, of course, it is a key area of focus for us.

Perhaps politically— I think this is right—it does not get the right level of attention that it should. I am keen to work with the division of general practice and all the other providers in the primary area to make sure that we do stick to that plan, implement it, and make sure that we are, as much as possible, stopping people coming into hospital in the first place, because that is a key part of meeting the demand of our community in the future so that, as the population grows, we age and we get sicker, we can be fixed more often. Preventing admission to hospital will be one part of providing the hospital of the future. There will have to be more beds and there will have to be more services at the hospital, but trying to keep people out will be a key focus, certainly for me.

THE CHAIR: Is the idea of quarantining beds for elective surgery for particularly day procedures and so on within the range of options that you are considering?

Ms Gallagher: I will explore anything in terms of how we can meet the needs of people on the lists. I don't know whether that is a legitimate option within our hospitals because of the reasons we have already talked about today. To some extent, beds are quarantined for elective surgery. That is the majority of the work that results in people being in the hospital in beds. As to anything further than what we can already do now, I don't know, because of the fact that we have to have the capacity to take whatever turns up on the day. But for the large part, beds are quarantined for elective surgery. That is one of the key ways you get into hospital.

THE CHAIR: Thank you for your appearance, minister, and Mr Cormack. We will now adjourn the proceedings.

The committee adjourned at 12.35 pm.