

CORRECTED VERSION

STANDING COMMITTEE ON FINANCE AND PUBLIC ADMINISTRATION

Inquiry into public hospitals performance data

Melbourne — 18 August 2009

Members

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Ms C. Broad
Mr M. Guy
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Witnesses

Dr S. Parnis, emergency physician,
Dr S. Mansfield, president, doctors in training subdivision,
Mr B. Harris, director, policy and public affairs, and
Mr G. O’Kearney, director, workplace and advocacy, Australian Medical Association Victoria.

The CHAIR — I welcome Dr Stephen Parnis, Dr Sarah Mansfield, Ben Harris and Geoff O’Kearney from the Australian Medical Association, Victorian branch. For the information of the witnesses and the committee, I point out we have a number of substitutions on the committee today. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and is further subject to the provisions of the Legislative Council standing orders. Any comments made outside the precincts of this hearing are not protected by parliamentary privilege. All evidence is being recorded by Hansard, and in the next couple of days you will be provided with a proof version of the transcript for any corrections. I now invite you to make any opening statements you wish to make, and the committee will then proceed to questions.

Dr PARNIS — Thank you very much, Mr Chairman. I wanted to thank the committee on behalf of the AMA for allowing us to address you and submit our report back in February. I would start with the comment that Victorian hospital performance is good, comparatively. It is probably better in most respects than other Australian jurisdictions; however, it is not very good, and we should be doing better.

Looking at performance we need to consider three key areas: access, quality and cost effectiveness. This committee has the opportunity to shine some light on some of the blind spots in that system that we have. For access, the key blind spot is waiting time to access outpatients. In terms of quality, the key blind spots are inconsistencies and the reliance on volunteerism to undertake core hospital functions. For cost effectiveness, the key blind spots are poor information technology links across the system and the false impression given that staffing is sufficient. Many doctors work well in excess of paid hours.

This committee has a number of resources at its disposal. Only last year a report commissioned by the Minister for Health into public hospital medical staff was released. It has a number of recommendations. We have the Auditor-General making clear the recommendation that the Victorian government should publish outpatient waiting times. We have the recently released National Health and Hospitals Reform Commission report. We also have the voice of thousands of dedicated clinicians who work in our health system.

The good performance of a health system requires dedicated staff, a sound culture — a culture of confidence in each other, in the system, in the resources — good and accurate data, and links to ensure that people get the best possible care in the right setting and at the right time. We need to promote innovation and reform in our health system — that is a given. Most importantly, we have to remember what our health system is for, and I think sometimes we lose sight of this: to improve the health of the Victorian community, not the health of the KPIs. For doctors, that is our reason for being — to promote health and to cure the sick. We would be happy to take questions.

The CHAIR — Thank you, Dr Parnis. I would like to start by asking you about basic staffing levels. I do not know if you are familiar with the submission to this inquiry received from the Department of Human Services, which talks about the increase in doctor numbers and the increase in nurses. In your submission you noted that over the last eight years there has been a 34 per cent increase in inpatient presentations and a 42 per cent increase in emergency presentations. At the same time, according to the DHS submission, there has been a 61 per cent increase in doctor numbers and a 41 per cent increase in the number of nurses in hospitals. On the face of it, it would appear that the number of clinicians has increased far in excess of the increase in patient numbers. My basic question is: why is there the problem, if we take these numbers on face value?

Dr PARNIS — I think in generalities that is true, and that is helpful. It is also about the quality or the type of staffing that you have. A doctor can be an intern or they can be a senior specialist, and there is a whole range in between. A nurse can be a graduate nurse — a first-year nurse who, while having got his or her primary qualification, still has a lot of training to do; or you can have, for example, a nurse who is highly trained in emergency care or in paediatric intensive care. In some of those areas where there is the greatest need, there is the greatest shortage. That is where often you see some of those gaping holes.

I acknowledge that government, hospitals and the professions themselves have been making huge efforts to try to recruit, to encourage the return of these people and to upskill people as well. That takes a hell of a lot of time. It takes a hell of a lot of resources. In the meantime, while we are playing catch-up, the system is suffering as a result.

Mr HARRIS — Another point to make there is that we had a real change in the mix of doctors and nurses working, as well as in the experience and the time. One of the key issues we wanted to put to you is that most

junior doctors — the doctors in training as they come out of university, as they are going through to be trained to become a specialist — do a lot of unpaid work. There has been an increase, from what we have seen, of part-time work in the system and probably less of a willingness with some of the cultural issues in Victorian hospitals to put in those massive extra hours which paper over some of those gaps that have been in the system. Dr Mansfield is from our doctors in training subdivision and could probably speak to some of the issues around unpaid overtime.

The CHAIR — Dr Mansfield, would you like to add anything at this point?

Dr MANSFIELD — With respect to unpaid overtime, I think Mr Harris has raised some important points. The vast majority of doctors in training would work a significant amount of unrostered, unpaid overtime every week. Interestingly the health minister, Mr Andrews, came to speak to a group of junior doctors a month ago, and when asked how many doctors in the audience had worked unpaid, unrostered overtime in the last month, every single person raised their hand. This is an extremely important issue. There is a lot of extra work that is not acknowledged or recorded going on that junior doctors are undertaking.

The second point I wanted to add to your original question was that certainly our members tell us, and we are very aware, of a number of hospitals where, although it sounds like there has been a massive increase in the number of doctors over the last few years, they are very understaffed, particularly in rural areas. There are situations where interns and very junior doctors are frequently on their own managing an entire hospital that is servicing a very large catchment area. There are several major rural hospitals where overnight, for example, you will have one intern managing emergency plus covering all of the wards on their own — with help on the phone, but often it is up to 10 minutes away before that help can get in. This increase in the number of doctors is not necessarily distributed evenly.

Mr O'KEARNEY — If I could just add one point that we see as being a really important point, and that is that when there are situations where, for instance, a doctor will put on their time sheet the amount of hours that are worked on a shift and that is altered unilaterally by a hospital, there are two issues. One is the legality around altering time sheets after the event, but even more importantly than that, I think, is the fact that that work then becomes invisible work. So then when you start to aggregate statistics it can appear that you actually have a well-resourced hospital system when in fact there is a shortfall, and it is this hidden work.

The CHAIR — What is the reason for time sheets being changed now? Dr Mansfield spoke about unpaid overtime, so I assume those extra hours are not part of —

Dr PARNIS — Cutting costs. Doctors wages are an area where hospitals can see a place where they can save money.

The CHAIR — So the unpaid overtime that Dr Mansfield spoke about is overtime that is not recorded on time sheets; is that correct?

Dr PARNIS — Or, if it is recorded, it is ignored or changed.

Mr O'KEARNEY — When it comes to the time sheets there are rostered hours, and they will not reflect 38 or 43 hours, which is the normal ordinary time hours that most people would be used to. It is actually a shift over a period of a week, a fortnight or a month, which would reflect maybe 50, 60 or 70 hours per week comprising people's normal hours, for want of a better term, and their overtime hours. So there is no argument that hospitals do pay that. When at the end of a shift it is obvious that the doctor is needed, the shift might end some time in the early morning, and that extends the time that the doctor is there. That is the unrostered overtime which is the subject that to us is extremely important data to capture.

The CHAIR — Is that unrostered overtime comprised predominantly of what I will call medical duties or is it administrative type activities?

Dr PARNIS — Often it is medical. An example would be where you are a doctor in an emergency department — I am an emergency physician — and half an hour before you go someone comes in critically unwell. You are in the resuscitation bay. Time flies when you are dealing with someone whose life is on the line. You cannot hand over that situation, because you are actively recruiting people and taking the measures that you need to take to save that person's life. To be honest, you are not looking at the clock. You are focusing

on that person, and you cannot clinically hand that over to a colleague — not safely. You could not walk away and sleep or live with yourself if that was the case. That is one example.

Another example is — and some people might call this administrative — again dealing with a resuscitation. I had one yesterday where this was the case. I spent an hour after the event making sure that adequate documentation was there about the episode so that all of the clinical factors were highlighted: what the patient's symptoms were, what their blood pressure was doing, what we needed to do, when things deteriorated and why, because in those cases that is the only documentation of very important medical decisions that is made at the time that people's lives depended on. Again, that is the reality of it. Some people would say that putting pen to paper is administrative, but I could not leave that until the following day. What would the intensive care unit have to deal with at 1 o'clock in the morning?

The CHAIR — Presumably there was no-one else that could do that other than you?

Dr PARNIS — No, they could not. Absolutely not. There might be alternatives to that such as dictating aspects into some voice-activated or audio program, but for many of us — and this raises another issue in the public health system — some of the IT systems belong in museums. Up until the beginning of this year I was using a computer system where the software program to run the emergency department was so old-fashioned it did not need a mouse.

Mr HARRIS — I think it is important to look at work you are very happy to do and go over, and I must say in an emergency if you have someone there you need to be looking after, you look after them. No-one gets resentful of that. The things that people do get resentful of are things like needing to transcribe things from drug charts into a computer because the doctors are queuing up to get on the computer. Dr Mansfield had an example of that recently where there was no rostered time for handover. You do not leave at 5 o'clock and say, 'Okay — your patient'. The clinical support to ensure that you are able to safely hand over that patient's care is vital.

There are issues such as teaching and training. In Dr Parnis's example, if he is working with a junior doctor, he would generally take time at the end of that incident to do some of the teaching and training and look at quality issues. All of those things which are clinically very important — what we describe as clinical support time — need to be done at some point, and unfortunately we have a culture in many of our public hospitals where those issues are pushed to the side. Dr Mansfield, you were transcribing things after hours. When was that?

Dr MANSFIELD — Last week, for example, I was working in an emergency department and basically because of the IT systems that existed I had to essentially type up the same information that I then had to write down on a piece of paper. I had piles and piles of this backed up from various patients I had seen over the day, and that needed to be done to ensure that discharge summaries were sent to GPs, because that is essential. Although it is I suppose in one sense administrative, I think all of us would regard that as important clinical work because it is the only way that the general practitioners can understand what has happened to their patient when they have been in hospital. That is a vital part of clinical care, and it needed to be done. Then the written record is required for the patient's records so they can have ongoing care within the hospital with the other team looking after them.

The CHAIR — And again it is something that you as a practitioner essentially need to do yourself?

Dr MANSFIELD — Have to, having seen the patient myself.

The CHAIR — The starting point on the AMA's submission is the need for cultural change in the public hospital system. Can you elaborate more on what you mean by cultural change?

Dr PARNIS — To use an example, it is always good to put it into some sort of historical context, and it is ironic that this example is the women's hospital. I was listening to a program about the 150th anniversary of the hospital some years ago, and someone — and I cannot remember what their role was — talked about how the change within the hospital culture had gone from a medical hegemony to an administrative hegemony. That is the idea that the priority had maybe changed from the focus of the doctors, notwithstanding the critical role of other clinical staff, which was focusing on patient care, to the focus of many administrators, where the priority seems to be to get in under the priorities set with KPIs rather than look at the quality of the care. That seems to be the focus, and that is the impression shared by many doctors across the system.

We have talked about increased numbers of clinicians. One figure that I got from the Centre for Independent Studies report recently was that from 2001 to 2005 the number of administrators across the Australian health care system went up by 69 per cent — in five years. We are clinicians; we are constantly being told to do more with less. We are happy to redesign our processes. I heard an example earlier, which was true, that 10 years ago or maybe even a bit more, taking out a gall bladder would mean up to a week in hospital. Now on some occasions you can do that as a day case or more often an overnight stay, which is great, because the patient benefits. That was a process driven by clinicians. That takes time and expertise. Now often I think there is scepticism on the part of senior doctors because the answer will be, 'We can't afford the equipment' or 'You haven't got the theatre time' or 'It's just not a priority in this year's budget because we haven't got the WIES funding for it'. It is that question of competing, conflicting priorities. Sometimes as a senior doctor the feeling is that you are being impaired by the system in trying to get care for your patients rather than being assisted and supported by it.

Mr HARRIS — There are two other points I would make in support of this need for a cultural adjustment. The first comes from the report of the Ministerial Review of Victorian Public Health Medical Staff. The executive summary states:

Many different issues need to be addressed to overcome low morale and disillusionment, the most important being to demonstrably value the work, commitment and opinions of clinical staff.

The second is from our EBA deal which was done in December 2008. We stated in our press release:

Doctors will welcome the commitment of extra beds as part of this deal; they want to be able to provide the best possible care to their patients, and extra beds will make this more of a reality.

The government's press release said it would make it easier for hospitals to meet their KPIs. I must say that since that time the minister and the Department of Human Services have shifted some of their rhetoric and have improved the clinical engagement, but it is still very patchy and we were starting from a point which was not all that helpful to patient care.

The CHAIR — I have one final question. What is your view on doctors being represented on the boards of the health services where they work or are associated?

Mr HARRIS — Many of our members have different views on this. The Australian Medical Association Victoria recognises that having an employee of an organisation on the board of that organisation is not appropriate. What we recommend and what the minister has recommended to hospital boards is that they seek better clinical engagement — for example, by having the chair of the senior medical staff as an observer at board meetings. There will also be many examples where a doctor who works for one health system is on the board of another. The real issue is the clinical engagement. In a good system doctors feel valued and their opinions are heard. Some health systems do this very well and others less so.

Dr PARNIS — Examples of that would be if you need key funding for certain bits of equipment or if you want your senior staff to actually have clinical support time so that they can do the teaching, research and quality improvement stuff, and the hospital plasters that all over its annual report, but then when it comes to getting that work done you are expected to do that in your own time. That is where push comes to shove when it comes to that rhetoric. That is what senior doctors are interested in.

Mr VINEY — I just want to pick up on the last points that you were raising about clinical engagement. What are some of the good examples of that? What are some of the best examples that you have of where that has happened?

Mr O'KEARNEY — We have an example at St Vincent's where the chairman of senior medical staff at that hospital is able to sit in on board meetings, is asked their opinion of what is going on and is asked to have input into that, recognising that they are not a board member but that they are available for members. It is similar to us sitting across the table. If there is a comment made by the chief executive or one of the executives, the board members are able to cross-examine them in one sense, but in another sense they are also able to simply use the chairman of the senior medical staff association, who is a very senior clinician in the hospital, to give a comment or a view which would be representative of the senior medical staff in particular. Yes, I think that is an example.

Mr HARRIS — I was going to add West Gippsland and Barwon, but I am conscious that rattling off a list of good ones will miss a lot which are very good.

Mr VINEY — My understanding is that in most hospital health services there is some kind of arrangement for senior medical staff to have their own processes to meet and discuss the issues facing the hospital separate from board meetings.

Dr PARNIS — There are senior medical staff associations across hospital management.

Mr VINEY — And presumably they have some process of engagement with the senior executives of the health service.

Dr PARNIS — This is an example that Mr O’Kearney just mentioned. Usually there is a chair for that group of senior medical staff, and in these ideal examples, or ones that approach that, the chair of the senior medical staff group is able to access the board and also, in some cases, senior executives, and is able to speak without fear or favour.

Mr VINEY — I guess I have my old management consulting hat on — and certainly with no health expertise — but can I ask: would it not be good practice to have arrangements between the senior medical staff and the executive? The board is operating at a broad policy level, and the senior executives are running the day-to-day issues, and that would be where the stronger interaction should occur.

Dr PARNIS — Agreed. There are times when that works well and other times when it is extremely fraught.

Mr O’KEARNEY — I think the other issue to consider, though, is that often the decisions that are being made are extremely long term and extremely costly in their nature, and they are often very appropriately made at the board level. Whilst there is an issue around interacting with the executive, arguably I think for a lot of people, particularly the senior clinicians, they really do have that view of the 5 or 10-year time frames.

Mr VINEY — Can I ask: the sort of views that you are presenting to this committee today, do you have opportunities to present those views to the department? Are there processes where the AMA has regular engagement with the department?

Mr HARRIS — Yes. I would be having an average of one, two or three meetings a week with department staff. Minister Andrews and his staff have been very receptive to engagement, though I would say that the department in the Victorian model has a more hands-off approach to hospital management than others. Recently the minister, as I stated, went to hospital boards suggesting better clinical engagement. Some hospital boards have done that very well, others have not.

Mr VINEY — You raised the issue of medical and nursing staff numbers. My recollection is that there was a period over the last 10 or 15 years where the federal funding for a lot of nursing and medical positions in universities either went backwards — and I do not recall the data — or did not improve, did not increase.

Dr PARNIS — There was a commonly held view through a number of years that we had too many clinicians. It was appalling. I think the Prime Minister said last week that he thought that the medical and nursing workforce projections were thought to be — I forget the word, but it might have been ‘appalling’ or something along those lines. It is true, and we are playing catch-up with that. The problem that we have is that in some areas, particularly those areas that are really the pointy end, where staff are overwhelmed — examples would be intensive care, emergency, even in aged-care settings — because so much falls on relatively few, those people for their own health and wellbeing are cutting back on their hours. That is not a desirable thing; that is their way of preserving their sanity.

Mr VINEY — In fact I think the Howard government refused to fund the medical school in Geelong and the Victorian government came in and funded it, to my recollection.

Dr PARNIS — I am not aware of the funding arrangements.

Mr VINEY — You then raised the consequent issue, which I think is a serious one, of the workload on medical staff, both nurses and doctors in our hospitals. I have to confess I am 55 years old and when I went to

university some of my mates were involved in medical training, and I seem to recall them talking about significant work hours that they were doing too. So this has been a long-term problem in our system, hasn't it?

Mr HARRIS — Absolutely. If I could just outline the time line for the cutting of medical staff numbers — I believe it was Minister Lawrence who put a cap on medical schools for the first time. It was cut under the first Howard government on two separate occasions down to 1000, I believe — I will check that. It went from 1400 to 1200 to 1000. So we now have a smaller number of Australian-trained doctors in the system to do the training. We have got many more international medical graduates, which has been a great boon for the Victorian system, probably less of a boon for the systems from which those doctors come.

We have had and continue to have a fairly destructive culture in medicine of 100-hour weeks. That is not reasonable, it is not safe, it is not legal, and it does not provide good care. Junior doctors still have problems, for example, accessing part-time work, accessing training on a part-time basis. Things like parental leave and family leave are still fairly difficult to get. It is a lot better than it was 10 years ago and a lot better than 20 years ago, but part of the cultural issues we have to do deal with in hospitals include, as you say, this view that we should be working people to death.

Dr PARNIS — It is right that things have changed over the years as well. For example, clinical audits — that idea of looking at the outcomes of the patients you have treated, whether it be as an individual, as a hospital unit, as a craft group — that is good, because it means that you learn from your experiences and your processes, your practices, improve. That did not occur 20 years ago. That requires time, that requires effort. The bar is higher. There are things that we are treating in emergency departments that frankly would never have got to hospital, and that is not just improved hospital care; it is also because we have such a world-class paramedical system in the state. The bar is higher in many regards, and because the bar is higher more is expected. That requires things now that were not necessary or required 20 years ago.

Mr VINEY — In relation to the medical training, I will ask Dr Mansfield: what is the ENTER score required now to get into medical school — around 99.9 or something, is it, something in that order?

Dr MANSFIELD — It is variable depending on the university. Every university has its own entry criteria and most of them consist of multiple different criteria. There is the ENTER score; there is usually some sort of test, like the UMAT test or the GAMSAT if you are a graduate, and there is often an interview component as well.

Mr VINEY — It would be in the 99 range, though, wouldn't it?

Dr PARNIS — You have got to do pretty well, don't you?

Dr MANSFIELD — Yes.

Mr VINEY — I guess my question, the thing that I ponder, is: are we suggesting that a student who gets 97 or 98 is not capable of being a good doctor?

Mr HARRIS — We are not suggesting that at all.

Mr VINEY — So it is not that we need to have people with 99s to be good doctors; it is purely the fact that there have not been enough medical training places that has forced that score up — because the demand is high? It is a demand driven thing rather than a clinical requirement, if you like.

Mr HARRIS — Yes, and the converse is true. There are plenty of people who got entry scores of 99 who do not make it through medical school.

Dr PARNIS — Do you want someone who is gifted and trained looking after you?

Mr VINEY — I want someone who is trained and who is capable. I want someone fit for purpose.

Dr PARNIS — We do not want the lowest common denominator for anyone.

Mr VINEY — That is not what I am suggesting. I am intrigued as to why we are at that level.

Dr PARNIS — It is a cultural thing. I remember when I was trying to get into medicine wondering if I would be up to it. You keep working at it. We are often our own harshest critics, I have to say.

Mr VINEY — I am probably more concerned that the person is fit for the task rather than being the brightest student in the class.

Mr HARRIS — That is why most universities since probably the early nineties have gone for a multi-assessment approach to entry. Monash is a great example. They constantly look at their testing processes, their interview processes.

Dr PARNIS — And that training process goes on well beyond graduation at university. That is one of our big concerns over the next few years because of the rapid rise in the number of graduates and undergraduates coming through. These people need the sort of training that I took for granted to be able to continue in the years to come. We cannot guarantee that.

An example was the traditional bedside teaching in the hospitals throughout the whole three years as an undergraduate and then the many years beyond. The figure I have is that in 1983 across this country there were 4.8 acute public hospital beds per 1000 head of population. Today across the nation there are 2.5 and in Victoria, 2.3 — we have actually got the lowest per capita. There are things that can be done away from the public hospital beds, but again there are people who would not have survived in years past who now come to emergency, or via their GP or outpatients, and need a public hospital bed, and it is not there.

Mr VINEY — It is a really interesting figure. One of the things that you put in your evidence just before is that in 1983 someone who had a gall bladder operation would be in hospital for several days if not a week; now it would be for a day. I guess there are complex factors at work in terms of the number of beds needed per 1000 head of population. Presumably there are. We have also seen an increase in nursing homes and other levels of care, where people who might have been in hospital are now in a different setting. That is true. Has the AMA done research on what that number ought to be?

Mr HARRIS — We have developed a number of ways of trying to work out the ideal bed numbers. There are some, for example, that look at a national average, there are some that look at an OECD average, there are some that benchmark with other states. To give you an idea of the efficiencies in the Victorian system, one of the benchmarks I looked at was: what if we had the same number of beds per head of population as New South Wales? Victoria's hospital efficiencies would mean that if we did that, we could look after Victoria, South Australia and Tasmania. So that is obviously a silly way to do it.

We also need to look at the mix of beds. We have serious shortages in intensive care in some places. You will remember last year the Royal Children's Hospital had major capacity issues and ended up sending a 10-day-old child to Canberra, which needs not be a scare. We need more step down beds. We need more innovative solutions around older people. Ensuring that the number of beds increases is important. Last year the Victorian government committed to 400 new beds. To stay on par we need about 100 to 130 a year. Our best guess at the beginning of last year was that we needed about 600 — but it is very much an inexact science and the mix of beds is probably as important.

Mr VINEY — You thought we needed 600; the government funded 400. So your argument is that there is still a 200 shortfall?

Mr HARRIS — Yes.

Mr VINEY — But you are saying it is an inexact science as well?

Mr HARRIS — There is a lot of data that suggests hospitals should run at around 85 per cent capacity to have peak efficiency.

Dr PARNIS — Let us look at some evidence that I think is salient, from which anyone can realise the impact. In relation to emergency department overcrowding, two different methodologies from research published this year, I think, or late last year showed that across the nation, as opposed to one particular state, the impact in terms of deaths from emergency overcrowding was equivalent to the national road toll — about

1500 deaths per year. That came from research in Canberra and Perth. There were different methodologies but they came to roughly similar numbers, about that, and that puts it in stark contrast.

Mr DAVIS — Of course the truth is that the low number of beds per population in Victoria, the lowest in the country, does have an impact on access block into emergency and ultimately impacts on patient care?

Dr PARNIS — It does. By now I think people are fairly familiar with corridor medicine and the ramping of ambulances. Another area where it makes a big difference is in terms of access to outpatients. If I have a patient who does not need to come in to a hospital — and I breathe a sigh of relief — but they need outpatient care, it is almost always what we call an overbooking.

If you just took one of the vacant spots invariably, it is further away than when you want it. It is not just ‘want’ but when you think the clinical need is there. We do not have access to the data to put that under some sort of scrutiny. Again, we always say, ‘Let’s put the evidence out there. Let’s assess it. Let’s be constructively critical’. But the Auditor-General has said, ‘Let’s publish the waiting time to get an outpatient appointment in the public system’. It is not done. Queensland does it, and the UK does it. We like to pride ourselves on being the best jurisdiction in Australia, why don’t we do it?

Mr HALL — Thank you for your time this morning and for your submission. Your submission lists a number of recommendations. We do not have time to explore all of those today, but I will refer quickly to a couple of them. We have just been talking about the benchmark as an 85 per cent average occupancy rate for beds; that is the benchmark we should be applying in Victoria. How does that benchmark compare to other states in Australia?

Mr HARRIS — Victoria does not actually publish capacity figures. My recollection is, and I am happy to take this on notice, that five states do and three do not. Victoria is one of the ones that do not. We publish occupancy rates for intensive care beds, and they are at about 97.5 per cent.

Mr HALL — What do the other states benchmark their occupancy rates at?

Mr HARRIS — Often they do not benchmark them, but generally they have been running above 90 per cent. I am happy to take that on notice and get those figures for the committee.

Mr HALL — Okay. The other one I want to ask is about outpatient waiting times. In particular you have suggested that we should be publishing waiting times as well as waiting lists — ‘information available for hospitals to publish waiting times’. Is that available to hospitals now, or would there be some requirement for doctors to actually to pass on that information to hospitals so it can be published?

Mr HARRIS — Outpatient waiting times are an important measure of demand, and ensuring we are able to know what the demand is assists in working out what services should be provided — what sort of mix of doctors, nurses and other health professionals. There are many, many models of outpatients in Victoria, and they are all different.

Your question was: would hospitals have that data? I am not sure. I know some do and some do not. Certainly, I know that doctors have told AMA Victoria that they just have a pile of ones that they have not yet put into the system, because there is no point putting them into a system which can only book 12 months ahead. I do not know whether you measure that in millimetres, centimetres or inches. Where that data is held is a mystery to us, and it will be very inconsistent.

Mr HALL — It seems to me to be a valid area that we should be pursuing. I think the Auditor-General was able to put a handle on some of those waiting times, so it is something we need to address.

Finally, I was surprised to hear about the IT systems across the health network. I had a recent experience where my personal health records — undertaken by a GP, specialist, radiologist, pathologist et cetera between the private and public sectors — were transferred digitally to those who were involved in my care and treatment. So are you telling me I was lucky in that instance, it does not always happen that way?

Dr PARNIS — That is the exception rather than the rule.

Mr HARRIS — There are some which are very good, and we would single out Barwon Health here. Dr Mansfield has worked in the Barwon emergency department. Would you like to give a couple of examples from Barwon, and then we will give a less good one?

Dr MANSFIELD — Yes, certainly. I recently worked there for the first time, having worked in a number of emergency departments and hospital wards across Victoria, and this was easily the best system that has been used. The entire patient progress notes, discharge summaries, everything is electronic. The patient records are electronic, it is well linked into the local GP's pathology and radiology — all accessible on computers. There were plenty of computers to access; they were all of a very high quality, and this makes a huge difference to your efficiency and your ability to care for patients.

Dr PARNIS — They had mouses — or mice!

Dr MANSFIELD — This is something that many of the doctors-in-training who work at Barwon Health do; they all report that they find that system one of the best that they have used, but this cannot be said for most of the other hospitals across Victoria.

Mr HALL — If I was working in a hospital, I went up to a hospital ward and clicked onto the terminal there, there are many cases where I perhaps — —

Mr HARRIS — Sorry, you are assuming there is a terminal there, which may or may not be the case. We literally have doctors saying to us that they queue up to use a computer, and these are people paid \$50 000, \$70 000 or \$250 000 who are wanting for a \$2000 computer terminal.

Mr HALL — You have answered my question. There are plenty of instances, it sounds, where that is simply not possible, whereas it should be in today's technology and I am as appalled as you, to suggest that.

Dr PARNIS — Our GP members are really uncomfortable about the fact that they cannot get timely access to the clinical handover of details so that when their patients leave the hospital system or see outpatients or come to emergency, that it takes sometimes two to three weeks for them to get hold of details, if they do get them. It is an area ripe for dealing with.

And you compare the haphazard examples, like Barwon Health, of excellence with the HealthSMART strategy that was supposed to fix all of this stuff but really has been a big disappointment from a clinical perspective.

Mr HARRIS — The safety issues that come with that are very important. Medication management is basically where all of the data suggests you get the clinical gains. If you know somebody has got the blue pills and a green pills, then you know not give them the red pills. Dr Mansfield's example of transcribing by hand, drug charts, is ripe for error, although I would also say that the department of health has recently asked some of the doctors-in-training to be involved in some of the health side applications. The doctors-in-training are the ones who will be using these systems, and we are hopeful that will improve some of the usefulness of the investments in health IT.

Dr PARNIS — There is a new chief information officer, a doctor-by-training background, who has said that his no. 1 priority, which the AMA shares, is to get electronic drug charts, electronic prescribing. We want him to have the authority, the resourcing to get that up and running because that will save lives.

Ms HARTLAND — I go back to the issue of outpatient appointments. Yesterday, when DHS was here, we talked a bit about that. I was really concerned by the fact that the department did not actually have a central way of knowing how long it was from when the person got their referral from their doctor, they rang the hospital, until they were actually seen for the first time. What solutions do you think there should be to that kind of problem?

Mr HARRIS — The simple one is to publish the data. I had two general practitioners on the phone this morning, who knew we were coming here, saying that is their big issue. Managing a patient in the community when you do not know when they are going to be seen has some major implications for health, the cost and for effective care.

Dr PARNIS — And the clinical input is: they either go back and see their GP who has already made that decision on what they need and can only offer maybe treatment or things that are less helpful than what they

actually need; or they end up in emergency; or they do not end up getting the care at all that they need, which leads to progressive, either delayed outcomes or delayed treatment. Inevitably there will be more illness and potentially death from those sorts of things.

Mr HARRIS — We do see that there are some advantages to the system and to the Victorian government in publishing the data, and as you know, the Auditor-General has recently recommended the Victorian government do publish the data, but the first would be managing demand.

If you know that, for example, in Western Hospital it is going to take you more than 12 months to get an appointment, then, and for example, if another hospital was six months, you might say, 'Would you like to go across town?'. If it is going to be more than six months everywhere, then the option of paying for private care might be slightly more attractive, and that would even out demand across the system and shift some of it to the private sector.

Secondly, it would give the department of health better data to plan what should go where. The sad thing is that we do not know whether people in the western suburbs, western Victoria, Gippsland or wherever have poorer access to medical care through outpatients, because we do not know what the waiting times are. I would say that the Auditor-General was correct in saying that the waiting time is the key issue, not the number of people on the waiting list.

Mr DAVIS — I return to the issue of access block and bed numbers. I am interested to know whether you have data about the number of beds in Victoria, and whether you have submissions or other information that can provide us with the number of beds and perhaps the spread of those in Victoria.

Mr HARRIS — That data is collected by the government. We would generally use their figures, with a bit of spot checking here and there, but I would suggest that the department of health would be able to give you better data on that.

Mr DAVIS — They are resistant to releasing that data, so if you have got the data in any material, we would certainly appreciate it.

Mr HARRIS — I am happy to take that on notice.

Mr DAVIS — That would be of great help.

The other point I come to is the issue raised in your submission, on morale:

The public health system in Victoria is under significant stress with low staff morale.

The culture within public hospitals has been significantly affected by government policies, both past and present. AMA ... has consistently presented the government with the challenge of rectifying these issues ... once again making Victorian public hospitals a good place to work.

And you referred to the ministerial review. Are there three things that you could point to that should be done there, and three things in terms of the measurement of that morale? We could go for a long time, so I am saying, tell us three?

Dr PARNIS — I am thinking, because there were, I think, 71 recommendations in the ministerial review — I think the one that we keep coming back to about better buy-in by hospitals from senior clinicians, and junior for that matter because the junior staff are probably there 24/7, the senior staff to a slightly lesser extent, so when substantive decisions need to be made, medical consultation should not be an afterthought.

Mr DAVIS — Is the morale measured? Are there some measurements of staff satisfaction?

Dr PARNIS — By us, it is, in terms of member surveys.

Mr O'KEARNEY — But generally not by hospitals. There is a number of methods for measuring morale, but one which has been used often is climate surveys of staff. I am not aware of that being a constant feature in public hospitals generally.

Mr DAVIS — Is there data that you have taken in terms of measurements of attitudes in the hospitals that you could make available to this committee?

Dr PARNIS — Yes.

Mr O'KEARNEY — The most significant for us would be the work that the ministerial review actually did in this area. They visited a significant number of hospitals I guess there are two elements — they themselves visited a significant number of hospitals; they themselves discussed issues with doctors on the ground. More importantly, they were building on work of previous reviews that have been undertaken. One of the questions that we were asked by that panel was, 'What are your suggestions, AMA, for how the recommendations of this review could actually be implemented?', when in terms of the last reviews that have been undertaken their view was that not many had actually been implemented.

Mr HARRIS — The ministerial review, if I could begin to quote from the executive summary, said:

The considered opinion of the [review] is that the public health system in Victoria is under significant stress with low staff morale. Senior medical staff are disillusioned with the public hospital system, which they believe places greater emphasis on throughput and budget accountability than on quality of care and outcome. They feel that their views are rarely taken into account in decision-making relevant to their work.

Dr PARNIS — As part of those recommendations one of the things that we have pursued a lot — and this is for both senior and junior medical staff — was that ability to be able to do the gratifying but necessary work of medicine that is not necessarily standing beside the bed and treating the patient — that is, teaching, researching, getting the quality up. It is the clinical support time and being encouraged to do that rather than discouraged from doing that. That would have to be in the top three.

Mr DAVIS — The final question I have relates to your role as an emergency department doctor. I wonder if you can give examples — perhaps in a non-identifying way — or you are aware of examples of where data manipulation has occurred in the emergency department?

Dr PARNIS — I will give an example that I think most people would understand readily — that notion of category 1, the patient who comes in and needs immediate care because their life is in jeopardy; the person who is having a major heart attack with the rhythm going all over the place. The data says 100 per cent are treated immediately.

I know and anyone who has worked for more than a shift in any public emergency department knows that resuscitation bays spend more time full than empty these days. If you consider having someone standing in the corridor with the ambulance officers going pale and saying, 'How are we going to treat this?', and someone is running over wanting to do something to them, but there is not much you can do in a corridor outside the resuscitation bay while someone is being wheeled out to God-knows-where because there is not a spare bed elsewhere, that does not constitute 'immediate care' for me, yet the data says 100 per cent of category 1 patients are treated immediately.

Mr DAVIS — So there are significant numbers of category 1 patients — —

Dr PARNIS — I could not hazard a number on that, but there are many peak times and even other times where you have got people who need resuscitation. We say 1 resuscitation bay per 15 000 presentations, but now the numbers are going up. Where 2 resuscitation bays were built 5 or 10 years ago, that clearly has not kept up and you need a third. You have maybe not got the physical space to do that, let alone the staffing, because that means 1 nurse per patient as opposed to 1 per 3 or 4. I think that is a tangible example of where, if you just think about it, you know the 100 per cent is not likely to be the case.

Mr DAVIS — What sorts of delays could be experienced or what are the sorts of time delays that you have seen? Are they, say, 1 minute?

Dr PARNIS — Let us say 5 to 10 minutes, for example. Let us say you have got someone in danger of cardiac arrest. The best result from a cardiac arrest is to prevent it. We know that you can do things to prevent it — not always, of course, but 5 to 10 minutes might make a difference sometimes, so it is that critical. When you know what you want to do — and this is one of things why morale gets sapped sometimes. You know what you want to give to that patient. The rule I apply and that most of my colleagues apply is, 'I am going to

recommend something if I could sell that to a relative'. If you cannot do that, it eats away at you like a cancer. It is that sort of resourcing.

It is not easy. We are the first to admit that these things are not cheap. Intensive care beds cost a fortune. Getting the staff trained up and the time it takes, that is expensive stuff. But where is our priority as a community? We want people to live longer and healthier. Preventive care is great, but it does not eliminate disease, and it does not eliminate death. People use those resources when they become unwell.

Mr DAVIS — I thank you for those examples. But also on the intensive care bed issue, can I ask you where Victoria is in terms of its numbers of intensive care beds relative to other states?

Mr HARRIS — I will take that on notice. We certainly have fewer than a number of states. One of the issues which again saps morale is trying to work out what options can you give a patient. There is a good and strong argument that intensive care beds should always be full. The issue comes with how much wrestling you have to do and how much horse-trading you have to do to get your patient in, to get someone else out.

Intensive care beds are hideously expensive. We have got a significant shortage of nurses who are trained up in intensive care. To a point, you could have as many intensive care beds as you like.

Mr DAVIS — But there are some benchmarks nationally and internationally?

Mr HARRIS — Yes, and we will get those, where available. Another morale issue is that emergency physicians, who are expensive and under pressure, spend a lot of time on the telephone trying to work out where there is an empty bed, where can you put someone.

Mr DAVIS — It is quite inefficient.

Mr HARRIS — Yes. Often you are arguing with somebody, saying, 'My patient is sicker than your patient, so I would like an intensive care bed, please'.

Dr PARNIS — It is not just inefficient; those are the places that find it harder to attract senior, middle-grade or junior staff, because the staff know that that is one of those soul-destroying aspects — conflict between you and your colleagues about the use of scarce resources, whether that be to get that last intensive care bed or to get onto the theatre list because you are 'bumped', to use the term, by that case that takes a higher priority. That conflict is something that does sap morale and make people think, 'What do I have to do to protect myself?'.

Mr HARRIS — To come back to the issue around safe hours and effective working hours, a lot of that is done at the end of the shift. You have clocked off, and you are spending a lot of time on the phone.

Mr TEE — I just want to come back to the start, where you were talking to Mr Rich-Phillips about the fact that there has been a demand but equally there has been a significant increase in numbers of doctors. The issue is, I suppose, the rural issue, and I will come back to that.

I think you raised the issue around mix of experience. Is part of that equation really how we deal with the changing nature of what is being presented at our hospitals? By that I mean, yesterday we had evidence that 50 per cent of people in hospital are 70 years and over. There is the ageing population, and there is the chronic disease, and it is about working smarter to meet those changing needs. Leaving aside the rural doctors, which I will come to, is that really, when you say 'the mix', the other bit that is missing? Would that be a fair assessment of where the debate is?

Mr HARRIS — Yes, and medicine changes all the time. These days it is much more of a team game. Emergency departments are full of some very experienced professionals not just in medicine, and that is to be encouraged. We have significant shortages in, for example, psychiatry.

Mr TEE — I want to come to the shortages because again particularly around the rural and regional issue, and I think there is an acknowledgement there, there are a couple of programs that we got via the DHS submission yesterday which talked about a couple of their initiatives to try to get more doctors into the rural and regional areas. I am just wondering if anyone here can give us some evidence about how they are progressing. It is the Region of Choice program and the Rural Medical Family Network. Are you aware of those programs and how they are progressing?

Mr HARRIS — Yes, we are aware of them. A number of these programs are progressing quite well, and we are quite happy for the department to try a few things that do not work. This is the sort of area where we do need a bit of innovation.

Rural care is fairly complex when you look at who provides what. For example, we have many small hospitals in Victoria which rely on general practitioner, visiting medical officers or VMOs. In Victoria VMOs are generally quite a lot older. I believe you have Dr Moynihan presenting, and he will be able to rattle these off the top of his head.

The ministerial review noted the number of GP proceduralists is way down on where it used to be: GP obstetricians, GP anaesthetists, GPs with surgical skills. General surgery is identified in the ministerial review as a critical area. But here we have one of the mixes between a state government which needs a workforce for its hospitals and a federal government which looks after general practitioners.

One of the things we did say when Mr Viney was asking us questions about caps is that there has been a longstanding cap on the number of general practitioner trainees to the point where it bottomed out at about 400 and those were not filled. We used to have half the medical graduates going into general practice; now it is a quarter.

Mr TEE — And just on those caps, I see we have talked about the fact that under the Howard government the caps went backwards but the Victorian government has been allocated I think 220 extra medical places for 2008 under the new government. Will that pick up some of that?

Mr HARRIS — Yes. But it is important to recognise the time frame. The shortage we have now is because of decisions made between 1992 and 1996.

Mr TEE — It is seven years, is it not? So it will take seven years for 220 places to start feeding through into hospitals.

Dr PARNIS — But there are dangers too.

Mr HARRIS — Sorry, can I just say the seven years will take you to the start of their specialist training. So for a general practitioner that is three years; for some surgeries it is eight years.

Mr TEE — So it could take up to 10 years to make up for decisions that were made by the Howard government.

Mr HARRIS — Ten to 15.

Mr TEE — Just the other issue that there was some consideration of — that was the unpaid overtime. Again I just want to get a sense of it. As I understand it, doctors are employed essentially by the hospitals and those are all now under federal agreements. Is that where we are placed now?

Mr O'KEARNEY — That is correct.

Mr TEE — All right. I am conscious of the time.

The CHAIR — Thank you, Mr Tee. We did have one for Ms Hartland coming after questions previously asked.

Ms HARTLAND — Yes. You were talking about morale before. In my previous job I became an extremely accident-prone person. I have ended up in the emergency room at Western General on a number of occasions — fantastic staff, terrible building. How does that kind of thing affect morale, when the building is obviously overcrowded, it is difficult to move around and seems to create blocks?

Dr PARNIS — It irritates. I think it is important that Sarah as a junior doctor speaks as well. From my perspective I found the thing that matters to me absolutely most is the people I work with. I have put up with buildings that are falling to bits if I have people who are supportive and are team players, who understand I am far from perfect, that I make mistakes, I get tired and I need a shoulder to cry on sometimes and vice versa. That is part of the reward or satisfaction of working as part of a team in emergency. That is why some of us do what

we do. But it would be nice to have some natural light. It would be nice to have some space but again in an emergency context I do not want an empire. I do not want a bigger emergency department; I just want my patients out of there when they are sorted.

Dr MANSFIELD — Yes. I agree with those comments. Ultimately there are other more important factors I think that affect morale, particularly for doctors in training. Having adequate supervision, support, education and training is a huge thing for us. It is going to be a massive concern with the number of graduates coming through; access to supervision is something that still has not really been addressed. There are not great plans for that.

Mr TEE — There is going to be a whole bubble, is what you are saying?

Dr MANSFIELD — Very junior staff. So getting them through that 7 to 15 years of training is going to be a massive task.

Mr TEE — There will be a ripple effect then in terms of the decision that was made a couple of years ago in relation to caps?

Dr PARNIS — Exactly.

Dr MANSFIELD — It is certainly an issue of dilution of experience and quality of supervision and training. So that is a huge element for morale for junior staff. That said, there are some infrastructure issues that affect us — IT was brought up.

Another very important issue for junior staff that is often forgotten about is having access to space where there might be somewhere to rest and make a cup of tea. Very few hospitals across Victoria supply adequate numbers of beds that are easy to access for junior staff who are working nights or need to rest at some point. Many of the common room facilities are very poor; in some places they are almost non-existent. That has been a significant change. We had some more senior staff telling us that many years ago when they were working they had quarters that were dedicated spaces that they could rest in, eat in, debrief in and they are extremely important areas for us in terms of morale.

The CHAIR — Thank you, Dr Mansfield. The committee appreciates — —

Mr VINEY — Sorry.

The CHAIR — Mr Viney, you have a had your opportunity. We are over time so we do need to keep moving.

The committee appreciates the AMA's submission to the inquiry and appreciates your attendance here this morning. We will have a draft version of the transcript to you within the next couple of days for any corrections you may wish to make.

Witnesses withdrew.

