

CORRECTED VERSION

STANDING COMMITTEE ON FINANCE AND PUBLIC ADMINISTRATION

Inquiry into public hospitals performance data

Melbourne — 18 August 2009

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Dr G. Phelps, member, quality expert advisory group, Royal Australasian College of Physicians.

The CHAIR — I declare open the Legislative Council's Standing Committee on Finance and Public Administration public hearing. Today's hearing is in relation to the inquiry into Victorian public hospital performance data. Specifically the committee is examining the capacity of hospitals to meet demand, standards and quality of care, resourcing and access levels, and the accuracy and completeness of performance data for Victorian public hospitals.

I welcome Dr Grant Phelps from the Royal Australasian College of Physicians. For the information of witnesses and the committee, we have a number of substitutions on the committee this afternoon. All evidence taken at this hearing is protected by parliamentary privilege, as provided by the Constitution Act 1975, and further subject to the provisions of 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 staff, and you will be provided with a proof version of the transcript in the next couple of days for any corrections. I now invite you to make any opening comments and we will then proceed to questions from the committee.

Dr PHELPS — By way of background, Grant Phelps is my name. I am a gastroenterologist from Ballarat, and I am here representing the Royal Australasian College of Physicians. Our college is the largest professional college in Australia, along with the college of surgeons, and we represent adult physicians, paediatricians across Australia and New Zealand — we are a transnational college — together with a number of other specialty areas, including palliative care, rehabilitation medicine and so forth. I am here as a fellow of the college and as a representative of our quality expert advisory group, the key policy group within our college which considers issues particularly around quality of care. However, we might choose to define that and perhaps that is something we can come back to to talk about. We appreciate the opportunity to contribute to this discussion.

The CHAIR — Thank you, Dr Phelps. I would like to start with a statement from the first page of the submission received from the college, where the college indicates:

Improvements in the quality of acute medical care could lead to a more rapid passage of patients through the system ...

Can you expand on what the college means by that statement?

Dr PHELPS — Let me rephrase the sentence a little by suggesting there are clearly some increased efficiencies which we can gain within our hospital system. Many of those efficiencies are around the process of care. I would argue as a clinician and as someone who is interested in health policy and health management that one of our challenges in the foreseeable future is to continue to improve the process of care across all of our organisations. In short, if we can improve the patient journey, if we can improve the process of care, we can unquestionably gain some efficiencies. Part of that efficiency will be around reduced length of stay or more rapid passage through the hospital system. How much can we gain? That is a moot point, but I do not doubt for a minute that there is significant improvement left in terms of our ability to deliver better care.

The CHAIR — What type of improvements would lead to freeing up the flow, if I can use that phrase?

Dr PHELPS — That is the question in reality. There is clearly room to move in our system in terms of providing clinicians with the resources they need to deliver better care, and the college's submission touches on some of those issues — around clinical data and clinical support processes. There is no simple one-stop solution to this. This has to be multifaceted. I think it needs to start with policy settings that are designed to enhance and develop patient care. There is an argument I believe that policy settings around health care at this point in time are largely focused on elements that are not necessarily specifically related to patient care, and that, I would suggest, is a conversation that we need to have as clinicians operating within our system and in a health policy context.

Clearly, having started with health policy, then it is going to become incumbent upon clinicians to continue to improve the care they provide at the patient coalface. That is about teamwork; that is about organisational structures; that is about high-quality data. To some extent it is also about adequate resources, and we would recognise that there are issues within our system around access to beds and access to the other resources that clinicians need to do their job. I do not believe we can give you a simple one-step solution to this; this has to be multifaceted. My view, and our view as a college, is that it has to start with policy.

The CHAIR — We have heard other evidence that suggests there might be more of a focus on financial drivers and financial measures rather than clinical measures. Is that what you were referring to with your earlier comment?

Dr PHELPS — I do not think there is any question that to drive a high-quality, high-performance health-care system you have to build it around patient care, and you have to ensure that your performance measures are really reflective of patient care, the logic being that clinicians ultimately deliver care. Those of us who work within the health policy environment — and I do — are simply setting the scene for the delivery of care. We are setting the scene for the core business, if you like. Our challenge is to ensure that our measures really do reflect patient care. Those of us who work in the system for a long time would see that, whilst some of these other performance measures around finance, access and throughput and so on are important, to some extent they are disengaged from the reality of those who are at the coalface delivering care in whatever care environment that is. There is a challenge, and the challenge is to bring those two together. I believe we can do that, and I believe that when we do do that across our entire system that that will be when we will start to see real gains in efficiency and real gains in patient care and quality.

The CHAIR — What type of measures do you believe, or does the college believe, should be the KPIs for measuring clinical performance? We heard evidence yesterday from some of the academics working in this area as to clinical registers and so forth, but equally there is a fairly extensive cost of setting up those types of registers. What do you believe, or does the college believe, is the type of material we should be collecting?

Dr PHELPS — We would support the view that there needs to be a range of measures around clinical care. Again, there is no simple one-step solution to this. We will need a range of measures that reflect both the breadth of patient care and the depth of patient care. Hospitals are different beasts and hospitals will differ in their ability to deliver certain types of care, so we will need a range of system-level measures that reflect patient care. Throughput and length of stay and so forth are clearly part of that, but we also need individual organisations to be developing a range of measures that are relevant to those organisations. At the moment clinical measures are somewhat ad hoc. They are not necessarily focused on the entire patient journey, nor do they allow a system-based view of care. The challenge that our system has over the next 5 to 10 years, I believe, is to move towards a model which incorporates performance measures around both the financial and the traditional performance measures, but also measures that really do reflect patient care.

Our college is starting to do some work around building a framework to support physician and paediatric practice. It is very much in the early days of that. Part of that work is around understanding clinical measures at a very deep level. We are also very conscious of work that is happening internationally, particularly in the UK where the NHS has done a lot of work around building, I believe, a very good suite of clinical measures or clinical indicators that in many ways do speak to system-level performance but also clinical-level performance.

I am strongly of the view that in order to get to a position where we understand clinical-level performance measures, we have to deal with issues around clinical engagement. We have to ensure that we have our key clinicians talking and working in a way in which they are contributing substantially to these measures and contributing to the broader understanding of them.

You will be aware, I am sure, of work that has been done in Victoria over the last two or three years looking at issues of senior doctor morale and so forth. We would argue that those issues are directly impacting on our ability to understand and deliver clinical-level information and clinical-level understanding. Ultimately this is an issue of clinical engagement, and that is something that our system will have to progressively deal with.

The CHAIR — Ultimately where does the responsibility need to sit for the development of clinical-level measures? Is it something that the individual colleges in their individual specialisations need to do, or is it something the Department of Health needs to drive as an overall system perspective?

Dr PHELPS — That is a very good question. My personal view is that it needs to sit across all levels, and the way to make that happen is to start thinking about the system at the level of patient care. If we understand that that is the core business of our system, then it becomes, I think, a little easier to understand how colleges, departments and other funding agencies, for instance, can work together to ensure that we have a complete and a collective or shared understanding of the way our system is working.

I think part of the issue we have had in Victoria — and, again, the Morey report that I was alluding to before talks to this — is that we have had a disconnect between the way the department and health policy thinks about clinical care delivery and the way clinicians think about it. We clearly need to address that and we need to ensure that we have people in the same dialogue and in the same conversation. That, I think, is one of the challenges that we face right now. I know from the health policy perspective there is some work happening around that.

Where does it sit? Ultimately the information needs to sit with clinicians who deliver care, as they are the ones who will use that information to change the way care is delivered and improve that. The responsibility for developing and monitoring and managing that information needs to sit across the entire range — from health policy to government to colleges to individual clinicians. To some extent it is about funding and it is about resources to ensure that these models are developed properly. I guess that is where government comes in.

Mr HALL — Thank you, Dr Phelps, for your time this afternoon. In your submission you spoke on the area of demand and commented about elective surgery, waiting lists and the bed block created by the competition between the emergency department and the elective surgery waiting list. We have had a fair conversation with a few people who have made submissions to the committee about waiting times and waiting lists. It has been suggested to us that for the sake of patient information it would be beneficial to be publishing waiting times. Do you have a view on that?

Dr PHELPS — Can I ask for your definition of ‘waiting time’?

Mr HALL — It has been put to us that the waiting time starts from the time somebody is referred to see a specialist and the delay therefore in getting an appointment with that specialist and the delay in waiting for the time of that appointment; and then the waiting list is established between the time a decision is taken by the specialist.

Dr PHELPS — It is perhaps worth pointing out one of the differences between physician practice and surgical practice. Most physician practice in a public hospital setting would not have much of a waiting list. I am a gastroenterologist, so I do do some procedures that require people to be put onto a formal list. Cardiologists and other procedural specialists would have a similar process in place. But much of physician practice is based on urgency, if you like, and waiting lists are not necessarily something that physicians — and paediatricians, particularly — would be involved in managing. To answer your question, though, there is no question that as a public hospital system we have real issues around access to consultative services, outpatient services. Our ability to provide those is limited in part by funding. Under the VACS model there is a limited amount of funding available to each hospital to conduct outpatient activities.

Mr DAVIS — VACS being the ambulatory care?

Dr PHELPS — The Victorian ambulatory care system, which basically provides hospitals with a certain number of episodes of care per annum. It is a bit like DRG funding for outpatients. As hospitals have moved into the CMBS arena for their ambulatory services, that has allowed some hospitals to certainly expand their capacity. That, I think, has helped deal with some of those waiting-time-to-appointment issues. The issue, though, is always going to be one of workforce, in that hospitals will always have some fixed limitation upon the number of doctors they can provide and the number of other clinicians they can provide into an outpatient-type environment. One of the solutions to that, I think personally, is to develop a much greater cooperation with the traditional private sector and ensure that private and public, as we previously understood it, are working much more closely around providing the capacity that is required across the entire system.

In terms of the waiting list issue, again I think that is real. It is live and it is something that many of us face on a day-to-day basis, and it creates significant concern for us as clinicians and significant concern for our patients. The solution is not easy. You could make an argument that we simply ramp up capacity dramatically. But that is not sustainable for a whole host of reasons — again, including, the workforce. Some of the solutions that have developed around establishing elective surgical centres, I think personally, make a lot of sense.

That is not, again, an issue that by and large physicians and paediatricians are going to face in their day-to-day work. But we do, I think, as a system need to be much more innovative about how we manage this challenge across our hospital setting of mixing emergency work and elective work. Again, that is a real-life issue, and we

all wish there was a simple solution. It is partly about capacity; it is also partly about the process issue I was alluding to in the earlier discussion. We have to do things better.

Mr HALL — Can I move to the section on resourcing where you have made some comments about physician staff numbers and infrastructure resources and also the need to bolster resources for physician training in rural and remote areas of Victoria. Representing an outer suburban and onto a rural area of Victoria, I am interested in terms of workforce issues, particularly as they apply in country Victoria.

Dr PHELPS — Sure. This is a subject near and dear to my heart, too. We have been conscious for some years of a significant disparity in workforce between rural and the city. In fact I, along with some colleagues, published some data on this in 2001 suggesting that the disparity was much larger than had previously been thought. At that time, for instance, there were of the order of 65 adult physicians practising in rural Victoria for a population of a million people. By contrast, there were well over 1500 in Melbourne for a population of roughly 3 million. So in numbers alone there has been an enormous disparity.

Since that paper was published seven or eight years ago the situation in rural Victoria has improved, but not dramatically. There is an enormous way to go in order to ensure that regional and rural Victorians have access to the sorts of clinical services they need. In physician practice at least those services will largely be built around the skills and capabilities of key clinicians, physicians, supported by nursing staff and allied health operating in a multidisciplinary team, but largely led by the skills of the physician.

How do we do that in an environment where hospitals are strapped for cash and are basically unable to readily expand their senior workforce? That is our challenge. Again, I would take a patient-centred view that says that we should be looking at the sorts of services that each community needs and at the sorts of services that are able to be delivered in that environment, and we should ensure that our hospitals are free and able to develop the sort of workforce and support that they need to deliver those services.

I guess what has happened traditionally — and Ballarat is a good example of this — is that over the years hospitals have progressively and incrementally increased their capacity, and in doing so have incrementally increased their ability to deliver local services. That, I think, is a pragmatic approach, recognising that by and large doctors particularly still want to work in Melbourne and that provincial centres are still somewhat difficult, or on the nose if you like.

Mr HALL — Why do they want to work in Melbourne?

Dr PHELPS — Why do lawyers want to work in Melbourne and why do accountants?

Mr HALL — They make more money; is that simply it?

Dr PHELPS — No, I do not think it is a money issue. In fact, you could make a strong argument that you could — as a doctor at least; I do not want to speak for lawyers — certainly as a doctor potentially make a lot more money in provincial Victoria, because the demand is enormous and your ability to meet that demand is limited. I do not think it is money; I think it is more about lifestyle. I think it is largely about professional issues, including peer support and collegiality and so on. I think these are challenges that all of the professions face, not just physician and paediatric practice.

Having said all of that, it is clearly something that we need to address, and I think hospitals need to be very innovative around the way they do that. One of the potential contributors to a solution, as we have alluded to in our submission, is around building physician training capacity. A number of hospitals, my own included, have been quite successful in increasing the number of junior doctors being exposed to these practice environments. Our hope is always that these junior doctors will go off and complete their training and come back to us as consultants, and thus help us expand our service capacity. That remains a challenge. The lure of the bright lights of Melbourne remains very strong, and it is up to us as colleagues in these environments to be very clever and innovative around how we attract our colleagues back.

That is very difficult, though, in environments where hospitals are limited in their capacity to expand service delivery and therefore limited in their capacity to expand senior workforce. It is fair to say that with expansion in senior workforce comes a whole host of downstream effects. A senior workforce means more junior doctors, it means more specialised nursing support and it may mean more physical infrastructure in the case of operating

theatres and day-procedure environments and so on. So simply placing extra doctors in these environments is not necessarily the answer. It needs to come with a whole suite of infrastructure and resourcing. We would recognise as a college that there are some enormous challenges within this, but quite clearly workforce is part of the solution.

Mr HALL — Is training provided in country locations, and does the college play a role in that?

Dr PHELPS — It absolutely does, and it most certainly is. I will push our own barrow for 30 seconds. Physician trainees spend quite a bit of time in rural Victoria, quite deliberately. Our college, four or five years ago, at the instigation of a number of very vocal rural physicians, insisted that in Victoria at least physician trainees should spend time in rural settings, because we recognised that was important from a service perspective and also from the perspective of helping to change the mindset.

We have been quite successful at achieving that, and just the week before last the first physician trainees to sit and pass our college examination process in rural Victoria have done so. That happened out of my hospital in Ballarat largely due to a lot of work that we did to build a training infrastructure and support for those trainees. That is a very exciting development, and it proves to people like me who have been playing around in training and policy land for a long time what you can do if you really do commit to it. To do that as we move forward will require some additional resources; there is no question of that. It will require additional senior workforce support. It will require perhaps a change in the way some hospitals see themselves. Regional and rural hospitals have traditionally been very service oriented, which is entirely appropriate, but as we increasingly take medical students and trainees out into these provincial environments, hospitals will need to shift their focus from purely service to becoming much more of a hybrid of service and training.

It is a hybrid that is eminently achievable, but it does take a culture shift, and it does take some significant resourcing. The advantages of doing that I think are manifold. It is much more attractive for senior staff to work in those environments when you get it right. It is potentially more costly in terms of the infrastructure you need, but I would argue, with some reasonable evidence, that you actually get much better efficiencies in the long term when you move down that road.

Mr HALL — Finally, the AMA indicated to us this morning their view of a gross inadequacy in the level of IT resources available within our public hospital system. Would you concur with that view? I note you have commented about IT resources in your submission.

Dr PHELPS — I think there is simply no question that our IT resource is limited. Our ability to provide clinicians with the information they need to manage patient care and to manage their practices is severely limited. Many of our organisations have, off their own backs, moved to address that, but many organisations are still struggling with that. Our view is that HealthSMART — and you will understand that there is a lot of work that has been done around that — has yet to address that concern and may not address that concern. I alluded right at the start of the discussion that until we actually have an ability to provide clinicians with high-level clinical data we will struggle to achieve dramatic improvements in efficiency.

Mr DAVIS — Just to pick up on some of your comments about paediatrics, I was interested in the standards of care for children and adolescents in health services document and one of the central points you made about aligning the measurement of information with clinical outcomes and results, which seems to me to be something that has been underdone in the evidence we have had to date. I wonder if you might just expand on how that might work, for example, in the section you have it in there, 'Paediatric specific issues'. What sort of measures would we be talking about, and how does that relate in the sense of children and adolescents to the sorts of measures that are there now?

Dr PHELPS — I should start by declaring first and foremost that I am an adult physician, and one of the joys and challenges we have in our college is that we combine both adult physician practice and paediatric practice. So I am not intimately aware of some of the issues behind the paediatric standards and the development of those standards, but I do know that my paediatric colleagues are doing a lot of work to understand the quality of care provided in the paediatric environment and would be, I am sure, willing to provide you with specifics around some of those measures. I would not be doing my colleagues a favour to talk specifically about that. I can talk in general terms about the place of data, but I would not want to talk specifically about measures.

Mr DAVIS — We are happy to take it on notice in that sense, but I think it is a very interesting area. We see very little data reported on the standards and outcomes for children and adolescents. You could probably extrapolate and use another area that you are more familiar with to give that example.

Dr PHELPS — Sure. We see very little data coming out of our system about outcomes per se, and that is a reflection of our ability to collect and manage data to some extent. It is also a reflection, I believe, of our focus. We do not focus our system on patient care to the extent of understanding what we are actually doing and what we are delivering as a result of our system, and I have already suggested that we clearly need to.

I would have thought with paediatric practice it is fertile ground to develop a really deep understanding of the outcomes of care. We should, for instance, be developing a longitudinal understanding of the outcomes of paediatric oncological care, and I know again there is some work happening in the state around that. We also have, I think, a very poor understanding as a system of the transitional period between paediatrics, adolescence and into adult medicine. We do not really understand how paediatric patients are handed into the adult system, and there may well be a suite of measures that we could develop around that. My paediatric colleagues though would be much better positioned to comment specifically around that.

Mr DAVIS — Perhaps you can take that aspect on notice.

Dr PHELPS — We certainly will. Thank you.

Mr DAVIS — Perhaps in coming back it may be valuable to have one of your colleagues talk on some of this, but I am also interested in the bed-state planning for maternity and neonatal services in particular.

Returning to point 5 in your submission:

The solution ... lies in increasing the time available to physicians for accurate data collection and for improving IT systems ...

You have referred in part to HealthSMART. Perhaps you could tell us exactly where the HealthSMART introduction is at Ballarat, which you are obviously most familiar with, and how that is addressing some of these issues.

Dr PHELPS — My understanding of the HealthSMART introduction in the context of my own hospital, and I should point out that I am part time at my hospital, so I am not necessarily intimately aware of some of the specific implementation issues, but my understanding of HealthSMART is it has no role at our organisation going forward. We have chosen not to be a part of it in part because of some of these implementation difficulties. There may be some nuances around that that I am not specifically aware of, so I apologise if that is the case. I think it is fair to say, though, that across the board the view of clinicians about the HealthSMART implementation is pretty negative. There is a sense that it is not meeting people's needs in terms of helping them to understand their clinical practice and it is not necessarily meeting people's needs in terms of providing them with the information they need to look after their patients.

Having seen other systems operating internationally I think it is fair to say that we have probably significantly underinvested in that, and we perhaps had some unrealistic expectations about what the system might be able to deliver to clinicians on the ground. My view around data is that as a system we need to be looking towards moving down the line of a formal electronic health record, electronic medical record, that needs to be system wide.

One of the challenges we have across the Victorian system is that in effect you have got one hundred and something hospitals operating as independent entities, and in the absence of a clear policy setting those independent entities will do their own thing to some extent, and that is why, as we have alluded to in our submission, you see doctors moving from hospital to hospital, particularly in their training, having to learn a completely new IT information management system in every hospital.

Mr DAVIS — So Ballarat has opted not to take HealthSMART.

Dr PHELPS — That is my understanding.

Mr DAVIS — Are there other hospitals that have opted not to take HealthSMART?

Dr PHELPS — I believe so. I believe there are some that are operating with elements of the HealthSMART suite of packages, but I am not familiar with which ones are.

Mr DAVIS — And the time available to physicians for accurate data collection, do you think that where there is a descriptor of a service there should be some element of time costed in for the collection and entry of data?

Dr PHELPS — I have a strong view, as I have alluded to already, that we will not see significant, dramatic improvements in our system until we have a strong sense of engagement between clinicians and the organisation that they work for around improvement. If we are going to be collecting clinical-level data and managing clinical-level data, it is my view, and I believe an evidence-based view, that we really do need to ensure that clinicians are contributing to that process. There is nothing more certain than the idea that if you give data to clinicians that is not clinically derived, they will be inherently suspicious of it and, frankly, rightly so. If we believe that clinical performance is important, and I do and I know my college does, then we need to ensure that clinicians are contributing to and assisting with the management of that data. Do they need to be entering the data? do they need to be sitting at a word processor?

Mr DAVIS — It needs to be costed in.

Dr PHELPS — Yes, the support required to do that absolutely needs to be costed in.

Mr DAVIS — Finally, bed numbers and access block, the physician groups in the hospitals sometimes have patients that are incredibly urgent and might jump up the queue, but it seems to me you also have a cluster of patients who, whilst very sick indeed, might not jump up the queue. You might want to elaborate on my point of acuity, the rationing of beds and access.

Dr PHELPS — I think one of the things that characterises physician and paediatrics practice is in the hospital setting, in the inpatient setting — and let us divide inpatients and outpatients. In the inpatient setting, at least, in essence everything is urgent. There is very little elective care. With the notable exception of things like endoscopies and other procedural elements, most people occupying a hospital bed for more than 24 hours are there because there is an urgency about it. It is a very heterogeneous group of patients, though, and a lot of the care we provide can be provided in a reasonably short space of time, so across Victoria I am sure you would find that the average length of stay for an acute medical patient is probably of the order of three to three and a half or four days.

Having said that, there is clearly a group of patients who require a lot longer in hospital. Often that is the very elderly and those with significant comorbidities or other illnesses and particularly those who are going to be requiring additional services or support in the community. There is no doubt that across many of our hospitals we have a problem with accessing rehabilitation services and accessing community services that might allow us to discharge our patients into the community or into other environments sooner than might be the case. The care that physicians and paediatricians provide in the hospital setting needs to be seen as being longitudinal and extending beyond the point of discharge from hospital. That becomes very difficult if we are not able to access the sorts of services we need downstream.

Mr DAVIS — The support in the community.

Dr PHELPS — Support in the community, access to nursing home beds, access to rehabilitation beds, access to geriatric evaluation beds — a range of facilities and services that we need in order to provide longitudinal care. Included in that may well be access to ambulatory or outpatient-style services, which increasingly, because length of stays have declined in recent years, we need to be able to access in order to ensure that we are able to provide longitudinal care.

Mr DAVIS — Returning to the point about bed-state planning — and you may not be able to answer this but you might add it to your list — do you have a breakdown of the paediatric and maternity beds? I wonder whether your college has a reasonably accurate understanding of the spread of those.

Dr PHELPS — We may do. I am certainly happy to take that question on notice.

Mr DAVIS — Thank you.

Mr TEE — I want to thank you very much for your presentation, and I suppose it is very much a sort of cautionary tale in the sense that there is a real ripple effect to any sort of decisions government or hospitals or the department make. Whatever we do, we should not jump to the quick fix because of the complexity in the system, and whether that is initiating a data collection mechanism, or indeed the evidence we have this morning about the consequences where the federal government cut the number of doctors being trained, now that numbers have been increased of course will have an impact for supervision and so on in 10 years time, so I want to start off by thanking you again for adding to that caution in terms of anything that we might think about.

I just want to in that context ask you to elaborate to your submission in the first paragraph where you note the broadness of the committee's terms of reference and you advise the committee that if further consultation is to occur, it would be beneficial to provide more specific information on the nature of the inquiry, and I was just wondering if you could perhaps elaborate on the concerns that you raise there?

Dr PHELPS — Thank you for the question. Perhaps if I could put a personal slant on it, I think what the inquiry is asking is really cutting to the question of what sort of health system we want to deliver, and I think that is an enormous question to which there are, as I have already suggested, no simple solutions. Clearly as this moves forward, and particularly in the current reform climate, there will be a need to have very substantial community and professional consultation around the specifics of some of these elements, and I think that is clearly what we are suggesting, that whilst we can provide you with some broad commentary and advice around issues such as demand and standards and quality, we can, I think, potentially add more value to your committee's work if we are subsequently invited to provide some more specific advice around key elements.

I think what we would say to you now is we are providing a broad view of these issues as we see them from a perspective of physician and paediatric practice. I am sure we would be very happy to help but be more specific if required.

The CHAIR — Any further questions?

Mr VINEY — Just a couple. Whilst you were giving evidence I was just having a look at some information about some of the investments that have occurred in rural health, and in particular at your hospital in Ballarat, with the rebuild of residential aged care. There is \$20 million in this year's budget in relation to a coronary facility and six day beds; expansion of women's health and a children's unit. You were raising a lot of really valid questions about the way we collect data in relation to quality of patient outcomes and so on. My question is kind of anecdotal, really, but in your time there have things been getting better or worse?

Dr PHELPS — I presume you want me to take off my college hat and talk personally now?

Mr VINEY — I spent a lot of my life trying to measure the qualitative things in businesses and communities and organisations. It is a very difficult thing to do, so I am just asking a qualitative — —

Mr DAVIS — What, polling?

Mr VINEY — I did more than just political polling, Mr Davis.

Dr PHELPS — To put some context on it, I have been in Ballarat since 1994, and there is no question that things have improved in that time. There has been an expansion in the number of senior staff and junior staff, as I was alluding to before. We have had across the combined public and private sector in that community new services developed and delivered and some real sustainability built into some of our key services, largely because collectively we have been able to ensure that we have reached a critical mass in some of our key specialty areas.

Having said that, there is a long way to go, and I guess this cuts to that culture change question that I was alluding to before, that many of our provincial hospitals — and Ballarat is certainly not unique in this — need to make a shift from being service-oriented to being hybrid service, teaching, training, academic environments, which, when we achieve that, they will all of a sudden become much more attractive to people.

My sense is that that is how we ultimately address this workforce capacity issue, but it is a tricky balancing act in that as we expand our workforce, we clearly need to expand our infrastructure and expand our ability to deliver services, and some of that is about culture; a lot of it is about funding; a lot of it is about other resources.

I think if you look across Victoria, again coming back to that paper I was alluding to before, since that was published in 2001 there have been significant improvements across many of our regional and particularly also our outer suburban hospitals. Has it been fast enough? Those of us who work in these environments would say, no, it is never fast enough, but unquestionably it has improved.

Mr VINEY — But that cuts to the issue, doesn't it, because the essence of your submission, which I think is a very interesting one, is that the easy-to-report headline data are not necessarily the things that matter to patients, I think is essentially what you are saying; and what you are also saying is whilst there have been improvements across the system in outer suburban and regional rural hospitals, the improvements that you are referring to are very difficult to measure?

Dr PHELPS — Absolutely right. I think what we as a system do — and I should say that I have a major personal interest in the quality issue, which is why I am representing this committee — is measure the stuff that is by and large easy to measure. We have an activity database that allows us to measure things very easily. It is not a clinical database.

We have a range of things that we can report from that data setting that superficially tell us something about the performance of our system. That is good and it is important, but it is not necessarily information that touches the relationship between a clinician and their patient, and I think the quality literature would tell us that if we are serious about fundamental improvement, we have to understand that relationship, and I think our challenge as a system is to move away from the easily measured towards the much more difficult and perhaps to some extent qualitative issue around what actually happens at the bedside, and that is a huge challenge.

It is a challenge that systems all over the world have struggled with. Some have met it to some extent. My view, and I am sure our college's view too, would be that if we want to make this transition to being a high performance health-care system, then that is where we need to be.

Mr DAVIS — Is there an example somewhere that you could point to elsewhere that would suggest that this sort of qualitative data measurement has been done well?

Dr PHELPS — It is partly qualitative, partly quantitative. I think if you look at the big US systems like Kaiser Permanente and Inter Mountain health care, which have led the way internationally around developing electronic medical records and around understanding clinical practice as a result of the data that can be derived from that sort of setting, you will see gains in efficiency of practice, but it is the gains in safety and quality of care that are really quite remarkable.

I should declare a personal conflict of interest in this in that I spent some time training with Inter Mountain health care in the US, and I think it is fair to say that those groups actually show us where we need to be. The veterans administration in the US similarly is operating in a way that we struggle to understand in Australia, because we simply cannot understand clinical practice to the same extent.

The NHS, as I suggested before, is doing some interesting things in this environment, and from some of the other work that I do, we are keeping an eye on that, and I think, as we move towards better understanding hospital performance in Victoria, it would be well worth watching that environment, because in many ways there are similarities in the way NHS hospital settings work to Victoria. Again, we cannot borrow a solution to this from anywhere in the world.

Mr DAVIS — No, you cannot lift one off.

Dr PHELPS — We can, though, look at culture, and I guess the one plea that I would make personally — and also wearing our college's hat — around this work is that we start to understand the impact of driving performance on culture, and conversely the impact of building culture as a driver of better performance.

Again wearing one of my other hats, we have been very interested to watch what is happening in Sweden where quite small health systems have achieved some dramatic improvements in patient safety and patient care, largely through driving a patient-centred culture. So there are certainly environments that we can learn from. I think one of the great beauties of being in Australia is that we can pick and choose and take bits and pieces from various settings. Again I think this starts with a policy question about what sort of system do we want to drive?

What sort of care do I want my patients to receive next year; in 15 years time when I'm looking to retire? What sort of environment do we want our kids to be brought up in?

I guess I would have a personal view that my obligation as a clinician working within the system is to leave it better than we found it. I think we have gone some way towards doing that in Victoria, and we can learn a lot from what is happening overseas.

Ms HARTLAND — Continuing on that theme, what are two or three things that you think could be done in Victoria to make data collection more transparent and of more use to you as a doctor?

Dr PHELPS — Let me deal with some big-picture things first, and then we can perhaps talk about some smaller issues. I think one of the challenges we face at the moment is the challenge of multiple organisations, a devolved management model. I have a number of patients who spend quite a deal of time at the Austin Hospital because I run a liver clinic program, and many of my patients end up in transplantation. I have no ability to access their clinical information. I am entirely reliant on a letter that I receive some weeks or months down the track from my colleagues to tell me what is happening to my patients who I am seeing, in extremis, tomorrow.

We need a system whereby individual hospitals talk to each other and where individual clinical information systems are able to converse. I find myself repeating tests that I know have been done, because I can't access them, or I find myself accidentally repeating tests because I don't know that they have been done.

The big-picture solution is that we need a system that is statewide — frankly, we need a system that is nationwide, we're not that big a country — and we need to do that in a way that actually reflects clinical need. But that is the big picture answer to your question.

The small picture answer to your question is that I think at a local level what we need to be doing is to ensure that we are creating a policy and healthcare environment that allows people to be engaged in this conversation, as I was suggesting before, about how we generate clinical data and what the clinical data might mean, and most importantly, how we might use that data for improvement.

Some of that, I believe, is around ensuring that hospitals are measured against their ability to engage with clinicians. At the moment hospitals are not judged on that, and my sense is that we must. Some of it is also around the way we resource clinicians to access information and to manage information. Some of it is also, frankly, around the way we as individual professionals work with that data, and some of the work that our college is about to enter into is around building a performance framework to assist us in our day-to-day clinical activities.

But in the absence of clinical data, that is pretty tough. I think there are two ways to look at that, but, again, without a big-picture view, then what we are doing is treating patients in isolation.

The CHAIR — Thank you, Dr Phelps, if there are no further questions the committee thanks you for your attendance this afternoon and also the college for your written submission. We will have the draft transcript to you in the next couple of days, and there may be some further follow-up questions on some of the matters that were raised.

Dr PHELPS — Thank you.

Witness withdrew.

