CORRECTED

REPORT OF PROCEEDINGS BEFORE

GENERAL PURPOSE STANDING COMMITTEE No. 2

INQUIRY INTO QUALITY OF CARE FOR PUBLIC PATIENTS AND VALUE FOR MONEY IN MAJOR NON-METROPOLITAN HOSPITALS IN NEW SOUTH WALES

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At Port Macquarie on Wednesday 22 May 2002

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The Committee met at 9.30 a.m.

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PRESENT

The Hon. Dr Brian Pezzutti (Chair)

The Hon. Dr Arthur Chesterfield-Evans
The Hon. Ron Dyer
The Hon. Doug Moppett

CHAIR: I welcome the media and members of the public to this hearing of General Purpose Standing Committee No. 2 for its inquiry into quality of care for public patients and value for money in major non-metropolitan hospitals in New South Wales. I advise that under Standing Order No. 252 of the Legislative Council evidence given before the Committee and any documents presented to the Committee that have not yet been tabled in Parliament may not, except with the permission of the Committee, be disclosed or published by any member of such Committee or by any other person.

Copies of the guidelines governing the broadcast of proceedings are available from the table by the door. In March of this year the Committee released a discussion paper on the terms of reference for this inquiry. Copies are also available on the table, and I encourage anyone with an interest in the inquiry to make a submission to the Committee based on the issues listed in the final chapter of the report. The Committee will be accepting submissions up until 11 June 2002.

The purpose of today's hearing is to hear from hospital management and the community on the issue of quality of care for public patients at Port Macquarie Base Hospital. The Committee has had the benefit of an early morning tour of the hospital thanks to the assistance of the Chief Executive, Mr Bob Walsh, and his staff. The public hearing will begin with evidence from Mr Walsh, then from the former Chief Executive Officer, Ms O'Brien, and a panel of community representatives.

The afternoon session will provide an opportunity for all of you to contribute if you wish. The Committee will hold a public forum session where people will be able to speak for up to five minutes to express their views on the quality of care at Port Macquarie Base Hospital and how quality of care should be measured for patients. I encourage all of you to read the terms of reference before speaking to ensure that your contribution is relevant to the inquiry, and also to register with the committee officer by the table if you wish to speak in the afternoon.

ROBERT LIONEL WALSH, Director of Hospitals, Northern Region, Mayne Health, Port Macquarie Base Hospital, Wrights Road, Port Macquarie, affirmed and examined:

CHAIR: In what capacity are you appearing before the Committee?

Mr WALSH: As the Director of Hospitals.

CHAIR: Are you conversant with the terms of reference for the inquiry?

Mr WALSH: Yes.

CHAIR: Should you consider at any stage during your evidence that in the public interest certain evidence or documents you may wish to present should be heard or seen only by the Committee, the Committee will be willing to accede to your request. Would you like to make an opening statement?

Mr WALSH: Thank you for the opportunity of meeting with you. I extend my apologies for miscommunication which resulted in information not being received by you prior to the 2002 discussion paper being printed. I would like now to address some of the issues raised in that report and my response to them. In November 1998 the hospital was accredited by the Australian Council of Healthcare Services [ACHS], gaining the maximum three years, and the ratings received were as recorded in your March document. I believe it is important for the Committee to be aware that it is not the number of recommendations made by the ACHS that is important. Part of the accreditation process is to give recommendations to hospitals, advising how hospitals may further improve their services and build on the services already given.

The hospital was again surveyed in April of this year. At the summation of that survey the hospital received no high priority recommendations. That means that the hospital did not receive any recommendations which would preclude it from being accredited for a period of four years. I would like to address some of the issues raised in your 2002 report. One was the downgrading of services outlined in your March document due to funding transfers. Port Macquarie Base Hospital has two streams of funding: One is for general in-patients funding and the other is for what we call direct bill funding. In this direct bill funding mental health services are funded, which was the centre of that report in 2002. Total budget areas for these direct bill areas is approximately $15 million per year and covers areas such as mental health, day hospital, physiotherapy, occupational therapy, oncology and the emergency department.

Port Macquarie Base Hospital manages these contracts for the Government and obtains no financial reward or benefit for this management, but is held accountable if the budgets run over their allocated amounts. That is, Port Macquarie Base Hospital makes no financial gain but wears the risk if the hospital does not effectively manage those budgets. Services are not cross-subsidised unless budgets have not been fully utilised. Any cross-subsidisation is with the agreement of the area health service. There has been no reduction in registered nurses. In line with moves throughout the public hospital arena nationally, Port Macquarie Base Hospital investigated the opportunity of employing enrolled nurses and assistants in nursing towards the beginning of 2001. The undertaking given to the staff at Port Macquarie Base Hospital was that no unregistered nurse would be employed in any patient care delivery. This undertaking has been honoured.

With regard to quality indicators, in October 2001, at the instigation of the Director of Health for New South Wales, Mr Mick Reid, Port Macquarie Base Hospital and the New South Wales Government entered into a four point plan. Amongst other things, the four point plan agreed that Port Macquarie Base Hospital would be treated as an equal base hospital, that is, it would receive its equal and adequate allocation of funding on the same basis as that given to other base hospitals in the area. Secondly, Port Macquarie Base Hospital would continue to maintain transparency in all of its activities. Thirdly, the community health forum would be established, and this new community health forum would replace the existing section 20 board, which became the Health Council. Fourthly, delegated authority to the area CEO would be given in terms of management of the contract.

Members may have a copy of my document of 27 March. I believe that that document highlights the significant contribution to quality health care that Port Macquarie Base Hospital makes to the community of the Hastings. Another area I would like to touch on is the treatment of complaints. The hospital has a transparent complaints mechanism whereby any complaints received in writing or verbally are registered and investigated by senior management and medical and executive staff of the hospital. A report is forwarded to the patient care quality review committee, which meets monthly and comprises at least three representatives of the medical staff of the

hospital. Upon completion of this inquiry, that report is then forwarded to what was the section 20 board or the Health Council, which then ultimately ends with the regional health board.

This process has been in place for many years and I believe is another reflection of the transparency that Port Macquarie Base Hospital has always functioned under. My report of 27 March also highlights the development activities at the hospital, the appointment of additional staff and the commitment that the management of the hospital has to the development of services, which are not only at the cutting edge but perform at the highest level of benchmarking when compared to other hospitals. As the inquiry is concerned with value for money, I believe that the performance report of 2000-01 highlights the value for money that Port Macquarie Base Hospital provides to this community.

The hospital prides itself on the high medical infrastructure and on the wide range of medical specialists that it has recruited. I believe and know that if the quality of services offered by Port Macquarie were not at the cutting edge and were not comparable to other benchmarks, then we would not be able to attract and retain the medical staff we do have. I believe the medical staff complement, the nursing complement, the infrastructure and the capital improvements that the hospital has made, and is continuing to make, are a direct commitment of the hospital management and Mayne Health to ensure that the hospital has the necessary medical infrastructure to meet the needs of the community and ensure that the services provided are in accordance with the service agreement under which the hospital operates.

CHAIR: Would you like to include that statement as part of your evidence? Have you seen the document that the department sent us, the submission from New South Wales Health dated May 2001?

Mr WALSH: I do not think so.

CHAIR: It looks like this.

Mr WALSH: No, I do not have that.

CHAIR: In that document it goes through the various area health services in terms of progress in improving quality. The only one of those about Port Macquarie Base Hospital talks about your ACHS accreditation, which it does not do for the other areas. It does not say what day those ratings were done. Have you just had a ratings report done recently?

Mr WALSH: We have had a survey but not the final report.

CHAIR: When was the survey completed?

Mr WALSH: In April.

CHAIR: In April this year?

Mr WALSH: Yes, but that document there probably refers to the 1998 survey.

CHAIR: It probably does, but at that stage you had received no major recommendations. What is the result of the last one?

Mr WALSH: We have not got it yet except there were no high-priority recommendations. Essentially, what that means is that the hospital is operating in a very safe environment for patients and staff.

CHAIR: I note that the Committee came rushing up here after it had discussions in Sydney to sort out a few problems but it is your view that you have been receiving your fair share of the funding of the Mid North Coast Area Health Service?

Mr WALSH: I believe that under the four-point plan we now have about equal basis of the distribution of funding and we are very happy with that. The thing that concerns us is that the money will not be enough to meet the growth needs of the Port Macquarie area, which is growing at a very high rate, and not only the rate but the age profile of the people over 65, who are the users and consumers of health care is growing at a rate which is not equal to anywhere in New South Wales.

CHAIR: Did you get from Mr Reid a direct idea of how he was going to split the money up fairly. There is a resource distribution formula [RDF], which is driving money, and we are told by the Government that for this year's budget all areas will be plus or minus 2 per cent of what they deserve to have. Did Mr Reid give you any indication of how the money was to be split between Taree, yourself, Coffs Harbour in terms of mid North Coast allocation of its funding, which is now meant to be getting a fair share from the State to you?

Mr WALSH: The only indication was the RDF being 1 per cent or 2 per cent above and we believe in terms of equality of distribution of the allocation made to the mid North Coast Area Health Service that we will receive our equal share of that money, which will be based on the RDF.

CHAIR: So that will overcome the problem of age, which you were talking about?

Mr WALSH: We hope so.

CHAIR: The biggest other issue is that the clinical indicators you put into your annual report may not necessarily be indicators reported by the Government. These are issues we are inquiring into and are appropriate indicators for the people of your area to understand whether you are providing a good service, yet in the annual report you put in the admission rate, the contaminated wound rate, clean wound rate, which are not necessarily the sorts of things that are reported in the 64 indicators, are they?

Mr WALSH: They are in there, but the 64 indicators selected by the department are far more comprehensive than the clinical indicators, which are the ACHS indicators. It is important to note that since October last year, when the four-point plan was signed, I was invited to sit on the area quality improvement committee and the clinical indicator committee—and I sit on that now. We are coming to grips with the reporting process across the region and have just finalised the actual indicators we all agree upon as directors of hospitals.

CHAIR: None of the 64 refers to patients who are readmitted within 28 days of being admitted to your hospitals. These are things the community wants to know about, whether you have done it right or you have discharged them too early, et cetera. Clean wound and contaminated wound rates are benchmarks used internationally but they are not in the 64 plans. Do you think that those sorts of indicators should be?

Mr WALSH: Absolutely. They are critical indicators.

CHAIR: Is there any reason why they are currently not.

Mr WALSH: I could not comment why they may not there.

CHAIR: In your waiting time frames for the emergency department, the time frames changed in 1999?

Mr WALSH: Yes.

CHAIR: Which makes it difficult, therefore, to compare your February-March 2001-02 figures with the 2000 figures?

Mr WALSH: The reason why they changed was because there was an additional allocation of funding made for medical staff and nursing staff to the emergency department.

CHAIR: No, the benchmarks themselves changed.

Mr WALSH: Yes, there was a change.

CHAIR: I notice that as of February 2002 since you have been augmented, appropriately, in your emergency department, those indicators have jumped dramatically.

Mr WALSH: Yes.

CHAIR: How would those now compare with the other peer hospitals?

Mr WALSH: I have the latest report, which is the end of March, and certainly that base hospital is the best performing hospital in terms of its ED triage categories across the region. I am prepared to table this for the

Committee. It also has the averaging effect across the whole of the region. It is important to note that as a result of this, we have been invited to speak to the area in terms of how we manage our various categories and achieve these benchmarks.

CHAIR: I would like to go to the huge amount of outflow which is done from the mid North Coast to other areas. I notice that there are no numbers for the Port Macquarie Base Hospital. Figures produced by the Mid North Coast Area Health Service talks about the outflows from Bellingen, Gloucester, Greater Taree, Great Lakes and Hastings is there. There are large numbers of outflows. Do they relate to orthopaedic services?

Mr WALSH: Amongst other things, ear, nose and throat [ENT] and orthopaedic.

CHAIR: The next table shows the top 10 surgical groups that refer to orthopaedic and the total public outflow is 482 of which 88 went to Central Sydney, 140 to Hunter and so on. Would these be total hips, total knees and so on?

Mr WALSH: Probably.

CHAIR: When they get transferred to Central Sydney, does the Mid North Coast Area Health Service have to pay for them?

Mr WALSH: No, I do not believe we have to pay for them. Certainly, Port Macquarie Base Hospital does not have to pay for them. We are capable of doing this work. The mid North Coast area is capable in orthopaedics of addressing the outflow. The difficulty is redressing the funding for those outflows.

CHAIR: Are you aware that the Mid North Coast Area Health Service had a deficit of $36 million for outflows because they are now counted?

Mr WALSH: Yes.

CHAIR: When you get your budget plus or minus the 2 per cent already you have lost $36 million. According to these documents that is going to the Central Sydney Area Health Service so if people on the waiting list for 1½ years at your hospital to have their total hip done choose the option to go to Central Sydney, the Mid North Coast Area Health Service is paying for it there but they will not pay for it here?

Mr WALSH: That is right.

CHAIR: Have you had discussions about that.

Mr WALSH: Yes we have. We are very conscious of that and we are working very closely with the Mid North Coast Area Health Service to redress these outflows. Of that $36 million it is important to remember that $12 million to $15 million maybe the tertiary activity, neurology, cardiology that we will never touch and do not want to touch. Also, we estimate in working with them that there is probably $20 million worth of outflow work that could be done here. We are able to do most of that work. In fact, apart from the super specialties of cardiology and neurology, all of the work that is indicated in the top diagnostic related groups [DRG] we are capable of doing in this region.

CHAIR: How do you stop patients jumping the queue when Central Sydney bone and joint says, "Come to us all ye who limp and we will fix you and we will charge your area health service."?

Mr WALSH: The only way of stopping that is for that outflow of funding to be allocated to hospitals on the mid North Coast that can do the work. It is a continual source of frustration to the medical specialists when patients who can be treated here have to wait and who can make a phone call and can be done in six weeks—every joint.

CHAIR: You have the longest waiting list in the State of New South Wales. Why is that so?

Mr WALSH: There are a lot of reasons for that. Firstly, funding is a major issue. We are inadequately funded for the demand. The other important factor is we have 54 specialist medical officers in Port Macquarie covering a wide range of specialties and that is unique outside of Sydney. People are attracted to this area from wide-

ranging outflow areas, not just the Hastings but from all over the hinterland, north and south of Port Macquarie. If you have a good product people want to use it.

CHAIR: Do you have people on your waiting list from Tamworth?

Mr WALSH: Yes.

CHAIR: If you did them, you would be pinching money from Tamworth to pay for it, under the inflow-outflow process?

Mr WALSH: When you say pinching money from Tamworth, it does not work that way. We have people who come to us who might be a category one, urgent one priority surgery so they come to us. As a base hospital, we cannot refuse them.

CHAIR: I accept that, but eventually the mid North Coast gets the money on the inflow-outflow process from the Northern Tablelands.

Mr WALSH: I am not sure if that process is working. I am not sure whether the inflow-outflow process works.

CHAIR: I assure you it does because the director-general gave us that information. It used to be shadow but now it is real.

Mr WALSH: The problem we have is that people from outside the area come, and this can be when hospitals north and south of us may not have specialists available on duty at a particular time. These people come to us and they have to be done because we are a regional base hospital. Therefore, people coming from outside the area consume the budget.

CHAIR: In other words, even if you get your fair share of the budget for the mid North Coast you are relatively underfunded because of the way in which people are moving within the area?

Mr WALSH: Yes.

CHAIR: What steps are you taking to ensure that it is fair for the people of Port Macquarie, which is the focus of our inquiry?

Mr WALSH: We are working very closely with the region in terms of developing network strategies across the region and we are certainly meeting with them to try to address this outflow problem, of how to get the money back here.

CHAIR: You have an inflow problem also.

Mr WALSH: Yes. I do not know how we are going to correct that because I do not see it stopping. As we see a decline in rural specialties outside of the coastal area of Sydney I believe this will only exacerbate.

CHAIR: How are you going to work out the problems associated with the internal movements of patients, such as a patient from Taree or Coffs Harbour coming to Port Macquarie, so the people of Port Macquarie are not disadvantaged?

Mr WALSH: We continually dialogue with the region and map these patients to see the volume increase and what might be happening.

CHAIR: One doctor commented in your annual report this year about the disputed amount of money that the hospital gets and referred to 3,200 bed days.

Mr WALSH: The Parker review.

CHAIR: Do you have a copy of the Parker review that you could share with the Committee.

Mr WALSH: I do not have a copy with me but I could make it available to the Committee.

CHAIR: Is that contention real?

Mr WALSH: It was an issue that arose in 1998 that under the services agreement the department had to take into account such factors as changes in demography, growth, health funds and a whole range of factors in terms of increased funding for the hospital. At that time we believed this was not occurring, that the department was not taking into account those factors and the hospital was not being funded appropriately. It was agreed between the department and our hospital that we would get an independent review of this, which was part of the services agreement and the disputes resolution process. We engaged a gentleman called Ron Parker, who used to be the Secretary for Health in Tasmania. He did a review and I believe his findings were that we should be funded an additional 3,200 bed days. That never came about. The Ron Parker decision was not binding on either side. Rather than pursue that further, it was agreed that it would be better to pursue this four-point plan because that was a positive moving forward into the future.

CHAIR: Those external justifications were grossly underfunded.

Mr WALSH: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In your letter you say that no nursing positions will be replaced by unregistered nurses. Is that correct?

Mr WALSH: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There was some controversy, I gather, about the replacement of registered nurses [RNs] by assistants in nursing [AINs]. Is that right?

Mr WALSH: Yes, there was.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You then instituted a training program for enrolled nurses [ENs] in September last year?

Mr WALSH: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are all those trainee enrolled nurses supernumerary, or are they replacing registered nurses?

Mr WALSH: No. They are meeting our workforce. There are three of them. Three people were trained. They are going through the program at the moment and are nearing completion soon. They will fill up vacancies in our workforce because we cannot recruit nursing staff.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They will be replacing registered nurses?

Mr WALSH: They will be, where they can be replaced or where there are no replacements available.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They will only be used if you are unable to recruit registered nurses?

Mr WALSH: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are they currently replacing registered nurses?

Mr WALSH: Where we cannot recruit.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Have you tried to recruit registered nurses for the positions that they are replacement for?

Mr WALSH: Absolutely.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But they are replacing registered nurses now?

Mr WALSH: Yes, but remember that an enrolled nurse is a registered nursing position.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is not the same. A registered nurse is usually one who has done three-year training, surely.

Mr WALSH: We gave an undertaking that we would not employ non-registered nurses, and an enrolled nurse is a registered nurse. They have to go through a training program. They are qualified.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They are usually referred to as enrolled nurses, though, rather than has registered nurses in common parlance, are they not?

Mr WALSH: They are.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They are not really registered nurses.

Mr WALSH: No, they are not registered nurses, but they are registered, as such. The AINs—I think you need to realise that in every hospital in Australia that I am aware of, because of the nursing shortages, we have to look at nursing and ask ourselves how we are going to structure our nursing force. Enrolled nurses are playing a significant role in meeting our nurse workforce demands across Australia at the moment. It is not peculiar to Port Macquarie. It is peculiar to every hospital in Australia.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I accept that, but you have made the unequivocal statement that no nursing positions would be replaced by unregistered nurses. You are now saying that these are being replaced by trainee enrolled nurses, or are they enrolled nurses who have completed the course?

Mr WALSH: They are being supplemented, being replaced, by nurses who have undergone a training program fully accredited by the New South Wales Nurses Board, and they are registered.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But they are registered as enrolled.

Mr WALSH: That is right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So they are enrolled nurses and they are replacing registered nurses on the ward.

Mr WALSH: Where we cannot get nurses, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: This only happens when you have advertised unsuccessfully for registered nurses?

Mr WALSH: Yes, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In appendix nine of your submission, there is a performance indicator contract signed off by Jeff Pattinson on 19 June last year. Is that correct?

Mr WALSH: Which document is it?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Appendix nine in your submission headed "Mid North Coast Area Health Service, PMBH Contract Management Performance Indicators". Under "Human Resources", it states:

> "Proportion of Registered Nurses employed to total number of nurses employed.
>
> Nursing hours per patient per day."

They are performance indicators?

Mr WALSH: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that already actually happening?

Mr WALSH: Let me say this: We have not signed off on everything in this agreement. This was signed off by Jeff Pattinson, but we have not agreed—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You have not accepted this?

Mr WALSH: Not all of it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that one of the things you do not accept?

Mr WALSH: No. We have not met with them to go through this document and finalise it because we have been working on a whole range of quality indicators across the region that we are aligning ourselves to.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: This document has not been implemented in 11 months and it has very little status?

Mr WALSH: No. It has been implemented. It has been implemented, apart from very few factors on that one.

CHAIR: Would they have such a contract with all of its other public hospitals?

Mr WALSH: I am sorry?

CHAIR: Would this sort of contract be the sort of thing you would expect to see Coffs Harbour and District Hospital to have to live with as well?

Mr WALSH: Yes. It is pretty standard.

CHAIR: Will they be reporting the results of those contractual standards—readmission to hospital, return to operating room, hospital acquired infection, and so on? Have they been adopted? In other words, if you sign this, it means that they have been adopted by the area health service?

Mr WALSH: The reason why we have not signed it is to make sure that this has commonality with every other hospital in the region.

CHAIR: In the State, or just in the region?

Mr WALSH: Just in the region.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You have had a nursing recruitment problem and you cannot get registered nurses. Is that right?

Mr WALSH: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are short of registered nurses?

Mr WALSH: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are filling that with enrolled nurses?

Mr WALSH: If we can. We cannot always get them.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you cannot get them, you are using trainee enrolled nurses?

Mr WALSH: No, not necessarily.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Hang on, you must be using one or the other.

Mr WALSH: Well, we are using a lot of overtime. Our workforce is burning out. This is a dilemma we have. Nurses are working double shifts so many times and our workforce is burning out. It is a major concern to us.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You cannot get enough nurses. There is a major recruitment problem?

Mr WALSH: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are using enrolled nurses when you can, or sometimes?

Mr WALSH: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you have not got enrolled nurses, you use trainee enrolled nurses.

Mr WALSH: We use nurses who are trainee enrolled nurses—the ones who are usually undergoing the enrolled nurse training program. We would have to be able to use nurses who are going through their three-year nurse training course or various stages of that. In many hospitals where there is a close supply of them through a university training school, they do come in and are employed basically as enrolled nurses or assistants in nursing for that period of time to get over the nurse shortage.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: These are registered nursing undergraduates of a university course?

Mr WALSH: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you are also using enrolled nurse trainees?

Mr WALSH: We only use them as supernumeraries.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You have no enrolled nurse trainees except supernumerary ones. Is that right?

Mr WALSH: Yes. These are the three that we have at the moment. They are doing the course.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And they are all supernumerary?

Mr WALSH: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In every ward they work?

Mr WALSH: Yes, I believe so.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: This indicator (viii) in appendix nine, "Proportion of Registered Nurses employed to total number of nurses employed", those figures are made available?

Mr WALSH: Yes, they are available.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Indicator (xii) states that they will be made available to the local community health forum.

Mr WALSH: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Has that happened?

Mr WALSH: We have not been asked for them.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is it not an obligation to provide them?

Mr WALSH: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That community health forum exists, does it not?

Mr WALSH: It does exist, but it has still got its training wheels on, I believe.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It has not yet received figures?

Mr WALSH: It has not asked for the figures yet.

CHAIR: Would those figures be available for any public hospital such as the Coffs Harbour and District Hospital?

Mr WALSH: I believe so. They should be. They are readily available.

CHAIR: Are they an indicator?

Mr WALSH: I am not sure.

CHAIR: Should they be?

Mr WALSH: I am not sure what they indicate.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In appendix two, there are a lot of figures missing.

Mr WALSH: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Why is that?

Mr WALSH: Where the figures are omitted, I believe there is an explanation of them.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I mean, do you have any figures at all for 1995-96, 1996-97 or 1997-98?

Mr WALSH: No. This data was not collected in 1996, 1997 or 1988. We were not required to collect this data. Under the new four point plan, we are given an obligation to collect this data wherever it is possible for us to do it, and wherever possible our IT software enables us to collect it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: All these ones from measure 20 onwards are not collected at all. Is that right?

Mr WALSH: The department would be able to extract that from information we give them every month.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you do not have that?

Mr WALSH: We do not have the information technology [IT] facility to extract them because we have a different IT software basis.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you do not give them those figures?

Mr WALSH: We give them all the information from which they extract the figures. They download it to their own system. I am aware that they can extract information that they require.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And you cannot?

Mr WALSH: Not from our IT system.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So they have better information on your hospital than you do?

Mr WALSH: They extract different information than we do.

CHAIR: But they take a long time. In the last publication, the yellow book was 1997-98. We have got some figures for some of these other indicators that the department gave us. I quoted them before, but they are not real time, are they?

Mr WALSH: No, they are not. They are retrospective.

CHAIR: So they use a fair bit of number crunching to come up with these things and we would have trouble finding the methodology for all that?

Mr WALSH: Yes. I think one of important things to realise is—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In measure 16, the private bed days are listed as 6.7 per cent of total bed days. How does that compare with other public hospitals? Is that a high figure?

Mr WALSH: It is probably a low figure.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that because the private patients are moved from your emergency section over to the private hospital rather than being admitted?

Mr WALSH: No, that is not it at all—not at all. Any patient presenting to our emergency department, as you know, has the right to declare themselves to be public or private. That is so in any public hospital in Australia—they have that right. These are people who may elect to be private and that means the advantage of selecting the doctor of their choice, and that is their criterion: It is at the discretion solely of the patient.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is not your policy to transfer them from the emergency department to the private hospital if they are private?

Mr WALSH: It is not our policy. It is the patient's election.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is the patient simply offered, "Do you want to stay here and be admitted, or do you want to go to Lake Road and be admitted there?" Are they given that choice?

Mr WALSH: No, the choice is, "Do you want to be admitted as a public patient or do you want be admitted as a private patient if you have private health insurance?" They will make that election.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are they not able to be admitted as a private patient to Port Macquarie Base Hospital?

Mr WALSH: Yes, they are. I am saying that they are admitted to the Port Macquarie Base Hospital—can be admitted there—as a private patient or they can elect to go down to the private hospital. It is very important to realise that if the private patients in the public hospital sector occupy a bed that could be used by a public patient, every patient who has private health that comes into the public hospital and elects not to choose that consumes some of the public funding money that is available for people who do not have private health cover.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you get that reimbursed by the private health insurance, do you not?

Mr WALSH: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And you have not had a critical bed shortage, have you?

Mr WALSH: We have times when we virtually do not have any beds, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is, 100 per cent occupancy?

Mr WALSH: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are your number of beds capped?

Mr WALSH: We have 14 beds that we have not utilised.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you can use more beds?

Mr WALSH: Yes, we can, if we have funding. Our capping has to be within management of the funds available.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But are you not paid on the number of separations?

Mr WALSH: Yes, we are.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Not on the number of people in beds?

Mr WALSH: Yes, we are.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you could actually use more beds?

Mr WALSH: If we had the funding.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Hang on, you are paid on the number of separations?

Mr WALSH: Yes. We have got the separation, but it does not matter what kind of separation. A separation uses beds. There is a length of stay for every separation.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you are capping your separations?

Mr WALSH: Well, every hospital has to cap its activity.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes.

Mr WALSH: But remember that the area health service sets us a target, that we will do X number of separations per year.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes.

Mr WALSH: And we usually always exceed that amount.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes. So it is irrespective of the diagnostic related groups [DRGs]. It is the number of separations?

Mr WALSH: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The patients are transferred from Port Macquarie to Lake Road. Are there other things that are transferred between the two hospitals? You mentioned three hospitals.

Mr WALSH: Staff, equipment at times when breakdowns of equipment may occur.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Pathology services?

Mr WALSH: No. The pathology services for the public hospital are contracted to the public hospital only.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you would not have two complete labs. Presumably some of the more complicated tests are transferred across?

Mr WALSH: No. In terms of the contract, Portpath is contracted to provide full pathology services to the publications.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that is on a per test basis?

Mr WALSH: They are paid a global amount.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are there other shared areas? Is the kitchen shared?

Mr WALSH: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is the payroll shared?

Mr WALSH: Payroll is done from Melbourne for every hospital.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And the laundry?

Mr WALSH: The laundry is shared.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Where is the laundry done?

Mr WALSH: At the base.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And it sends the laundry to the other hospitals, does it?

Mr WALSH: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And there is repayment back for that?

Mr WALSH: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: From the other hospitals?

Mr WALSH: Yes, there is pro rata payment back.

CHAIR: Has the department set a figure for the items?

Mr WALSH: No. That is our cost.

CHAIR: Is that benchmarked against, say, the Lismore Base Hospital's laundry?

Mr WALSH: We do not benchmark that.

CHAIR: Is that reported separately?

Mr WALSH: No, it is not.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So there is no actual fee for service for the laundry provided by the Port Macquarie Base Hospital to the other two hospitals?

Mr WALSH: Yes. They pay a cost back to the base hospital for those activities.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And that is itemised? That can be seen?

Mr WALSH: Yes, it can be found. But it does not matter because it is how we manage our cost. It does not cost the Government where we get our laundry from: that is not the issue. We could get our laundry from Tibet if we wanted to. It does not make any difference. The point is whether the quality of laundry supplied to the patients of the hospital is meeting Australian standards, which it is.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No, but if Port Macquarie Base Hospital was subsidising the laundry of Lake Road and Armidale, obviously that would be a problem if the service fee was not negotiated.

Mr WALSH: What difference does it make? The issue is whether the quality of laundry provided is meeting Australian standards.

CHAIR: I can see what the Hon. Dr Arthur Chesterfield-Evans is getting at.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes. Of course everyone must have clean laundry, and obviously that has to be clean laundry for the people at Port Macquarie Base Hospital.

Mr WALSH: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If the people at Lake Road and Armidale also have clean laundry supplied by Port Macquarie Base Hospital, and they are private hospitals, they may be the same to Mayne but they are not the same to the New South Wales taxpayers, are they?

Mr WALSH: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is a service coming from Port Macquarie Base Hospital.

Mr WALSH: That is right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If it goes to private hospitals that do not have a connection with that contract, they are being subsidised externally.

CHAIR: That is assuming that they do not pay a fee for the service.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If there is not a fee being paid.

Mr WALSH: That is right, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So there is a fee being paid.

Mr WALSH: Yes, absolutely.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And that has been negotiated?

Mr WALSH: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And it is a line item?

Mr WALSH: I think so. There is certainly a fee paid back.

CHAIR: But the department would look at that fee to see if it was reasonable.

Mr WALSH: No, not really. Why would it?

CHAIR: Because, as the Hon. Dr Arthur Chesterfield-Evans said, you could be charging out to Lake Road at half the commercial cost and the taxpayers of New South Wales would be subsidising that. That is the argument that the Hon. Dr Arthur Chesterfield-Evans is putting.

Mr WALSH: The argument is this: The Government says that this is the DRG price that we will pay you, as it is going to say to Coffs Harbour and to Manning. Here is the DRG price that we will pay you for a DRG. It pays us that. Provided we deliver quality health services that meet the standards and quality indicators, what does it matter?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You mean if you can, within the budget the DRG gives you for linen, do it sufficiently cheaply to do the linen and then send it somewhere else, that is your business. Is that what you are saying?

Mr WALSH: It is our business. It does not have anything to do with—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So if you do it cheaply enough on the DRG for laundry that you have from the base to then send it for free to your other hospitals, you would say that that is your business?

Mr WALSH: That is our commercial business activity.

CHAIR: Are you saying that you get episode funding?

Mr WALSH: Yes.

CHAIR: Do the other area health services operate on that episode funding?

Mr WALSH: Yes. We certainly do across the mid North Coast.

CHAIR: When did episode funding come in?

Mr WALSH: It will come into effect 100 per cent from 1 July. Our activity measures now are all episode funding.

CHAIR: So when you look at the table you have produced in appendix 3 you have the average length of stay and the cost of separation, which you come out very cheap on. Once you get episode funding, should all these things not be the same?

Mr WALSH: The actual bench rate can be the same. There is a benchmark set. It is set at, say, $2,400. That is the benchmark; that is the maximum. That is the benchmark target you have to aim for. Some hospitals go above it; some go below it. It depends on how efficiently a hospital can operate.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you are cross-subsidising laundry because you are getting below your DRG, do you cross-subsidise other things like pathology from this bulk payment you get?

Mr WALSH: No. It cannot be. That is paid separately to this company to provide pathology services.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Have mental health services been reduced to pay for budget overruns in other areas?

Mr WALSH: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is mental health on the same budget?

Mr WALSH: No. It is a direct bill budget.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is with a number of other items, as you said.

Mr WALSH: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is the occupancy of the mental health beds very high? Is it 100 per cent?

Mr WALSH: Yes. It is very high.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are the community health teams at full strength?

Mr WALSH: They are full strength in terms of the budget allocation that we have.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, but if that were cut to help, say, your emergency department—

Mr WALSH: No. There is no cross-subsidisation.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No connection?

Mr WALSH: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is the money on the number of separations related to the mix of DRGs?

Mr WALSH: The overall DRG price—say $2,400—is an aggregate of the whole basketful of activity that you will do.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, but some DRGs like cystoscopies might have to do less work per dollar received. That is something like a total hip replacement.

Mr WALSH: Sure.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you did more cystoscopies and less total hips you would have the same number of total separations but you would make more money from doing the cheaper DRGs, would you not?

Mr WALSH: What you are saying is: Are we picking what we do?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes.

Mr WALSH: No, and let me tell you why. Eighty per cent of the activity of the hospital comes through emergency so we have no control over it. So 80 per cent of our budget is consumed by stuff coming through emergency, obstetrics and children that come through. So we have 20 per cent of the budget approximately that we can control in terms of elective surgery. That elective surgery is controlled by the doctors, who assign an urgency category to a patient. A category one patient must be done within I think it is seven days, whatever it might be. We do not determine what goes on the list. The doctors determine what goes on the list because they categorise the degree of urgency of a patient they have seen in their consulting rooms and referred to the hospital for intervention.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But things like total hips might be a DRG that is not very lucrative because it has very high costs. Of course, they also have a low degree of urgency. Put those two together and the waiting list might be very long in, say, orthopaedics and quite short in, say, cystoscopies.

Mr WALSH: But the degree of urgency is not determined by the cost of profitability. The degree of urgency is determined by the doctor's classification of the patient. A category one is more life threatening than a category two, which is more life threatening than a category eight, which is someone with a hip who might be waiting, whose life is not being threatened because they need a hip or knee replacement. Overriding all of that is an activity plan that is set by the department which we agree to, that we will do X amount of these procedures. We agree to sign off that we will do X amount, attempt to do this amount of procedures in any one year.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And you meet that? And that is a mix of DRGs?

Mr WALSH: We endeavour to meet that because the controlling factor is what comes through our hospital through emergency.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is your mix of DRGs the same as the other hospitals?

Mr WALSH: I believe so.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Does the Department of Health monitor that?

Mr WALSH: Absolutely.

CHAIR: And it reports on that?

Mr WALSH: Yes.

The Hon. RON DYER: On the nursing issue, am I correct in assuming that there are no assistants in nursing at all?

Mr WALSH: Yes, I believe so.

The Hon. RON DYER: Well, you say you believe so. Is that the fact or not?

Mr WALSH: There are no AINs employed at the hospital.

CHAIR: What are you calling an AIN?

Mr WALSH: Assistant in nursing is the classification of a person who has done—

CHAIR: They are the sort of people you see in nursing homes.

Mr WALSH: Yes.

CHAIR: But you have none?

Mr WALSH: We have none.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are your enrolled nurses not AINs improving themselves?

Mr WALSH: No. An AIN is a person who does, I think, a six-week technical course.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, but your enrolled nurses would have the AIN when they started.

Mr WALSH: Not necessarily, no.

The Hon. RON DYER: You have only three enrolled nurses at this stage. Is that the position?

Mr WALSH: Who are training.

The Hon. RON DYER: How many enrolled nurses do you have in the hospital?

Mr WALSH: I can make that available to the Committee. I could not tell you off the top of my head.

The Hon. RON DYER: Can you express it as a proportion or a percentage?

Mr WALSH: Fifteen per cent. I am just guessing. I can make this available.

CHAIR: We could also ask mid North Coast because they would have those figures.

Mr WALSH: They may have them.

The Hon. RON DYER: I want to understand how the direct bill budget system operates. You say that certain services such as mental health, prostheses and oncology, to give some examples, are within that. I take it that there is a global budget for those direct bill services.

Mr WALSH: Yes.

The Hon. RON DYER: You say in your letter to the Hon. Dr Brian Pezzutti that if one of those services is not utilising its full budget then services may be allocated to another direct bill budget service.

Mr WALSH: Yes.

The Hon. RON DYER: Have there been cases of underutilisation and reallocation?

Mr WALSH: Very few. It certainly has not happened of late. An example was in one year the transport budget was not fully utilised.

The Hon. RON DYER: Have there been examples of overruns and funds being denied perhaps to some other direct bill service?

Mr WALSH: Let me give you an example. Prior to DHN—it is still a component there until we sort it out from the beginning of July—the medical services budget was always underfunded from this direct bill account. For many years the hospital wore the cost of that overrun. Any overruns, and if there is going to be any reallocation, it is done in full consultation with the area health service and the contract manager, and the budgets are set every year. We endeavour to obtain additional funding wherever possible in every area. Like everyone else, we have to compete for it, and we do not win all the time.

The Hon. RON DYER: During my tour of the hospital earlier this morning the Director of Nursing made reference to referrals for which the hospital is not funded. Are you familiar with that concept? I take it there are referrals possibly from out of area.

Mr WALSH: These are the outflows that you have been referring to, the people who are not in our catchment area who get referred to us. For instance, a classical illustration is if in a hospital—Coffs, Manning or whatever it might be—they may have no specialist support cover, and the patients presenting to that hospital who need urgent attention will come down to us. We accept that. It is part of the role of a regional base hospital.

The Hon. RON DYER: When that occurs, is that at the expense of services your hospital would normally supply?

Mr WALSH: Yes.

The Hon. RON DYER: What is the incidence of such referrals?

Mr WALSH: I do not have the exact figures on that. The reason is that it is expected of a regional base hospital that you provide these services as a regional base hospital. The reverse also happens. On some occasions, but very few, we have not had specialist cover and the other hospitals have picked up perhaps one or two days for that to occur. For instance, at the moment there is no paediatric cover, I believe, at Taree. That happens. We have a referral base there. If there is a problem, they come to us.

The Hon. RON DYER: You made reference in your initial oral remarks to a concept I think you described as an equal basis distribution of funding. Is that a concept that the area health service adheres to?

Mr WALSH: Yes, it is a concept that is written in the four point plan.

The Hon. RON DYER: There appears to be a perception at Coffs Harbour in particular that they are badly done by compared with Port Macquarie. Do you have any view regarding that? Do you say that you only get your fair share?

Mr WALSH: I believe and am aware that Coffs Harbour gets more funding than Port Macquarie Base Hospital. But you cannot just say that there are different infrastructures. The actual infrastructure support of the new base hospital necessitates additional funding available to it just to maintain the infrastructure of the new hospital there. However, in terms of Port Macquarie being given a disproportionate amount of funding compared to the other hospitals, that is not the case. Regardless of the funding, if you look at your DRG base, if you are being paid on a DRG base you are getting funded for an episode of care. That is what you need to look at.

CHAIR: I have a question that arises from the Mental Health Co-ordinating Council. The document entitled "The Long Road to Recovery" released by the St Vincent de Paul Society states:

> It is of great concern to us that for the Hastings Valley, population approximately 87,000, the mental health staff are unable to offer crisis support outside Port Macquarie Base Hospital. They are unable to offer any form of continuing case management and no longer

> visit their clients at our homeless persons shelter. Some people with mental illness have been moved to other areas to get the assistance they require. This is apparently referred to as the geographical cure.

What comment would you like to make, given your appendix 6, which is about psychiatric services? Because it is done on this direct bill basis, do you cut your cloth absolutely to meet what you can?

Mr WALSH: Absolutely.

CHAIR: So if that means withdrawing community-based services, you have to?

Mr WALSH: We have to do that. The mental health department has a budget which it is expected to run to. Unfortunately, we believe that that budget is underfunded.

CHAIR: The other complaints we have received about mental health funding, not because of another inquiry but for other reasons, is that the money going to other areas means that the mental health funding is not transparent. Certainly, if you are being funded on an occurrence basis it is very transparent.

Mr WALSH: Yes.

CHAIR: Would that be the case for Taree and Coffs Harbour?

Mr WALSH: I would hope so.

CHAIR: How could you possibly know?

Mr WALSH: I do not know that.

CHAIR: How could anybody know?

Mr WALSH: I think the statistics could be done and they could be looked at. Certainly, I know our director of mental health and our hospital has done comparative studies in terms of pro-rata staffings.

CHAIR: How can we be sure that this report and that sort of comment about recurrent funding at Port Macquarie hospital is being used for fixing up the lifts, operating the switchboard and so on?

Mr WALSH: That is because the auditor of the department comes in and audits.

CHAIR: Is that audit made public? Yours would be the only mental health funding for a hospital of your size and nature where it is separate because all the others are just wound up in the hospital.

Mr WALSH: Absolutely. I am not sure whether the department makes the audit available. I believe they make some statement that the funding was allocated appropriate to the service to which it is designed. I believe that statement is made.

CHAIR: But are the audit books of Port Macquarie Base Hospital public documents?

Mr WALSH: No, they are not.

CHAIR: Why is that?

Mr WALSH: Because the financial aspects of our operation are audited by our main corporate body.

CHAIR: But those audits are available to the department?

Mr WALSH: The department has open access. It is an open-book approach to the department for the hospital.

CHAIR: When we did the estimates committee hearing last year I found out that the department was paying $7.06 million for its access to Port Macquarie. That is a form of capital payment that I would call rent. The Minister admitted that although it was in the capital budget it was actually a form of rent. Would places like Coffs Harbour and Taree suffer from the same sort of notional allocation of capital money?

Mr WALSH: No, they do not. I do not believe they do because my understanding is that the capital allocation for a new hospital up at Coffs Harbour is a one-off payment.

CHAIR: Is the $7.06 million considered as part of your running costs?

Mr WALSH: We do not see that side of it. The rent that is paid is between the managing body of Port Macquarie Base Hospital Pty Ltd and the Government.

CHAIR: But would that come up in the Government's accounting figures in any way about your running costs?

Mr WALSH: Yes.

CHAIR: In other words, your DRGs?

Mr WALSH: It does not come in our DRGs, no.

CHAIR: When Minister Refshauge used to say "Port Macquarie hospital is the most expensive to operate, $3 million more" he would have included that figure?

Mr WALSH: Absolutely.

CHAIR: That meant that you were $4 million less expensive really than any other hospital in the system?

Mr WALSH: Yes.

CHAIR: This has been the disparity that has been of concern to me for a long time.

Mr WALSH: Yes.

CHAIR: You are saying you are underfunded by comparison. You have missed out 1, 2, 3, 4, 5, 19, 24, 25, 26, 27, 28, 29, 30 and quite a few between 37 and 42 and so on. Why are they not there?

Mr WALSH: As I said, our infrastructure does not allow us to—

CHAIR: But the department could do that. It does it for every other department, why could not do it for you?

Mr WALSH: I think they will become available now, that is for sure, but up until this time, 1999, we were producing them.

The Hon. RON DYER: If those indicators are not specified, how will we be in a position to form a view as to whether or not you are underfunded?

Mr WALSH: I think you need to look at the critical ones in terms of looking at the DRG basis, which is very simple and you can get a clear snapshot. You can compare that in terms of the population demography of the area and what is happening with the RDF and it is easy to see whether the hospital is underfunded or not. These indicators are operational indicators and I always question what we are using the information for. Are we just collecting it or are we using it to make changes to the outcomes of patient care?

CHAIR: They are certainly not quality indicators.

The Hon. RON DYER: I take it that the mental health component of the direct bill budget is always fully expended?

Mr WALSH: Absolutely.

The Hon. RON DYER: In fact, it is not enough?

Mr WALSH: No, it is not enough.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: This hospital has always made a profit since it has opened?

Mr WALSH: Yes, it has.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So if the number of separations are capped and you are making a profit you must be able to choose between profit and delivering more services, obviously?

Mr WALSH: No, because the Government buys from us what services they want. This is very important. The Government buys the services they want. They tell us what they want us to do. We do not determine. We cannot say, "Tonsillectomy is the most profitable. We will rip the tonsils out of every child in the Hastings Valley." They tell us what is needed and what they want to buy and that need is generated by the waiting list and consumer demand.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you have a three-year waiting list for total hips, you could presumably do those total hips and have less profit?

Mr WALSH: I would love to do more hips and knees.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you are funded on a total number of separations. If you changed your DRG mix to do more expensive DRGs you could actually cut the waiting list in some areas. Your profit would go down but the waiting list in those areas would also go down.

Mr WALSH: Yes, but I think you need to come to grips with the fact, if you understand episodic funding, that for every operation one has to wait and it is swings and roundabouts. We are a base hospital and we are required to provide services in a range of delineations—I think there are about 42 of them. We are expected to provide a service in these areas, so we cannot cherry pick what we want to do.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The number in each DRG is specified?

Mr WALSH: Yes. They say, "This is what we will do", so many hips, so many knees.

CHAIR: They are not prepared to pay for more. They do the number of total hips that they are funded for because if they do more, then that the department has to pay for them under the DRG arrangement. The profit you make is the difference between what they allow for the DRG and what it costs you?

Mr WALSH: That is right.

CHAIR: And the difference between that is the way in which your building is efficient, the number of people you employ, how much electricity you charge, and so on compared to Coffs Harbour and Taree, which the Government built?

Mr WALSH: Yes.

CHAIR: And either efficiencies or inefficiencies built in and the way in which it is staffed and the way in which people work?

Mr WALSH: Yes.

CHAIR: So, ethics and morale, all of those things matter?

Mr WALSH: Yes.

CHAIR: I understand you are coming back this afternoon. The Committee may wish to ask you further questions at that time. We may also wish to put some question to you in writing. Will you be happy to answer those?

Mr WALSH: Yes.

(The witness withdrew)

(Short adjournment)

CHAIR: I remind witnesses that we have already read the warning about the media being present and the guidelines are available at the door.

TERRANCE JAMES CLOUT, Chief Executive Officer, Mid North Coast Area Health Service, PO Box 126, Port Macquarie, 2444; and

STEPHEN DONALD BEGBIE, Chairman, Medical Staff Council, Suite 1, The Highfields Specialist Centre, Wrights Road, Port Macquarie, 2444; and

CHRISTOPHER EARL JENKINS, Chairman, Port Macquarie Base Hospital Community Board of Advice, PO Box 1810, Port Macquarie, 2444, sworn and examined:

ANTHONY JOHN O'GRADY, Manager—Organiser Services, New South Wales Nurses' Association, 43 Australia Street, Camperdown, 2050, affirmed and examined:

CHAIR: At any stage during the evidence, should any of you feel that in the public interest certain evidence or documents you may wish to present should be heard or seen only by the Committee, the Committee will be willing to exceed your request. Are you familiar with the terms of reference for this inquiry?

ALL WITNESSES: Yes.

CHAIR: Mr Clout, do you have any further comments to add to the submission you have already made?

Mr CLOUT: No, I do not.

CHAIR: Mr O'Grady, do you have any further comments?

Mr O'GRADY: No, I do not.

CHAIR: Dr Begbie, do you have anything further to that?

Dr BEGBIE: I have prepared a written statement.

CHAIR: You may read it or quote from it. If you would like to hand it over as evidence, the Committee would be more than happy to take it as evidence.

Dr BEGBIE: Sure.

CHAIR: Would you like to make an opening statement?

Dr BEGBIE: Yes. I have held the position of Chairman of the Medical Staff Council for the past six months and I am appearing before the Committee to give a clinical perspective on the issues that the Committee is addressing. I am trained as a Fellow of the Royal Australian College of Physicians and I have subspecialised as a medical oncologist. I moved to Port Macquarie 5½ years ago to take up a position as the Director of the Oncology Unit. I moved largely because of the thriving medical community and the new base hospital facility. There are only actually three specialist medical oncologists outside the corridor between Newcastle and Wollongong, with Wagga Wagga and Albury being the other two. The thing that disturbed me about the current discussions concerning the Port Macquarie Base Hospital is that we hear in the media and through local interest groups things that seem poles apart from the apparent excellence in medical services when compared with regional centres of similar size.

In the department of medicine, Port Macquarie Base Hospital boasts 10 physicians covering a wide range of medical specialties and has a one in eight on-call roster which would be the envy of many similar sized hospitals. We have a varied surgical department and we have specialties that are supported by three full-time intensive care specialists, one of whom runs the accident and emergency department, and a variety of diagnostic services. There are various difficulties such as with anaesthetics and the provision of resident staff, but over all the medical staffing of the hospital has been excellent. In short, in my view it is an exciting time to be in medical specialty at this hospital from the perspective of peer support and a multidisciplinary approach to illness. However, it has been distressing to see recent media concerns about the management of Mayne Health spilling over into criticisms of clinical standards in the hospital.

One only needs to read the *Sydney Morning Herald* on a regular basis to see that every hospital in New South Wales has problems with waiting lists, delays in, or closures of, accident and emergency departments and

unfortunate patient outcomes, but for the staff of the Port Macquarie Base Hospital there seems to have been a persistent barrage of criticism for the same sorts of problems that are endemic across the system. As to the question of whether the private operators of the hospital have a positive or negative impact on clinical care, I am in a position to make only a few statements. First, doctors are drawn to centres where there is a critical mass of colleagues with whom they can work. The management of Port Macquarie Base Hospital has fostered an open and welcoming environment for doctors to move to Port Macquarie. This has had a self-perpetuating effect which has meant that we are well staffed medically.

Second, despite a period of significant concern with the management style of Port Macquarie Base Hospital, the Medical Staff Council has been listened to over the past 12 months and local management has returned, as opposed to having distant management from head office. This has been a significant improvement but we are still working to improve the lines of communication with hospital management and will continue to hold them accountable for decisions. Third, it must be said that it makes life difficult when one is the meat in a sandwich at Port Macquarie Base Hospital. There have been a number of instances, most recently regarding Treasury Managed Fund cover for medical indemnity, where being one of only two hospitals in New South Wales run by a private operator has been a disadvantage. It is ridiculous that clinicians who are trained to treat sick patients, both public and private, need to suffer significant anxiety and expend significant energy in seeking equity for our patients and ourselves.

CHAIR: Does that mean that you are not covered by the contract, or you did not get the contract?

Dr BEGBIE: We are now, but it became an issue that needed to be discussed in more detail than it would have been in other places. While I am sure that there are other issues that will come up in questioning, my appeal to the Committee would be this: Through no fault of the population of the Hastings Valley or the clinical staff at Port Macquarie Base Hospital, the New South Wales Government made a decision several years ago to sign a contract with Mayne Health for the management of Port Macquarie Base Hospital. As the submissions to the Committee roll in, you will be able to list both positive and negative outcomes of this decision. But as I look round at Port Macquarie Base Hospital, I see that the population of the Hastings Valley has an excellent facility and, I believe, excellent staff to look after health care. I ask that the Committee provide these clinical staff with relief from the political and media pressure that is often unjustly placed upon it. If the contract is there to stay—and at this stage, it appears that it is—let us get on with our work, and treat us like any other medical professionals in New South Wales.

CHAIR: Mr Jenkins, would you like to make an opening comment?

Mr JENKINS: No.

CHAIR: Mr O'Grady, would you like to make a comment on behalf of the New South Wales Nurses' Association? We have your submission, but you may wish to make a brief comment first.

Mr O'GRADY: Yes. In terms of Dr Begbie's comments in relation to the quality of the service that the medical staff provide, I think it is important to endorse those remarks. While there may be criticisms made, I think it is important that that should not reflect adversely on the nursing staff, particularly in my case, or on other medical staff in terms of their commitment to proper care. The issues contained within our submission relate to two concerns which have been expressed by members. One relates to the actual skill mix and staffing of the hospital and the other broadly relates to transparency of budget control which the Committee has already commented on in its discussion paper.

The specific impacts in some of these matters can, at times, relate to broader issues. I am alluding to a concerted drive by Mayne Health some 12 months or so ago across Australia to actively change the skill mix within nursing within its hospitals. That was right across Australia. It presented real issues for all nurses, not only in relation to some of the proposals which were made in various States that initially contravened legislation in some instances but also in terms of the concerns that staff had for the impact on care. At Port Macquarie Base Hospital as such, there was a commitment given at that time that the mix of RNs and ENs would not change within the hospital. It is my understanding that by and large that has been maintained: It was acknowledged by Mayne Health that some of their proposals just did not apply to acute care hospitals.

There are some specific concerns which have been raised by members in relation to skill mix and one issue relates to mental health. The association recently did an occupational health and safety inspection of the mental health unit at the Port Macquarie Base Hospital as we indeed have done in many hospitals throughout the State.

One of the issues there relates to the actual number of staffing levels on that unit and the skill mix, which presents a real problem when you have only two staff within a mental health unit. Even though there are no gazetted beds, the patients' conditions can deteriorate, which puts a strain on the nursing staff and presents some risk to staff in terms of violence at times. When you have one RN and one EN on duty, as I understand occurs at times, that poses problems with relation to the actual level of care that might be able to be provided because of the different skills of those people.

CHAIR: That is a matter of funding and staffing, as I understand it.

Mr O'GRADY: Which relates to funding and staffing, and how that is operated at a local level.

CHAIR: We are doing an inquiry into mental health services, and I can assure you that that matter will be looked into closely. The issue of the nurse ratios would be a matter of discussion between, first, Mayne and its staff but, second, as we heard the CEO say, between the department and Mayne Health. But as far as you can tell there have been no changes that you would not see in any other public hospital for the reasons that the CEO gave earlier.

Mr O'GRADY: As far as I know there have been no changes within Port Macquarie, apart from what was reported in our submission. It varies from hospital to hospital, depending on a large number of factors.

CHAIR: Including ability to recruit and so on.

Mr O'GRADY: Indeed, yes.

CHAIR: So walking into Port Macquarie Base Hospital you would not see a mix or staffing arrangements or staffing skill levels which were very different from, say, Coffs Harbour or Taree?

Mr O'GRADY: My understanding is that the staffing mix at both Coffs Harbour and Taree would have a higher proportion of registered nurses to ENs than what you actually do in Port Macquarie Base Hospital. There was a definite aim, as I understand it, to set almost a fixed skill mix at Port Macquarie Base Hospital which does not exist in other hospitals.

CHAIR: So it has not actually been done.

Mr O'GRADY: It was implemented, as I understand—I am not certain of these figures at this point in time—to about a 70:30 mix RN to EN.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that supposed to be the mix? Were the staffing proportions not agreed when the hospital was set up?

Mr O'GRADY: No. I have no knowledge of any discussions at that time about what the staffing mix would be. That would have been something which would have carried over from previous arrangements, I understand.

CHAIR: We will ask Mr Clout this question because he is the CEO of the area health service. Do you have visibility of these staffing arrangements, and are they approved by the area health service?

Mr CLOUT: The exact staffing mix is not. However, I would say that in the past 12 to 18 months there has been great co-operation between the management of Port Macquarie Base Hospital and the area health service to enable us to be comfortable that the services being provided are being supported by appropriate staffing. The way that that is done is not necessarily by the hospital providing an establishment and us approving it. That is not something that I would do at any of the other base hospitals.

CHAIR: Given that the shortage of registered nurses and in fact enrolled nurses cuts across the whole system in New South Wales, have you thought of implementing the same arrangements and the same efficiencies of using people for the task that they are supported by, rather than perhaps a higher level of staff, in your other hospitals in the area health service? If you are comfortable with what is happening at Port Macquarie, are you thinking of doing the same thing at Coffs Harbour and Taree?

Mr CLOUT: We treat Port Macquarie Base Hospital in that regard, as we do in others, exactly the same way as we do in our other hospitals.

CHAIR: The Nurses Association person said that there is a bit of a different mix of skill levels providing services but there does not seem to be any detriment to outcome, according to Dr Begbie and his own information. Have you thought of using the same processes in your other hospitals?

Mr CLOUT: The way that that works is that we have an area director of nursing. Our area director of nursing looks, with the directors of nursing at each of the hospitals, at the particular services they have. In addition to that, there are guidelines and regulations that operate from the State level. I am not aware, but I understand from Mr O'Grady's comments, that there is any discernible difference in the mix of nursing staffing between enrolled nurses or registered nurses.

Mr JENKINS: This issue was of concern to the board when it was first mooted some 18 months ago. It is not so much the mix of ENs to RNs. The proposal was to introduce assistants in nursing, that is, six-weeks trained nursing staff.

CHAIR: Are they the same as you see in nursing home?

Mr JENKINS: Yes.

CHAIR: But that has not happened.

Mr CLOUT: That has not.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Have you been given those figures?

Mr JENKINS: At that stage we received figures from the management to give us the staffing mix, and we had an undertaking from them that that mix would not change.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Have you had updates about that?

Mr JENKINS: We have sought advice on it. We have not actually received figures but we have been assured that the mix has not changed.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you have asked for it and you have not been given it. You have been given an assurance that is okay.

Mr JENKINS: Yes.

CHAIR: But the reports will be with Mr Clout. Are you aware of the employment of any assistants in nursing in any of your major public hospitals under our requirement, which is at Coffs Harbour, Port Macquarie or Taree?

Mr CLOUT: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Mr Clout, I am a bit concerned that you are not aware of the nursing mix if you are interested in nursing standards, particularly in a hospital that is a subcontracted hospital. Do you think that the mix of staff skills is vital in the maintenance of nursing standards?

Mr CLOUT: Yes I do but the way that you measure that is by the outcomes of the care that is provided and whether or not there are concerns being raised in relation to such mix.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: By whom and when and how?

Mr CLOUT: If there are indicators as to adverse outcomes you would investigate those immediately, and we have a mechanism with Port Macquarie Base Hospital which is no different to our other hospitals for doing that. If they were raised by the association then we would sit down with the association and/or Port Macquarie Base Hospital management, and I would involve my directors of nursing and clinical services with theirs and we would work through those issues.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you do not get those figures regularly, even though it has been pretty controversial, shall we say.

Mr CLOUT: No I do not, and unless it were being raised as an issue I would not think that it was unusual that I would not.

The Hon. RON DYER: Does the Department of Health have a standard by which it operates so far as the mix between enrolled nurses and registered nurses is concerned?

Mr CLOUT: Not a formal standard, no. There are guidelines put out by the Chief Nursing Officer and by the College of Nursing. They are put out as guidelines because they change, depending on the particular circumstances of each and every hospital in the care and services it is providing.

The Hon. RON DYER: What would the guidelines you referred to provide?

Mr CLOUT: It is not as black and white as saying that there is a guideline saying that it is 60:40, 70:30 or 50:50. What it says is that there are different circumstances and you have to ensure that you have an appropriate skill mix. The same issue arises not just between assistants in nursing and enrolled nurses and registered nurses, but the level of experience of registered nurses. The same issue can apply.

The Hon. RON DYER: Earlier Mr Walsh told the Committee that approximately 15 per cent of the nursing staff at Port Macquarie Base Hospital are enrolled nurses. Is that a satisfactory mix so far as the area health service is concerned?

Mr CLOUT: I have no evidence of any inappropriate outcomes as a result of it or no issues on my desk or at the area's desk or otherwise that are indicating there is a problem with it.

CHAIR: To be fair, Mr Walsh did say that he would check that figure and get back to us. But if you say 60:40 is the sort of mix across the area, that would include places like Macksville, and all sorts of places.

Mr CLOUT: That is right.

Mr O'GRADY: If I could perhaps clarify the matter, the reason I raised this initially is that it was a concern that had been expressed by our members. I also gave a specific example where that would impact. I think it is important to clarify the association's position. We are not opposed to enrolled nurses when they are suitably trained and qualified. In fact, enrolled nurses are a very important component of the nursing work force. It has been a concern of our members at Port Macquarie specifically which arose with the AIN proposal which was last year which we were assured by Mayne at that time that they would not introduce AINs. In addition to that, though, it is very difficult, when you are looking at staffing mix, do you take an across the board figure? That is why I gave the example of the mental health unit in one instance where that poses a problem. It will vary from unit to unit, depending on the the size of the unit, the acuity, et cetera. I apologise if I took the Committee off on a slightly different track.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Has there been a problem recruiting registered nurses in Port Macquarie?

Mr O'GRADY: I think there has been a problem recruiting nurses generally. In Port Macquarie and in other areas of the area health service, Mr Clout probably has more specific details. My understanding is that it varies from town to town.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, but is this town not better? This morning Mr Walsh said that he only recruited enrolled nurses if he could not get registered nurses. That was my understanding, and that is why I am asking whether there is a problem recruiting them in this town. I understood that medical recruiting is easier in this town. Presumably nursing recruiting would be easier in this town than in other towns perhaps.

Mr O'GRADY: I cannot answer that specifically for this town, I am sorry.

Mr CLOUT: I can probably throw some light on that if it would help. It is very clear that recruiting to rural New South Wales for all manner of clinical professionals is difficult. Everything, though, is relative, compared to any of the rural areas west of the great divide. The situation for the mid North Coast and for northern rivers is very good.

We actually do not have a general problem in recruiting nurses in any of the categories. There are some particular areas at particular times we have difficulty in. Mental health nursing staff are at times difficult, and intensive care staff of good experience are difficult but, even compared to metropolitan areas, this area health service is able to recruit well-qualified and experienced nurses through the categories. Medical staffing is difficult but it is variable, too. Dr Begbie is right when he says that if you approach it the right way and encourage it, you do well, and that has been what has happened. I give credit where it is due to Port Macquarie Base Hospital management and their doctors. They have managed that well.

CHAIR: My understanding is that Coffs Harbour is not in the same happy position.

Mr CLOUT: I think we can learn some lessons from what has happened over the last five years, particularly through the medical staff and with the support of the hospital and we need to learn that lesson.

Dr BEGBIE: The issue we are talking about is an example of last year's problems and why they flared up. The decision by Mayne Health to run their 60-odd hospitals along similar lines, which means that this hospital, which is very different to most of their private hospitals, got caught up in that and the desire to have AINs introduced was strongly opposed both by the board of advice and the medical staff council and the nursing staff. As a result of those discussions local management back in Port Macquarie had been withdrawn to Melbourne in many ways and since that time the wisdom of local management has at last come home to Mayne Health—

CHAIR: To be perfectly frank, there is a place for AINs even in a base hospital because a large number of nursing home type patients are living within our base hospitals because of the lack of nursing home beds. AINs are perfectly appropriate even in a base hospital for that sort of care, would you not agree?

Mr O'GRADY: Yes, and within aged care facilities.

CHAIR: An argument in one of the submissions we received is that because of the mix of emergency of Port Macquarie Base Hospital, Mercy Hospital and others that Mayne operate like this, it is not appropriate to use those sorts of patients. That is the argument that the chief executive officer put to the board of Mayne and that was successful. How are you going to make sure one that Mick Reid's press statement, which was not signed by the Minister or the Premier, about treating Port Macquarie Base Hospital like any other base hospital, as it should be, in terms of funding, how will that work now that you are meant to be getting close to your fair share of funding across the State?

Mr CLOUT: That is a simple question that requires a complex answer. The first issue is that we do have a four-point plan that has been signed off by the area health service. I signed it on behalf of the board and Mr Walsh has signed it on behalf of Port Macquarie Base Hospital and Mayne Health. It institutes the principles that you have indicated and they are important principles. When the board looks at the dollars that it has from government, it looks at how we need to enhance services. We have a strategic plan, which have involved Mayne Health and the commissions that Mayne Health has been involved in the development of, which have identified our areas of weakness and our areas for development. We involved clinicians from Port Macquarie Base Hospital and every other hospital in all of our planning exercises.

We have established three clinical councils to advise the board and those clinical councils are a medical council, a nursing council and an allied health council. They are the bodies that the board goes to, to get advice on how we should spend the additional funding. That helps us with looking at ensuring that we have different levels of equity but that our approach is that the equity we look for is not an equity between hospitals but that the equity we look for is equity across communities.

CHAIR: You look directly at access.

Mr CLOUT: Also funding. If we look at the area health service we have got, in the northern part we have three local government areas and they basically form a clinical network and it has been accepted that we will develop that clinical network that basically has a health needs adjusted population that would be about 33.5 per cent of the total population: the central one, which is Hastings-Macleay about 36 per cent and the southern one because of the

outflows to Newcastle is about 29 per cent. We then look at the way we distribute the funds across those clinical networks to ensure they are approximately appropriate to the health need and then do an internal RDF.

CHAIR: You are going to do that?

Mr CLOUT: We are doing that.

CHAIR: How does that overcome the outflow problem for the whole area and Port Macquarie and the inflow problem into Port Macquarie, Coffs Harbour and Taree? If you are on the tablelands you might as well come to the coast for an operation.

Mr CLOUT: Yes.

CHAIR: Those internal ones: New England would pay you for some, you would pay Hunter for some, and some would go to other area health services. How do you recompense places like Port Macquarie, which is an individually budgeted hospital because of its special contract, for those inflows from other areas, and what steps are you taking to stop the haemorrhage of what was for last year $36 million worth of outflows?

Mr CLOUT: I will take that in reverse order. There are about $33 million worth of services provided in public hospitals for the residents of this area health service that are provided in other facilities outside our area. We know the areas where they are. They are basically in cardiac services and orthopaedic services.

CHAIR: That is about half.

Mr CLOUT: Yes, and some general surgery. There is about $15 million of that that we will never attempt to reverse because it appropriately should be done in the major teaching referral hospitals. The others we need to plan for them to come back to the area health service. As you would know, that is not an easy thing to do but we are planning to do it. One of the difficulties for us is that before we do that we have to make sure that we have in place what I call the bread and butter services for each of our three base hospitals.

Everyone recognises this as being an underfunded area health service. That is now being addressed but it is not going to happen overnight. Our strategy is to make sure that we have a suite of bread and butter services in each of our base hospitals and that we have those in place. One of our strategies for doing that is to make sure that our district hospitals within each of the clinical networks is doing what it should be doing so that we do not have work in the three base hospitals that will clog them up and should not be there. If they are clogged up with that work, we will not be able to reverse the flows from outside. That is the strategic plan that has the support of the three hospitals and the three clinical councils.

CHAIR: This year's budget should give you your fair share.

Mr CLOUT: This year's budget will take us to within 2 per cent of our equitable share.

CHAIR: Your total budget will be about $200 million?

Mr CLOUT: About $229 million in the next financial year.

CHAIR: So it is plus or minus $4 million and you will be there?

Mr CLOUT: Correct.

CHAIR: Actually, it is minus $4 million.

Mr CLOUT: Correct.

CHAIR: It is plus $4 million for the Greater Murray. In trying to stop the outflows, what is to stop someone from Port Macquarie, who is on the biggest waiting list in the State, deciding to go to the bone and joint department of the Royal Prince Alfred Hospital to have their operation and send you the bill?

Mr CLOUT: At the moment they do not send us the bill.

CHAIR: Don't they?

Mr CLOUT: No, they do not.

CHAIR: When do you get funded for the cross-border stuff. Northern Rivers gets funding for it this year.

Mr CLOUT: It flows from other States, southern to Canberra, or Canberra to southern area health service, greater Murray to Victoria or northern rivers from Queensland, that is happening.

CHAIR: Internal ones turn up in your budgets though, because we have seen them during the estimates committees.

Mr CLOUT: Yes, they do.

CHAIR: They are notional, but they are there.

Mr CLOUT: Yes.

CHAIR: And that is what makes up your $229 million.

Mr CLOUT: No. The $229 million does not include the $33 million that is being provided outside our area health service.

CHAIR: Are you absolutely certain of that?

Mr CLOUT: Yes, I am. Do you want me to check it?

CHAIR: Absolutely because the evidence was not that.

Mr CLOUT: The director-general was talking about the last financial year. I am going to give you figures now for this year.

CHAIR: The $33 million is not included in the $229 million. That would indicate to me that the people of the mid North Coast are getting in excess of their fair share because they are not just getting their fair share, they are getting $33 million which is being spent elsewhere. That cannot happen.

Mr CLOUT: The money that is spent on our residents outside of our area health service goes into the resource distribution formula because it is being spent, and historically has been spent, in other area health services. That is taken off before we get our net cost of service budget.

CHAIR: They do include it when they do the RDF?

Mr CLOUT: That is correct.

CHAIR: You get $229 million plus the $33 million and that makes up your fair share but the reality is that the $33 million is still there and included in what the Governments says it costs to run the mid North Coast.

Mr CLOUT: Yes. The figures I am going to give you are expenditure figures so they include revenue; they are not net cost of service. This financial year our expenditure budget for the total area health service was $236,607,000. If you include in that the funds that are spent on our residents in other area health services, that total would be $269.8 million, which is short of our equitable share of the total expenditure.

CHAIR: That is right, but next year's budget will include that and include your fair share minus about $4 million or $5 million?

Mr CLOUT: Next year's budget will not include the money that is spent on residents outside our area.

CHAIR: So you will have a cut of $39 million?

Mr CLOUT: No, we will have exactly what we have got this year, plus—

CHAIR: Mr Clout, we will check this because I know that in terms of transparency the RDF is picking up, and has been for the last three years, the out-of-service stuff.

Mr CLOUT: Yes.

CHAIR: I am worried about how you stop the bone and joint from pinching your money because Port Macquarie Base Hospital does not get the money to do the hips and joints here.

Mr CLOUT: Yes.

CHAIR: How are you going to stop it because we have received evidence that you can go from here and in six weeks from consultation you can have your hip done in Royal Prince Alfred Hospital, and it is happy to do it because it is taking your money.

Mr CLOUT: I do not think that we are going to stop that.

CHAIR: Then how are you going to get your fair share spent locally on things that you can do locally, that is the question?

Mr CLOUT: We have to negotiate with South Eastern Sydney Area Health Service and Central Sydney Area Health Service for the budget that they currently get to cover the cost of doing work on our residents and the referrals of that work back to us. The difficulty with that is not the referral of the budget back to us; it is getting the patients.

CHAIR: You have to get some control over your waiting lists at Port Macquarie Base Hospital, which are the result of long-term underfunding, otherwise you would not have the new four-point plan, would you?

Mr CLOUT: I think the reality that I am, like everyone else in New South Wales, struggling with how to answer that question. If we have a public system in this country that says, "If you attend a particular hospital and have that service provided as a public patient—and that is what the Medicare agreement does—and we have differences in waiting times, waiting lists and funding, then what you have illustrated is going to happen, and although we can make attempts to try and address that, I do not know the answer to that.

CHAIR: How can people at Port Macquarie be assured that they will get their fair share, given that they are sharing the facility with people from Tamworth and that some of the money that could be allocated here is going to Central Sydney?

Mr CLOUT: There are two answers to that. The first is: Is the community getting access to services? The answer to that is, yes, they are.

CHAIR: With the longest waiting list in the State, I would have to challenge that.

Mr CLOUT: The reason for that, as you know, is that this area health service has historically been underfunded and that is being addressed. We are putting $8.3 million of recurrent funding into addressing that issue. We have worked that through the clinical councils and each of the hospitals, including Port Macquarie Base Hospital. The end result is that we will have addressed long-wait patients probably by October-November this year across the area—around that time. The allocation of that money, rather than as a once-off but on a recurrent basis, will mean that we will reduce that. It is not going to happen overnight, but it will happen to reduce this.

The Hon. RON DYER: An explanation we were given by Mr Walsh for that issue earlier this morning was that this area is attractive to medical practitioners. Given that is the fact, that there are more medical practitioners here—and by that I mean specialists—they are generating more services and that has some input as far as the waiting list is concerned. Would you agree with that?

Mr CLOUT: I think it is a good theory, but I do not think there is any evidence to support that. I think the reality is that this area health service has been underfunded in total and the waiting list as a result of that, that is being addressed. There is no doubt, however, that there is a formula that is hard to write down. That has been used and was referred to by Dr Begbie. That means that we have more specialists here in a number of specialties than we have elsewhere. We have to look at the things that have made that happen and again put those in place over time. I

do not think, however, that there is any evidence to support the fact that that has added to the waiting lists. We have had long waiting lists at Coffs Harbour and District Hospital and at Taree.

I think the common factor is that, historically, with previous management systems, collective surgical has been used, as it has in many places in New South Wales and elsewhere, as a management tool. One of the things that we worked through with the clinical council and the general managers of the hospitals last year and this year was an undertaking and a deal we did that we would treat all hospitals the same. That is, we got the advice of the clinical councils as to where we should spend the money, the surgical money. The deal we did with them was that we would work out exactly on what specialties we would spend it—how many hips we would do and the procedures we would do. We would write that down and we would know exactly what we were going to do and what dollars we were going to put to it. The proposition I took to the board of the area health service, which was supported, was that we would stick to that. Regardless of what a budgetary situation was, we would not reduce the deal we did in terms of the activity and the dollars.

The Hon. RON DYER: Mr Walsh told us earlier that there are some 54 specialists in Port Macquarie. It is not entirely unreasonable, is it, that that would generate many medical services and could conceivably lead to waiting lists?

Mr CLOUT: It is entirely possible. The approach we have taken, though, to address it is to look at equity in terms of the health weighted population.

The Hon. DOUG MOPPETT: If I may interpose—an earlier inquiry I was involved with showed that, fundamentally, the waiting lists are generated by the doctors. They are the ones who put the people on the list, and it is not the area health service which says, "We have these people waiting." It is the doctor who puts them on the list, so the more doctors you have, it would seem that that would be more likely to generate a larger waiting list, even if the waiting time is only very short. They are the ones who compile the list.

Mr CLOUT: It is possible. I know that a number of senior managers across New South Wales and in the rest of Australia think that that is true and therefore put absolutely strict caps on the number of visiting medical officers and specialist positions that they will allow. I ascribe to the opposite view and that is that, fundamentally, it is the demand of the population that drives the number on the list. Therefore what I do is I have no limit on the number of specialist positions I will enable to be filled on the basis that I do a deal with the general managers of hospitals and medical staff each year that says, "Here is how much activity you can do and in these areas. Here is how much budget there is. You cannot go over either."

CHAIR: For example, if the Coffs Harbour and District Hospital decided to get rid of both of its orthopaedic surgeons, there would be no waiting at the Coffs Harbour and District Hospital, but they would be waiting somewhere else, would they not?

Mr CLOUT: That is correct, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Since 1994, what annual amount has this budget been given in the Department of Health allocation to the Port Macquarie Base Hospital?

Mr CLOUT: I am sorry, could you put that again?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Since 1994, what annual amount has the Department of Health allocated to the Port Macquarie Base Hospital?

Mr CLOUT: Look, I do not have that readily here. That has been provided, however, in the Department of Health's submission.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can I ask why those details are not in the annual report?

Mr CLOUT: In the annual report of the area health service?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes.

CHAIR: I think they are in the annual report of the department, quite frankly. The annual report of the department does not go into hospital funding. Is it in the area health service's annual report?

Mr CLOUT: The expenditure is certainly in the area health service's annual report.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Not the amount allocated to the Port Macquarie Base Hospital, though. That is not in the annual report.

CHAIR: This is where we get the difficulty because we cannot find for other reasons how much is actually spent on mental health in a particular area health service.

Mr CLOUT: May I just comment on both of those? The total expenditure—and I am not speaking for a period before January 2001—but since January 2001 and increasingly, the arrangement that we have with the Port Macquarie Base Hospital, particularly after the four point plan, has led to a situation where there has been almost total transparency about the money, the services and all detail that I would normally expect and get from many of my hospitals. There are some very limited issues that are not matters upon which I can divulge information and certainly some matters upon which I do not have information, but they are very limited and they do not affect, in my view, in any way the capacity of the area to monitor or to provide services. In terms of the costs, we record the costs. In terms of mental health services, there is no secret in this area health service, nor am I aware of any other, about the amount of money that is spent on mental health. That can be provided.

CHAIR: That is a matter for another inquiry.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can we look forward to those amounts being provided with a breakdown of which areas they are spent in, even within the pool of a number of services?

Mr CLOUT: I provide that information openly to local members here in my area health service, to all of the general managers, to the clinical councils and to the media, so there is no problem with it being available. It is made available and is available to our consumer community health forum.

The Hon. RON DYER: There is an allegation made to the Committee in the New South Wales Nurses ' Association submission that the downgrading of services such as mental health to subsidise budget overruns in the other high demand areas is a management strategy used at the Port Macquarie Base Hospital. Do you know anything about that?

Mr CLOUT: I was not aware of the allegation and I do not have any evidence, nor has that issue been raised with me before. What I would say, though, is that there is no doubt that across all of this area health service and more generally, the provision of funds for mental health services has been a major issue. That is being quite aggressively addressed in particular in this area health service. What we have done is create an area mental health service and that includes, and has been including quite openly and co-operatively, the medical staff in mental health, including the clinical staff in mental health in Port Macquarie, and the Port Macquarie Base Hospital management.

The Hon. RON DYER: Mr O'Grady, do you have a view on that, given that it is contained in your association's submission?

Mr O'GRADY: Yes. In relation to this submission, I think it is important to recognise that this is based on concerns of consultation with branch representatives. There has clearly in the past been a concern expressed about the way that moneys may be utilised within the hospital, and this goes in effect to a matter to which I alluded earlier—the question of transparency of budget. I have to be honest and say that we often have arguments with hospitals and area health services about how moneys are spent, but the transparency issue that we generally have with Port Macquarie would seem to be different with the departments because we have in the past been successful. It is not easily done at times to get more detailed information in relation to their budget's flow and staffing levels, et cetera.

I would also like to add by way of explanation, to put it into the context of the concern that members expressed about the very issue of how budgets are used, that recently we were advised by members at the Port Macquarie Base Hospital of a concern or a rumour that consideration is being given to closing the mental health unit for the purpose of reining in budget overruns. That did not happen, but it is a concern which has been, and continues to be from time to time, raised with us. It is in the forefront of members ' minds, and it is in that context that that comment is made.

Mr CLOUT: I wish to comment on that issue. There are two issues. One is that there has undoubtedly been concern in the past that there has not been a level of transparency, that there has not been a level of co-operation between the area health service and various other organisations and Port Macquarie Base Hospital. I think the four point plan has turned that on its head. I think that is a significant initiative by the Government and particularly by Mick Reid as the Minister's envoy in that. I think that was a significant turnaround. Since then, I think that issue has changed. The relationship we have now with the Port Macquarie Base Hospital in terms of service changes is very simple and identical to any other hospital in New South Wales. They are not at liberty to change the delivery of services that they provide without discussions with me and without my approval and without the approval of the board. I would take most of those issues to my board. Indeed, under the Health Services Act there are certain of those that would need to be in the knowledge of and approved by the Director-General of Health and/or the Minister.

The Hon. RON DYER: As far as the Port Macquarie Base Hospital is concerned, though, as Mr Walsh told us, mental health services are part of a direct bill budget to the hospital, so there is an allocated sum nominated for mental health. Should not the position be quite transparent in that respect?

Mr CLOUT: I think it is. What Mr Walsh says is absolutely true and it is true of every service and every hospital in New South Wales. Within the global budget that they give to each hospital are programs, and one of those programs is mental health. Mental health has a budget and we cannot exceed the budget. If it needs to do so because circumstances change, the hospital management needs to come back and discuss the issue with me. Ultimately I discuss it with the board if I wish to change that.

The Hon. RON DYER: May I ask you about a matter regarding mental health. The New South Wales Nurses ' Association submission makes an allegation that community-based palliative care services in the Hastings district have to place clients on waiting lists, despite enhancement funding allocations. It has been said that the enhancement funding was supposedly quarantined for this specific purpose. It does not appear to have been used for its allocated purpose.

Mr CLOUT: There is no doubt that that was an issue. I would have to say that that was an issue 18 months ago and an issue which the area health service did not agree with—that is, the step that was put in place by the Port Macquarie Base Hospital. When it was brought to our attention, we sat down with the hospital and worked those issues through. That position was redressed. I do not want the Committee to think that that is something that only happens because it is the Port Macquarie Base Hospital and there is a different arrangement. There is clearly a different arrangement and, yes, it does make it difficult. Dr Begbie referred to a Treasury Managed Fund issue. That was resolved. Everyone is happy with the outcome. They have got the same cover and finished up being treated exactly the same way as every other hospital. However, it was difficult, but we resolved it. So that may not have been a problem two years ago or it may not have been the outcome two years ago, but the four point plan has addressed that.

The Hon. RON DYER: So that palliative care problem is no longer a continuing problem?

Mr CLOUT: That particular issue—it is probably better for Mr O'Grady to comment—clearly was one of those ones where we actually sat down with the hospital management and reaffirmed with them that they cannot do that without that service change, and that they cannot do that without coming back to us. It is up to us to make that call. I heard the evidence or what Mr Walsh said in terms of the area health service stipulating what services are provided. That had not been the case until the budget before last. That is now the case.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The four point plan has been implemented?

Mr CLOUT: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And Mayne has accepted it?

Mr CLOUT: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The Mid North Coast Area Health Service contract performance indicators have not been accepted. They are the ones from Mr Jeff Pattinson of 19 June last year.

Mr CLOUT: Yes, they have.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And they have been accepted?

Mr CLOUT: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: By Mayne?

Mr CLOUT: By Port Macquarie Base Hospital.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are those things being implemented?

Mr CLOUT: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So those staffing ratios that we talk about are in that arrangement, as you may know.

Mr CLOUT: Staffing ratios are not a clinical indicator.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: "Proportion of Registered Nurses employed to total number of nurses employed", and "Nursing hours per patient per day", are under the heading of "Human Resources" in (viii) in that agreement.

Mr CLOUT: You are correct and I am in error. That component was not agreed. I agreed that that one should not progress because I believe that if we are talking about clinical indicators, that is not a clinical indicator.

CHAIR: But all of the other things you are applying to all of the hospitals in your area, which is the other question that was asked of Mr Walsh and he did not know the answer.

Mr CLOUT: All of the clinical indicators, yes, and Port Macquarie Base Hospital has representatives on our area clinical indicators committee.

CHAIR: So this is the same for Taree, Coffs Harbour, Port Macquarie, whatever.

Mr CLOUT: That is correct, except as has been correctly said by the Hon. Dr Arthur Chesterfield-Evans. Staffing ratios, I get from everywhere else.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you do not get them from Port Macquarie.

Mr CLOUT: No, I do not.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think that is satisfactory?

Mr CLOUT: Yes. I am in a situation where, if a problem arose in terms of the quality of care being provided or if one of the associations came along—or anybody else, for that matter; the community nurses at the hospital, doctors at the hospital—and said that they are doing something here that is a problem, I would sit down and look at it. I would ask my area director of nursing and clinical services to go out and look at it. He would give me advise if they said there was a problem. We then go and have discussions with the hospital.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that not inconsistent with the idea that Port Macquarie Base Hospital is being managed the same as every other hospital?

Mr CLOUT: There are certain things we have to accept as being realities in the difference of the arrangement. They are very few and in my view they are not material in terms of ensuring that the services being provided are appropriate and the underlying philosophy that they will be treated the same as every other hospital. Having said that, everyone has to accept that it is a different arrangement.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: One other thing in the agreement was that Port Macquarie Base Hospital would adhere to public sector employment policies and practices. What steps have you taken to ensure that that happens?

Mr CLOUT: We have had discussions with Port Macquarie Base Hospital at a number of levels, particularly our human resources staff, in terms of, for example, our Aboriginal employment strategy. They are actively participating in that. The equal employment opportunities strategy, they are taking part in the area strategies on that. Occupational health and safety, all of those matters are now matters that are dealt with by the input of staff at Port Macquarie Base Hospital when we were dealing with those issues on an area level.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Have you ensured that there is a staff representative on the area health service board? I understand that there had to be a staff representative on that board. Is there a staff representative on that board?

Mr CLOUT: Yes, there is.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Was that representatives voted for by the members of the hospital, its employees?

Mr CLOUT: The election is done by the electoral office. It is currently under way for the new term.

CHAIR: I have further questions for Mr Clout but he has to leave. Can we put those on notice? Mr Clout, would you mind taking the questions that the Hon. Dr Arthur Chesterfield-Evans has and subsequent to this meeting give us an appropriate answer?

Mr CLOUT: That is fine.

CHAIR: Dr Begbie, you were going to say something about another matter.

Dr BEGBIE: Just a couple of issues. We focused primarily on the direct bill budgets. I would have thought that they are particular areas where there is greatest transparency. I run the oncology unit, where there is a specific budget. We have a very clear overview of the budget on a monthly basis. Both the hospital and the area have access to the same information. One of the differences with mental health is that it is a much more unpredictable, difficult to plan for set of problems. Also, I think there are big issues in terms of the overall funding of mental health, which I understand you are looking at in a separate inquiry. I would have thought that it is the bigger bits of pie within the hospital that are the ones where scrutiny is more difficult. Both Mr Walsh and Mr Clout have been focusing on the end results as being the best ways of measuring those.

CHAIR: The cost of your drugs is now picked up by the Commonwealth.

Dr BEGBIE: That is correct.

CHAIR: Therefore the unpredictable part of your budget is zero.

Dr BEGBIE: Yes.

CHAIR: Whereas for just about any other part of this budget, transport, they are all terribly fluctuating.

Dr BEGBIE: Yes.

CHAIR: Your only exposure, which used to be a huge exposure for the public health system, is now taken away because the Commonwealth pays it all.

Dr BEGBIE: I agree, but the main point I am making is that we are focused on areas which are much more transparent than the big aspects of budgeting. The other point I wanted to clarify is the issue of palliative care, which I thought was largely an area health service responsibility. I am unclear about the area where the Port Macquarie Base Hospital was taken to task on that particular issue.

Mr JENKINS: In response to the assertion that the number of doctors at this hospital does not act as a honey pot, we have done some analysis of the source of patients within this hospital and it is clear that people are coming from out of area, that is, from the north sector. There are quite a few people from north of Macksville and Taree. As the Hon. Ron Dyer alluded to earlier, it is clearly because there are specialties here that are not offered not only within the mid North Coast but from Newcastle to Queensland so the reason that the waiting list—

CHAIR: That is fairly easy to find by looking at their postcode.

Mr JENKINS: Exactly.

CHAIR: It is not rocket science.

Mr JENKINS: Absolutely.

CHAIR: This will be sorted out by the fair sharing arrangement of the four point plan, as I understand.

Mr CLOUT: If I can comment on that, we look at that all the time. The outflows and inflows, the externally and internally. The measure is whether or not people of postcodes within the Hastings-Macleay are getting equitable access to services. You measure that by looking at what services they are actually having provided to them and where it is being provided. The reality is that out of a total budget or cost of services, both acute and non-acute, that is being spent in this central clinical network, which has a budget of some $68 million a year—that is for the total clinical network—the outflow component of that is about $2.5 million. While it is something that we look at and concentrate on, in the scheme of things there are pluses and minuses across that which do not change the equity of resources.

CHAIR: I have to agree that if you are going to look at Port Macquarie Base Hospital you have to do the same thing at Coffs Harbour, Taree and Tamworth and see whether it is on an outlier.

Mr CLOUT: And Sydney.

CHAIR: That is why we did this inquiry, in which we included all of the others to see if Port Macquarie is getting its fair share. We had to do that, because you cannot otherwise do a comparison which is legitimate.

Mr JENKINS: Absolutely.

CHAIR: So you will find people from Taree, Tamworth, Armidale and Lismore here. But you will also find people from Tamworth in Armidale. It is just the way they move around because they have relatives and all sorts of things. They should be funded.

Mr JENKINS: If you are talking about equitability of access to people within Port Macquarie or the Hastings, we are not getting equitable access because we are being crowded in by people from out of area.

CHAIR: Yes but New England should be paying mid North Coast for that access under the inflow-outflow arrangements, and that is where budgets are very important. In other words, you should be getting money out of—it is $33 million of yours which is an outflow net. It is a net, is it not?

Mr CLOUT: Yes.

CHAIR: That is made up of inflows and outflows. You are net exporting $33 million?

Mr CLOUT: Correct.

CHAIR: But you are importing perhaps $3 million from New England.

Mr CLOUT: I will put that into some perspective. Our inflows—if we just want to talk about them—are worth about $2.5 million for the whole area. Of the $2.5 million, there is almost none that comes from New England. There are some and they are very, very small. The main inflower is actually from the southern part of the Northern Rivers Area Health Service into Coffs Harbour. That is demonstrable.

CHAIR: And Lismore certainly pays for that. Northern Rivers actually pays for that.

Mr JENKINS: What I am talking about from out of the mid North Coast area. I am talking from out of the Hastings area, from the northern sector and the southern sector, just by virtue of the fact that we have more than 50 specialists here. There are half of that at Coffs Harbour and even less in Taree. People are travelling.

CHAIR: Mr Clout has indicated that he will do a lot of work in attracting more specialists to Coffs Harbour to overcome that problem.

Mr CLOUT: I suppose my issue with that is that I have to facilitate the clinicians and the managers during that, which has been successfully done here. Just in terms of Mr Jenkins' point, however, there is a ratio. It is a national and statewide ratio, standard separation ratios which are used to measure that exact issue. It measures people from particular postcodes, what level of access they are getting to services, compared to access across the whole State. The reality is that the residents of Hastings and Macleay come up above the statewide index, which is 100 in most areas. There are a couple that do not. Mental health is one, aged care and rehabilitation is another, regional services is another, and palliative care services are another. That is why they are our top four in our strategic plan. But the inadequacy of service in those four areas is constant and standard across the whole area.

CHAIR: But of course there is no RDF for mental health. That is part of your problem, is it not?

Mr CLOUT: No, there is not. That is part of the problem.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you supervise the case mix of the base hospital, and is it the same as the other hospitals in the area?

Mr CLOUT: Yes I do, and no it is not. When we look at case mix we look at the case mix broken down firstly between medical and surgical, and then we look at it within each of those by subspecialty. What we do is compare the case weight of the work that is being done in each specialty. For example, we look at the average case weight for orthopaedics at the three base hospitals. Bear in mind that there are 50 or 60 of those that we look at, and we look at that constantly. The clinical councils have access to that as well. One thing that we have picked up in that, for example with orthopaedics, is that the case weight of work being done in orthopaedics is about two to 2.1 at both Manning Base Hospital at Taree and at Port Macquarie Base Hospital. It is about 1.2 at Coffs Harbour.

Looking at those figures, we say, "Why is that so?" We then go back to the clinicians and the managers and say, "Why is that so?" When we discover that one reason for that might be the fact that in the past we had different decision paths being made. In that particular one we have said to Coffs Harbour, "We don't think that mix is right." So when you put your budget and your activity budgets together next year you will have X budget, work on the basis that you will have the same case weight in orthopaedics as the other two do." If you look at the base hospitals across New South Wales it is about two. So we said to them, "Make the mix of your work so that it is two." We will have to accept in that less activity but the case mix should be similar for orthopaedics across the base hospitals. We monitor that fanatically almost.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Obviously some procedures or some DRGs are more lucrative or more expensive, depending on which way you look at it, and the hospital cannot change that mix. Is that what you are saying?

Mr CLOUT: In elective work it certainly can change that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You can change that.

Mr CLOUT: In emergency work it cannot, but in elective work it absolutely can change that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In elective work it can, thus it could effectively cherry pick DRGs, could it not?

Mr CLOUT: It could cherry pick. I do not like the word "cherry pick" because I do not think it is actually done for that purpose. It is done because there are other imperatives that historically have been put on area and hospital managers which we would argue as to whether or not they are right, wrong or otherwise, and they have been there over periods of 15 years. The fact is that there are differences made, but the role of the area health service and the clinical councils is to monitor that and to make the judgments on that.

Dr BEGBIE: The data you have just presented illustrates that Port Macquarie Base Hospital and Manning, in terms of orthopaedic DRGs, are close to the State average and that there is one hospital in the area that is not. So if we are looking at cherry picking, it does not seem that Port Macquarie Base Hospital is cherry picking in the area of orthopaedics because the balance as indicated by the DRG seems to be consistent with State numbers.

Mr CLOUT: I did not intend to make any suggestion that that was the case, that either Port Macquarie or Coffs Harbour were doing that.

The Hon. RON DYER: Mr Clout, did I understand you earlier to say that the area health service has an Aboriginal employment strategy?

Mr CLOUT: Yes, we do.

The Hon. RON DYER: I direct your attention to appendix 8 in Mr Walsh' submission to the Committee. He says that the total number of employees is 550 and indigenous Australian employees 2.5. That appears to be very low. If we compared that with other hospitals in the area what would we find?

Mr CLOUT: We would find that it is variable but the employment strategy we have is twofold. Firstly at an area level—we set this target in March 2001—we set a target of doubling the number of people from Aboriginal and Torres Strait Islander backgrounds who would be employed within the area health service by 31 December 2002 across the area. Secondly, we asked each of our major hospitals to engage an Aboriginal liaison officer. Thirdly, we have asked all of them to take part in our cultural awareness programs, and all of our hospitals, including Port Macquarie Base Hospital, have agreed to take part in that.

Having said that, Port Macquarie Base Hospital has not got as good a track record as some of our other hospitals. They recognise that. We will be working with them to ensure that those objectives are achieved. About 3.5 per cent of our population is Aboriginal but it is variable. At Kempsey it is about 9.2 per cent, but we can expect that to be reflected in those places.

CHAIR: If the Committee has any other questions we ask that they be taken on notice.

(The witnesses withdrew)

SANDRA YVONNE O'BRIEN, Company Director, Port Macquarie, sworn and examined:

CHAIR: Are you conversant with the terms of reference of the inquiry?

Ms O'BRIEN: Yes, I am.

CHAIR: Did you receive a summons issued under my hand?

Ms O'BRIEN: Yes, I did.

CHAIR: If you should consider at any stage that in public interest certain evidence or documents you may wish to present should be seen or heard only by the Committee, the Committee will be willing to accede to your request. That means if you want to go into camera at any time you can. Your submission was marked confidential, which means we will take notice of the content of your submission but we cannot ask questions directly from it. That does not mean that members of the Committee cannot frame questions but we cannot quote from the submission during this hearing.

Ms O'BRIEN: I understand that.

CHAIR: Would you like to make an opening statement before we commence questions?

Ms O'BRIEN: Certainly. I am appearing here today as the former chief executive officer of the Port Macquarie Base Hospital. I had concerns about appearing before you and so sought legal advice. The advice received was to be honest, open and transparent, and this is what I will endeavour to do today. On 2 November 1994 I was the director of nursing of the newly commissioned Port Macquarie Base Hospital. In 1996 I was appointed director of clinical services. In 1997 I was appointed deputy chief executive officer. In August 2000 I was appointed director of the hospital, a term commonly known as the CEO, until my position was made redundant on 31 March 2001.

My comments today, therefore, to this Committee, maybe dated and I want you to all understand that. I have no knowledge and I do not have any access to any information of changes which may be made. However, in these roles I was able to observe at first-hand the outcomes of the first privately owned and operated hospital in Australia, which had a contract with government to provide public services to a community. There is no doubt that the construction of a purpose-built facility was badly needed. The extent of community angst which followed the Government's decision to go down the privatisation path, however, was certainly unpredicted.

The hospital has had many problems of acceptance to overcome, not only by its own community but the broader health community as well. It has only been recently acknowledged that Port Macquarie Base Hospital will be treated by New South Wales Health and Mid North Coast Area Health Service in the same manner as all public base hospitals across New South Wales. This has significant ramifications not only for the operator, Mayne, and the Mid North Coast Area Health Service but also for the Port Macquarie Base Hospital staff and the community which the hospital serves.

I know that the single most important fact about the success of the Port Macquarie Base Hospital is the quality and commitment of the staff. Without their dedication to patient care and a keen desire to prove that the hospital provides excellence, the model would have failed miserably. Over the past 7½ years they have been called upon time and time again to go beyond what is the norm. It has been extremely difficult for staff to work in an environment with two opposing philosophies.

The first is dominated by the corporate master whose sole objective is to make a profit. The second is the need to provide the only public base hospital services in the Macleay-Hastings valleys. These two opposing philosophies many times clash with brute force. From 1994 until 2000 the health care division of Mayne Nickless was known as Health Care of Australia [HCOA]. Corporate executives had extensive experience in health management, particularly in public health administration. Their role was to provide the best possible health services to Port Macquarie through the base hospital and to promote a climate of clinical excellence. Above all, the hospital was to act like any other public hospital.

Affiliations were made with the three university medical schools in New South Wales and a clinical excellence model developed, attracting many new specialist medical staff to Port Macquarie. Profits were optimised.

By this I mean changing the way things were traditionally done to more proactive and empowering models. Middle managers were seized with enthusiasm and the model worked successfully, both clinically and financially. In July 2000 Peter Smedley was appointed CEO of Mayne Nickless. Amongst many other things he set about a major restructure of the company. He introduced a franchise model with central corporate management in Melbourne. The localised authority and decision making of the hospital CEOs was lost, standardised national policies and procedures were introduced and, in those days, public hospitals did not fit easily into this model.

At the corporate level senior executives with public health experience left the company or were made redundant. Senior management became more aggressive, bottom-line driven, with a large focus on the financial aspects, that was, to maximise profits. During this period the key issues that seemed to be lost on the Mayne senior executives were, first, that local administration with local knowledge and presence could not be replaced by nameless, faceless people at the corporate office in Melbourne without the inevitable breakdown in communication; and, second, a privately owned and operated base hospital could never be run exactly the same as a large stable of private hospitals due to the different clinical needs, demands and culture. Any organisation that continually loses senior staff members breeds insecurity and mistrust.

Port Macquarie Base Hospital had six CEOs in six years and more recently has had two directors of nursing in nine months. In my opinion, based on my perceptions on the time that I was employed at the base hospital, the model has been successful, notwithstanding the many barriers put in its path, initially by New South Wales Health and, more recently, by Mayne itself.

The Hon. DOUG MOPPETT: The significant thing we need to examine is the extent to which the profit motive to which you alluded actually interferes with the delivery of contractual clinical services and whether that has manifested itself in anything that we could measure, such as the long waiting lists?

Ms O'BRIEN: It has to be said that from day one Port Macquarie Base Hospital made a profit. It has been a financial success for the operator. Mayne put in an initial amount of $5 million so the return has been significant with that small amount of investment. The profits are made from the different philosophies and management style. The public sector has never focused on making a profit. The different processes and practices in place certainly achieve that. Things were going quite well until the new aggressive style came about in July 2000 where the new way of doing business at the corporate level caused people on the ground a great deal of angst.

Under that model, the model that was proposed was to change the staff mix and the skill mix of the staff. Irrespective of the role and functioning of the hospital, you have to remember that in one small hospital several hundreds of thousands of dollars could be saved by changing the staff mix to one of assistants in nursing [AINs], which have been discounted by Mayne, or trainee enrolled nurses. Therein, the profits can be maximised. That caused a great deal of angst among the staff and probably still does. It has to be remembered that private sector practices do not always fit into public sector services. What happens at Port Macquarie Base Hospital should be mirrored with what is happening elsewhere in the public sector. I do not know if that answers the question.

CHAIR: The management style at Port Macquarie is turning a profit. Why is it not being done at Coffs Harbour and Taree?

Ms O'BRIEN: I do not know. I could not answer that. It is a different focus entirely. Instead of waiting for weeks or some time to get things done and review things, at the base hospital it was done daily, staffing levels, staff mix, et cetera.

CHAIR: So this was better financial risk management put up-front?

Ms O'BRIEN: Yes.

CHAIR: If Mr Clout is going to treat the Port Macquarie Base Hospital like all the other base hospitals, can we look forward to the base hospital at Port Macquarie costing a lot more to operate?

Ms O'BRIEN: Possibly.

CHAIR: Because that is the downside, is it not? If it is all to be done by consultation and interference from the Mid North Coast Area Health Service, the Port Macquarie Base Hospital could become less efficient? That is the downside?

Ms O'BRIEN: I would like to think not, but it is possible.

CHAIR: The flip side is: What is there about Port Macquarie that Mr Clout should take on board, adopt and push down the neck of his CEOs at Coffs Harbour and Taree, let alone the other areas?

Ms O'BRIEN: I cannot answer that. I do not know what has happened in the last 18 months.

CHAIR: Even up until you left, which was 2001, Port Macquarie Base Hospital was operating more cheaply for the equivalent DRGs than the other hospitals?

Ms O'BRIEN: There could be reasons for that, though.

CHAIR: But they were?

Ms O'BRIEN: Yes.

CHAIR: And was the quality low, middle or high?

Ms O'BRIEN: The quality care at Port Macquarie Base Hospital was certainly consistent with peer base hospitals. Some months it was better, some months it was average but it was certainly a good standard.

CHAIR: So the people of Port Macquarie can be assured that the quality of services that they were receiving was good. The quantity may have been the issue to do with funding?

Ms O'BRIEN: It may have been but I believe that the case mix could have been better managed. The waiting list was mentioned as part of the first question and there was no direct—although it may have changed now—prescriptive actions from the area health service to say, "We want you to do X number of cases in that category." It is quite easy to perhaps get a profit and compare favourably with the DRG costing model when you do not have that constraint.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you saying, firstly, that the DRGs were not specified by the area health service and, secondly, that the DRG mix was adjusted in order to maximise the profit, which presumably would impact upon the waiting list? Is that what you are saying?

Ms O'BRIEN: Yes. We had three types of budgets. We had a core budget, we had a DRG budget and we had a DUA budget. We did not do cases in the DRG budget in which you could not maximise profit. They would go onto the general waiting list. So, yes, it can be manipulated.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And it was?

Ms O'BRIEN: Yes.

The Hon. DOUG MOPPETT: Do you think that the circumstances—we are talking about a time when you were with the hospital—of the provisions of the contract and the way it was administered failed to give the sort of open accountability about the services that were being rendered by the new hospital in Port Macquarie, including whether there was indeed, shall I say, movement towards services that might cost less to provide the more profitable to institute?

Ms O'BRIEN: I think there are about three questions in there. The contract was drafted in 1992. It is about 10 years old. There is no way that people who drafted the contract could predict or foresee how it would work. I guess the contract is in need of urgent review. It does not have, or it did not have, a clause whereby a review would take place every three years, four years, five years or whatever. That is the first point. There was no way either in those early days that if you lost the philosophy of public sector thinking it will be treated like a public hospital. Once that was lost, it converted to the private model and would be a large private hospital.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What evidence is there? Can you say how the DRG is influenced? This morning I asked Mr Walsh a question that is similar to this and he said that the case mix was determined by the clinicians and the waiting lists were determined by the urgency of the cases. That was my understanding of how the hospital uses its resources, and not according to profit maximisation, of course. Can you tell me how the hospital influences that, presumably in the interests of shareholders ' profits?

Ms O'BRIEN: The Port Macquarie Base Hospital—Port base—manages its waiting list like any public hospital. There is a priority system whereby urgent cases are done straightaway, in a week, or in a month, or whatever. Clinicians have an input on that. There is no doubt that people requiring acute and urgent care at Port base get it, and they get it very well and they have good care.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is principally elective stuff that we are talking about.

Ms O'BRIEN: The elective waiting list, certainly, and even the semi-urgent on the waiting list. People are put on the waiting list and sometimes they are there for three years. I am sure that things may not have changed. The funding does not seem to have come through anyway. You can manipulate the cases you do because if you are faced with the situation in which you have to get through an activity budget of 9,500 or 10,500 admissions or separations per year and you have corporate saying that you need to make some profit, then of course if you have the option, you will do the cases, particularly when there is no urgent priority on them and they are just on the waiting list with priorities of sevens, eights and nines, to suit the bottom line.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So does management decide who comes to the top of the waiting list? Are the clinicians aware or unaware of the cases being pushed up or pushed down?

Ms O'BRIEN: We did have a review system where we sent to every clinician their patient list every month and we would ask them, because the waiting list was so long, to reprioritise patients and ask for their clinical input. I assume that still happens; it is suicidal if it does not. Where you run into problems, including the most expensive cases who are on the list, is that you are looking at people who have been waiting for a long, long time and you are looking at the cost of their care.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That the hospital is paying for—the interim care while they waiting?

Ms O'BRIEN: No, not at all. I heard the term "cherry pick" and you can do cherry picking. The priorities and the clinical parts of the list are adhered to, but if you have a choice, you will not do a case under a DRG funding model which costs you more than what you will get.

CHAIR: But to do that, you have to change the operating time from surgeon A and give that operating time to surgeon B. In other words, if you are going to cherry pick and if you are going to do no hips and knees because they are expensive and you are going to do tonsils and hysterectomies, which Port Macquarie is pretty high on, then you have to allocate from doctor X who is an orthopaedic surgeon to doctor Y who is a gynaecologist.

Ms O'BRIEN: It can occur within the list, too, Mr Chairman.

CHAIR: I accept that, and we know that across the system people often say, "Look, we have got time to do five or six arthroscopies of the knee but we have not got time for that hip because we cannot guarantee an intensive care bed or we have not got the physios here this week." There are subtle ways in which management can do that, but is there any real evidence that the Port Macquarie case mix, for what is basically only 20 per cent of the business—

Ms O'BRIEN: Yes, that is correct.

CHAIR: We heard from Mr Wallace this morning that 80 per cent of their businesses really what walk through the front door rather than what you electively bring in.

Ms O'BRIEN: Yes.

CHAIR: Is there any evidence that its case mix, given the number of people waiting and so on, which is higher in Port Macquarie, looks different from, say, Coffs Harbour, or Taree, or Lismore for that matter?

Ms O'BRIEN: When I left the base, we did not have access to that comparative data so you are always operating in the field of unknown as to what is happening outside.

CHAIR: Well, when we did the waiting list figures—I am speaking from memory and it is a while ago now—the numbers were aggregated, but you could work out how many hips were waiting. People who have sore hips need operations, but hips or cataracts or various types of DRGs were waiting in each area and for each hospital. In fact I brought the figures with me that the honourable member for North Shore, Ms Skinner, puts out. She put them out because the department was not putting them out. You could tell how many hips, eyes, and ear nose and throat cases were waiting.

Ms O'BRIEN: Yes, but we do not know how many cases the other hospitals were doing in comparison with what was being done at the base. That is the point I am trying to make.

CHAIR: No, that is true, but the department could.

Ms O'BRIEN: At the point when I was there, I had none.

CHAIR: But the department has all these figures. The front sheet goes in. Mr Eckstein puts it all in and Mr Eckstein can see which hospital is doing what. We know that the department took action against some hospitals for doing exactly that—no hips or knees and doing a whole lot of arthroscopies to keep their throughput up and to keep their numbers up; to keep their 10,000 cases per year or operations going through, but not doing the expensive ones.

Ms O'BRIEN: Sure.

CHAIR: We know that the department took action. Do we know if the department took action against the Port Macquarie Base Hospital at that time because the department knew the numbers?

Ms O'BRIEN: To my knowledge, there has been no action taken by the department, no.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think that the area health service properly monitors the activities of the Port Macquarie Base Hospital? Mr Clout admitted this morning that he did not monitor the staff mix, or did not seem to think it was important.

Ms O'BRIEN: In the early years, no. There was no interest in monitoring activities of the base hospital. In the last six months before my departure—maybe 12 months—there was a change in attitude of the area health service. I think that was directly as a result of the Minister's intervention after a change of Minister. That is a perception and an assumption that there was a definite change with a change of the CEO in the area health service. The big thing was, though, that we could certainly do what we wanted to do with regard to case matters. We could do that. The problem I have had with the area health service on frequent occasions was their inability to think differently, to treat people in the community and to free up beds for public patients. There was a total resistance of the area health community health staff to be able to do that. There was a no-go zone between the hospital and the community, and they were part of that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The community freeing up beds?

Ms O'BRIEN: The community health staff. If they had been able to support the hospital and adopt some current practices, they would have been able to assist the base getting through more people on the waiting list by treating people in the community.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So the lack of community support inhibited your discharge rate, presumably?

Ms O'BRIEN: Well, yes, from the perspective that many people in hospital do not need to be in hospital to have an IV injection once a day—things like that. Current contemporary practice should be reflected, but that was one barrier of the area health service or why it happened.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: My understanding is that the hospital is funded by having so many separations, so effectively that would not have made any difference. If you got somebody out of there quickly, you could not have put anybody in there. You could have in the short term, but over the year, you could not.

Ms O'BRIEN: Well, yes, but it is always nice to do the right thing by the community as well.

The Hon. RON DYER: What community health activity is there in Port Macquarie?

Ms O'BRIEN: I could not comment, I am sorry. There seems to be a lot of staff. They seem to be very busy.

The Hon. RON DYER: How much was there when you were serving in senior positions at the Port Macquarie Base Hospital?

Ms O'BRIEN: I do not know the numbers. I could not be exact.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Were you disappointed by the output of that number of people being busy? I think that is the implication.

Ms O'BRIEN: From the hospital's perspective, yes, but I am not doubting that they were very, very busy doing things that they had to do.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you do not know a lot about what they did?

Ms O'BRIEN: No. Nothing.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think that the current contract is enough to stop the idea of the shareholders' profits that you said was difficult to supervise, particularly in the areas that are hard to quantify?

Ms O'BRIEN: Are you talking about services which do not produce revenue?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You were criticising the contract a bit earlier. I am asking you to expand on that.

Ms O'BRIEN: The contract does not have enough guidance in it to prevent the operator from not providing public services. For example, I was told on many occasions by corporate not to pursue a service which did not produce a revenue.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Which service? Is mental health one of those?

Ms O'BRIEN: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If so, what others are there?

Ms O'BRIEN: There were mental health services in particular. The base went through a review after 12 months of its operation and it was decided by an expert committee under Professor Beverly Raphael that the community mental health services not be managed by Port base. That clinically was a very unsound recommendation and I went in to fight for the mental health service to be retained by Port Base. Corporate and the then CEO said, "Don't waste your time. It doesn't produce a profit, so don't worry about service, don't worry about the community." That was the attitude for the renal chairs as well.

The Hon. RON DYER: I will come back to mental health for a moment. That does not appear to be the position now, does it?

Ms O'BRIEN: No, it is not, because we turned that around. It took 12 or 18 months to reverse that decision, but the community mental health team is based at the base hospital with the integrated in-patient services.

CHAIR: The department, particularly Professor Raphael, was highly resistant to any mental treatment or anything that whiffed of private treatment, was it not?

Ms O'BRIEN: Correct.

CHAIR: When she saw private, she saw horror.

Ms O'BRIEN: Yes. It was a barrier.

CHAIR: She is now the Director of Mental Health Services in New South Wales.

The Hon. RON DYER: I wish to try to crystallise for a moment what your reservations or objections are to the Port Macquarie Base Hospital model. Is it your perception of a lack of accountability? Is that central to your concern?

Ms O'BRIEN: I guess my concern is that the profit exceeded everything else and patient care, or it could do that. My concern is that there is nothing to prevent Port base becoming a large private hospital with no responsibility. I believe Mayne does not have a social conscience and therefore will not respond to and reflect the community need.

The Hon. RON DYER: Leaving aside for a moment whether they have a social conscience or not, they do have contractual obligations, I presume.

Ms O'BRIEN: Yes, they do.

The Hon. RON DYER: What you are saying is that the contract is lacking in certain respects as far as the delivery of service is concerned?

Ms O'BRIEN: I think it should be reviewed. I think that any contract between a private operator and government should have a clause that both parties sit down every three years and review it, or certain things—like the four point plan, for example, of the former director-general, Mick Reid, which is an excellent initiative. Because of those points in the four point plan, the contract will need to be reviewed to reflect what he said.

CHAIR: The issue was brought clearly to my mind when I read last evening this year's annual report of the Port Macquarie Base Hospital. The Chairman of the Medical Staff Council said that there was a review undertaken by Mr Parker.

Ms O'BRIEN: Yes.

CHAIR: He has found that there are 3,200 bed days that Port Macquarie should have received if there had been a fair increase associated with the increase the mid North Coast was getting. In other words, it was only getting its fair share of what the mid North Coast was getting. That seems to me to be supported by the evidence that you would know about, which was that in March 1995, when the current Government came in, there were 802 people waiting at Port Macquarie Base Hospital, which was not terribly different from Manning and Wagga Wagga, less than Tamworth and so on. In 1998, when you were the deputy CEO, by that stage Port Macquarie had grown to 1,375, whereas Tamworth had dropped or stayed the same and Wagga Wagga had stayed about the same. The waiting times had increased from two months to 5 months. In other words, the period under review by Mr Parker, from 1998 onwards, you were obviously running into trouble with the amount of money you were getting for the demand out there because the population was growing so fast. What was there that you were aware of in the contract that allowed the number of Port Macquarie services to grow in the period after 1995, when it started to cope with the large number of people who kept moving to this area, which obviously generated these sorts of waiting lists?

Ms O'BRIEN: There are two reasons, I believe, for the waiting list to be what I consider to be totally unacceptable. The first is the growth of the area and medical staff being appointed, but the medical staff were appointed in line with the hospital's role delineation. You are aware of that.

CHAIR: Yes, I know.

Ms O'BRIEN: There was initially concern—

CHAIR: And those appointments have to be approved by the department.

Ms O'BRIEN: Yes. The other reason, and it is a perception only, is that Maynes, because they are in the private hospital in Lake Road, mainly a surgical facility, wanted the waiting list to be kept long to encourage people—

CHAIR: It was not Mayne though; it was the HCOA which you said had an eye for quality. Is that it?

Ms O'BRIEN: For the base, yes.

CHAIR: And the HCOA owned both.

Ms O'BRIEN: They do not own the base hospital. They only operate the base hospital.

CHAIR: But the HCOA had both the base hospital and the private hospital in Lake Road.

Ms O'BRIEN: Correct.

CHAIR: Before Mayne took it over.

Ms O'BRIEN: The changes in Mayne.

CHAIR: But the HCOA was a separate operator from Mayne.

Ms O'BRIEN: The HCOA was the health division of Mayne Nickless. It was not a separate operator.

CHAIR: Initially it was not. In 1995 the HCOA was not part of Mayne.

Ms O'BRIEN: Yes it was. The contract is with Mayne Nickless.

CHAIR: What was it in 1995-98? We now go to 2001 when we have 3,000 people waiting at Port Macquarie.

Ms O'BRIEN: I think it is the continual desire to make Port Macquarie Private Hospital profitable and not address the waiting list. Mayne had every opportunity, with the result of Mr Parker's decision, to go in and exercise its rights under the contract, and it chose not to. It could have picked up another $3.5 million to address the waiting list problems if it had exercised its rights at law.

CHAIR: So you are saying that the Parker decision was binding on the department?

Ms O'BRIEN: According to the contract, yes - a legal process could have been initiated and Mayne chose not to pursue it.

CHAIR: So if they got in an independent person like Mr Parker, Mayne could have gone to mid North Coast and said, "We need $3.5 million more."

Ms O'BRIEN: Correct, and if it wasn't received legal action could have followed.

CHAIR: Just on the basis of what was lost up until 1998.

Ms O'BRIEN: Correct.

CHAIR: We will check that this afternoon. Even so, the waiting lists have grown in every other area health service since then, and now we have massive waiting lists across the State. Do you think this is a ploy by the State Government to force people into private hospitals?

Ms O'BRIEN: I have no idea. I could not answer that question. It is a philosophical statewide issue.

CHAIR: Are you prepared to say that you think that Mayne takes that view?

Ms O'BRIEN: I cannot comment on that, no.

CHAIR: I thought that was what you said.

Ms O'BRIEN: In Port Macquarie it was a definite tactic in the early years, and certainly supported by the rebadging of the company in July, that Port Macquarie Private Hospital had to be supported at all costs, and that meant encouraging people to use their private insurance or to self-insure at the private hospital.

CHAIR: It is interesting, I was watching the Minister talking recently and he was asking public hospitals to try to up their insurance rate admissions.

Ms O'BRIEN: Yes.

CHAIR: Because he is trying to get some of the private dollars into the public system. Yet the Commonwealth Government has done this thing with private insurers to try to get people out of the public system so that the public system can be available for public patients and not clogged up with private patients. Which is the right approach?

Ms O'BRIEN: I do not know.

CHAIR: You are a CEO who manages an institution with owning both. You operated Port Macquarie private, you operated Port Macquarie public. Wherever they went, the dollars were going to go into your pocket.

Ms O'BRIEN: Correct.

CHAIR: What is a better arrangement—to get people who are privately insured to go to private hospitals, or to get privately insured people into public hospitals?

Ms O'BRIEN: I think that depends entirely on their clinical condition and why they need to go into hospital. There are many private patients who definitely need the services and support infrastructure of a public facility, intensive care, et cetera.

CHAIR: But to be admitted to a public hospital you are meant to do it only on the basis of clinical need.

Ms O'BRIEN: Correct.

CHAIR: You can come off the waiting list as a private patient if your clinical need is greater than somebody who is a public patient and who is not going to pay.

Ms O'BRIEN: Correct.

CHAIR: How can that be manipulated by an administrator unless the doctors are complying with some form of corrupt practice?

Ms O'BRIEN: I would not like to comment on doctors' behavioural patterns but if I was a patient with a painful hip and I was told by my doctor that I had to wait for three years at the public hospital or take out insurance and have it done in a private hospital I know what I would do. If I could afford it, I would do it. That may happen everywhere.

CHAIR: It does. What about other patients who take the other option and go down to the bone and joint wards at Prince Alfred and the North Coast must take them over?

Ms O'BRIEN: So be it.

CHAIR: There are a lot of distortions in the system.

Ms O'BRIEN: There are.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can I come to the crunchy bits of your allegation? You said there were changes to the lists in terms of the DRGs, in terms of the operating lists.

Ms O'BRIEN: No. We would only do DRG cases that made a profit.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, but you must have changed the list so that the unprofitable ones went further down the list and the profitable ones went further up the list. Did you do that or were there protocols in place where management ensured that that happened?

Ms O'BRIEN: No, we did that. I was part of that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You were part of that?

Ms O'BRIEN: I was part of that because I knew what corporate wanted.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How did you encourage certain DRGs to go up the list and certain DRGs to go down the list?

Ms O'BRIEN: I just instructed staff, as I was instructed as well.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Under instructions to you, you instructed staff to push DRGs up, and they then sent letters out to patients and told the doctors that those operating times were available?

Ms O'BRIEN: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And that was done by you as the CEO.

Ms O'BRIEN: As the deputy CEO.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So that was an active intervention by the deputy CEO in the case mix that the hospital was doing.

Ms O'BRIEN: Under instruction, yes, and knowing what the corporate needs were.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And you believe it continues.

Ms O'BRIEN: I could not comment. I do not know.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you think that, given you had a falling out with them on this basis, if you are saying that the profit has increased it is likely to be happening more rather than less.

Ms O'BRIEN: It could well be. I could not comment.

CHAIR: She cannot comment on the reason for that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I note that the number of private patients in Port Macquarie Base Hospital is lower, I gather, than most and obviously they are going to private hospitals. We heard evidence from Mr Walsh that this is a patient choice; when they go from the emergency department they have the choice of going either to Port Macquarie Base Hospital or to Lake Road. Are they encouraged by management in any way to go to the other hospital?

Ms O'BRIEN: Depending on their clinical condition.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If so, how is that encouragement made?

Ms O'BRIEN: It filters down from the management to the staff. If a patient's condition was okay, needed admission but not terribly ill, private patients were encouraged to use their private insurance at the Lake Road facility.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How did that encouragement manifest? Was it a protocol?

Ms O'BRIEN: No, there was no protocol. It was just a practice.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So nothing is written about that?

Ms O'BRIEN: No.

CHAIR: Would that be done by other public hospitals?

Ms O'BRIEN: I cannot comment on that.

The Hon. RON DYER: I come back to your concerns about the model applying to Port Macquarie Base Hospital. Under our procedures, I am not allowed to directly quote from your confidential submission, but it does appear to me that you have a concern about the degree of independence the senior managers at the hospital have and how that relates to their accountability to public bodies such as the area health service. Is that a central concern you have?

Ms O'BRIEN: Yes. It is a concern. I just do not believe that under the current management structure a CEO has the local accountability factors at heart. I think the four point plan, however, if it is made to work like it should work, will be the driving force and overcome that concern.

CHAIR: But all it does is ensure that Port Macquarie Base Hospital gets its fair share of the dollars, which will increase Mayne's profits even more.

Ms O'BRIEN: There are lots of other issues in the four point plan than the dollars.

CHAIR: Like what?

Ms O'BRIEN: I will have to read them.

CHAIR: That is fine, because this is part of the inquiry. We do not have the four point plan in front of us.

The Hon. RON DYER: You say that the four point plan will in some ways ameliorate the unsatisfactory or oppressive aspects of the contract.

Ms O'BRIEN: If it is made to work, yes. If it is rigorously enforced, yes.

The Hon. RON DYER: How can that be if the contract has known settled conditions, as it clearly would, being a contract? How can some external source cut across that?

Ms O'BRIEN: I do not know. I could not answer that.

CHAIR: You might just tell us what your perception is of the four point plan in terms of its advantage to the people of Port Macquarie. I have seen the press release but it has not been given as evidence to the Committee.

Ms O'BRIEN: I guess the first thing is transparency, and that in itself is a lot. The first point, as I heard this morning, PMBH will conduct itself and be treated by New South Wales Health and the area health service in the same manner as all public hospitals across the State. PMBH will meet all quality benchmarks, adhere to public sector employment policies and practices, which was an issue some time ago and hopefully that will be resolved now, ensure access on clinical need—that is a given—and enhance relationships with general practitioners, which I know is a vexed issue. I spoke to my GP recently and the hospital has suspended the division of GP having a departmental role at the hospital.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What? Unilaterally?

Ms O'BRIEN: Yes. That is first-hand from a GP. If the thing is rigorously enforced it will work, but if things—

CHAIR: It also has in there that it gets access to the dollars. It will be treated like every other public hospital. Its access to the 3,200, the Parker report—

Ms O'BRIEN: Three thousand eight hundred bed days.

CHAIR: Yes. The Parker report should flow, which means that they get more dollars, which means in reality that perhaps it should make more profit.

Ms O'BRIEN: Correct.

CHAIR: Not that there is anything wrong with profit if they do the job at the same price as Coffs Harbour and Taree.

Ms O'BRIEN: If they are doing the same cases.

CHAIR: That is what I am saying. He has already indicated part of the hook for this four point plan is a watch on the mix and that Port Macquarie is not outside the mix at the moment. Coffs Harbour might be but Port Macquarie is not.

The Hon. DOUG MOPPETT: In the time we have available I am concerned that we are spending so much time on things that have happened since. Ms O'Brien has come as an expert witness. We do actually have the four point plan in front of us. One thing it refers to is strengthening the community input and the sense of community ownership. During your time would you care to comment on how the advisory board operated and what limitations you saw in its structure at the time?

Ms O'BRIEN: The community board of advice is just that, it is a board of advice. Therefore, they do not have any governing power. I believe that initially—and I am going back a long time now—the wishes of the Parliament to have a community board were not acceded to by Mayne Nickless. The CEO is a board member but, really, they are there in a purely advisory capacity. If the contract is going to be reviewed, that issue could be looked at.

The Hon. RON DYER: There is reference in the four-point plan to the establishment of a new consumer community health forum. Has that occurred?

Ms O'BRIEN: That has occurred. It is only in its infancy. There is no information flowing to that forum yet from the clinical indicators that Port Base and the area service agreed to.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Has the committee asked for that information?

Ms O'BRIEN: No, we have not asked for it but we will.

The Hon. RON DYER: You see the forum as a positive development, do you?

Ms O'BRIEN: Yes, and it's statewide as well. It is not just for the four-point plan between the area health service and Port Base. It is a statewide initiative.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The hospital has an obligation to provide that information to the forum. That is in the agreement.

Ms O'BRIEN: I imagine so. Under the four-point plan, definitely so.

The Hon. RON DYER: Would it be your position regarding the contract that it is of undue length and a particular concern you have is that it is not subject to periodic review?

Ms O'BRIEN: Yes, I would agree with that.

The Hon. RON DYER: Is it an issue of concern also that the contract runs for 20 years and it is only reviewable some short period prior to its expiry?

Ms O'BRIEN: Yes, year 17, I think from memory.

The Hon. RON DYER: In year 17 negotiation can then occur between Mayne Health and the Government, is this correct, regarding its continuance or variation?

Ms O'BRIEN: Correct. The contract lasts for 20 years without any opportunity to change it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you believe that the contract that looks after the interests of public employees was complied with in your time?

Ms O'BRIEN: I think initially there were great problems associated with all the transferees employed and paid under the public sector awards, which happened, that they did not have a right of appeal or promotion, which was a deficiency. We had many meetings locally with the area health service and the Sydney Department of Health and we could not resolve that issue. However, with the four-point plan for Port Base to be treated the same, that means that staff were to be treated the same.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Does that mean that they could appeal to Government and Related Employees Appeal Tribunal?

Ms O'BRIEN: I am yet to hear of any policies or procedures that have been put in place by the area health service or Port Base to reflect that. If that four point plan is enforced then this will have to happen.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And you are monitoring that as part of the community forum, presumably?

Ms O'BRIEN: No, I was not going to, but I guess—

CHAIR: The issue in this four-point plan is that the Mid North Coast gets an increase in the authority to manage locally the contract whereas before that the contract was done by the director-general and Mayne?

Ms O'BRIEN: Yes.

CHAIR: The Hastings community is to receive an equitable share of the resources. This has been the single biggest issue, particularly for mental health funding, which we will not deal with today, but for general funding, which is why the Parker review was done?

Ms O'BRIEN: Correct.

CHAIR: Should the community be given better access to the amount of money, and is it getting its fair share from the Mid North Coast Area Health Service and is the area health service getting its share from Sydney?

Ms O'BRIEN: I think the whole process should be transparent. If the four-point plan is to work properly, you have to have the trust of the community that both parties are fair dinkum.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think there is sufficient transparency?

Ms O'BRIEN: To date, no.

CHAIR: Do you think there was sufficient transparency with the operation of Coffs Harbour Base Hospital?

Ms O'BRIEN: No.

CHAIR: That is the problem. I understand from Mr Clout that the area health service has moved to episodic funding, which I did not think was coming in until next year. Port Macquarie has kept up separations, of which 80 per cent are walk through the door, whereas Greatest Taree and Coffs Harbour have not, by comparison with previous years. They are about 1,000 off. Port Macquarie has grown.

Ms O'BRIEN: That is good.

CHAIR: It is good, but the difficulty is: how do you know that the other places are operating efficiently and effectively?

Ms O'BRIEN: I cannot comment.

CHAIR: I ask you because you were chief executive officer. How can one hospital within an area—and all hospitals within this area a relatively underfunded compared to others—some grow and some die in terms of numbers and the costs per DRG for Coffs Harbour and Taree continue to rise while Port Macquarie remains about the same. How does that happen?

Ms O'BRIEN: By the case mix.

CHAIR: You reckon it is only case mix.

Ms O'BRIEN: That is one major factor.

CHAIR: Why is Coffs Harbour in strife, because the orthopaedic stuff is off the mark compared to Taree and Port Macquarie, which Mr Clout said this morning?

Ms O'BRIEN: Yes I heard that. I could not comment.

CHAIR: It is a very multifactorial business, is it not?

Ms O'BRIEN: It sure is.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think case mix is the major reason why Port Macquarie is more efficient or do you think it has areas where it simply manages things better?

Ms O'BRIEN: It could be both. Management has a much higher focus on cost control than what happens in the public sector.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is obviously a combination of both?

Ms O'BRIEN: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You talked about profits. What profits are there in this?

Ms O'BRIEN: That is a pretty sensitive issue. The profit factor has been an issue since the day the hospital was commissioned.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: My understanding was that Mayne did not object to that being stated. They said they were transparent with the figures.

Ms O'BRIEN: Sorry?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Perhaps I should not speak for Mayne.

CHAIR: No, that is not what they said.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Could you give us any indication of what sort of profits they have? Are they divided by the three hospitals involved? Were you involved with the three hospitals?

Ms O'BRIEN: No, not really. My position during my time with Mayne was purely at Port Macquarie Base but we had a lot of services and we worked as one executive team, but my role and responsibility was at the base.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What sort of profits were at the base?

Ms O'BRIEN: It is pretty sensitive information.

The Hon. RON DYER: Sensitive on the basis that it relates to the contract?

Ms O'BRIEN: No, I am trying to think through my head the sensitivity of that. It was information that people have been seeking for a long time.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: These things should be transparent.

CHAIR: Yes, but if they are part of the contract, unless the other side agrees, the release of that information is not authorised.

Ms O'BRIEN: It is not part of the contract.

CHAIR: If it is not part of the contract, that is fine.

The Hon. DOUG MOPPETT: With respect, it might be more appropriate to ask whether she thought it was transparent enough but to ask about profit is inappropriate. It should be directed to the actual owners. You are here to tell us your opinion, you are not hear to be cross-examined about our opinions. Mayne Nickless has had some publicity about its activities in other areas. What is your opinion of them as a company? Do you think it is an appropriate company to be running public hospital services in places like Port Macquarie?

Ms O'BRIEN: I guess what you are alluding to are the fines for breaches of the Trade Practices Act. They were fined $7 million recently for breaches. As late as last December 2001 they were fined an additional $280,000 each for two cases and there are further charges outstanding. It is not for me to comment whether they are suitable, however, it seems to me to be the height of folly for a contract to be signed between the State Government and a public listed company and the contract again should be reviewed. It is up to others to sit down and say, "Hang on, Mayne, are you fit and proper? You have all these fines before you. Is that appropriate?"

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you cannot talk about profits, I will ask this. Are there transfers of other goods between hospitals? We heard evidence this morning that the laundry is all done at Port Macquarie Base Hospital and it then goes to Lake Road and then Armidale, is that correct?

Ms O'BRIEN: That is correct.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: My understanding is that is paid for within the DRG and if there is extra capacity within the laundry, still within the DRG and adequate at Port Macquarie base, what the corporation chooses to do in terms of transferring that as laundry rather than as property, if you like, to somewhere else is their business?

Ms O'BRIEN: The staff in the Port Macquarie Base laundry—the base hospital buys the linenfor the other two hospitals. They purchase the linen. That is a company decision. The staff at the base hospital do the work, they do the laundry and that is transferred to the private hospital and to Armidale.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When you were there was there a budget for laundry per DRG so that you could say this was just part of the DRG and you get X dollars and you could allocate it?

Ms O'BRIEN: There was a laundry cost per patient day when I was there. They have probably moved on to have a laundry cost component of the DRG payment system but it must be remembered that that cost for the DRG was for public work of public base hospital staff doing work for the private hospital.

CHAIR: Did either here or Armidale pay a fee per item of linen?

Ms O'BRIEN: When I was there, no.

CHAIR: They paid nothing at all?

Ms O'BRIEN: Correct.

CHAIR: For doing it, not just for the article?

Ms O'BRIEN: No.

CHAIR: There was no cost for the transfer of doing the service?

Ms O'BRIEN: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If there was a cost per DRG of $X for linen and the linen was washed for 90 per cent of X, in other words, there was a 10 per cent profit in that, and instead of taking that as profit to the bottom line the laundry simply did more linen and sent that somewhere else, it would still be getting that much money from the DRG?

Ms O'BRIEN: That seems to be a very convoluted process. Why would you use your profits like that?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Because if you turn it into profit you will presumably pay tax and then pay that money to your other hospitals—

Ms O'BRIEN: Which would then have to reimburse you.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: By the linen service, yes.

Ms O'BRIEN: That was not the case when I was there. There were many services provided by the base hospital to the private hospital that were not accounted for.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What other services?

Ms O'BRIEN: Human resource management, payroll, things like that. There was probably about $500,000 worth of services a year provided to the port private hospital and Armidale which came from the base hospital budget or revenue streams.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And they did not appear on any bottom line?

Ms O'BRIEN: To my knowledge, no.

CHAIR: Was not the pay done from Melbourne?

Ms O'BRIEN: In very recent times, yes, but they still have payroll staff on site.

CHAIR: And there was no payroll staff at the other two places?

Ms O'BRIEN: No, human resources.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you believe mental health was downgraded to pay for other services while you were there?

Ms O'BRIEN: We had to manage those budgets. Mental health was part of the direct bill budget, which meant there was no profit from that area and you always had to maintain the budget. If the budget was going over, you had to take steps to correct that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Sure, but presumably, you cannot control the casualty department's or the emergency department's budget because people more or less walk through the door as a result accidents. The situation is more or less fluid. You cannot control that.

Ms O'BRIEN: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There must be other elements in what you call the fixed budget.

Ms O'BRIEN: The direct bill budget.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The direct bill budget, yes, that you can control, so you squeeze those because you cannot squeeze the other.

Ms O'BRIEN: You have to manage, though.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Was mental health squeezed as part of that? If so, how?

Ms O'BRIEN: In one year, we closed the ward for a period of time to bring the budget on track.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The mental health ward was actually closed, all 10 beds?

Ms O'BRIEN: The specific ward was closed and mentally ill people were relocated to another part of the hospital with general patients.

The Hon. RON DYER: Was that so that part of the control budget—the direct bill budget—was not exceeded during that particular year?

Ms O'BRIEN: Correct. Mayne was responsible for any overruns in the direct bill areas. Mayne had to pay for that.

CHAIR: Just to concentrate your mind a bit, would you take any questions on notice directed to you?

Ms O'BRIEN: Sure.

CHAIR: They would be covered by the same privilege, whether you do it here or elsewhere. They will be in writing.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Were the community mental health teams staffed less as part of the downgrading of mental health services?

Ms O'BRIEN: Yes, they were.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There were actually less staff employed?

Ms O'BRIEN: No. When the staff went on leave, they were not replaced, as a means of controlling the budget.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So the establishment was the same, but the people on the ground were down.

Ms O'BRIEN: Yes. That is a practice in public sector land.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Of course. That is not exclusive to Mayne.

Ms O'BRIEN: No. That is a common practice.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you are saving money, you are looking good?

Ms O'BRIEN: Yes.

The Hon. RON DYER: There appears to be a community involvement in mental health services at the hospital now, though.

Ms O'BRIEN: There is a very strong community consultative committee which was established during my time. They are very vocal and they have good advocacy skills as well.

The Hon. RON DYER: On the assistants in nursing issue, are you aware that Mr Walsh gave evidence to the Committee this morning that no assistants in nursing are employed at the hospital at all?

Ms O'BRIEN: I am aware that the hospital has embarked on a recruitment strategy to train enrolled nurses, which are in fact at the same skill level as AINs.

The Hon. RON DYER: You say the same skill level, but my understanding is that enrolled nurses have a substantially enhanced period—

CHAIR: These are enrolled nurses in training.

Ms O'BRIEN: Trainee enrolled nurses have the same skill level as an assistant in nursing. They are on a commendable program to, over 12 months, be up-skilled, but initially it is at the same skill base.

The Hon. RON DYER: Mr Walsh told the Committee this morning that he estimated, although he did not have a precise figure, that some 15 per cent of the total component of nurses at the hospital would be enrolled nurses.

Ms O'BRIEN: That is fine, provided that that reflects what was happening in the public sector because the role and function of the base hospital, its services demand and culture, have to be reflected in the staffing mix. I understand or I guess that is why those indicators were set.

CHAIR: The Mid North Coast Area Health Service has 30 per cent, but that would take account of Macksville and all sorts of other places.

Ms O'BRIEN: Yes.

CHAIR: You would have to look at peers who are doing same sort of work.

Ms O'BRIEN: Correct.

CHAIR: That is what the argument was about, how many. I mean, 15 per cent might be far too high, or it might be about right, or it might be too low, might it not? It depends on the needs for care of the patients in place at the time.

The Hon. RON DYER: Are you saying that the nursing mix at the Port Macquarie Base Hospital now is, in your perception, out of kilter with what it should be?

Ms O'BRIEN: No, I do not know the facts. All I am saying is that whatever happens at the base hospital should be consistent with what is happening at the other base hospitals, and not have 20 per cent of the staff as AINs, which is the case at the Port Macquarie Private Hospital.

The Hon. RON DYER: That is not an unreasonable thing to say. However, is it your belief that there is any imbalance compared to normal public sector hospitals?

Ms O'BRIEN: I cannot comment. I do not know the figures for the other hospitals.

CHAIR: When you left in 2001?

Ms O'BRIEN: There was none.

CHAIR: Was that about the same as the other public hospitals?

Ms O'BRIEN: It would have been about the same.

CHAIR: Given that Port Macquarie is a bit different from Coffs Harbour and different from Taree—

Ms O'BRIEN: Different, yes.

CHAIR: I mean, something has to give soon about the number of nurses being attracted to the work.

Ms O'BRIEN: Sure.

CHAIR: We are luckier here than in some parts of Sydney, certainly, and some parts of the western New South Wales. It is a big issue.

Ms O'BRIEN: Sure.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If we go through the transcript and we want to clarify some more issues, can we put those questions on notice?

CHAIR: If we want to clarify something in particular, that is what we would be interested in. Mr Walsh will be coming back this afternoon. We will be publishing the transcripts for today but we will not publish the transcripts until you have seen your part. That will take about a week. If there is anything that you think you have missed out or that you would like to clarify in the evidence, please let us know because your evidence carries considerable weight.

Ms O'BRIEN: Okay. Mr Chairman, I have been thinking about the question asked by the Hon. Dr Arthur Chesterfield-Evans relating to profits. I am comfortable to answer that.

CHAIR: Yes.

Ms O'BRIEN: As I said in my opening remarks, Port base made a profit from day one. The average annual profit from the base was $2 million plus another half a million dollars that was sent straight to corporate because corporate was concerned about the profits. They thought it was obscene.

The Hon. RON DYER: I am sorry, what does the expression "corporate" mean in the sense in which you are using it?

Ms O'BRIEN: Corporate is like the Department of Health head office. It is the corporate office of Mayne Nickless. It is about $2.5 million every year for the base. Because of the interrelationship between the private, it was considered that some of the profit from the private hospital could be attributed to the base. When I left the group, the profit was about $6 million. With the recent changes, I am sure that that profit would be certainly higher than that. It can only go up.

CHAIR: That does not even account for the $7.06 million that the State Government pays as an access fee.

Ms O'BRIEN: That is correct. That is paid to the owners, not to Mayne.

CHAIR: Who are the owners?

Ms O'BRIEN: The owners of Port base is a company called Port Macquarie Base Hospital Pty Ltd which is currently owned by the State Street Bank. Up until 12 months ago it was owned by the State Street Bank.

CHAIR: The State Street Bank?

Ms O'BRIEN: Yes. It is a bank.

CHAIR: Where is that?

Ms O'BRIEN: It is an American bank.

The Hon. RON DYER: You mean a superannuation fund?

Ms O'BRIEN: It is a bank.

CHAIR: It is a bank—an American bank. So that $7.06 million is quite off everybody's mark?

Ms O'BRIEN: Yes. That is why, during the last few minutes while we were hearing about the profit thing, when people think of profits, they think of $10 million. They are not; they are $6 million—and rising, certainly, but the thing that makes one uncomfortable talking about profits is that we have a long waiting list for public patients and Mayne gets a good return on public patients. How many hospitals in the State make a profit out of public patients? Yet that profit is not offset by addressing the waiting list.

CHAIR: The only question, of course, is if they were all operated like Port, would they have the same dollars or not? That is the question.

Ms O'BRIEN: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can we ask what the input is to get that output?

Ms O'BRIEN: The turnover? The last budget I dealt with was $39.55 million in total. The inpatient budget was where the profits were made from, and that was about $23.5 million. So in a $23.5 million budget for patient care, the profit of about $3 million is achieved.

CHAIR: I thought the Mid North Coast Area Health Service said it was $68 million—the cost of services.

Ms O'BRIEN: No.

CHAIR: We will ask Mr Walsh this afternoon but he said that the cost of service was 35 per cent of the cost of the services that were going to this valley, of which the base hospital is the major part.

Ms O'BRIEN: Also included may be the Kempsey District Hospital and Wauchope District Memorial Hospital, and the publicly managed community health centres for Port Base. It is about $23.5 million, from memory, which was the inpatient budget for the year 2000-01.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And the direct bill?

Ms O'BRIEN: The direct service is about $15.5 million to make a total of approximately $39.55 million for 2000/01.

CHAIR: You do not make very much money out of the direct bill?

Ms O'BRIEN: No money from the direct bill at all. It is only purely from the inpatient budget that the profits of about $3 million are achieved.

(The witness withdrew)

(Short adjournment)

CHAIR: The Committee will now hold a public forum. This is less formal than the public hearing we have just had, but as a parliamentary proceeding there are some ground rules which I need to explain now. You will be given the opportunity to speak for up to five minutes to express your views on the quality of care at Port Macquarie Base Hospital and how quality of care should be measured for patients. I will have to ask you to wrap up after five minutes to allow as many people as possible to speak. The Committee may choose to ask questions to clarify what you have said.

I encourage all of you to read the terms of reference before speaking to ensure that your contribution is relevant to the inquiry. I also encourage you to make your comments constructive, with suggestions for change where and if change is needed. I must also insist that you avoid the use of people's names in any criticisms made because, as a matter of fairness, those people are unlikely to be in the room to respond to any comments made. The Committee must first agree that evidence adverse to a particular person is relevant to this inquiry before such comments are made.

Finally, I need to ask any of you who wish to speak to register with the Committee officer. A transcript of this forum will be made and we will need to send it to you to check your comments. Please identify yourself by name before speaking, and speak slowly and clearly to assist Hansard in preparing the transcript. I have a list of people who have indicated that they wish to speak and I will call them in turn. The first person on the list is Mrs Stella Hughes.

STELLA HUGHES, Port Macquarie,

Ms HUGHES: My name is Stella Hughes. While I do not have anything relevant to offer for today's talk about the hospital itself, I would like to tell you what happened in my family in 1999, if I may. This is very relevant to what you were talking about this morning about getting in nursing aids and people who have had four weeks training and who are then let loose in the wards. It is just over three years since I left my 94-year-old mother one Sunday afternoon in the care of an almost empty of staff Port Macquarie Base Hospital after she had been adjudged to be fit in both mind and body to receive a hip replacement operation. She left five days later in a coffin.

Her operation was judged by the hospital to be completed in 2¼ hours by virtue of an epidural injection. In fact, the operation took four hours and 10 minutes, by which time she had suffered a massive stroke. Records show that this was not diagnosed for approximately 10 hours and then too late at night so she was left. On the same night she was also left without any pain-killing medication for approximately 12 hours until I found her the next morning at opening time. She was in terrible pain, her one arm still bandaged pressing against my head and trying to tell me of her plight by squeezing little tears from her eyes.

Two witnesses told me and made statements to the hospital that although she could not speak and could only flail one arm for help, she had been both physically and verbally abused. I was told that my complaint was hospital whispers. I have never been able to obtain satisfaction of this cruel happening, except for the health commission sending the person responsible for the lack of the care over the pain-killers to a two-hour lecture to be taught how elderly people should be treated. I believe that this answer to lack of compassion is reprehensible.

I had looked after my mother for 25 years, also nursing my husband for three years from cancer from which he died terribly on today in 1996. So my grief and anger at her treatment and non-compassion that brought her to death's door is with me still after having a verbal apology with a promised letter of apology which has never materialised. After my mother died I decided if I was ill I would like to know I would have better treatment—Mum was a public health patient—so I joined a private health fund as a pensioner, only to find that Mayne Nickless not only ran our base hospital but the one in Lake Road as well.

You may imagine my own distress at the thought of suffering similarly as my mother if ever taken to that hospital. My mother had me to bring her plight to light. I do not have that chance. I believe Mr Fahey and Ms Wendy Machin should be told of how, by not taking any notice of the 60 per cent plus town's referendum against letting a private company run a base hospital, our situation has deteriorated. Certainly, my mother's sister, now 95, having had two hip replacements at 91 and 92 years of age and enjoying life, wonders why her sister should be three years dead.

The Hon. RON DYER: Was there any coronial inquiry into your mother's death?

Ms HUGHES: No, nothing.

The Hon. RON DYER: Did you make any complaint to anybody?

Ms HUGHES: Yes. About three days afterwards I made a complaint to the hospital, and the witnesses also made complaints. Nothing happened; it was just called hospital whispers. The two people who made the complaints were actually sitting looking after their aunt who they could not trust the hospital at that time to look after. The poor old dear had broken her leg and when she wanted to go to the toilet they made her wait and all that sort of thing. Poor old lady. So they stayed there as long as they could in the evenings to be with her, and they came in the mornings as well. And this happened to my mother in the evening after her operation, when she had had a stroke and could not speak.

The Hon. RON DYER: There is a body known as the Health Care Complaints Commission.

Ms HUGHES: Yes. I have been to the Health Care Complaints Commission, and they recommended that the person who said she forgot to give my mother pain-killers should be sent for two hours to learn how to look after elderly people. I think it is quite disgraceful that anybody should be employed in such a position to anybody in the hospital, let alone elderly people, to need to go out for training to look after them. I understood afterwards—I have this second-hand—that the person with the tablet business was one of those people who go to TAFE or something for a short course, or they did in those days—maybe it is different now—and then they are put on the wards to do whatever.

The Hon. RON DYER: An assistant in nursing.

Ms HUGHES: Presumably, yes. I heard that mentioned this morning.

The Hon. RON DYER: We have been told there are no—

Ms HUGHES: I am going back to 1999. I am hoping that things will be better now. It is just that I was promised a letter of apology from the hospital. I got a verbal one from a person up there over the phone and I said, "I want one by letter". I am still waiting.

(Ms Hughes withdrew)

CHAIR: Thank you, Mrs Hughes. The next person is Teresa Mackay.

THERESE MACKAY, Port Macquarie,

Ms MACKAY: I am a member of the Hospital Action Group but I am speaking as an individual also. We have come across Mrs Hughes before. Sorry to hear that the complaint has not been resolved, but that is not unexpected. It is very relevant to what I have to say because I am coming from the angle of the corporate character of Mayne Nickless or Mayne. As for why people do not get responses, I think the issue is that Mayne just does not care. I will quickly read what I have here.

For the Hospital Action Group which formed in January 1992, it has been a very long haul. We have lost many of our original members as the decade past, due to illness and old age. I am pleased to be able to stand here for those who held true to what we believed then, which was fairness and justice and equal access to the same quality of health care that all New South Wales people expect. In all that time, sadly, we have not once been proved wrong in our original concerns of the impact of the privatisation of our public hospital. Year after year we have raised issues about Mayne Health, brought to us by employees, patients, their relatives and friends, and the local business community. We have contacted official bodies and explained the issues frequently in the media, but nothing seems to touch this company.

Mayne is not a company known in the business world or in the community for caring what anyone thinks about the way it does business or treats employees or the community. Times are changing. The Federal Government recently introduced new legislation making it compulsory for companies to disclose where they stood on ethical, environmental and labour issues. Likewise, issues of corporate governance are becoming increasingly central to the growing number of socially responsible investments. These issues have been highlighted with the collapse of HIH, Enron and One.Tel. Good governance means transparent and well-disclosed processes in relation to managing

social, environmental and corporate governance risks. It is a complex issue but one which will affect all companies, such as Mayne, whether they like it or not.

Grant Fleming, a senior lecturer at the School of Finance and Applied Statistics at the Australian National University, believes that the list of stakeholders should be expanded to include non-financial claimants such as employees, employers and local communities. Monash Sustainable Enterprises from Monash University tested the reliability of the processes it uses to establish a rating for governance issues. Mayne was one of the companies put through this process. According to this study Monash gave certain ratings to Mayne. This is very relevant. The lady I spoke to explained to me the meaning of the terms "emergent" and "nascent". "Emergent" meant that Mayne was just beginning to think about certain to issues and "nascent" meant that Mayne was just becoming aware of the need to be then think about these issues. Mayne scored the emergent rating for environmental performance for workplace performance and for corporate governance. This means that Mayne was just beginning to think about those are vitally important issues, and that is pretty shocking when you think that this is health care.

This is a very bad result for Mayne but nothing compared to the fact that the Monash study found that as far as human rights and community performance Mayne was given the lowest rating, nascent. Julie Macken from the *Australian Financial Review* explained to me that this means that Mayne was just becoming aware of the need to even think about the issues and I would like people to think about that and the implications for our community. It is not a good result for a company which in this area has an absolute health monopoly. The implications of the above findings are alarming and unless addressed by this inquiry will lead to growing problems and inequities in the health care system in this area.

The Monash study also isolated for key areas that Mayne needed to address. The first is vertical integration within the health care industry; second, transparency; third, workplace relations; and, fourth, the environment. Vertical integration within the health care industry as far as Mayne is concerned is about the growing trend for Mayne to own privatised or co-located hospitals, private hospitals, general practitioner and specialist services, radiology services, pathology services and pharmaceutical distribution. Doug Holmes from the Monash study said it was especially this area that rang the alarm bells. The immense amount of power that vertical integration promotes and allows affect not only the services which Mayne owns but also allows them to wield enormous power over "independent" doctors and specialists, who are the gatekeepers to all Mayne services. The former Independent member of Parliament for Nowra, John Hatton, warned exactly of this back in 1992 at the public accounts inquiry.

Transparency, workplace relations and the environment also were found wanting within Mayne health care. On any one of those issues someone doing good, solid, honest research would easily be able to flesh out the implications of a health care company not being up to scratch. This is not my job but if governments allow this to go on, it will rebound on them. The Government is not as powerless as it would make out to be and I believe that the Government's bureaucracy lacks the will to investigate and correct these areas. Mayne's record and reputation in all the areas are lacking, not just in our minds but according to the Monash University study. The *Australian Financial Review* stated:

> Smedley (Mayne's CEO) cut costs too hard and too fast. The only reason Mayne hospital beds were full in the first half of the year was because demand had been so great and doctors had no choice but to point to the group's hospitals.

Unfortunately, we in this area do not have that luxury.

CHAIR: Unfortunately, we are running out of time. Could you summarise what you have to say?

Ms MACKAY: Okay. I will finish down to here. We have no public hospital, only the privatised Mayne hospital and the private health hospital in Lake Road, which is also owned by Mayne. We have the alarming issue of Mayne owning radiology and almost all pathology in this town bar Port Pathology. Mayne wields enormous power and has set up a monopoly of vertical integration.

CHAIR: You have made the same point a number of times.

Ms MACKAY: Can I just read this one last thing?

CHAIR: Yes.

Ms MACKAY: We still have 12 years of this disastrous contract to serve and Mayne is already and will be even more so entrenched in this community that it does not bear consideration, that is, if it has not sold us on to some other company. I seek to table this document.

Document from Theresa Mackay tabled.

(Ms Mackay withdrew)

NEIL LESLIE THRIFT, Port Macquarie,

Mr THRIFT: I will find it difficult to get through this because there are further issues that need to be raised. I am also a member of the hospital action group and there is so much to tell. We have tried to condense it as much as we could without going over things but five minutes is not very much time.

CHAIR: I am sure if you address what you have we will get through it all.

Mr THRIFT: Health Department problems are many but the problems facing the Hastings area are most unique. As all people, especially those in this area, will know, the hospital action group was first in the very early 90s to start community awareness of the typical American privatisation of our community built public hospital. In a government ballot people voted against it. We now have, as predicted, a monopoly monster growing by the fact that Mayne is removing all opposition in all fields of health. Mayne already owns at least 22 per cent of private pathology, radiology, corporate general practitioner and specialised centres. Mayne is now the main employer in this area and that is monopoly power.

We all remember the knowledgeable Independent member for Nowra, John Hatton, who once said in 1992 that Port Macquarie would become a company town as far as medical services are concerned. The best monopoly can dictate to or own pathology and all other services, suppliers, labour and contractors. All promises made in the delivery of services by Mayne prior to contract signing are now dead. Accountability and openness by Mayne is non-existent. The complaints are just a joke, as you have already heard. There are so many complaints unresolved. Reports are given to the board of advice and are accepted without even the members of the public involved being able to verify the contents of the report.

I will give you an example from March 2001—and some people here will remember what was called the Smithtown medical evacuees, a report, by the way, that none of the complainants have seen. We believe Mayne said there was no pregnant woman when, in fact, there was, and she was threatening to miscarry. She also had a miscarriage history. These people were all sent away. As of two weeks ago no information was available from the Health Insurance Commission and as of this morning one of these people who is still waiting for the report to come back to them still has heard nothing, and that is from March 2001. This woman who allegedly was not pregnant did not miscarry and has a healthy baby boy, I might add.

Mayne must be made to conduct itself as if it were a public base hospital, that is all their reports, discharge papers, complaints and investigations must be performed on the same level expected of a public base hospital, and why not. It is our taxpayers money. This commercial confidentiality is a major problem and must be removed to be ever able to move forward. All public hospitals, including the Health Department, have freedom of information.

Many more complaints are related to cost-cutting. I have many more things, but I will just go over a couple, such as X-rays not being done on an elderly woman with a broken hip and a young girl with a broken knee, the reason being that it was on a weekend. This was called at that time "acceptable treatment" by the then CEO of the hospital. Another one was a young man was sent by his doctor for X-rays but he was sent home without being X-rayed. Later his doctor arranged an X-ray, which confirmed a fractured spinal column. A woman with symptoms of viral meningitis was brought to Port Macquarie Base Hospital from Kempsey by ambulance—she did not just turn up. She was given a Panadol and sent home. This has had much coverage. That same morning she was diagnosed in Kempsey with viral meningitis. Again this was called acceptable treatment by the then CEO of Port Macquarie Base Hospital. If that is acceptable treatment, I do not need to be there.

The list goes on. A man who was suicidal was refused admission to Port Macquarie Base Hospital. He returned with razor blades and threatened to cut his wrists and only then was admitted. A man with severe mental illness was refused admission to Port Macquarie Base Hospital and later on was hospitalised at Kempsey hospital for nine weeks so seriously was he affected. This was cost-cutting again. Wardsmen are doubling as security guards and only one security guard for a hospital of that size after 11.00 p.m. Since the Kempsey tragedy, which you may or may not be aware of where a person died, the security has been increased but only minimally. We all remember the

rescue helicopter that was tampered with by a mental health patient due to lack of security but nothing was done about security at that time. There are critical staffing shortages in mental health and it goes on and on.

There is a lack of mental health in-patient services, group therapy in mental health and this was referred to by Professor Raphael back in 1988, but as far as I am aware, nothing has been done substantially to overcome these problems. It is more of a joke. The pink ladies, bless them all, have a new task to perform at Port Macquarie Base Hospital. One is as a receptionist and another job they have is to re-roll and recycle bandages and repack washed bed socks, and I have seen that personally. What other jobs they do now, who knows? What happened to the quality time these people used to give to the patients? Do they not need that now and is cost cutting the answer?

Finally, but no means least, the corporate character of Mayne: Early in the 1990s the ICAC found that Mayne has been found guilty over a period of time of corrupting government officials to gain access to confidential information. This is the contract signing period of this privatised base hospital. ICAC said that the behaviour was known and condoned in the highest levels of the Mayne corporation.

CHAIR: What is the name of that report?

Mr THRIFT: It will be on record.

CHAIR: Will you get us that information please?

Mr THRIFT: Yes. It was part of the culture of Mayne Nickless. In 1994 the Mayne corporation was fined $7.7 million for what was being called by the Trade Practices Commission Australia's biggest price-fixing cartel. The managing director himself was ordered to pay a fine of $40,000 for his central role in this issue. There are still ongoing problems in the interaction between the two main hospitals of Port Macquarie. The doctors have also much to speak about this monopoly situation. I wait for the return of our public hospital, a good chance I believe if our local member is on our side. The contracts are so bad I believe they can be broken.

(Mr Thrift withdrew)

CHAIR: Ms Louise Barr?

Ms BARR: I will not be speaking.

CHAIR: Mr Ron Barr?

Ms BARR: He will not be speaking.

CHAIR: Mr Bob Boss-Walker?

BOB BOSS-WALKER, Port Macquarie,

Mr BOSS-WALKER: I wanted to speak particularly about mental health issues in relation to the Port Macquarie Base Hospital [PMBH]. First I will begin by saying that I believe that, given the resources that are available at the hospital, a very good and high level of care is provided. The real issue at the base hospital is the fact that since 1995 when the mental health service began operations there, there has effectively only been one full-time equivalent staff increase in staff numbers for the service. There have been a number of extra staff, but they have been positions that have been common to services across New South Wales. Relatively speaking, there has only been one full-time equivalent position increase.

When we compare that with other mental health services in this area health service alone, we find that, for example, compared to Kempsey on a per head of population basis, Port Macquarie has about half the number of mental health workers per head of population that Kempsey has. That has an effect obviously in terms of the delivery of care. On the one hand it means that fewer people are able to receive quality care and it nevertheless also has an effect on the quality of care because all the time people are being stretched because of the need that is out there in the community. Since 1995, the need has grown every year in terms of people making presentations and referrals to the service. Obviously if there has been any increase in staff, something has to give in that time.

Naturally enough there have different changes in the way the service has been delivered over that time. That has primarily been, on my understanding, because of a lack of an increase in staff numbers.

CHAIR: Are you aware of the way in which Mayne is funded for the mental health services?

Mr BOSS-WALKER: Yes, I am aware of that.

CHAIR: Have you written to the Mid North Coast Area Health Service about this?

Mr BOSS-WALKER: We have certainly made a submission to the inquiry into mental health services.

CHAIR: That is a separate one that I am doing too.

Mr BOSS-WALKER: We have expressed that there. I think there is an issue related to that and it is the issue of transparency. The mental health service comes in for a lot of criticism from people in the community on the basis that there is a belief that Mayne is a making profit out of the mental health budget. My understanding is that that is not the case but that is a difficult question to make clear to people while things such as budget and amounts of money and so on are not transparent. It would certainly be of great benefit and would take a lot of unnecessary flak out of the situation if transparency was introduced into that kind of budget situation.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: May I ask what your position is in mental health?

Mr BOSS-WALKER: Yes. I am the mental health social worker. I previously worked for the mental health service at the base hospital but I have been employed by the local division of general practice for the past three years. I am no longer employed by the hospital.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So the community mental health teams are employed by the hospital?

Mr BOSS-BOSS-WALKER: That is correct.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Have they been fully staffed? That has been a matter on which we have had a lot of representations from both the nurses and from the Port Macquarie Base Hospital itself.

Mr BOSS-WALKER: In terms of being fully staffed, I think the available positions have been filled almost all the time. Of course there are times when people resign that they are not, but the issue is not have they been fully staffed, but how much staffing should they have. In comparison to other services in this area, and if you take that across the State, they are way, way, way behind the eight ball.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Presumably they are way below demand but they are also way below State benchmarks. Is that what you are saying?

Mr BOSS-WALKER: That is what I am saying, yes.

CHAIR: We have received another submission from Dr Campbell to another inquiry which both the Hon. Dr Arthur Chesterfield-Evans and I are on in relation to mental health which goes to the whole history of mental health services and the lack of them.

(Mr Boss-Walker withdrew)

CHAIR: The next person is Mr Mark Baker.

MARK BAKER, Port Macquarie,

Mr BAKER: Thank you for making the time available to listen to us locally and across New South Wales. This is certainly a complex area and thank you again for considering the issue. You may choose to revisit some aspects of the area. From my perspective, for patients in regional New South Wales, it is access to health care which

is clearly a priority. It should be understood within that statement that quality of care is paramount and quality care is what we are after, not just care in itself. Access to that care or the lack thereof becomes the major issue among my colleagues and myself and is reflected strongly locally, as it is right across regional New South Wales. Port Macquarie enjoys a critical mass of excellent medical services. There are always going to be difficult situations clinically which we heard stories of earlier today, but that critical mass is growing as part of the need for people to want to work and live here. It is also attracting an increasing population and that population is ageing. There is an increase in the severity of illness, acuity and complexity of their disease processes.

Within that, my field, or any of the fields of surgery, the complexity of surgery that is performed is equivalent to that of any teaching hospital I visit or have worked in, in the past. The doctors and nurses at the base hospital locally have the ability to perform interventions at the highest level. We can take any example—vascular surgery, endoluminal reconstruction, dialysis, although we do not have a dialysis unit because that is funded elsewhere, carotid surgery, general surgery, complex resection-reconstruction surgery, new renal and urological surgical techniques that are being offered, hand surgery that is being offered at an advanced level, reconstruction arthritis surgery—all that is offered locally. In orthopaedic surgery, the first minimum invasive joint replacement which allowed patients to go home within 24 hours, in regional New South Wales if not outside a private hospital in Australia, was performed at the base hospital. Trauma services are excellent. In the first few years of the hospital, we barely touched on the air ambulance budget that was written into the contract because we dealt with pathology locally. There is no difficulty really with innovation or the ability of local staff to perform surgery.

There are teething problems. There are issues of housekeeping with staffing levels, equipment levels, stores and ageing services—sometimes the computers are down and the airconditioning can be a problem. But these exist within any hospital. We have to live with those. Certainly we like to remain incredibly vigilant to keep on top of that. I remain an independent practitioner. I do not wish to be employed by Mayne and I share the concerns about monopolies. I think they should be watched closely. But I personally have few concerns regarding the quality of the care that I am able to provide at the base hospital. I remain vigilant on that, though.

Over the time I have worked here, my patients, once they have been in the hospital and have been treated, universally feel that they have been offered terrific care. A patient who required a knee replacement which I performed about six weeks ago this week had waited 809 days to get into hospital but he and his wife were absolutely full of praise. They were unhappy prior to getting into the hospital. A lady I operated on last Wednesday at the hospital had waited 1,848 days to get into hospital for a knee replacement. These are unacceptable access numbers but this is dependent on the resources the hospital is given. It is dependent on the dollars directed to the hospital, some of which was written into a contract that could not look ahead well enough to predict the dollars necessary. Population growth has been greater than expected. Illnesses are different perhaps to what was expected. We cannot control admissions coming through the accident and emergency department such as road accidents, heart attacks, appendicitis or anything that any of us could get on the way home this afternoon.

The only way that the management of the hospital, and in that case every hospital in New South Wales, can control its expenditure to come in on budget is to limit elective surgery. The base hospital does run to a budget. I am sure that the hospital takes a management fee, probably commensurate with any company administering any particular contract. Though that is written into the contract, they do administer a budget which is determined by the Department of Health. In a sense, that does make them really transparent because when that budget runs out, we stop working, or the money stops for us to treat patients.

CHAIR: Is there any indication—you are a surgeon, as I understand it?

Mr BAKER: Correct.

CHAIR: Has there been any indication for you to do lower level surgery rather than hip replacements or joint replacements?

Mr BAKER: I missed the start of your question.

CHAIR: Is there any pressure on you on doing the list that you do—

Mr BAKER: It has not been a pressure to do the cheaper cases but the smaller cases certainly have been used by management to keep us working—to keep the staff working—at times when the budget gets tight. That brings me to the next area of comment, to mention a little about access. In January 1999, joint replacements were 35 per cent of my waiting list. By that time, 75 per cent had waited more than six months. Between January 1999 and

September 1999, only nine joint replacements were done. That is grossly unacceptable. I have colleagues in Sydney who are doing five a day. By January 2000, joint replacements constituted 55 per cent of my waiting list and 95 per cent had been waiting more than six months. By January 2002, 62 per cent of my list were joint replacements and 50 per cent, 135 patients, had been waiting more than 12 months. We can all do the simple mathematics.

As a surgeon, I want to operate. I want to help patients and I see the results. Joint replacement is a very effective operation but it is not only the joints that are important. All areas need to be addressed. Really it is the funding to allow the patients to come in and be treated by the nurses and it is the funding to buy the implants that allow those patients to be treated. Both of those are a block to our access. Unfortunately, this is not peculiar to our hospital. I have a letter from Bob Walsh which states:

> Currently, with the amount of trauma, cost of prosthetics that have been put through year to date we have found we will not be able to book major joint replacement surgery for the month of June.

A very similar letter was received by my colleagues at Dubbo today from the Macquarie Area Health Service. They have no joint replacements and no major surgery at all at Dubbo next month and the same is applying all over.

I have a recent concern which I would like to touch on as well because we have done more work in recent weeks. Statistical manipulations can influence funding and that worries me greatly. Under the instructions of the Department of Health, various things are being done at this stage both locally and across New South Wales. Clerical staff within the department are not prepared to blow whistles on this: I have heard that said, and I am personally a little fearful of what a local area health service can do to me by way of recriminations with a further limiting of resources at the base hospital. The current initiative by the Department of Health is to impact on long-wait patients. There is a desire in the current term of Parliament not to have many patients waiting longer than a year by the end of this term of Parliament. Despite assurances that long-wait patients would be funded, the majority of my patients I have found have been reclassified, really by sleight of hand as 'not ready for care'.

I am told this is under a directive from the Department of Health. It is not the local decision. The local hospital really does not wish to get off side and is trying very hard to do everything by the letter. What we have is a situation where manipulations—I call it manipulations but there could be other names for it—where a reclassification has been done. We have seen this before where thousands of operations have been reclassified as non-operations so the waiting list disappeared in previous years. But local patients were then written a letter inviting them to have their operations elsewhere in other towns, other centres or by other surgeons. They were given an assurance that if they did not, that would not penalise them, but now they have all been reclassified. I do not know whether Mayne Health has a desire not to do more work. Doing it at a marginal rate may be against—

CHAIR: I will have to stop you there. This has been said before. If they answer yes, they are not ready for care because they have to go to somebody else. If they answer no, they are not ready for care and they get reclassified off the list anyway. That was said last time. I am sorry.

Mr BAKER: Currently we have 24 patients waiting for one year, according to the Department of Health. There are 135 on this list alone.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We have had the allegation made that the DRG has been manipulated so that the waiting list has altered and the smaller cases come to the top. You are saying that that does actually happen, but that it is openly done. Is that right?

Mr BAKER: I think I can say that it is openly done. I mean, it is there for us all to see. When the budget gets tight the endeavour is to still get as many patients through as possible, but one joint replacement will equate to many other lesser operations. But what happens over time is that you end up with a whole waiting list becoming expensive operations and then nothing gets done, potentially.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So there is cherry picking.

CHAIR: He quoted a letter. Could you table that letter?

Mr BAKER: Yes.

CHAIR: There are also colleagues of his in Dubbo who got the same type of letter.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Sure. I am not saying that it does not happen.

CHAIR: It is not so much cherry picking. We will come back to the question about the waiting list numbers later if there is time.

Mr BAKER: I think it is important because the statistics drive funding.

CHAIR: I know.

Mr BAKER: If we are told that these people do not exist, it is terrible.

(Mr Baker withdrew)

ANGELO SICURELLI, Port Macquarie,

Mr SICURELLI: We are here to find out the truth about the health system. What is the truth and how it can be run properly to satisfy everybody, doctors, providers, patients. I consider this an impossibility to be adjusted to satisfy everybody. So it is an ongoing debate all the time. The sooner we fix something, something else goes wrong so we have to keep on fighting. But how long can we fight for? People get exhausted. Doctors are overloaded and they have a lot of patients. When you go and see a doctor late in the afternoon he is totally exhausted and he keeps on chasing the patients or chasing the money. I do not know what the situation is. It is a bit of a worry because he cannot provide the service as he should be. He should work fewer hours and spend the rest with his family or do leisure time or whatever. He will make a better doctor for that. Some of the doctors who come up here work 12 hours a day, seven days a week. That is a bit of a worry. That is one thing.

I always want to find out whether the human is a true creature or not. My grandfather said to me once, "Do you think a true human is a man, a lesbian, a woman or a gay?" I said to him, "Well, I don't know." He said to me, "This falsehood represented every manifestation possessed and unconventional possibility of a schizophrenia spiritual resurrection of the ecstasy of education, politics, religion and sexuality, where psychiatry and spirituality seem to be an articulate expression of an obscure methodological hereditary, biological and historical background reaction that without any problem can overpower our ego and therefore will slice open the so-called healthy mind.

CHAIR: I wonder if you could stick to the terms of reference a bit more closely. It is about whether or not the people of Port Macquarie are getting their fair share of the funding dollar or whether they are getting their fair share of quality.

Mr SICURELLI: The more dollars we pour into the health system in my opinion, the more service providers we have to provide. We have to provide more doctors, we have to provide more nurses and cut down their hours, cut down their earnings. The earnings of one doctor should be shared by three doctors. They do it better. I know I will be in the soup. It would be a better performance. It is better for them, better for their health. They will live longer. That is what I believe. So we have to open the gate to younger people to become doctors and nurses because we have an influx of indescribable mass coming up and they demand an enormous amount on health and other services. Who will provide for them? All the money in the world will not do it. We do not have the human resources.

(Mr Sicurelli withdrew)

CHAIR: Thank you. The next speaker is Dr Peter Reed.

PETER REED, Port Macquarie Base Hospital, Port Macquarie,

Dr REED: My name is Peter Reed. I have been a surgeon in this town for nearly 25 years. I am now the Director of Clinical Training at the hospital, and I am heading up the new University of New South Wales School of Rural Health medical school campus. I think the hospital provides excellent services to the community. I experienced the waning days of the old hospital, as we all did, and we were getting nowhere. The new hospital has provided a range of services and complexity which is quite extraordinary for a town of this size. I think it acts as a model for recruitment and retention of doctors in the community, which is flavour of the month. As far as its

standards are concerned, we have had two recent independent external surveys. One survey was by the Australian Council for Hospital Services, which was looking at standards of hospital care delivery and management services, and the other survey was by the Postgraduate Medical Council, which looks at the welfare and training of junior doctors.

Both of those surveys took place in April this year, and both survey teams complimented the hospital on the standards that had been achieved and were being maintained. There are two things I would like the Committee to look into if its terms of reference allow. One is our resident numbers, the junior doctors who perform such a vital service within the hospital. We were trapped in a time warp. Each hospital has a quota. Our quota is five and it was 15 years ago. Similar hospitals up and down the coast would have at least twice that number. There are some difficulties now in getting junior doctors. Because of the way the universities have changed their entry requirements, the number of junior doctors available is a lot less. We have no trouble in accrediting positions. We have no trouble in recruiting doctors but at the moment when there is a dearth we are being asked to return to our quota number of five when for instance in Taree and in Coffs Harbour the number is nine, and in Lismore and Tamworth it is greater than that.

I think the Committee should look into the distribution of junior doctors in hospitals, both ours and in others, which should now be reflecting the change in demographics of society and the movement of populations to the bush. The other thing that Dr Baker talked about was the waiting lists. We have the resources, the operating theatres, the teams of anaesthetists and surgeons, the back-up services of the ICU and the x-ray department. The hospital provides levels of great acuity. There are 30 per cent more patients being treated on respirator care now than used to be. Admissions to the emergency department are going up.

Medical admissions to our hospital are increasing by about 25 per cent per annum. This reflects the demographics of our society, the increasing population which is age weighted. People tend to be sicker and older than average, and these people coming in on medical emergencies through casualty are putting a great strain on our budget and on our beds. As Dr Baker said, the thing that gives way is surgical admissions because that is the only thing you can control. The hospital has the ability to deal with its waiting lists if it is adequately funded. We did believe in the formula that was introduced when the hospital started that there were trigger mechanisms to trigger enhancement funding if activity levels reached a certain point, and it seems that this trigger mechanisms is failing. We would like to see that investigated to see why. As our activities and demands on the hospital are increasing, then the contract should allow us to do more work, which we can very well do with the facilities provided.

The Hon. RON DYER: You have a particular concern regarding the share of junior doctors that come here, is that so?

Dr REED: Yes. It is to do with the fact that we are trapped in history. The population here has grown, the hospital services have grown and the hospital allocation quota to our hospital reflects another time. Nevertheless, other hospitals on the coast have higher numbers of junior doctors and they have been doing work of certainly no greater acuity and with no bigger hospitals. It seemed to me during the turmoil and the controversy that surrounded the development of this hospital that I think everybody concerned went into closed discussion and the number of junior doctors to look after 60 per cent more beds and work of greater acuity and complexity was just overlooked.

CHAIR: Will this be overcome by the commitment to the four point plan, where this public hospital will be looked after in the same way as other public hospitals are looked after?

Dr REED: I hope so. I hope lots of things will be changed by that.

CHAIR: That is the understanding I have from both Mr Walsh's evidence and the evidence of Mr Clout.

Dr REED: The Postgraduate Medical Council determined the quotas but the only way it can determine quotas at the moment is to take other doctors from, say, Coffs Harbour or Taree, which is not our intention.

CHAIR: Perhaps we are misunderstanding. You are using the word "quota" as though the number allocated to Port Macquarie is a specific number.

Dr REED: Yes, that is right.

CHAIR: Whereas if there were more doctors available you would get more doctors.

Dr REED: There were more doctors available last year and we did get more doctors. However, during this present crisis of doctors we have been reverted back to our quota, which is about half of what other hospitals have of equivalent size.

CHAIR: Again the Postgraduate Medical Council would dictate how many the hospital could cope with to train. That is what the council does, is it not?

Dr REED: Yes.

CHAIR: If it indicates that it might be 20, then it is simply a matter of funding and whether the doctors are available but whether Port Macquarie, being treated like any other public hospital—

Dr REED: We should have the same number of junior doctors as other hospitals of the same category, yes.

CHAIR: That should be a matter for Mr Walsh and Mr Clout to discuss as a matter of some urgency. If you have half of what they have in Coffs Harbour, there should be some sort of sharing.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is it a problem that the physicians do not exist or they are paid for separately? If the funding is on a DRG basis, then the hospital presumably has the budget out of which it pays medical staff, does it not? It could simply hire them, could be not? The Postgraduate Medical council only accredits positions, does it not?

Dr REED: It also determines quotas.

CHAIR: It determines where they go.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Only for training positions, though. You can have non-accredited positions, can you not?

Dr REED: What has happened this year is that we have recruited more doctors than our quota. We got four more, two in the emergency department and two extra in medicine where we were paying overtime to two junior doctors to the point where their workload was just excessive. The hospital was willing to pay for those out of its budget, and we were able to get them accredited by the Postgraduate Medical Council. But when the number of doctors in another hospital not far away became less than its quota, even though its quota was twice ours, it complained to the Postgraduate Medical Council whose response was to bring us back to our quota, which is five. So we need that quota increasing, and I think a nudge from a government body might help.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There is a position of non-training positions; they used to call them clinical assistants. Do these still exist? A doctor of, say, middle aged who does not want to become a specialist and thus does not stay in a training position for higher training nevertheless continues to work in that job as a salaried medical officer.

Dr REED: There is a group of doctors who are a now unstructured. They are basically called career medical officers [CMOs]. We use a lot of them in the emergency department but their source is not reliable. The most reliable source of junior doctors working on the wards to improve patient care would be through a recognised rotation system which is accredited for education and that is what we want. We want that quota to be raised.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Not career medical officers.

CHAIR: Ms Mackay, you wanted to ask a question.

Ms MACKAY: I want to make the point that I thought this one-hour session is all the public is allowed to have a say and would be just for members of the public, rather than employees of Mayne. I thought there was a whole section of the day for other people, but the people here only have one hour.

CHAIR: Given that there have been no employees of Mayne present and giving evidence before the inquiry, I wonder if you could point out that person.

Ms MACKAY: I thought Dr Reed worked for Mayne.

CHAIR: He is the Director of Clinical Training which I presume is associated with the University of New South Wales.

Dr REED: Director of Clinical Training is a paid appointment at the hospital which is part time. I am fully funded by the university in my medical school capacity.

(Dr Reed withdrew)

CHAIR: I thought so. Are there any other comments that anybody else who has arrived would like to make to the Committee?

NOEL CRAIGIE, Port Macquarie, and

Mr CRAIGIE: I am with the Combined Pensioners and Superannuants Association. There are a couple of things I would like to question more than anything. Why have we been informed that the hydrotherapy pool, which was said to have been inadequate right from the beginning, has had one session closed, the excuse being given that the assistant left the hospital? I do not know whether that has been spoken about.

CHAIR: No.

Mr CRAIGIE: There is a great need in this town for more hydrotherapy services and unfortunately when we lose one session, that means less services to the people. The other question is that the funding that comes from the State Government—and I am not sure of the figure—but something like 30 per cent goes out to profit to Mayne Nickless before any work is done inside the hospital. I would like those two questions confirmed.

(Mr Craigie withdrew)

CHAIR: We might be able to refer those questions to Mr Walsh this afternoon. Does anyone else wish to make any comments? As no-one else wishes to speak, I will ask that Mr Walsh return for further questioning.

ROBERT LIONEL WALSH, Director of Hospitals, Northern Regions, Mayne Health, Port Macquarie Base Hospital, Wrights Road, Port Macquarie, on former oath:

CHAIR: Issues raised relate to the hydrotherapy pool and the 30 per cent profit.

Mr WALSH: The hydrotherapy pool will be closed for a month in the near future for a necessary upgrade of the service. It is about seven years old now and it needs new lining and new tiles. We have just put new airconditioning in, and it needs repainting. The only way we can do this, and the quickest way, is to close it and do it all in one hit. We regret that. There have been criticisms of the pool and we are aware of that. We have had this in our plan to close the pool to do this necessary refit and upgrade. It is regretted but we want to make sure that the service and the pool we have got there is up to standard. With regard to the profitability of Mayne and the operation of the hospital, that is commercial in confidence and I do not believe it is part of this inquiry.

CHAIR: It is not properly, no.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are reluctant to be transparent in terms of your costs, is that the bottom line.

Mr WALSH: The cost you already know. The cost is the price that the department pays.

The Hon. RON DYER: You are referring to profit, not cost.

CHAIR: No, the cost of operating the hospital is based on what the department pays, that is the cost of services and that is all that is able to be made public.

The Hon. RON DYER: I thought the question of the Hon. Dr Arthur Chesterfield-Evans was directed to the matter of profit.

CHAIR: That is right, but that is not part of the inquiry and, more importantly, it is part of the confidential agreement between the State Government and Mayne Health.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I was incorrect before. You are not willing to have transparency in your profits, that is the bottom line?

Mr WALSH: Absolutely not.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are not.

Mr WALSH: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Within the framework of shareholders you do not have profits of individual units of the company?

Mr WALSH: No. The profits of the company are wrapped up in a consolidated report that Mayne does each year to its shareholders.

CHAIR: Other questions were raised such as junior doctors. Is that a constant battle for you?

Mr WALSH: It is a constant battle. We continually pursue the region for any additional funding that might be allocated in terms of rural initiatives for the employment of doctors. We are rigorously pursuing that with the department. We have some funding applications before them at the moment to pursue additional funding in that area. It is important to know that right from the start before DRG funding came into play that Port Macquarie Base Hospital did not receive any specific medical funding for its registrars and junior medical officers. That was borne as an expense of Mayne.

CHAIR: Specialists in training?

Mr WALSH: Yes, the registrars.

CHAIR: You were not given extra money for them.

Mr WALSH: No, never have been.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are other hospitals?

CHAIR: They sure are.

Mr WALSH: Yes.

CHAIR: How many registrars do you have?

Mr WALSH: I think it is seven, which costs about $1.3 million.

CHAIR: Or is it nine.

Mr WALSH: It is nine, which is about $1.3 million or $1.4 million a year.

CHAIR: That is an increased outgoing?

Mr WALSH: Yes.

CHAIR: The other question that came up earlier was about the 3,200 bed days and whether you pursued that after the Parker report?

Mr WALSH: We pursued that vigorously and in discussions with the department and ourselves we discovered we could go to court but even if we did we were not convinced that we would win the case and we were concerned that we would pour out huge amounts of money to lawyers so we agreed to go down the path of the four-point plan. By negotiations with the department we would arrive at the situation we are at today where we would get equity of funding.

CHAIR: Where you would throw the past out and you look forward to the future?

Mr WALSH: Yes. There comes a time where you have to draw a lie in the sand and move on.

CHAIR: Is it likely that you could go backwards with this arrangement?

Mr WALSH: No, we could not go backwards. An important part of the contract is that despite its faults that people have alluded to today, the one very important part of the contract which has secured the health of this community is that in any contract year we cannot be funded less than the preceding year and that is important.

CHAIR: The next issue was raised by Dr Mark Baker on reclassification of people who are waiting, to reduce the waiting list, without dancing around by fraud.

Mr WALSH: It is an initiative of the department that we write to any person who has been on the waiting list—and we do hear from people who have been on the waiting list for nine months—and we ask them would they be prepared to undergo their surgery with another surgeon in another place and we could give them a guarantee that that surgery would be within six months. People were asked whether they wanted to do that or whether they wanted to remain with their original surgeon. Very few said that they wanted to change.

CHAIR: If they wanted to change what is that the impact on the waiting list?

Mr WALSH: The waiting list would then come down once those people were allocated time.

CHAIR: While they are waiting to be allocated somebody else and be accepted by the other surgeon, are they still counted?

Mr WALSH: Yes, they are still counted.

CHAIR: If they elect to wait, are they still counted?

Mr WALSH: If they elect to wait, if they are not prepared to go to another surgeon within a time frame, then they come off the waiting list.

CHAIR: So if they have been waiting for two years and you say, "Are you prepared to go to Adelaide to have your hip done" and they say "No, I would rather wait for my surgeon", they continue to wait and they stay on the waiting list but they are not counted anymore?

Mr WALSH: They are not ready for the classification.

CHAIR: So you can rapidly reduce your waiting list. They are still on the waiting list but they are not counted.

Mr WALSH: That is right.

CHAIR: Do you keep account of those people who are still on the waiting list who are not counted?

Mr WALSH: Yes, we do.

CHAIR: What would that make your waiting list at the moment?

Mr WALSH: That would not have changed much. It would have come down a little bit.

CHAIR: It is about 3,000.

Mr WALSH: I think it is about 2,600.

CHAIR: So if it suddenly drops to 2,200 I know that you have not done 400 extra operations.

Mr WALSH: I would like you to believe that, but no.

CHAIR: Dr Baker also raised the issue of your writing in a letter stating that "with the ongoing review of the amount of funding we have allocated to orthopaedic surgery and with the amount of trauma and the cost of prosthetics they have been put through the year to date we have not been able to book major joint replacements for the month of June." Is that an initiative of yours or something that happens elsewhere?

Mr WALSH: It is a standard initiative that occurs in every hospital. It is managing public hospitals and managing public contracts. The only way that we can control our throughput and our budget is to reduce elective surgery. We are moving to the next few months fearful of what the winter will be like. If it is a bad winter where we have an increasing number of people coming through our emergency treated with respiratory and cardiac problems and non-surgical then we have no alternative but to restrict elective surgery. We restrict elective surgery for two reasons. One is that we have run out of money and secondly if we have no beds because the hospital is full of medical patients.

CHAIR: We have heard that is increasing from Dr Reed. Mr Clout said he is likely to get some augmentation for the winter. The Minister said he will do this. Will you get your fair share of that?

Mr WALSH: I believe so.

CHAIR: Are you not certain enough to allow the orthopaedic surgery to go ahead?

Mr WALSH: We have not been told any amount of money and it will not come into effect, I believe, until 1 July.

CHAIR: And even when you do get the money you will use it on the winter ills rather than on orthopaedic surgery?

Mr WALSH: That is right, it is competing with the increased volume.

CHAIR: Another issue raised by a couple of people was complaints and how they are dealt with. Some area health service annual reports have a section on that. Do you feed your complaints to the area health service?

Mr WALSH: Yes. They are investigated fully at the hospital by the management of the hospital and the medical staff at the hospital. The report goes to the patient care committee, which comprises representatives of the community board of advice and they have at least three doctors sitting on the board. They are fully investigated and upon completion of that, they are forwarded to the community health forum, which used to be the health council, and from there they go to the regional area board.

CHAIR: From this diagram, it appears that the health council can report directly to the Minister?

Mr WALSH: Yes.

CHAIR: That is the old section 22 committee?

Mr WALSH: No, does the health council report directly to the Minister or to the area health service?

CHAIR: The diagram shows the director, the contract manager, the health council, which can report directly to the Minister.

Mr WALSH: That would be right.

CHAIR: So the council has quite substantial output for the community, not just to the contract manager; they can actually go to the Minister. It is a fairly decent job ahead for those people, isn't it?

Mr WALSH: Yes, quite substantial.

CHAIR: Who appoints them?

Mr WALSH: The health council has changed since this report because the health forum has come into being. They are appointed by the local area health service, I believe.

CHAIR: That is the one that does not exist anymore, is it not?

Mr WALSH: Yes, that is right.

CHAIR: Their appointments ran out and the whole thing folded?

Mr WALSH: Yes, and there was the new community health forum.

CHAIR: How will that fit in?

Mr WALSH: They will report directly to the Mid North Coast Area Health Service Board.

CHAIR: They will go directly to the contract manager?

Mr WALSH: Yes.

CHAIR: They would not go to the Minister anymore?

Mr WALSH: No, to the area health service board.

CHAIR: They have a way of bypassing you if they are concerned about matters. They can go straight to the Mid North Coast Area Health Service Board?

Mr WALSH: Yes.

CHAIR: What sort of the things are they likely to be able to accomplish in relation to input in helping you get to Mr Clout?

Mr WALSH: The community health service will have an important role to play in determining and helping the area health service board be aware of community needs, that this community needs better access to mental health, renal dialysis, cancer care, palliative care. These are important issues for this community and I believe the community forum will take those issues directly to the area health service and their spokesbody for this community, I believe without bias.

CHAIR: Okay. Having obtained community input, what sort of input can they get from you or what sort of investigative or close look at you can they have to advise the regional area health service on whether or not you are doing a reasonable job?

Mr WALSH: Apart from the commercial-in-confidence financial side, we agreed to be—and I believe we have always been—transparent in all of our activities and are prepared to maintain that.

CHAIR: If somebody is really concerned about what is happening at the hospital, they complain to you and they are not happy, they could actually go to this body?

Mr WALSH: Absolutely.

CHAIR: And if that body did not think you were making a reasonable fist of it, they could take it to the Mid North Coast Area Health Service?

Mr WALSH: Yes.

CHAIR: Do you report on all the complaints you receive—whether it is about the food, untidiness, rude staff, or the failure of people in answering the phones—to the Mid North Coast Area Health Service?

Mr WALSH: Yes, we do. As I said, every complaint that comes to the hospital is registered and investigated. A report is written. It goes to our patient care quality committee and is then forwarded to the health forum and on to the area health service.

CHAIR: In other words, if you have dealt with it, you tell them what you have done. If you have not dealt with it, and if it is a serious complaint such as a nurse being touched up by somebody or other—

Mr WALSH: That has a different reporting mechanism. That would be reported immediately to legal people. There are specific issues in the hospital—misadventures, if you like—that have to be reported to the department immediately within 24 hours of occurrence. For instance, death on an anaesthetic table has to be reported within 24 hours to the department.

The Hon. RON DYER: In regard to a complaint made to the hospital by a member of the public, such as Mrs Hughes who spoke this afternoon, leaving aside the merits of that particular case, what sort of response could she expect to receive?

Mr WALSH: The response in that case was fully investigated. We always advise the people responding that they can go to the Health Complaints Commission [HCC], the independent body set up by the Government. We encourage people to take that option that is available to them because they might think that there may be bias—at least the danger is that people always think it is that we are biased and that we are not objective, or that we are subjective. We encourage them to go to the HCC because that removes our subjectivity.

The Hon. RON DYER: Mrs Hughes indicated that she had received some form of oral response but not a written response. Would that be correct?

Mr WALSH: That is true. Sadly with regard to Mrs Hughes, I am sorry that she still does not feel that the issue has been resolved. An enormous amount of time and effort was spent with Mrs Hughes. I was not aware that the issue had not been resolved to her satisfaction.

CHAIR: Do you have something brief to say?

Ms HUGHES: I would like to ask this. This business of somebody dying on an operating theatre or of somebody having a stroke in an operating theatre and eventually dying, what happens in the hospital? Can Mr Walsh tell me if reporting it to somebody else to get it investigated happened in 1999, or is this something quite new?

Because if it was happening in 1999, I was never offered that. I had to do all the work. I had to go to the Freedom of Information Act.

CHAIR: Was that matter reported to the Coroner?

Ms HUGHES: Nobody did anything for me.

Mr WALSH: I could not tell you off hand.

Ms HUGHES: I was left high and dry, and when my mother was abused there were two witnesses. I was told that it was hospital whispers and nothing had ever been done about it. The only thing that has ever been done—

CHAIR: Mrs Hughes, I will ask Mr Walsh to look at the matter of whether it was reported to the Coroner. If there is any death that followed surgery, that would normally be reported to the Coroner. The Coroner may not wish to inquire into it.

Ms HUGHES: Yes.

CHAIR: But if the Coroner decides not to have an inquiry, that is the Coroner's problem. But the matter should have been referred to the Coroner.

Ms HUGHES: That is what I would like to know.

CHAIR: It may well have been. You do not know whether it has not, do you?

Ms HUGHES: Nobody has told me.

CHAIR: Would you take that up?

Mr BAKER: I will follow that up, Mr Chairman.

Ms HUGHES: Thank you.

The Hon. RON DYER: Regarding the four point plan, Mr Walsh, the second point provides that the Mid North Coast Area Health Service will be given increased authority to manage the contract at a local level for Mayne Health. Is that something that has occurred to date?

Mr WALSH: Yes it has. It is occurring. It is delegated authority.

The Hon. RON DYER: That being the case, has that led to some change in the dynamics of the relationship between the hospital and the agencies of the State Government?

Mr WALSH: Yes, in terms of its positiveness. A very positive working relationship does exist between the department at the area level and the hospital. That is reflected, I believe, in terms of access that staff now have to various committees, involvement in the total area health service and in having input into the development of things that Mr Clout referred to this morning—the strategic plan, the clinical indicators and the quality activities of the region. We now have input into those committees.

The Hon. RON DYER: You see that as positive then?

Mr WALSH: Absolutely.

The Hon. RON DYER: What happened previously?

Mr WALSH: They did not want to know us.

The Hon. RON DYER: Who did not want to know you?

Mr WALSH: The area health service here did not want to know Port Macquarie Base Hospital.

CHAIR: They wanted you to deal with Sydney all the time?

Mr WALSH: They wanted us to deal with Sydney, and Sydney did not want us. They wanted the region to deal with us, so we were very much the meat in the sandwich.

The Hon. RON DYER: There is a dialogue at the local level?

Mr WALSH: Yes.

The Hon. RON DYER: The position has improved in that respect?

Mr WALSH: Absolutely. It is a very positive relationship that we now have with the area health service.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Allegations have been made about the changes in the DRG with regard to the lists. Mark Baker said that he felt that it was known that this happens and that less expensive operations were moved up, even on his lists. Do you have any comment? Do you or does anyone in Mayne change these lists in order to cut costs?

Mr WALSH: There is not a direction from myself or Mayne that we will manipulate the lists for what has been said earlier—financial advantage. The DRG funding component of our current budget this year is a very specific area of funding of DRGs and that is to do a list of work at a very reduced rate for the Government. Within that DRG funding, we endeavour to allocate cases whose costs will be met by that DRG and that is what we do. We endeavour to pick those DRGs, those cases that can be met within the funding made available to us by the department under that specific DRG funding. In terms of what Mark said, it is very true that at times if we know that—and this is up until this year—the prosthetic budget might have been consumed, as it has been, then we will endeavour to fill that list up with minor DRG cases which can be done. That is to ensure that doctors have work.

The important thing is this: we cannot manipulate the waiting list. We cannot manipulate the lists because, at the end of the day, the Government is giving us a certain amount of money to do a certain amount of work and we have always done more work than the Government has paid for at our cost. We cannot control our waiting lists in terms of making people go to the private because it does not matter what happens to the waiting list; the Government is paying us to do a set amount. Historically until about 18 months ago, the Government came to us every year and said, "This is the work you did last year. We want you to do the same amount of work next year." That is how it went on for about four years.

CHAIR: Despite the growth in population?

Mr WALSH: In spite of the growth. There was minimal enhancement funding, but it was minuscule and some of that was in this DRG area in which they funded us at the very low rate to do some extra work. We took it on, in good faith, but now we sit down with the department and every year we work out exactly by the DRG what we endeavour and hopefully will achieve within the year. So it is very much a negotiated activity level. Terry Clout this morning said that that will be signed off by the medical councils, by the chairman of the medical council of the hospital, the hospital and the region. This is our plan for the year and we are held accountable for that plan.

The Hon. RON DYER: Is there anything that you wish to say by way of general response to what Mrs O'Brien was saying this morning?

Mr WALSH: I would like to make a few statements. Thank you for the opportunity.

CHAIR: One of the people who presented to us earlier this morning referred to the Smithtown people. Is it possible for anybody to see the register of complaints that were made, or is it possible for somebody in the area health service to check whether the Smithtown people were on the register? I know there may be possible problems about privacy.

Mr WALSH: Yes.

The Hon. RON DYER: Mr Chairman, I asked a question and Mr Walsh has not had the opportunity of responding.

Mr WALSH: Thank you for the opportunity of responding. Mrs O'Brien made the statement about questioning whether Mayne Health is a right and proper company. That point was also made by people earlier this afternoon. There was a statement that Mayne was fined $7 million. Mayne was fined $6 million in 1995. This was an issue arising out of 1980 and it came out of the trucking business of Mayne. I can find no record of the statement that in December 2001 there was a $280,000 fine. My corporate people know nothing about that. With regard to the claim that there are more cases pending, we are aware that there is only one case which has been going on for approximately four years in Western Australia which is between the AMA and Joondalup Health Campus. I am aware that the AMA has been dealt with by the ACCC and that Mayne Health is vigorously defending our place and our response to that.

With regard to open management, we do have local autonomy, direction and decision making at the hospital. Well and truly before the issues came up in the paper last month, it was recognised by Mayne that particularly in Port Macquarie local autonomy was vital to maintaining decision making and maintaining forward direction at the hospital. Hence I was asked to return here, which I did last year. The Parker review—as I said earlier, there is no guarantee of completion or of winning that one. I think it is important to realise that Port Macquarie Base Hospital in many years has done more activities and more patient throughput than the State Government has paid for. At some times there has been an inability for us to manage the total volume that is coming through and, fortunately well and truly for the community, we have taken on the extra work.

We cannot manipulate the waiting lists. We cannot do that. We cannot redirect people or manipulate waiting lists to complement the activities of the Port Macquarie Private Hospital. It stands as a business unit in its own right. We recognise in the public hospital the right of people to elect to be public or private. In closing, my statement would be that I concur with some of the speakers today. I believe that that we do have in this town a fantastic hospital, fantastic medical staff, great nursing staff and non-clinical staff at the hospital. I believe that each and every one of those people is totally committed to delivering a high standard of care that we have in this town. I know and believe—and the record speaks for itself—that the hospital can hold its head very high. It is regretted that in any facility, any hospital—it does not matter where it is—there are complaints. I can give my assurance to the people who have complained today that we treat complaints seriously with integrity and there have been many changes in the hospital because of complaint investigation.

CHAIR: There is a further question that has been asked of me to ask you. Can you explain a slight dichotomy. You will be able to look after people who are ill over winter if you get more money, but if you got more money you could do more operations. How many beds do you have empty at the moment that could be opened if you were given more money?

Mr WALSH: Fourteen.

CHAIR: In other words, you could deal with the winter illnesses plus do more surgery if you got the money because you could get more staff.

Mr WALSH: Yes.

The Hon. RON DYER: Mr Chairman, how do we know that that is a factual response when we do not have access to the contract?

Mr WALSH: In what area?

The Hon. RON DYER: You say that you could open 14 more beds if you were given the funding. The Committee is not in possession of the details of the funding in the first place, so how are we to be in a position to assess the truth of that response?

Mr WALSH: Mr Clout made it very clear this morning that the allocation of funding is a public record. That information is readily available from him. I am prepared to make that information available to the Committee—the actual funding that is given to us by the area health service.

The Hon. RON DYER: For clinical and hospital services?

Mr WALSH: Yes. I am very happy to make available to the Committee the total funding breakdown.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Full funding details you are happy to make available, but not profit figures. Is that right?

Mr WALSH: Absolutely, yes.

CHAIR: Is it proposed that all pre-prepared meals be sourced from one central location in the future?

Mr WALSH: Absolutely not.

CHAIR: Therefore the second question is not true but I will ask you to answer it. Is it true that this will mean the loss of employment from current kitchen staff?

Mr WALSH: No.

CHAIR: Just as a matter of interest, how many beds did you operate when you first opened?

Mr WALSH: I could not tell you offhand.

CHAIR: Are you operating more beds now than you were then?

Mr WALSH: Yes. It has gone up. We were probably operating about 130 beds in the first year or so.

CHAIR: Including the mental health beds, how many are you operating at the moment?

Mr WALSH: One hundred and sixty-one less 14. That is 147.

CHAIR: So basically you have half a ward closed.

Mr WALSH: Yes.

CHAIR: Is that whole thing ever filled?

Mr WALSH: Sometimes we overflow into it, yes.

Ms MACKAY: Excuse me, those bed figures are wrong. I have the bed figures at home. They were between 100 and 110. There are 161 beds at the hospital. I cannot remember what the old Hastings hospital had but we had a waiting list of 500 then. We have 2,600 now. That was time enough for a new hospital. I do not know what people think now. I make another point. I think this room would be full of people making complaints except that most people have said to me that they are too afraid to make a complaint because they do not have the choice and people seem to think that that counts. If you have one company doing pathology, radiology—

CHAIR: I think you have made that point.

Ms MACKAY: Yes, but with the implications here in this town we do not have a choice. We cannot go to Hurstville, Royal North Shore, wherever. We are stuck with this and they control everything. This is health; this is not groceries. That is really important. You have a choice where you go. We do not.

The Hon. RON DYER: Mr Walsh, one of the more significant points that Mrs O'Brien appeared to be making this morning was that she was querying whether your senior managers at the hospital have sufficient independence to maintain public accountability with the area health service and other State Government bodies. What response would you wish to make to that?

Mr WALSH: We have total autonomy at the hospital to maintain that relationship.

The Hon. RON DYER: Are you saying that your accountability to public agencies is not compromised by your responsibilities within your own corporation?

Mr WALSH: Absolutely not.

(The witness withdrew)

CHAIR: One gentleman did not hear my final call, and he wants to make a comment.

WILLIAM THOMAS BEHAN, Port Macquarie, before the Committee:

Mr BEHAN: My name is William Thomas Behan. I thought this meeting was questions and answers for people who have a gripe with the hospital. I am a veteran affairs patient who went to the local hospital three times. I had an accident. I was taken to the local top hospital, the base hospital, and turned away. I got there at 2 o'clock; I was turned away at 8 o'clock at night and sent home in a taxi to my door. The next morning I rang my local doctor, who sent me back to the private hospital as a patient and I was there for five days. I was insulted by two staff. I will ignore that for the time being. As justice serves me, I had another accident. I blacked out in my own home and fell 15 stairs. I got taken to this hospital once more. I was turned away again, put in a taxi again. Not an ambulance. Three times, four times now. They have never once admitted me into that big one and I would like to know why I was not admitted.

My daughter had to come up from Sydney. She was in charge at the time, 200 staff and personnel officers. She had to nurse her dear old dad. She is 50, my wife is 85. I had that many things wrong with me I was a hospital case. I still would love somebody to tell me why I was turned away. I was told that I could have gone to veteran affairs but I did not. I could have dobbed on the two people who insulted me but I did not. The girl who insulted me, my wife sitting alongside me. I had not used my bowel for five days and I do not have bowel trouble. They decided to work with my wife sitting there. She said, "Hit the button, Dad." So I hit the button. Nothing happened. By the way, the office was just outside my door. Four girls were having a cup of tea when mum has seen them all. None of those girls came to me. Some other girl did, wrestled me to the toilet, cleaned me up and put me back in bed.

When this other big accident happened I told the ambulance drivers, "Don't take me near that private hospital." That is the only person I spoke to about where I wanted to go. Right to this very day I am still suffering with my back, my sternum. I broke this little finger. They never even put it in plaster. I had blood all over my right arm, never cleaned me up. My doctor had to send me for an x-ray by ambulance from my door again. That is the three or four times. I go for the x-ray and they said I cannot get it done for three weeks. My doctor blew his gaffer and they finally did it. When I went in to get the x-rays done on my head they insulted me. They called me an extra special patient. While I was sitting there my bloody head opened up, and I could have had blood clotting. But wait three weeks, they said. I have had my say. I could say a lot more. I have it all written down but I am so uptight about it. I want to know why they would not take William Thomas Behan into that hospital as a patient.

CHAIR: Have you made a complaint to the administration?

Mr BEHAN: You are the only people I have spoken to, other than my mates and friends. I have got a lot of feedback from a lot of other guys who have been in the same boat. It was mentioned to me that because I hold a gold card that bars me from going into the base hospital because the Commonwealth Government is too tight, too slow at paying its bill. Think about it. That is what was told to me.

CHAIR: Have you made a complaint to veteran affairs?

Mr BEHAN: I have not once spoken to veteran affairs about it. What is the point? Is it called self-inflicted? I fell down, I just blanked out. As a matter of fact, Pat Rafter was playing some guy in tennis. I was listening on the radio and I said, "Mum, I've got to go downstairs and see the show." I got to the top of the stairs—and bingo. I know nothing, not a thing. Straight down on my chest.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you suggesting that you were put in the private hospital because you were a veteran and there was a reason, in terms of your insurance status, that you were put in the private hospital rather than the base hospital? Is that the essence of the allegation you are making?

Mr BEHAN: Not for the first time. I had two separate accidents in my own home. The first time I fell off the silly damn table and broke my ribs. That was the time when they picked me up at 2 o'clock, took me to the base hospital and sent me off. Two taxi drivers are involved in this. They had to get me in and out of cars, both cab drivers, and I got their names. If I was a rich man I would take them all to court. But I am not a rich man. I have been a pensioner for 20 years.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Why do you think you were not put in the base hospital but were put in the private hospital?

Mr BEHAN: Not from the base.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Because your own doctor hassled, is that why?

Mr BEHAN: Not from the base, I was not put in hospital at all. The first time I fell I got put in the base by my own doctor, my own GP. A bloke called Dr Sen Gupta, I think he is the guy who looked after me while I was in the private hospital. I never went back to that private hospital on that particular occasion. I have been back on one more occasion to get a cancer taken out of my leg. I am talking about the big one. I reckon I should have gone into the big one the very first time I went near the place. I could not scratch myself. I was absolutely hopeless. How do you like your own mother and daughter holding their father under a shower? That is how it was at my place. Having the gold card did not even get me into the big hospital. Are you from the big hospital?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No. I am just trying to ascertain why you went to the private hospital and got admitted when you did not get admitted to the base hospital.

Mr BEHAN: I will say it slower. I went to the big private hospital by ambulance, 2 o'clock in the day. It was Saturday.

CHAIR: The private hospital does not have an ambulance.

Mr BEHAN: At 8 o'clock at night they put me in a taxi, called it for me and sent me home. The taxi drivers can verify this because they are the guys who helped me in and out, if I want to make a Federal case out of it.

CHAIR: That would have been a decision by the doctor at the hospital.

Mr BEHAN: I did not get back into the private hospital until the Monday morning, when I rang my private doctor and he sent an ambulance for me to take me into the private hospital.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That was his decision, though, not the admitting doctors at Port Macquarie Base Hospital.

Mr BEHAN: No. That was his own. Blind Freddy could see how I was. I was jelly.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So it does not relate to a decision made by Port Macquarie. There are two separate decisions made by two separate people is what I am saying.

Mr BEHAN: Why did Port Macquarie doctors not accept me in there?

CHAIR: That is a good question.

Mr BEHAN: You tell me that one. I was a case, you have no idea. I could not scratch himself. But then I come home. I got a broken hand and broken finger. Never saw the broken finger and never patched it up. I had blood pouring out of my arm. They did not do anything at all for William Thomas Behan. They did nothing for him. I just wanted to air it with somebody. I have not spoken to veteran affairs.

CHAIR: I think it is certainly worthwhile taking up with veteran affairs and also with the hospital.

Mr BEHAN: If they keep on doing this to people, and those people insulted me. I never told you the second bloke. When the girl said to me that I am a bell ringer, because I disturbed them having a couple of tea while my bowel was working, later in the morning we both got sugar. I got sugar, the old bloke is on sugar. He is on needles also. They have been tubbing him every day. I have not been out of bed for five days. This bloke said to me, "Get out and do your own tub." I intervened; I said, "Leave him alone. Can't you help him?" He said, "Get out of here. Get under the shower yourself. This is not an old man's home."

CHAIR: I would like you to take those matters up with the hospital because I am looking forward to my gold card when I am 70 and I want someone to make sure that it is all right for me too.

Mr BEHAN: It has not worked for me.

CHAIR: Let us hope that something can be done.

Mr BEHAN: I am original with a gold card. Mine goes way back to when they first gave them out. Just for the record, I have been in the nut house also. That does not say I am mad. I am not dangerous.

CHAIR: Thank you.

(The Committee adjourned at 3.45 p.m.)