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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON HEALTH AND AGEING

(Roundtable)

Reference: Health funding

WEDNESDAY, 24 AUGUST 2005

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON HEALTH AND AGEING

Wednesday, 24 August 2005

Members: Mr Somlyay *(Chair)*, Ms Hall *(Deputy Chair)*, Mr Cadman, Mrs Elliot, Mrs Elson, Mr Georganas, Mr Johnson, Ms King, Mr Turnbull and Mr Vasta

Members in attendance: Mr Cadman, Ms Hall, Mr Georganas, Ms King, Mr Somlyay and Mr Turnbull

Terms of reference for the inquiry:

To inquire into and report on:

How the Commonwealth government can take a leading role in improving the efficient and effective delivery of highest-quality health care to all Australians.

The Committee shall have reference to the unique characteristics of the Australian health system, particularly its strong mix of public and private funding and service delivery.

The Committee shall give particular consideration to:

a) examining the roles and responsibilities of the different levels of government (including local government) for health and related services;

b) simplifying funding arrangements, and better defining roles and responsibilities, between the different levels of government, with a particular emphasis on hospitals;

c) considering how and whether accountability to the Australian community for the quality and delivery of public hospitals and medical services can be improved;

d) how best to ensure that a strong private health sector can be sustained into the future, based on positive relationships between private health funds, private and public hospitals, medical practitioners, other health professionals and agencies in various levels of government; and

e) while accepting the continuation of the Commonwealth commitment to the 30 per cent and Senior's Private Health Insurance Rebates, and Lifetime Health Cover, identify innovative ways to make private health insurance a still more attractive option to Australians who can afford to take some responsibility for their own health cover.

WITNESSES

Committee met at 9.34 am

BROWN, Mr Greg, Chief Executive Officer, North Shore Private Hospital, Ramsay Health Care

CLARK, Dr Leon Wakefield, President, Australian Private Hospitals Association

COGLIN, Dr Michael Anthony, Chief Medical Officer, Healthscope Ltd

FOLEY, Ms Mary Christine, Catholic Health Australia

GREENMAN, Mr Roger Ernest William, Chief Executive Officer, Cabrini Health

ROFF, Mr Michael, Executive Director, Australian Private Hospitals Association

SALIBA, Mr Lewis, Chief Financial Officer, Cabrini Health

TOBIN, Mr Patrick Dudley, Senior Policy Analyst, Catholic Health Australia

TOEMOE, Mr George, Chief Executive Officer, St Luke's Hospital Complex; Director and Chairman, Finance and Audit Committee, Australian Private Hospitals Association

CHAIR (Mr Somlyay)—I declare open this roundtable public hearing of the House of Representatives Standing Committee on Health and Ageing in its inquiry into health funding. As I said yesterday, you are no doubt aware that COAG, the Council of Australian Governments, at its meeting on 3 June agreed that senior officials would consider ways to improve Australia's health care system. That COAG process included the private hospitals and their relative role in health care. The COAG process is a committee of senior officials and this committee is running this inquiry in parallel with that inquiry because our terms of reference are not dissimilar. We felt that there were parties to the health industry in Australia that will not get a say in the COAG process and it will be strictly limited to the bureaucrats at a Commonwealth and state level. We wanted to make sure that the industry, private and public, also had a voice in that process because I believe there will be major reforms coming out of the COAG process.

Yesterday we had the health funds, the hospitals, the AMA and the anaesthetists talking across the table in this roundtable format. It was informal but structured so we could tease out what each sector of private health felt was important in the running and funding of the private health sector. Today we are concentrating on private hospitals as such, meeting with you as hands-on people responsible for the management and delivery of health care services. You also have to deal with the problems associated with the funding.

The format today will be similar to yesterday's. I invite each of you to make an opening statement and tell us about your organisation or the hospital you represent and then we will open it up for discussion. I want to thank Mr Greg Brown for the opportunity to use these splendid facilities. The committee appreciates the generosity of North Shore Private Hospital. The committee felt that holding a meeting in this context gets away from the sterile atmosphere of Parliament House and gives more of a hands-on feel. I appreciate everybody's participation in this roundtable. Do any of you wish to say anything about the capacity in which you appear?

Ms Foley—I am appearing as a nominee of Catholic Health Australia but the views I express will be my own.

Dr Clark—I am also the Chief Executive Officer of the Sydney Adventist Hospital.

CHAIR—Thank you. I now invite Greg Brown, the CEO of this hospital, to open the discussion and tell us about his hospital.

Mr Brown—Thank you. I am CEO of the North Shore Private Hospital, which is part of the Ramsay Health Care group. In our facility, which some of you will look around later on, we have in total 176 beds. We are collocated with Royal North Shore Hospital and we certainly see ourselves as complementing the services provided in the public sector. We are a comprehensive facility. We provide cardiothoracic and major neurosurgery, 11-bed ICU, eight operating theatres et cetera. We think the collocation complements what we provide in the private sector. We work very closely with Royal North Shore Hospital and the area health service to provide a comprehensive service, and we enjoy a close working relationship. That is all I have to say at this time.

Mr Roff—I am the Executive Director of the Australian Private Hospitals Association. The committee probably heard enough from me yesterday so I will defer to my colleagues at the moment. I am happy to take part in the discussion.

Mr Toemoe—I am the Chief Executive Officer of the St Luke's Hospital Complex, which is a medium sized, not-for-profit charitable and public benevolent institution of 100 beds and four theatres. We also run aged care, self-care and home care. We have no ownership but in the event of a wind-up of the organisation the assets go to the Anglican Church.

We treat about 9,000 patients each year and we employ approximately 100 staff in the hospital. We provide a number of specialty services. These are orthopaedic, mainly in the area of lower joint replacements; ear, nose and throat; sleep studies; gynaecology; plastics; and both inpatient and outpatient rehabilitation as well as injury management. We also provide hand and plastics fellowships, and we are affiliated with the University of New South Wales as a teaching hospital.

I am also here as a representative of the APHA board, representing the not-for-profit large independents. I am Chairman of APHA's Finance and Audit Committee, and I have particular interests in reform, insurance and information technology as it applies to clinical information systems in the health sector. Prior to working in health, I had senior roles and CEO positions in some interesting industries such as mining, manufacturing, high tech, the waterfront and local government, so I sometimes come from a different perspective from some of my colleagues and I do not apologise for that at all.

The key matter I wish to raise that goes to health fund contracting or health fund pressures is the never-ending cost pressures that hospitals, including private hospitals, are facing. These pressures are in five areas: nursing wages, prostheses, workers compensation, medical indemnity insurance, and capital expenditure and replacement requirements. Nursing wages have increased by 18 or 19 per cent in the last 2½ years, with some 15 per cent of that having come in one year. Some other states have had similar cost pressures, while some are lagging—so the pressures for

them are still coming, in some ways. That is not to say that nurses are not worth what they are paid, that they are not worth the money, but cost recovery is the real game. Traditionally, as soon as those costs go up other costs such as superannuation and workers compensation go up as well. We have increasing pressures, particularly in New South Wales with the 14 per cent flow-on from the public sector rise which was recently awarded.

I have mentioned workers compensation, which goes up as much as 30 per cent. So it is on top of that. It goes up not due to any organisation or sector experiences but just because governments are trying to fill what I would call substantial deficit black holes. It is a statutory charge and the only control is a superb OH&S performance—but that does not count for much.

Prostheses have skyrocketed, not only in absolute terms but also in pricing terms. That follows the reform of prostheses by the government some years back. The only result of that, unfortunately, was what the organisations and suppliers have gained in terms of the prices that they charge. Both the hospitals and health funds have been wearing that, and really it comes down to the hospitals. Health funds use the excuse that their expenditure in prostheses has gone up, and so they restrict the amount they will pass on to hospitals in benefits. Hospitals are ending up paying for that as a result.

Indemnity insurance for medical malpractices has skyrocketed, as you know. Our premiums have probably now stabilised, but they are something like 400 to 500 per cent higher than they were some three years ago. There are what I call continued government blockages. The government are not removing some other barriers to reducing premiums, such as joint and several liability, capping and statutory limitations on claims. Those things have been afforded to the doctors but have not been afforded to the private health sector.

I have also mentioned capital. Capital replacement or capital expenditure, whether it is for expansion or new equipment and so on, is also an issue. It is an additional cost in terms of finance and depreciation. That leads me to say—and I am going to talk from both a smaller independent perspective and also an industry perspective—that in my view health funds are the insurers and the underwriters and therefore the risk takers on usage and cost of the products that they sell. But they expect hospitals to take and share the risks via pricing. That is how they do it, and I think that is a ludicrous concept. Examples are if we move to what are called case payments. The hospital wins if we can get people out in shorter time frames; the health funds win if we take longer time frames. But, as soon as something changes in favour of the hospital, the health funds change the rules so they go against hospitals in terms of efficiency and so on.

Health funds acknowledge the cost pressures and have publicly said that they need to pay hospitals to be able to provide the services for their members. That is where the rhetoric stops. Despite repeated and exhaustive justification of costs by hospitals and also increasing provision of efficiencies, increases and rates set by health funds bear no resemblance to our costs or to the rhetoric. For example, they use our cost pressures as justification for their own premium increases, but they do not pass them on. There needs to be a correlation between health fund premium increase justification and what goes to the health sector.

The strategy of negotiation seems to one of attrition and tender, and I would use the word ‘tender’ in inverted commas. The tender ends up being an opportunity to renegotiate. They start at minus 1.5 per cent and slowly go up, and it takes months. Who benefits? The health funds

benefit because they keep the cash that they would have paid out in normal increases. They are not taking into account the financial movements, the costs and the actual money they are keeping. So essentially it is a take it or leave it or scare them approach with significant downsides to hospitals if they go off contract and go into copayments. Copayments is a strategy that people are looking at but, certainly in some smaller private hospitals—this is where I am coming from—there is a substantial downside in going down that path if we get it wrong. Doctors do not want to get involved. They essentially are our customers, and they will go elsewhere. They do not want to get involved in barneys between health funds and hospitals. That is where portability is an important issue, and I believe it was raised yesterday.

What can hospitals do? If we are networked—and St Luke's is lucky in that regard—we can lobby the Prime Minister, the federal minister for health, senior advisers and senior captains of industry. We can go to the top levels of health funds and we can use APHA. All that takes time and also sometimes the right timing. If they do not have those connections, it is extremely difficult for small independents to negotiate with health funds, and I suspect it is probably the same for some of the larger organisations as well. There are very restricted legal avenues, such as the ACCC. The ACCC does not give us much respite at all. The Private Health Insurance Ombudsman liaison is very useful. The advice that he gives is very much appreciated and, I think, very wise.

However, going off contract, as I said, has significant downsides and, in my view, the public and the consumer are the ones who are ultimately affected. If private hospitals cannot get the prices they need to maintain their viability, they are faced with closures, restriction of services and so on. That leads to the public being affected by lack of choice, having to travel further or having to change funds. The public is the meat in the sandwich. In this regard, hospitals are price takers—that is, we are being paid what health funds think it is worth, not what it costs to provide a high-quality service.

Additionally, hospitals are debt collectors for the health funds and we take the brunt of public disquiet if there are any gaps or additional costs. We feel we should be paid by the patients that we provide the service to and they should then claim it from the health funds, who would then have to justify any shortfalls, product flaws and so on. They are the underwriters, not the provider. That is the hospital, and we end up being the bad boy. As far as I am concerned, the private health sector is happy to return to free market forces, which used to be the case before what some people call the Lawrence reforms. I am talking in summary about going from cost pressures to a health funds contracting environment, which is very difficult. There are some ways around that, and we are certainly happy to explore those. It cannot go on the way it is.

CHAIR—It was remiss of me not to introduce the members of the committee. Steve is from Adelaide in South Australia; I am from the Sunshine Coast in Queensland, and I represent some regional private hospitals; Jill is from Newcastle; Catherine is from Ballarat in Victoria; and Malcolm is from the eastern suburbs of Sydney. So we have a fair geographic spread on the committee and we represent a wide range of private hospitals in our electorates.

Dr Clark—Sydney Adventist is the largest private hospital in New South Wales, with 329 registered overnight beds and a total of 425 beds, if you measure it in conventional terms. It treats in excess of 30,000 patients each year and employs in excess of 2,200 staff. We are a not-for-profit hospital owned by the Seventh-day Adventist Church. We are their only facility in

Australia, so we are totally independent. We provide a full range of services, including an accident and emergency department, which sees in excess of 20,000 attendees per year. We have a 24-bed combined ICU-CCU, which is an intensive care and coronary care unit. I will try not to use acronyms.

Ms HALL—Use jargon; that is fine.

Dr Clark—I am a doctor by background, so acronyms are part of the language. In fact, I used to be at Newcastle. I was a specialist there for many years.

Ms HALL—I thought I recognised the name.

Dr Clark—I have been in my role for 14 years and in my current role for four years. Sydney Adventist Hospital is also actively involved in preventive health and overseas aid. We organise teams from across Australia and send them overseas. We do four of those a year. We have been strong in preventive health for the 100 years that we have been in existence. We have a school of nursing, which we fully support. Our total educational program costs us in excess of $2.5 million a year, none of which is funded by the government, although we are now starting to get some funding through HECS, which is a relief and will help us to provide those services better and more comprehensively.

You would be aware that APHA has done a study on education in private hospitals. The contribution of the private sector is very large. Currently, it is not supported by government but there is, I think, significant potential for government to spend money wisely and efficiently in the area of education and training in the private sector. The public sector is struggling. With that, a lot of work is now going to the private sector. You would have seen the information provided in the APHA submission, which gives details of that. The private sector stands ready to be involved in that. I think it is something that should be considered by government as perhaps a more efficient and effective way of providing those resources. We are an affiliated teaching hospital of the University of Sydney. We take medical students and we also have registrars. We are very pleased to be involved in that way, providing a comprehensive service not only to our community but to the wider community as well.

There are a couple of things I wanted to mention. You have the APHA submission and I will not go over those things. There are one of two extra things I would like to mention. One is private patients in public hospital. You would have seen the figures in a recent document showing the disparity between the states. In New South Wales, 11.8 per cent of patients in public hospitals are known to carry insurance, but it is probably significantly higher than that. We believe that is a waste of public money. On the only costings I have, which is what they charge overseas patients, which is supposed to be cost recovery—$1,000 a day—they get about $200 a day. The money comes from the Commonwealth. I do not know where the additional $200 a day goes, but I presume it adds to their own revenue.

I think that is inequitable. There are many ways that the private sector could take the burden from the public sector and relieve a lot of the problems they have—particularly the problems that state governments face because of the publicity surrounding waiting lists for routine surgery. I think there is significant potential for change as far as that is concerned. I am happy to make suggestions around that. We understand the issues and could make suggestions about how that

might change. I will not say any more for the moment because, as I said, most of the things we had to say are in the submission.

CHAIR—Thank you. Mr Toemoe, for the benefit of those who come from out of town, where is St Luke's?

Mr Toemoe—It is in the eastern suburbs of Sydney—not quite in Mr Turnbull's area.

Mr TURNBULL—Just over the border.

Dr Clark—Sydney Adventist Hospital is in Wahroonga, which is a northern suburb of Sydney.

Dr Coglin—In addition to being part of the APHA delegation, I am the Chief Medical Officer for Healthscope Ltd. Healthscope is a publicly listed, for-profit private hospital owner-operator with 33 private hospitals in all states and territories of Australia, with the exception of Western Australia. We will treat 200,000 Australians in our hospitals this year. We employ 10,000 people and the perspective I bring to today's discussions is that of a large for-profit national footprint operator of which there are three—us, Ramsay Health Care and Affinity Health. Those three groups together account for approximately 50 per cent of the private hospital industry in Australia. In addition to bringing that perspective, I have a personal background in both public and private hospital management in rural and metropolitan settings and in both the private sector and public hospital system. So I have a particularly broad overview and am not misled by some of the misconceptions that elements of those sectors have towards each other.

The three specific issues that I have come prepared to discuss today—if that is your wish—relating to your terms of reference are, firstly, the regulatory environment of the private hospital sector and the inconsistencies and regulatory burden on hospital operators that operate across different Australian states. Secondly, there are the opportunities for constructive engagement between the public and private hospital systems. Thirdly, if required, I can comment on the current public liability malpractice litigation environment which forms a considerable part of my role in my company.

CHAIR—Mr Saliba, do you wish to make some opening remarks?

Mr Saliba—I am here with Roger Greenman, the Chief Executive Officer of Cabrini Health, who is probably the more appropriate person to make the opening remarks.

Mr Greenman—Cabrini is located in Melbourne. Our main hospital in Malvern has 450 beds. We have a 50-bed acute hospital in Brighton and we have a 24-bed acute palliative care facility in Prahran, which is close to Malvern and attached to the main hospital, and we have a 90-bed aged care facility. We also have a biomedical engineering company that services a number of public and private hospitals and a linen service that services hospitals as well. In our main hospital, we cover all specialties. We have about 140,000 bed days a year in the main Malvern hospital. We are the biggest public or private provider in Victoria for day chemotherapy services. We have midwifery and all specialties covered.

We also have the Cabrini Institute that covers research and education. We have very comprehensive coverage there. We have a chair in nursing, surgery and oncology, and we are establishing a chair of medicine. We have third-year medical students from Monash and also the Notre Dame University students will be starting in 2007. We have a lot of what we class as outreach services to the community similar to Sydney Adventist and we send teams of people overseas. Through our apostolic planning committees we allocate in the order of $1½ million a year in cash to support other services and charities that we consider worthy. Our staff give their time freely to these services as well.

About 40 per cent of patients at Cabrini are medical patients, particularly as we have an emergency department. In the past private hospitals have come under criticism for cherry picking. If you have an emergency department then you take all comers. It becomes very difficult. Emergency departments are extremely expensive to run. We lose in the order of $2 million a year in direct costs. It is very difficult to move on medical patients. They clog up our beds. I do not think health funds like longer term, chronic, complex patients. It is a very difficult issue.

Technology is also an issue. Advancing technology is difficult to recognise financially and is an ongoing issue for both health funds and hospitals. Also, drug costs are increasing dramatically and I think that is going to be a big issue for the future. Again, health funds are not keen to cover lots of emerging drugs and expect hospitals to cover these under their normal contracts, with some exceptions, and often these drugs cost tens of thousands of dollars.

Ms Foley—I am the chief executive officer of St Vincent's and Mater Health, which is the New South Wales group of services of the larger Sisters of Charity Health Service, and we are an affiliated member of the Catholic Health Care Association. I should say at the outset that, while proudly wearing all those hats and nominated to attend through Catholic Health Australia, my views of course will be my own as a necessity rather than those necessarily of my employer or of CHA.

By way of background, St Vincent's and Mater Health would have annual revenues in excess of $500 million. We have about 900 beds, depending on how you count them. We employ about 6,000 people. Our group includes a major public teaching hospital in St Vincent's. We provide the heart and lung transplant service for New South Wales. We are one of the two centres for unmatched donor, bone marrow transplants. We are the national centre for HIV-AIDS and so on. We also conduct two leading private hospitals—St Vincent's Private Hospital in Darlinghurst and the Mater North Sydney, which is just down the road from here. We also operate two subacute public hospitals—the Sacred Heart Hospice and St Joseph's Hospital Auburn—which provide palliative care, rehabilitation, aged care, psychiatry and those kinds of services.

Through St Joseph's Village we also have Commonwealth funded aged care where teaching and research institutions conduct undergraduate and postgraduate education programs in both public and private sectors. We have affiliated medical research institutes that have spun off from our organisations—the Garvan Institute of Medical Research and the Victor Chang Cardiac Research Institute—as well as our own research activities within our institutions which our doctors undertake as part of their clinical practice. St Vincent's is a major research entity in its own right, but our two private hospitals are also increasing their involvement in teaching and research. We also operate public and private pathology and radiology and we fund a number of

social advocacy and social justice activities as part of our mission. Through our private hospitals we fund the Sisters of Charity Outreach service and the Mercy Foundation, which pursue programs for various groups of disadvantaged people.

My background, like the organisation I am CEO of, straddles experience in both the public sector and the private sector. I have a background in public policy at federal and state levels and have negotiated many a Medicare agreement in past lives. I have spent almost 10 years in the commercial sector and also built private health care businesses and been involved in the whole commercial side of mergers and acquisitions in that regard. My academic interests and published works relate particularly to public and private mix in health care and also comparative health financing systems.

In terms of what I would like to put on the table today—I am obviously happy to follow wherever the committee wants to go on these very important subjects—I would like to raise some of the issues from the patients' point of view. Just as within our organisation we have most of the elements of the Australian health care system—public, private, Commonwealth funded and state funded and so on—and the poor patients have to navigate their way around that system, particularly patients who need chronic and complex care. If you need a single episode it is all right because the system is fairly straightforward, but with an ageing population and the sorts of care that people need—the cancer patient is a very good example—the structure of the Australian health care system presents particular challenges. Unfortunately, while the Australian health care system has many strengths, when it comes to patients who need care coordinated across a number of delivery sites and from a number of different types of health care workers, the system is becoming increasingly fragmented. I think both public and private sector policy and focus struggles to deal with that.

As our CHA submission asserts, I am coming from the position of support for a universal health system, which I suggest is essential to a civilised society. In having that discussion, rather than breaking it down into ideological debate of public versus private it is important to note that all developed countries seek to have universal systems for their populations. Even the United States, while its system has failed quite badly and 40 million or more people are not covered, does not expect individuals to finance their own health care. It endeavours to have a comprehensive system whereby, for those over 65, the federal government takes over, and employers are meant to look after it for individuals younger than 65. Then the Medicaid system is meant to act as a safety net for the others. As we know, that system does not work very well but the United States does not expect individuals to look after their own health care.

In other countries, similarly, it is a varying mix. All citizens are in the risk pool and the financing is through taxation methods, compulsory insurance methods or some combinations of the two. How all of that fits together is what each country struggles with. Each country has very similar issues to address. I think it is far more beneficial, particularly at the patient end, to think about these issues systemically rather than having ideological battles about who gets the private patients, or about whether private health care is better than public and so on.

In Australia the public-private mix in health care has always been a very strong feature of the health system. It has many strengths but now it also presents challenges for patients. I am happy to explore those with the committee if you are interested. The original concept of Medicare, back in 1984, was good at introducing a comprehensive universal system. To simplify it, the situation

of the financing system with regard to GPs was that most GPs bulkbilled, so free primary care was available to most Australian citizens. If you were really crook you went to a public hospital and a comprehensive system with state-of-the-art care, as it was back then, would largely be there for you. Private hospitals were a much smaller sector and were a useful adjunct and safety valve, particularly for elective procedures.

More than 20 years later we have a very different scene with the private hospital sector having grown enormously and providing a much greater proportion of the essential care. But it is still a very limited product and it is mainly geared around—certainly its financing system is geared around—a patient admission, a procedure and a discharge. It is not well geared to any other kind of care.

You have a public system that is expected to be comprehensive but is less and less so. Part of that is due to the pressure of growth in technology versus funding and to the way technology is changing the nature of care so that more and more care is ambulatory—'ambulatory' does not mean something to do with ambulances; its meaning is in the sense of 'walk in, walk out'—including more and more essential care that once upon a time involved a long hospital episode. People can come in the morning and go home in the afternoon for a bone marrow transplant, yet that is one of the most high-tech treatments you can have. There are two designated centres in this state for that treatment. Similarly with cancer care, you only need to be admitted for cancer treatment for something that could kill you. A surgical procedure, chemotherapy or radiotherapy can be done on a walk in, walk out basis.

As care moves in that direction, the poor patient is trying to navigate around it. They might see a specialist in private practice in one specialty, Commonwealth funded through Medicare, and then be referred to another specialist in their rooms, Commonwealth funded through Medicare—probably co-payments in both cases. They might need a hospital admission for a surgery—public and private options. Radiotherapy is a doctor's office service or it might be undergone at a public hospital. In addition—and the cancer patient is a particularly good example—the patient has to make a number of choices about what combination of care they are going to subject themselves to. The system is now not well geared to putting a comprehensive service around that patient as they move between not just public and private but Commonwealth and state funded health care.

So I think some very special structural implications fall from the debate that we are having. It is very timely that this review is taking place. Answers are not easy to find, but if the focus goes to the patient and to the delivery of good care and good outcomes of care then that will lead to a much more productive discussion.

Mr Tobin—Like Michael, Francis and I had a good opportunity yesterday to make our opening remarks, so I will allow for debate to continue.

CHAIR—Today is less structured than yesterday. Four themes were covered yesterday, but today I am going to hand it over to you, as CEOs and people involved in the day-to-day running of private hospitals and hospital systems. The committee is basically looking at funding. How adequate is the present funding model for private hospitals? How can it be improved? How do private hospitals interact with public hospitals? Before I ask for your comments, I will invite my colleagues to put forward any specific areas they want covered.

Ms HALL—I found all of your opening statements very interesting. Ms Foley, your statements about the complexity of the system and our need to be patient focused were particularly interesting, because delivery of health care services is about being able to deliver the services that patients need when they need them and about ensuring that they understand the complexity of the system. I would be very interested to explore that a little further.

I noted the statement about private patients in public hospitals and the ideas about how the system—the interface between the two hospital sectors—can be improved. Constantly underpinning that is the concept of delivering the best services to people when they need them and in the most timely fashion. The costs that are incurred—the cost pressures—within your sector are very important.

Given the fact that we have a skills shortage in the medical profession and the allied health professions, I am also very interested in any ideas you have to address that and any recommendations that you can make to the committee. I am particularly interested in a proactive approach, where you come up with some ideas that we can look at and discuss as a group in order to come out with some good recommendations. We are from different parties here, but I think that everybody on the committee is committed to improving the system. We will have some differences along the way, but overall our aim is to come up with some really good recommendations that the government will take up. I think you have a very important role to play in that. I will leave it at that.

Mr GEORGANAS—I have some general comments. I was very interested in some of the comments that Mr Toemoe made about the spiralling costs of liability and other expenses and how that is adding to the burden of hospitals. I would be very interested to see how we could come up with a solution to assist in ensuring that those costs do not continue to spiral, especially in the liability area, which is becoming a very big burden, I think, for the health industry.

Ms KING—We heard yesterday from the private health insurance industry that it is pretty difficult for them to take seriously hospitals' claims that they are struggling financially unless they actually have access to your books to see the detail of what is happening with your finances. What do you think about that?

Ms Foley—Are they happy to reciprocate?

Dr Clark—Yes, that is the whole thing. They want all of this information, but they are not happy to share their information. They insist that we fulfil certain quality criteria, but they do not have any. There is no form of quality criteria for funds themselves in terms of how they run the business or any other aspect of what they do. This raises another issue that I just wanted to throw into the mix—that is, the issue of nursing quality. A nurse can be out of the system for many years and then suddenly come back in. Doctors cannot do it, but nurses can. They can suddenly be treating patients and be involved in very critical parts of health care. There are some issues around those sorts of things. But, as to sharing information with them, to the extent that we have been willing to do that, it has made no difference. I guess that is the reality. It is a catchcry. I do not think it actually makes any difference.

Ms KING—I will take one of the private hospitals in my area as an example. I know they certainly are making some very strong claims about being under financial pressure. They were

very good and actually took me through their entire financial structure. I have a very small accounting background and, when I looked at their structure, the claims they were making were pretty solid claims. But, in their contract negotiations, the private health insurers were obviously not privy to that information at all. If you are going to continue to go tit-for-tat—we will not show you ours until you show us yours—how are you going to get past that?

Dr Coglin—I have a few comments from the point of view of the for-profit group. Firstly, grossed up, the public companies' financials are on the public record. Secondly, if a health fund came to us with an in-principle agreement to pay us on a cost-plus-margin basis with agreement on what that margin might be, we would happily open our books to them. But, surprisingly, we have never been made an offer like that. So, in my view, their interest in the cost of our inputs is voyeurism and nothing else.

Thirdly—and this analogy is a little crude, I know—if I go into my butcher's shop, all I am interested in is whether I want that product there, whether it is the quality I am seeking, and whether I am prepared to pay his price. If not, I will take my business to the butcher down the road. I have no legitimate interest whatsoever in his wholesale price, what he pays his apprentice or by how much the landlord put his rent up last week. As a purchaser of that product, all of that is of no legitimate interest to me whatsoever.

Ms HALL—I actually wanted the issues that I raised discussed. I was hoping that you might be able to address the issues of cost, the private-public interface, and where the patient is set in the system, given the complexity of the system. Do you have any suggestions to address that? I also wanted some comments on the work force and the skills level within that work force, and any ideas you have to address that. I actually wanted to hear from you, rather than just for me to mention it.

CHAIR—And also how we get over these work force problems. If we put $1 billion on the table today, we would not get one graduate for six or seven years. How critical is the work force situation in the private sector, given that there is so much mobility between the public and private sectors? In what areas are the biggest shortages?

Dr Clark—Speaking as the only private hospital in the country that provides registered nurses, I think there is significant potential. Catholic Health have put their hand up to be involved, and are increasingly involved in that. It involves no capital expenditure by government; all they are doing is paying HECS, which they pay to students in their own institutions. There are great opportunities for government to get value out of the private system, but the issues between the state and the Commonwealth, and the fact that this funding is split, creates a whole range of problems like that.

I am in the electorate of the minister for education, and he is very sympathetic. I have had a number of discussions with him about increasing the number of HECS places that we get. He says there are a whole heap of people that are asking for them that are just opening their doors to anybody who will walk through the door, and the criteria they are using for entry are specious. A lot of these people will never get through. There are issues around perceptions of public and private which create some real barriers.

I just attended a conference which was largely public sector oriented. The lack of acknowledgment by state governments of the existence of the private sector creates major problems in developing any real relationships and synergies between the two. They have no interest in the private sector at all. Every now and then there is an inquiry which stimulates some interest, and because they have been told they have to do this they exhibit interest for a while. The most recent example was only a couple of years ago in New South Wales. That dies after a few months and you hear nothing more about it.

Ms HALL—What do you think can be done to improve that? That is what we want to know.

Dr Clark—I think it is a spin-off from the issue that Mary raised about this split-funding arrangement that there is at the moment. Each is really only interested in their own. One of the advantages the private sector has is that we are generally funded federally. There are significant potentials to do things in the private system and to move forward in some areas which do not exist in the public system because of that divide. Two or three years ago the federal government set up the Private Health Industry Quality and Safety Committee, which was composed of people from across the private sector funds, the AMA and the private hospitals. It has just lost its funding, presumably from a ministerial determination that that should happen. All the momentum that had been generated, through what I think is a significant potential to lead in the area of health care and look at doing things better, has been lost. There is potential there to do it, and I think the private sector can and is willing to become involved in a whole range of things which, at the moment, it is not being used for.

Dr Coglin—My own comment on that is that this problem is far and above most severe in rural Australia. With apologies to members of your committee who come from large provincial areas such as Ballarat, the Gold Coast and so forth, genuine remote and rural Australia—places like Dubbo; Burnie in Tasmania, where we have hospitals; and Gippsland, where I have worked in a past life—feel the full brunt of health work force, particularly medical work force, issues. My personal opinion now is that that will never be rectified unless the Commonwealth allocates access to Medicare benefits—that is, provider numbers—on a geographical specific basis. The idea is that a graduate, whether in general practice or in a recognised speciality, has unfettered opportunity to set up practice in the leafy inner suburbs of Melbourne and Sydney and fully participate in Medicare benefit payments, while in that same community in Omeo, Wycheproof or Wilcannia, people rarely see a specialist and it is a constant struggle to find a well-trained Australian medical graduate. So the opportunity for doctors to practise where they choose and draw on Commonwealth funding to support that practice needs to be fixed.

Mr TURNBULL—Dr Coglin, isn't it surely part of the problem that there is not enough traffic in those remoter areas, so it is essentially an economic decision by the doctor?

Dr Coglin—I do not agree.

Mr TURNBULL—I am asking you the question.

Dr Coglin—My view would be that the income potential of a doctor in Burnie in Tasmania would be at least equal to if not greater than that of his or her counterpart in Glen Iris or Mosman. The issue, though, is lifestyle. It is a far more congenial lifestyle, given the demographic from which health professionals tend to come, that they live in and enjoy the

amenities of capital cities. I am not critical of that at all but in terms of simple earning potential, the number of patients they see and gross practice receipts, it takes weeks to see a doctor in Burnie. It does not take weeks to see my doctor in Hawthorn.

Mr Tobin—When they come in from some of the Catholic rural hospitals, what they most strongly advocate is for training of people who come from those areas to take place locally in those regional areas. Experience has shown—

CHAIR—Give us some examples of the areas.

Mr Tobin—Rockhampton, Townsville and Wagga. Some of those larger towns are growing at the expense of smaller settlements not far away from them, but people from those areas who do their training in those areas are more likely to stay in those areas. The comment that has been made to me, which refers a bit to what Mike said, is that coercive measures are less effective than people often think. Certainly for medical bonds, what has been said to me is that on graduation a lot of people, rather than staying in regional areas, will either pay out the bond or will actually leave the country at the time when bond payment comes. I think we have to be very careful about coercive measures. It is the same with location specific provider numbers. Obviously, politically, the AMA and the other organised medical groups will likely protest strongly, but the other danger that you have to be aware of is that that could actually scare people away from undertaking those specialities if they think that they may have some coercive action taken as to where they can practise.

CHAIR—Are some of these smaller regional hospitals in danger of closing because of work force shortages?

Mr Tobin—It think it is very close. It is very regrettable. We had an example earlier this year—and I know this is about one of the prostheses manufacturer representatives who are here—at a couple of our hospitals that have orthopaedic services in rural Australia. There was a conference put on by a manufacturer in North America. Those hospitals lost the services of their orthopaedic surgeons for a couple of weeks. They had no idea that was going to happen. Those people just left. Basically, in a very large geographic area you lose access to that specialty. That just shows the brittleness of the specialist presence in rural areas.

CHAIR—But that happens in the public sector and the private sector?

Mr Tobin—Yes. But in the private sector, obviously, you are dependent on fat throughputs. If you do not have specialists admitting patients, you have the very high capital expense of maintaining the hospital and the facilities, you are paying additional freight costs and your patient load is hugely variable—even if you have doctors there, but obviously if you do not then you have problems.

Ms HALL—You would have to fly them in and out.

Mr Tobin—That does happen but, again, the people who do that are also spread fairly thinly. That is one of the answers, but it is not the total answer.

Ms HALL—Obviously not.

Dr Coglin—Last year, we operated a public hospital in a private wing in Devonport or Latrobe in northern Tasmania. The sole obstetrician at that hospital at one point was on duty continuously for 46 days and 46 nights. Our ability to recruit even a second obstetrician in Australia to help him carry that burden was zero. There was no interest whatsoever from any Australian trained obstetrician in coming to work in that hospital in that community. I do not need to elaborate on the patient safety ramifications of what I have just put to you, not to mention the occupational health and safety implications for the doctor concerned, being on duty for 46 days.

CHAIR—Was that exacerbated by medical indemnity?

Dr Coglin—No. There were two doctors. A doctor left for normal reasons—he wanted to move elsewhere—and he proved impossible to replace. There was not an opportunity to fly in people. When a woman comes in in labour you cannot fly in an obstetrician to fix it. There was no other alternative provider for 45 minutes in any direction, and certainly obstetric emergencies cannot wait 45 minutes. So that community and that hospital were in crisis. I suspect stories like that could be told all around rural and regional Australia.

Ms HALL—So are there solutions?

Dr Coglin—The only one that I put to you—and I accept the wisdom of Mr Tobin's warnings—is that there has to be some more measured approach to the distribution of the medical work force. I think the problem is more in its distribution than in absolute numbers in most branches of medical practice.

Mr Roff—I want to make a comment in relation to the nursing work force. One of the issues there is the ageing nursing work force. I think the average age is getting close to 50. In the last figures I saw, the average age of a private hospital nurse was slightly older than in the public sector. Going back about two years now, there was a national review of nursing education and training. One of the very concerning findings of that was that a very high proportion—I cannot remember the exact number, but I think it was around 70 per cent—of nursing graduates exited the profession within the first three years after graduation. I think one of the problems there was the expectation gap. Without wanting to open the whole debate about hospital based training versus university based training, one of the things that we have been pushing for is to get trainee nurses into the hospital sooner as part of the training—in their first year at university, they would be spending periods of time within the hospital environment—so that, by the time they graduate, there is not that expectation gap that exists now.

Another proposal—and I am happy to provide the detail on notice to the committee—that we put previously is a scheme of HECS fee relief for nursing graduates so that, once they graduate, they would be entitled to relief from their HECS fees if they worked in a hospital environment, public or private, for a certain period. So, say, after six years working in a hospital, they would have effectively expunged their HECS debt, and that would go a long way towards solving some of this ageing problem and providing an added incentive for the new graduates particularly to stay working within the hospital environment.

About a year ago, when we first costed it, I think it was going to be something like $9 million in the first year and then out to about $16 million in subsequent years. So it is not, in the scheme

of things, a lot of money to look at keeping the new graduates coming through and staying in the hospital system, which is going to be a big problem if it is not addressed in the next couple of years.

CHAIR—What about your capacity to employ doctors—and how does that interact with the demand for doctors in the public sector?

Mr Roff—I might pass over to Mr Toemoe, because there are some barriers to employing doctors in relation to the professional indemnity issues that hospitals face.

Mr Toemoe—Private hospitals generally work with what are called visiting medical officers or accredited medical practitioners, who are their own bosses, so to speak. They are given the facilities of a private hospital, theatres and so on, to carry out their operations. Whilst they are in there, they are the captain of the ship and, therefore, they carry their own insurance—which is another question. But in terms of what we call registrars, visiting or registered medical officers, employed medical officers and so on, they are employed by hospitals normally as a back-up, as part of a quality/safety approach to make the patient feel that they are in a good organisation. It is not an issue for those people to get medical malpractice insurance, because under the employers liability act the employer has to indemnify that employee, so it does not matter whether or not they have medical malpractice liability.

It is medical malpractice insurers, underwriters—and there are only two—that provide medical malpractice insurance in Australia that covers registered or employed medical officers. Both of those are Lloyd's based syndicates. Unless you have got that cover for employed medical officers, you take a substantial risk in employing them. Other professional indemnity insurance companies will cover nurses and other staff but they will not cover doctors. So there is a gap there if you do not take out this indemnity insurance, and that is where the indemnity premiums have been driven up to a major extent. Just because the title 'doctor' sits there, the medical malpractice insurers say, 'They're the ones who get all the claims, they're the ones who put us at risk; therefore, we will put a substantial premium on their insurance.' That is a major barrier. As I said before, unless the joint and civil liability is removed to some extent—which does not apply to registered medical officers—caps and so on and statutes of limitations are going to be a perennial problem.

CHAIR—But how as a private hospital do you pay for that—out of the money that you receive from the contracts with the health funds?

Mr Toemoe—Yes, it is a recurring expenditure.

Ms HALL—And you are in a different situation, aren't you, to the public hospitals?

Mr Toemoe—Doctors employed in the public sector have full indemnity.

Mr GEORGANAS—You may not want to answer this—and that is fine; I can understand—but in the last few years what would be the average number of indemnity claims made against the hospital?

Mr Toemoe—In my hospital or generally?

Mr GEORGANAS—Generally, what would the average per hospital be?

Mr Toemoe—I think I have been on the record as saying 'virtually nil'.

Mr GEORGANAS—So you have a good record.

Mr Toemoe—An excellent record, and the record sort of comes into it, but there have been some major claims. The major one was a $14 million obstetrics claim, which I think is under appeal; there has been one like that. There has been a $7 million one—I think that was obstetrics again. So there have been some fairly major claims, but there are a number of claims sitting around probably the $100,000 to $200,000 mark.

Dr Clark—There are a number of outstanding issues here that really have not been resolved. One is the blue-sky scheme introduced by the Howard government to indemnify doctors in the future against claims of over $20 million, if they have insurance up to $20 million. In private hospitals, that does not apply; it applies in public hospitals. So, what Mr Toemoe was referring to is an extra burden the private system has. In addition, we have to insure them whether or not they have got insurance, so often they are carrying double insurance. Despite the fact that they have got insurance, we have to insure them as well, but they are not eligible for the blue sky cover in private hospitals. For some reason the legislation has not encompassed that, so to give them that is a very expensive exercise. They do not want to be employed under that because they do not want to cover off on it—we do not want to cover off on it! Ultimately, we carry the liability, but it is a risk that we carry because we cannot get that sort of insurance.

Mr CADMAN—Which specialists will be affected?

Dr Clark—All specialties.

CHAIR—But these are employed specialists?

Dr Clark—No, these are visiting medical officers.

CHAIR—But they carry their own insurance.

Dr Clark—They carry their own insurance. Sorry, it is largely employed specialists. We have to insure employed specialists. But we cannot offer them blue-sky cover, so we are at a significant disadvantage. If we have got a radiologist who, for example, thinks he might work in the private sector, we are exposed on his behalf beyond the $20 million. Of course, he might say, 'You might not be here tomorrow.' So it makes it very difficult to employ these sorts of people, because they get more security in the public system. It makes no sense.

Ms HALL—And the public system is underwritten by the state government?

Dr Clark—For their insurance, up to the $20 million, but the Commonwealth government covers the blue-sky above the $20 million. It is an anachronism in the legislation that needs to be looked at. Another thing that is an anachronism in the current situation is the issue of the Bolam principle, whereby the standards by which doctors are judged in the courts are different from those by which they are judged in hospitals. So in a particular situation, for example, a doctor

may not be liable but, if the hospital's part of the claim is more than 10 per cent, as I understand it, and the doctor is not liable but the hospital is, the hospital has to pay the lot. We have made submissions to various people within the federal government to see if they can do something about that, but there seems to be no willingness to do it. Michael would know more about the sort of response that we have had to that. It is an anachronistic situation.

CHAIR—What percentage of your costs are medical indemnity insurance? Is it significant?

Dr Clark—I can only speak for our costs. Our professional indemnity insurance in a hospital with a total revenue of $150 million is around $1.5 million. It is more than that because we have to pay the first $250,000 of any ordinary claim and $500,000 on a maternity claim.

Mr GEORGANAS—Do you receive a blanket cover that will cover individual doctors, or are you insuring individual registrars, or is it a blanket cover for your doctors that are employed by the hospital?

Dr Clark—As Mr Toemoe says, if you want to cover your doctors it costs you a lot more money, but you are only covered to the extent that you take out insurance for a certain amount—say, $20 million.

Mr GEORGANAS—But you do not have to individually insure each doctor that comes into the hospital?

Dr Clark—We have to notify the insurance company about every doctor that we have. They want to know about them every three months; we have to send that information in every three months.

Mr Toemoe—To further answer the question, in terms of percentage, it depends on the level of cover and so on, but different hospitals have got different premiums in terms of medical malpractice. In my case it is closer to five per cent of the cost. If I mentioned it went up by 500 per cent over three years, it was at one per cent. So a four per cent erosion in margin or, should I say, lack of margin, is a substantial reduction in terms of your other costs.

Could I also add a bit to what Michael was talking about on nursing. I only want to focus on the nursing work force because that is the only area I have got any knowledge of. If I have got the numbers right, something like 40,000 registered nurses in Australia are not working as registered nurses. We have a shortage of 4,000, so we need to get 10 per cent of those people back—forgetting for the moment the ones that need to come through the graduation stream, which I think has already been covered to some extent. How do we get those back and so on? A fair day's pay for a fair day's work is probably retaining nurses, but it is not bringing nurses back. The nurses association is on record as also saying that it is a case of working conditions, working conditions, working conditions. So that is where the focus needs to be.

Putting aside the differing interface between public and private for the moment, there are some innovative ways that we use, and other people might use, to retain nurses as well as to attract them. For instance, at St Luke's the age of our nurses is lower than the average—that is in the hospital; I would not say that it is the same in the aged care business. How do we do it? We do it by working together with the nurses on things like setting up a pool of casuals and rostering

according to their needs as well as our needs, and working with doctors in that regard. I will give you an example: we have budding actresses who are also working as nurses. We can mix and match the rosters according to their requirements, so they are happy and we are happy. It is the same for people who have children and so on. We provide nurses with additional training on the job that is specific to the work they are doing, more specific to the things that are relevant to them and relevant to us. We also make sure that we do not—and I hate to use these sorts of words—kill them on the job. That means making a culture that is not a blame culture, a culture that is empathetic and which has a fair day's pay for a fair day's work. We work them hard without being over the top.

The other part of it involves IT. I mentioned that I have a strong interest in IT for clinical information systems. The electronic patient record and those sorts of things, which are also part of the HealthConnect initiatives, will also assist in better productivity and better use of nurses. There have been surveys done. Instead of a nurse having to walk an average of 14 kilometres per shift—which is good for their fitness but I am not sure what else it is good for—looking for pathology results, X-ray results, medical records, discharge notes, allergy data, where the patient's drugs are and what sort of therapy they might need as they come out of the acute episode, electronic patient records and the ability to access them immediately is another way of substantially improving their productivity. The information is ready and there for them, so instead of walking they are by the bedside, providing patient care.

This also reduces the risks associated with forgetting to give patients their pills, forgetting to give therapies or forgetting to measure vital signs or whatever. All of those things work to give better productivity and reduce the risks, as well as reducing the stress on the nurses. These are the sorts of things that are available and being looked at, and they are what we are doing to minimise nursing shortages. If those sorts of things come in, that will help to retain and attract nurses.

CHAIR—How would you compare nurses in the private sector with those in the public hospital sector?

Mr Toemoe—In terms of pay?

CHAIR—Not so much in pay but in how many patients nurses in the private hospitals would look after compared with public hospitals.

Mr Toemoe—I do not know if I can answer that. I could take a guess.

CHAIR—You would expect productivity to be higher in the private sector.

Ms Foley—I would like to comment on that. Having both sorts of hospitals within our organisation I do not really detect any difference. It is just that public and private hospitals are very different products. The jobs that nurses do in the wards are very similar, but in other aspects of care such as running emergency departments—St Vincent's Public Hospital would have 500,000 outpatient clinic attendances, there is community health nursing and so on so it is much wider. The director of nursing in a large public hospital has a quite different span of control and nature of work than, say, the director of nursing in a private hospital.

In a public hospital, especially a larger public hospital, you have a large employed medical infrastructure; whereas private hospitals do not because the senior medical staff are all visiting medical staff, and the in-house nursing staff provide much more of the clinical infrastructure and management control. So they are different. You will get nurses who prefer to be in public and nurses who prefer to be in private, but I do not detect differences. The level of nursing to the patient in both kinds of institutions, from my experience, relates to measuring the needs of the patient.

As I am sure the committee is aware, there is a worldwide shortage of nurses. It is a huge structural problem and not easily addressed. I think all of us, whether we work for public or private hospitals, have done everything we can think of. In the private sector you have more flexibility and in the public sector you have to act within the rules of the state system. We have done everything from paying HECS to granting flexible hours and support for education. But what you are doing is trying to shore up a situation where there is a fundamental structural problem. We can count the number of nurses, now and moving forward, from the intakes into the various nursing programs around the country and know that they will not fill all the nursing positions that we know we have, public or private. Ultimately, the structural solutions probably lie in major shifts in the work force. It is already happening and hospitals in this country—public and private—have had to lead the way with, I think, the tertiary education sector lagging behind.

In the seventies, when nursing went from hospital training—a sort of trade based approach—into universities, it also went with a philosophy that the RN—the registered nurse—does everything for the patient, from the most menial and intimate care through to the most high tech. In this system each RN has a number of patients allocated to her or his care. So university education and that model went hand in hand. What we have had to do as delivery institutions—and this has happened worldwide—in the face of nursing shortages is to develop a stratified nursing work force. You now have registered nurses, assistants in nursing and enrolled nurses. In fact hospitals, public and private, have had to engage in their own programs for developing assistants in nursing and enrolled nursing to get sufficient coverage for their hospitals.

I think universities are slowly shifting their approach to thinking about the nursing task. What we are finding worldwide is that there is now a shift. There is the development of the nursing practitioner at the high end of nursing and you have got other categories of nursing care developing. This is occurring similarly in allied health, where there are also great shortages, in physiotherapy and radiotherapy and so on. There has to be some significant structural adjustment and it probably impacts on the education system and the structure of education of the health professions, which has tended to be siloed, with each progression going through its own stream and coming into the health delivery end of the system.

There are no easy solutions. In our own organisation we had a nursing task force, which I chaired, involving doctors from public and private hospitals and nurses both in leadership and from the coalface, public and private. All of our institutions individually had done everything they could in terms of attracting, retaining and recruiting nurses. But the directors of nursing said to us that there has to be a whole-of-organisation response. Frankly, nursing is a tough task and you cannot roster everybody on the advantageous morning shift or afternoon shift or to fit in with school hours or whatever.

CHAIR—How does agency nursing fit in?

Ms Foley—Agency nursing fits in as an attempt by nurses themselves to have more autonomy and control over their time. If they are with an agency they can say, 'I can only work Mondays' or 'I can only do this or that.' That is the attraction of agency nursing.

Ms HALL—A number of nurses have said to me that it is very difficult for them to get a permanent job with a hospital—be it public or private. They are put on contract after contract and therefore they do not have any security of employment. Would you like to comment on that?

Ms Foley—I can only comment from the perspective of the institutions for which I am responsible, but I find that surprising because our whole thrust has been to reduce our agency nursing. For one thing, it is high cost but even more importantly there is a quality issue in that you need nurses and staff that are geared to your systems and processes and so on, so if you have got people—

Ms HALL—Not necessarily through the nursing agencies; I am talking about offering direct contracts to nurses as opposed to employing them and offering them permanent jobs.

Ms Foley—As I was saying, we have permanent vacancies which we fill by agency. Our whole thrust is how to fill them permanently. We are also looking at whether we can have our own agency or pools for those nurses who prefer to work that way, to opt in and opt out as it suits them, so that we have a permanent work force that is our work force and does not depend on whoever the agency can provide on that shift on that day. There may well be those issues for smaller institutions where they may need, particularly in the private sector, to maintain the flexibility of the total numbers of their nursing work force to match the ups and downs of their patient numbers. We do not have that problem with our private institutions, because they are full—they are bursting. We are always trying to recruit a permanent nursing work force.

Mr Greenman—On the issue of the contract business, my advice is that, if you have a contract with a staff member that you roll on and renew, it then virtually becomes permanent employment, so the word 'contract' is a bit of a misnomer. We certainly never use them in that way. If you can get a nurse on a contract as a permanent, you take them, because they are a rare breed.

Ms Foley—Exactly. Some of the other things we are looking at structurally include developing a different relationship with universities. We are actually developing a program with the University of Tasmania and the University of Notre Dame for jointly badged, jointly conducted nursing education programs. In the University of Tasmania's case that is an accelerated program where you fit three years into two. Part of our thinking there is to have, from our own organisation's point of view, a greater influence over the development of those nurses, to develop a sense of alma mater with particular institutions and to start to reshape the status of the nursing profession.

The issues are that it is hard work and the hours are inevitably not attractive. The dollars now with the pay increases are actually very attractive. If you look at the comparative rates of pay for graduates, nursing does very well against accountancy and a whole lot of other graduate rates of pay, but when you look at the status of the profession, your ability to exercise professional autonomy, how you are seen vis-a-vis other health professions within the institutional context and some of those cultural historic elements which are still very strong, quite frankly women

have other choices and they are taking them. So there is a fundamental structural problem that is not easy to address.

I suspect the long-term answer probably lies in nursing as a highly educated profession moving further up the scale professionally and in having categories of other health professionals at other levels and more of a breakdown of some of the boundaries between the different professional groups. In a number of places—the United Kingdom, for instance—there is a major thrust both in the university sector and in the National Health Service about the shape and the look of health professional education, getting much more of a multiskilling focus, more shared programs between the health professions in the education mode and things like that. I think some of the longer term answers rest in some of those things. It is also a worldwide market.

Mr TURNBULL—I have one question on nursing and then I want to move to the Commonwealth-state issue. In your experience, are hospitals taking steps to make their workplaces more family friendly? Obviously a lot of nurses are mothers—and indeed fathers, no doubt. To what extent are you taking steps to enable nurses with family responsibilities to better the work-family balance.

Ms Foley—All the time. But the issue in the end is that you do have to fully staff a 24-hour roster. If you look at the staffing profiles on a shift in a ward in any hospital, public or private, you are going to find a whole array of different individual arrangements with different individuals as to their hours and so on. Ultimately, you have to cover the 24-hour shift. Not only that, but you have to get the right skill mix within each shift, so you cannot have a whole series of junior workers or a whole lot of agency workers; otherwise you start to put quality at risk. So steps are being taken to the extent possible, but there is a fundamental contradiction between getting home for the kids in the evening or looking after an elderly parent—with the ageing profile of nurses, we found elder care was as much an issue as child care—and getting those hours to be flexible. As I say, the nature of health care delivery is such that it is a 24-hour operation.

Mr TURNBULL—Let us go to the Commonwealth then. I do not want to pick on you, Ms Foley, in comparison to everyone else but you have recommended, as have a lot of people:

That the Commonwealth should assume financial responsibility for all publicly sourced health funding—

but you say—

(but not for the ownership of public hospitals, or the delivery of public hospital services) ...

What I am interested in—and perhaps everyone could comment on this—is: in your ideal world, what would the Commonwealth pay for? And if that involved the Commonwealth covering the cost of all publicly sourced health funding, what, if any, should be the continuing role for state governments? If they are not paying the piper, why would they call the tune or any part of it?

Ms Foley—If I could just make a point of clarification, that position is in the CHA submission. I think I am inclined in that direction personally and I have certainly argued, in academic papers I have written, about the problems produced by the split levels of health care

delivery, which all go back to how the Constitution is structured. I would like to put that on the record.

Mr TURNBULL—What have you put on the record? Are you saying that you disown it or agree with it?

Ms Foley—It is not that simple. I think—this is my personal view; it is not the CHA view and it is not necessarily my employer's view—there are elements where the Commonwealth could become involved, because it already is involved. To give you an example, I go back to one of my earlier statements. Once upon a time, and it is probably only 20 years ago, if you were really crook you were gathered into the bosom of the public hospital system. There were not as many treatment options then for a start, but it could look after you. That was all looked after by the states. Then the out-of-hospital elements of Medicare were looked after by the Commonwealth, by reimbursement or paying a benefit to patients when they saw a GP or a specialist in their rooms. That also extended to things like pathology and radiology. But back then there was not nearly as much stuff that could be done. Also, if you needed anything serious you tended to end up in hospital as an in-patient. So now a lot of what the Commonwealth is funding is actually important care.

Mr TURNBULL—I do not want to be rude but could someone answer the question that I asked, which was: do you believe that the Commonwealth—that was what your submission said but you have said you are not sure whether you agree with it or not—

Ms HALL—You are mixing the roles. That is Patrick's. It is from Catholic Health.

Mr TURNBULL—All right. If someone could address that question.

Mr Tobin—The reason we put that recommendation in was that where there are multiple funders there are boundaries and at those boundaries there are all sorts of conflicts. In fact, many people have said in the past that there is a whole industry of cost shifting, where state governments have people in their bureaucracies working out how you can shift costs onto the Commonwealth. One example might be discharging people from the public hospital and saying, 'You get your drugs from the pharmacy.' There are holes in the coverage because of that, so I guess what we would like to see is one government entity having responsibility for the operation of the whole system and accountability for making sure it works, and removing those financial disincentives. As to the actual provision of services, obviously state governments have been doing it for a long time and they have expertise. They may well be contracted by the Commonwealth to continue to provide those services. It may well be that, in our vision, the private sector may also play a role in providing services for public patients, running public hospitals—there is that capacity.

We would like to separate the funding and responsibility for delivering to Australians a health system that works from the people who actually provide it. Provision could best be done by a whole range of organisations—public, private, religious, for-profit or whatever—on the basis of who is best placed to do it. Certainly, if one level of government takes over all responsibility you at least get rid of a whole layer of bureaucracy that is devoted to cost shifting; and you remove the holes because, if there is a hole, it is obvious that the Commonwealth or the state or whoever has responsibility has responsibility.

Dr Coglin—The answer to Mr Turnbull's crucially important question is in fact within the hands of the Commonwealth. The Department of Veterans' Affairs has been selectively purchasing hospital services for its clients in both public and private hospitals for five or so years now. That is a competitive process based on price, quality and patient satisfaction. The experience of Veterans' Affairs in purchasing for its clients from both public and private operators will show you the answer. From a provider point of view, private hospitals are very pleased to compete for that work, very pleased to treat veterans and very pleased to do business with DVA.

Mr Toemoe—Earlier I mentioned that I have a great deal of interest in reform. To answer Mr Turnbull's question—and I am only talking about the hospital part of it, not primary, subacute or whatever—let me say at the outset that there is a place for the public sector and I am not denigrating the public sector in any way, shape or form. But I think there are substantial economies of scale and savings to be made in the Australian health sector by changing the way that the responsibilities and so on work. Firstly, in terms of the ageing population, that is administered under the Aged Care Act, a federal act. The states have no role, as far as I can recall, to the extent that New South Wales recently repealed the New South Wales Nursing Homes Act. So that is run, administered and funded by the federal government in terms of accreditation, responsibilities, legislation or whatever. In terms of the state government, Morris Iemma—forgetting about his political alliances—at one stage combined something like 17 area health services into eight and saved $140 million as a result. That is one example of what can happen.

Mr TURNBULL—Is that $140 million in recurrent annual cost?

Mr Toemoe—Yes.

Mr TURNBULL—And that was from eliminating people—salaries?

Mr Toemoe—It was from eliminating salaries, boards—duplication. Mary might tell me something different in a moment. That is one example. My view is that we have duplication—and maybe triplication in some cases. We have state bureaucracies, state boards and state health departments trying to run health. It is funded by the government and there is duplication. I go back to the aged care sector, which has been reduced. There are certainly state offices of the Department of Health and Ageing, but there is no other duplication. Bob Carr himself volunteered—I do not know if there were any conditions attached—to transfer the New South Wales health sector to the Commonwealth. He estimated that it would save something like $5 billion a year if that were done Australia wide. My estimate is in the order of $5 billion to $8 million, and I will go into broadly how that will be managed. Doing that would eliminate duplication. There are a lot of people who are not really delivering health care. They are just bureaucrats. Certainly they are not doing any clinical work or patient care.

I would go one step further. We should not only do that but we should also—and this is why I commented that the public sector is here to stay—look strongly at the private sector possibly helping, and maybe even managing, the public sector. So the public sector would stay but it would be managed by the private sector. The reason I bring that up is that the Productivity Commission some years ago compared the two sectors and indicated that the public sector costs

something like $100 to $150 per patient day more than the private sector, putting aside differences such as emergency departments and so on.

There are potential savings to be made there in terms of management. So there are savings in reducing duplication but also, I think, efficiency savings in how the whole health sector is managed. I believe the private sector is much more efficient and much more productive. There are savings to be made. If you can save $100 per patient a day on something like four million public sector admissions per day, with an average length of stay of four days—and I think it is actually higher than that—you are talking about $2 billion. Eliminate area health services, the state health departments and so on and you will probably get another $2 billion to $3 billion, plus some ongoing things. There is a lot of money there that could then be poured back into the health sector, whether it is for continuing the health rebate or providing more money for nursing or more money for research and development or more money for the PBS or whatever—$5 billion.

Proceedings suspended from 11.11 am to 11.27 am

CHAIR—Is it the wish of the committee that the submission tabled by MBF Australia Ltd be accepted as evidence to the inquiry and authorised for publication? There being no objection, it is so ordered.

Ms KING—Mr Brown, I have a question particularly for you, given we are in your facility. You are co-located with a public hospital. Can you talk a bit about the interactions between the private and the public systems? Are there any examples of programs where you share—share staff or share training and have similar sorts of IT systems? Then maybe we can open that question up to the rest of you to have a discussion about the public-private interaction.

Mr Brown—From our perspective, there are a number of things we share, not only directly from an inpatient service but also support services like radiology and pathology. From both a radiology and pathology perspective, I think there are some very good relationships where staff specialists from North Shore are involved in private practice at North Shore Private, which obviously provides financial incentive for them. It also assists the area health service to attract good people to this campus. We also support financially a lot of training and education programs as well as the North Shore medical research program. Part of the original agreement or arrangement when North Shore Private was established was that we would support that. A lot of registrars assist our specialists in the operating theatre in orthopaedics, neurosurgery and general surgery.

We provide some fellowships and scholarships to residents and registrars. We also have a lot of joint arrangements in relation to education support for nursing staff. A lot of the clinical meetings are held on our site. We have a VMO lounge which we offer. On many occasions the VMOs and the registrars have clinical meetings on our site because of the facilities. These facilities are always available. So there are quite a number of things that we do collectively.

As I said, the other area where we see ourselves as very much complementing the public hospital, particularly if they have a lack of beds and particularly in ICU and those critical areas, is where private patients are sometimes transferred from the public sector to make way for public patients. We see the relationship being very cordial and working very well.

Ms HALL—Is there any way that you think it could work better?

Mr Brown—There are sometimes private patients who are treated in the public hospital for whom it could be appropriate to treat in our hospital directly. There are some who are not. Some obviously come through A&E, and that works very well. They are identified in A&E that they have private health insurance and are transferred directly to us from A&E. In general terms, we believe it works very well. Our biggest issue personally is the availability of beds and theatre capacity, which we are currently looking at addressing—increasing the size of our theatre facilities and bed capacity to address that future growth.

Ms HALL—Are all the theatres in the public hospital used 100 per cent of the time? Is there room for any sort of arrangement in that area?

Mr Brown—It would be difficult for me to comment. I am not sure. I do not really know the answer to that categorically but certainly our theatre facilities are occupied more than 100 per cent and we would have the potential to increase them.

CHAIR—Do your surgeons also operate in the public hospital?

Mr Brown—They do, and I think that is a very good arrangement for us. A lot of the surgeons who are appointed to the public hospital actually have their consulting suites on site, so they work between the two. Basically they can treat their private patients here and their public patients across the road, and see outpatients as well, which I think is a very good arrangement for them and for us.

Mr Tobin—The Catholic sector has a number of co-located facilities as well. One of the comments that is made is that it is a very good system for the doctors in particular because they can work privately plus they are able to stay working in the public sector and do not have to travel. I think it is quite an attractive model for doctors.

CHAIR—Is it going to become a trend?

Mr Brown—I suppose it depends on the physical ability of some of the other hospitals. There are a number of sites already where there are co-locations. I am not sure about the states but certainly in New South Wales a lot of the larger public hospitals have co-locations. From my understanding, they all work very well.

CHAIR—In Queensland, Prince Charles sold off part of their hospital to Holy Spirit, and they operate now as a co-located public and private facility.

Ms HALL—We have got John Hunter and the Newcastle Private, and the consulting rooms there too.

CHAIR—St Vincent's operates like that also in your area.

Mr TURNBULL—It does.

Ms Foley—And has done for 100 years.

CHAIR—That was before my time!

Ms HALL—I think Ballarat has a very good—

Ms KING—The relationship does not always work; it is always difficult.

Dr Coglin—Healthscope has co-locations in seven different states. The variability between the level of cooperation and efficiency across those different states is enormous. You would think that what would make sense somewhere would make sense everywhere. At its best, those cooperative relationships are to be found in Tasmania. At its worst, they are to be found in New South Wales.

Ms KING—Can you tell us a bit more about that? Why does it work in some areas and not in others? Is it about the personalities? Is it about the finances? Is it about patient transfers?

Dr Coglin—Those relationship issues have survived different hospital managements, different health department bureaucrats and different governments of different political persuasions. It strikes me that there is a state of mind, typically driven from the department in each state, which, as I say, survives changes of officials and which governs the relationship of the department—that is, the public hospital sector—with the private sector. That is a very durable mindset. To me, it is a huge missed opportunity. When you can see these models working well—and I can take you to several where, from every perspective, and particularly the patient perspective, whether insured or uninsured, these models make total sense—that shows you what is possible. And then, when you look at the missed opportunities in other places, it is very disappointing.

Mr CADMAN—Dr Clark, are there limitations to this concept from a hospital's point of view?

Dr Clark—No, I think the private sector has risen to the challenge every time these have been raised. It is a matter really of what the current supply is in the area and whether there is a potential for that to happen. North Shore here was previously referred to as the largest private hospital in Sydney. It was over half full of private patients. A co-located hospital of this kind made absolute sense from that point of view. In other areas it is quite different.

Mr CADMAN—What about Westmead? It would help me if you could talk about Westmead. In Westmead, as I understand it, a number of wards closed, and yet there are a number of private hospitals operating in the vicinity of Westmead.

Dr Clark—I think it depends on your philosophy whether it is better to treat private patients in private hospitals or public hospitals. We have a clear view about that, which is not necessarily shared by the department. But there is an increasing realisation in New South Wales, with a change in some of the bureaucracy at the higher level, that it is insanity really to be treating private patients in public hospitals when there is no clinical reason why they need to be there. From a financial point of view, it does not make sense—or even from a care point of view and a choice point of view as well.

Mr CADMAN—Treating private patients in a public hospital?

Dr Clark—Yes.

Mr CADMAN—Isn't there a financial advantage for them to do that?

Dr Clark—It is a strange sort of perverse advantage. We come back to the state-federal relationship. I mentioned this before. The cost of having a patient in a public hospital far exceeds the payment by the funds, which is about $200 a day. So you have some revenue going to the hospital, but the feds are paying for the patient's care at a much higher rate than that, so it is insane.

CHAIR—So you are saying that the cost of care of a private patient in a public hospital is being paid for by the health funds as well as the public sector?

Dr Clark—That is right. There is no net gain to the public sector. There is a net cost.

Ms KING—So you are saying that there is a significant incentive for public hospitals to poach private patients? We talked a bit about that yesterday. Does that happen with your hospital, Mr Brown?

Mr Brown—There would certainly be occasions when private patients are treated in a public hospital.

Ms KING—Yes, and that might be their choice.

Mr Brown—Yes, it might be their choice.

Mr TURNBULL—Could you illustrate that perhaps by comparing the costs and where the money goes and comes from with a private patient in a public hospital and a private patient in a private hospital?

Dr Clark—In a private hospital—

Mr TURNBULL—Say in your hospital.

Dr Clark—if a patient is insured, then the cost of their care in the hospital is fully covered by the health insurance rebate that we get, if they are in the top table. In a public hospital, they get a default benefit—which I think, Russell, is about $250 a day? Mr Schneider informs me that it is $260 a day. That is all the public hospital gets, but of course that is all gain for them.

Ms KING—Yes, because they are also getting the—

Mr GEORGANAS—Where does that $260 come from?

Dr Clark—If they are privately insured, that comes from their health fund.

Mr TURNBULL—So if a public hospital has an uninsured patient and a privately insured patient, there is an extra $260 per diem by providing a bed for the privately insured patient. That is the point.

CHAIR—That is if they declare that they are privately insured.

Dr Clark—Yes. It depends on the philosophy of the health department. The health department here was encouraging that up until a few years ago. I think there are some saner views now prevailing there which say that this does not make sense.

Mr CADMAN—I am sorry; I cannot get that bit. Why doesn't it make sense?

CHAIR—Because there is a shortage of beds in public hospitals.

Dr Clark—There is a shortage of beds, for a start. There are people on waiting lists who cannot get in. These people are occupying those beds in public hospitals when they could be treated in the private sector.

Mr CADMAN—But you are $260 better off.

Dr Clark—The hospital is, but the feds are still paying for the bed.

Mr CADMAN—That does not worry the state one little bit.

Dr Clark—That is right, and this is one of the problems with the federal-state divide.

Mr TURNBULL—I think this leads into what Dr Coglin was saying earlier. I might be mischaracterising what you said, Dr Coglin, but I gathered from your earlier reference to the DVA example that in your ideal world, or in an ideal world, the federal government would pick up the whole cost of public hospitals, in the way the CHA submission and others have suggested, but would contract directly with hospitals for the provision of those services and be indifferent as to who owned the hospital—a church, a state government or a private company—thereby eliminating all of those many layers of bureaucracy that Mr Toemoe was talking about earlier, such as the various health authority boards. The hospitals would be there as independent business units, and they would be contracted by the federal government. Is that what you were talking about?

Dr Coglin—A version of that. The federal government would be the ultimate purchaser. The operator would be state owned and operated public hospitals, competing with private hospitals to the extent that the private hospitals chose to compete. Mr Greenman's hospital might—

Mr CADMAN—That is not good from the Commonwealth's point of view. We are forking out the dough and other people are spending it. There is no direct responsibility in that process. Is that what you are saying?

Dr Coglin—No. The Commonwealth is the ultimate source of funding now, at arm's length through the grants through the states to hospitals. The Commonwealth might say to my hospital: 'We would like to buy 400 cataract procedures. We've looked at the hospitals on the Gold Coast

and we like yours, so could you please do our 400 cataract procedures at an agreed price.' We compete with the Gold Coast public hospital and with competitor private hospitals for those 400 cases, if we choose to. There are requirements on the successful provider around quality, access, waiting times, clinical outcomes—all of those things. The discerning purchaser, the Commonwealth purchasing agency, purchases services for the uninsured community on that model.

CHAIR—Can the state government do that now or not?

Dr Coglin—The state government receives a percentage, maybe 45 per cent of its operating costs of hospitals, through Medicare grants from the Commonwealth.

CHAIR—Yes, but can they use that money to purchase 400 procedures from the private sector?

Dr Coglin—Yes, that model is open to the states now and there are Healthscope hospitals where exactly that happens. For example, in Burnie in Tasmania the state health department, through the local public hospital, purchases all obstetric services from the adjacent private hospital on the co-located site. And it makes sense in Burnie, because there are not enough midwives to have a public unit and a private unit. It would be madness, from the community's point of view, to duplicate that capital investment, so it makes total sense. We are constrained by quality requirements under our contract, and I invite you to test the workability of that contract over the last 10 years with our purchaser, the Tasmanian government. It is a superb model.

Ms KING—Is it easier to do that with a class of patients? DVA is a class of patients, and the Catholic Health Association's submission on over-75s, which we replicated through our Medicare Gold policy, is about exactly that: a class of patients which the Commonwealth would take over. You are saying that is only for the uninsured, so the current system for private insurance and negotiation with the private hospital would stay at the status quo.

Dr Coglin—Correct.

Ms HALL—So what you are effectively advocating is a brokerage model, where people tender, or it is put out, and people advise whether or not they would like to undertake that work. You are talking about a brokerage model for all health services.

Dr Coglin—For in-patient hospitals.

Ms HALL—That is what we are talking about.

Mr Tobin—I would like to clarify. I think we are talking about a couple of different levels. The incremental level would be the selective purchase of a limited range of services or some specified services. That is something we would support and have supported. At a much bigger picture level, we are talking about a much more radical reform of the system whereby the Commonwealth would take responsibility for all of the publicly sourced funding. That is something we would support but, if we cannot have the big picture, which might take a long time for obvious reasons, there is no reason why we cannot go ahead with the smaller picture that is already happening. I guess we just need to be a bit more up front—

CHAIR—That is what I was getting at with my question. Does it work better if the state government does it or the federal government does it? What are the advantages of each?

Mr Tobin—Obviously we can have arguments about which way it would work. If the Commonwealth took over, the advantage would be to have a consistent national approach. There are hospital groups that operate across jurisdictions and find difficulty in having to deal with separate jurisdictions. The Commonwealth also has better financial resources—that has been the case since World War II with income tax and so on.

The advantage of the states doing it is that they actually do operate health services at the moment so they have that local knowledge and they can prioritise according to local conditions. Again, that could be a disadvantage because you might have one state government that is less interested in health services than another state government. For example, if you lived in Albury and Victoria had a higher priority for health you might find a whole lot of people crossing the border. So, on balance, we are attracted to the Commonwealth doing it: a consistent national approach which is well-resourced.

Ms HALL—There was something I wanted to ask way, way back when we were talking about the private patients in public hospitals. There are occasions, though, when private patients need to be in a public hospital—how would you deal with that situation?

Dr Clark—There are clearly clinical reasons in some situations where those services are only provided in that area by the public hospital. The other reason is choice; you have got to maintain choice. That is fundamental to our philosophy and the product that we have.

Mr Roff—Even if there is a requirement for them to be in the public hospital for clinical reasons there is no requirement for them to be there as a private patient. They have the Medicare entitlement.

Dr Coglin—I met a man in Darwin a couple of years ago; we were in the Nightcliff Club, a drinking hole, and he was there in a blue singlet. We started talking and he mentioned that he had to have a hernia operation and that he was going to wait two years for it. I said, 'That's a shame. It is a pity you don't have private health insurance, because you could get it done at Darwin private'—which was our hospital—'next week.' He said, 'But I do have private health insurance.' I said, 'Are you telling me that you have to wait two years for this relatively straightforward procedure?' He said, 'My doctor sent me to surgical outpatients at Royal Darwin Hospital. I took several weeks to get an appointment. I saw a young doctor and he said, "Yes, you need your hernia done and I will put you on the waiting list."' And he thought that was all there was to it.

Not only was that a tragedy for him but it was a tragedy for the Aboriginal patient who was the one after him in the queue, because he was competing for access to the public system by standing in that queue with the Aboriginal patient or the uninsured Australian white patient or anyone else up there who did not have that choice. That was a tragedy for all of them.

Ms HALL—So there is a system flaw.

Dr Coglin—Absolutely.

Ms HALL—Then how would you address that system flaw?

Dr Coglin—One very expedient way would be to encourage the state governments and their public hospital systems to audit people on public hospital waiting lists to find those who actually did have health insurance and to expedite access of those people to specialists in the private sector and in private hospitals—a very simple measure. But for the New South Wales department, for example, that is forgone revenue; that is $200 a day that they will lose, so there is no incentive for them to do that whatsoever.

Ms HALL—That is a good idea. And what about at the doctor level?

Dr Coglin—Again, the surgeon who was ready, willing and able to do the hernia of the man in Darwin had had no contact with him. There was a flaw back there when the GP sent that man to the public outpatient department where his insurance status could have been determined right there and then when he made the appointment, mind you, rather than send him to the surgeon in his rooms.

Ms KING—What would you suggest in relation to doing something about the financial incentive for public hospitals to take on private patients?

Mr Brown—Remove it—take it away.

Dr Clark—Just on that education issue for the general practitioner, if you had more people training in or having exposure to private hospitals during their training, they would understand the system better. I suspect, speaking as a doctor, that that GP had never had any exposure to the private system. That could be remedied and other problems solved by that issue being addressed.

Ms HALL—And it could probably be addressed through their urban division too.

Dr Clark—Sure.

Mr Tobin—I expressed concern about this issue yesterday in terms of Catholic private hospitals. I think we need to be a bit careful about taking away the $200 because there could be a number of unintended consequences.

Ms KING—What would they be?

Mr Tobin—Basically, a patient who has private health insurance can elect to be treated in a public hospital as a private patient. It may be that they just want to get a more comfortable room or choose a doctor. But you may have to be in that public hospital to get a particular treatment. We are concerned that some state governments are aggressively pursuing the treatment of private patients in public hospitals at a time when there are long public waiting lists. We have that concern. There is a financial incentive that underpins that. We should probably look at it, but I think we should be a bit careful about making a unilateral recommendation to withdraw it without working through what the consequences are or may be.

Ms HALL—Mr Greenman and Mr Saliba, you have not spoken a lot. You come from the Victorian perspective and I would be really interested in hearing from you too.

Mr Greenman—The number of private patients in public hospitals is relatively low in Victoria, but it is growing. I agree with Patrick that to take it away unilaterally would cause difficulties. But maybe there could be some sort of limitation on the percentage of patients with private insurance in the public sector so that it is kept to an acceptable level, there is choice in both services and the balance is maintained.

Dr Clark—It is clearly managed differently in different states. There are variations from 11.8 per cent in New South Wales down to about four per cent in some other states.

Mr GEORGANAS—Is there any way of gauging what the total percentage of private patients is? What are the numbers for private patients going into public hospitals? I think it would be good for us to know accurately what amount it is.

Dr Clark—We only know the ones that are declared, in New South Wales anyway.

Mr GEORGANAS—And you are saying that it is about 11 per cent in New South Wales?

Dr Clark—It is 11.8 per cent.

Mr GEORGANAS—And in Victoria it is much lower, you were saying?

Dr Clark—Yes, it is about six per cent.

Mr GEORGANAS—Is there any way we could—

Mr Tobin—It is also published in a Commonwealth publication called *The state of our public hospitals*.

CHAIR—Does anyone have any objection to Russell Schneider coming back to the table so that he can answer those questions?

Ms HALL—Maybe he could submit the figures to the committee.

Mr GEORGANAS—I think it is important to know the exact figures for what is happening or whether we are just talking about the odd occasion in Darwin.

Dr Coglin—Can I suggest that the untold story here, as Dr Clark just mentioned, is not the 11 per cent of people who, at the door of the Royal North Shore public hospital, say, 'I want to come in here and I am a health fund member.' In amongst the other 90-odd per cent of people in there are people who are health fund members who, for a variety of reasons, do not feel the need to declare it. That is the untold story.

Mr GEORGANAS—So we do not know what that number could be?

Dr Coglin—We do not know. All we know about is those who own up to being a health fund member.

Mr GEORGANAS—So it could be as low as 0.01 per cent or as high as—

Dr Coglin—It has to be more than 11 per cent. We already have 11 per cent saying, 'I am a member.' Somewhere above that is another group who are health fund members but who come in as public patients. That is an unknown.

Mr CADMAN—The story I hear most often is that the ones who do make a declaration find themselves being treated exactly the same as a public patient and getting a big bill at the end of the day. Why does that happen?

Mr Roff—I will come to that in a second. Just to clarify that point, the figures that are available—for example, the 11 per cent or whatever it is in New South Wales—

Dr Clark—I have the figures here. It is 11.8 per cent in New South Wales, 11.3 per cent in Tasmania, 8.6 per cent in South Australia, 6.7 per cent in Victoria, 6.5 per cent in Queensland, 5.2 per cent in Western Australia, 5.2 per cent in the ACT and 2.1 per cent in the Northern Territory.

Mr GEORGANAS—In amongst some of those would be people who had no choice but to go to a public hospital because of the procedure.

Mr Clark—Yes, sure.

Mr Roff—Those are people who we know have claimed on their health insurance in a public hospital. So there is the issue that Dr Coglin referred to about our not knowing how many other public patients had private health insurance and could have accessed a private hospital.

Mr CADMAN—The subculture says, 'Never make a declaration; don't tell them.'

Mr Roff—The other issue is that we do not know how many of the 11.8 per cent made a genuine choice and declaration and how many were badgered into it by the health insurance liaison officers that we now find employed in public hospitals. But coming back to Mr Cadman's question—

CHAIR—Can you say that again?

Mr Roff—We know that they employ private health insurance liaison people—they are called various things—to check the people coming through the door to see whether they have health insurance and to try to get them to make that declaration to ensure the hospital gets the revenue. But there is another cost shift to the Commonwealth in this whole exercise, because when they are treated as a private patient in the public hospital, the arrangements for the payment of the medical bill change. It is then picked up by Medicare and by patient gaps, depending on what the hospital charges, whereas that is picked up under the general hospital grant.

CHAIR—And pharmacy.

Mr Roff—Yes. The whole funding arrangement changes once you become a private patient, and some of it is a cost shift to the Commonwealth through the Medicare claim from the doctor.

Mr Tobin—The salary of the doctor has already been paid, so the state government will not save any money; there is just additional money claimed from the health fund. One point I was going to make is that those figures may sound relatively small, but in some regional towns—and Victoria is one case—where there is a private hospital and a public hospital and the public hospital aggressively competes for private patients, that has been causing problems for already stressed private facilities in those regional areas. So behind the figures in some areas it is actually a much bigger issue.

Mr CADMAN—If people go into a public hospital, though, and they are paying insurance, they want to be treated in accordance with what their insurance covers—they have probably been paying it for years. It is not so much that they might not want to be treated as a second-class patient but that they want their own doctor. If they go into the public set-up, with your proposal to contract it out—'Okay, run them in and treat them as public patients'—that is a different deal. They are insured.

Mr Clark—We support your right of choice and that, if you have private health insurance and you want to be a private patient in a public hospital so that you can get choice of doctor and perhaps better accommodation, you have the right to do that.

Mr CADMAN—But often that is not the case, and I do not know whether your model allows for that process. You are saying, 'Why shouldn't we have these contractual arrangements?' But surely insured patients would have to be treated as insured patients, wouldn't they?

Mr Clark—They should be but often they are not; that is the point we are making. It is just a cash cow for the hospital, basically.

CHAIR—I wonder how much impact the 11.7 per cent in New South Wales would have on the cost of health insurance premiums that are being cost shifted. It is a question I have to ask Russell.

Ms Foley—I think it is very little. I think we need to get this into perspective. Different states have different histories of how they have organised and funded their public hospitals throughout the previous century. For instance, the Queensland public system never had private medical practice within the public sector. That has happened only in more recent times. New South Wales and Victoria, particularly New South Wales, traditionally had very strong private medical practice within public hospitals, particularly public teaching hospitals, so that has always been embedded in public hospital incomes.

When Medicare was introduced in 1984 more people dropped their private health insurance and opted to take the choice of being public patients in public hospitals. There was a big drop in the number of private patients in public hospitals in New South Wales, and there has been a steady decline in the number of private patients in public hospitals ever since. A few years ago that number was more like 15 per cent and a few years prior to that it was 20 per cent. While it may cause some issues in some places, as Patrick alluded to, I do not think it is a major structural issue that impacts on the $63 billion worth of health costs and the relative pressures on both public and private hospitals.

The pressure on the private health insurance product means that there is a big increase in the pool of people, with lifetime cover et cetera being introduced, and now you have that pool of people accessing the service, especially with an ageing population, improved technology and greater consumer expectation. You have a fixed pool of members paying their premiums and an ever-increasing demand on those services and that is where the pressure comes for the private health insurance product. The fact that some private patients in public hospitals pay $260 a day is not the critical factor that creates the cost pressures they have to deal with.

CHAIR—The critical factor for us as MPs is that in our electorates people's premiums are going up from eight per cent to 10 per cent a year and, when they have to access what they are paying for, they find that there are large gaps that they have to pay for as well, and I would like to ask why?

Ms Foley—Those gaps are mainly related to what the doctor charges—which is quite separate from the hospital—or it relates to the product itself. If the product has a front-end deductible or if people have opted for a cheaper table then that is where the payments come from. Under contracts with health funds—we have contracts with all the health funds—for the fee that the health fund gives us for their member, we provide everything. So the out-of-pocket components relate to the bits that sit outside the private hospital structure, namely, the doctor and the product itself.

Mr Greenman—More and more bits are starting to sit outside what patients insure for, and I think this will be the issue in the future: expensive technology that the health fund cannot afford to cover and the hospital cannot afford to cover. It is growing and growing. We have the prosthesis table that is coming through very soon that will have gap payments included. Even though people are going to be on a top table, where they think they have 100 per cent cover on the top table, it is a misnomer. They are not fully covered; they are partially covered. Then when we get into these tables with exclusions—

CHAIR—That is a hospital cost?

Mr Greenman—A hospital prosthesis.

CHAIR—As distinct from the doctor's?

Mr Greenman—Yes.

CHAIR—That will not be covered by the contracts between the—

Mr Greenman—Partially and sometimes, depending on what the doctor uses. Pharmaceuticals, the cost of new drugs coming out that are not on the PBS, drugs that are on the PBS that are used for other conditions where they work and yet have not come on can be very expensive. Some of the drugs cost up to $60,000 or $70,000. We have had out-of-pocket costs for drugs for one patient of over $60,000, which we have to cover. We cannot continue to do that. There will be out-of-pocket costs for people with insurance. I do not see how it is avoidable.

CHAIR—What implications does that have for the number of people insured?

Mr Greenman—I think people need to know what they are covered for. Obviously, the insurance product is extremely complex and the variation in tables makes it more complex. If you can get a 'no surprises' type arrangement that people understand—and I doubt that you can—we should strive towards that and I think that is the best we are going to do.

CHAIR—Otherwise, people will go back to the public sector?

Mr Greenman—They could do.

Dr Clark—I will just comment on something that Mary said. In the states that have the lowest percentage of public patients in private hospitals, the rates have been falling. In the states that have the highest percentage, they have been rising, so there are clearly different philosophies. Rates in New South Wales have risen from 10.4 per cent to 11.8 per cent over a five-year period; in Tasmania, from 7.3 per cent to 11.3 per cent; in South Australia, from seven per cent to 8.6 per cent. But if you get down to the bottom, the ACT has gone from 6.9 per cent to 5.2 per cent. So there are clearly different philosophies there driving patients in different directions.

Mr CADMAN—That is very interesting information. Thank you for bringing that accuracy to the table.

Dr Clark—The rates are actually increasing in New South Wales and some of the other states quite significantly.

Mr Tobin—Chair, to answer your question about costs of premiums: one of the problems that hospitals face is that, on the ground, most contracts would be settled for three per cent or less. Three per cent is quite a high outcome for hospitals negotiating contracts and getting increases. When they see premiums going up by eight per cent plus, they get the blame in the public mind—and in the politicians' mind as well—for being responsible for these high increases. So it is not getting to hospitals on a per service basis. There has been a slight increase in volume through the years, but most of the increase is going to increased costs of technology, particularly prostheses and medical services, and particularly for gap cover schemes. A lot of the medical gaps that people faced before 2000 have been filled in to some degree, but it has come at the cost of increased premiums.

The other thing is, obviously premiums are going up at a very high rate. We are concerned about the membership, and we are concerned about the adverse selection impact. At the moment the average age of health insurance members is going up, so I think we need to make some concerted efforts to get a wider range of younger people into health funds. Obviously we have put forward some measures in relation to increasing the levy for high-income earners who do not have private health insurance. We are advocating doubling that. We are also suggesting that, for people who join over the age of 30, the lifetime health cover penalty increase from two per cent a year to three per cent a year—which would be a little more accurate in terms of people's likely claims on funds. But I think we do need to get more low risk people in, otherwise premiums are going to continue to increase at that high rate. We have not yet got to the stage where we were in the 1990s, but it is on the horizon somewhere unless we have a hard look at where we are going.

Mr CADMAN—Could I make the suggestion that you all work very hard to make sure that patients know the gap or no gap? That is really significant.

Dr Clark—We do from the hospital's point of view—

Mr CADMAN—I understand that you do—

Dr Clark—We have no control over the doctors.

Mr CADMAN—Multiple billing drives people nuts. They think they have paid and then another bill arrives, and then another one, and another one, and they do not know what they are up for. I do not know whether there is any way of bringing a cohesive approach to the thing.

CHAIR—We raised that with the AMA yesterday.

Dr Clark—Tony Abbott is very conscious of those, you know from personal experiences, and he is riding that one very hard at the moment. I think we will make some progress on that one. We talked about the state-federal issue. Just to give an example of something which affects all players, other than the federal government. You may or may not be aware that if a patient goes from a hospital to a nursing home, they have to have an assessment. That is called an ACAT assessment. The legislation says that that has to be ratified by another person who is approved to do that. But it has not been administered—at least in our area, it has not happened at all. The federal government has suddenly made a decree that this must happen.

The problem is that there are significant delays in ACAT assessments anyway, and it is much worse in some places than in others. It is much worse in Victoria, for example, than it is in our particular area of Sydney. We are not too badly served, but there can be delays of up to a week before you get an assessment. Now they have added another delay, which they say will be a day. I believe it will be two days at least, on average, that this document will sit in somebody's in-tray before it is looked at and approved. That is costing the funds hugely, it is costing the state governments hugely, and it is costing the private hospitals hugely. The dictum has been made by the federal government and it is no cost to them, except perhaps a few more ACAT assessors—and they do not pay all that anyway—and the cost penalty will be huge. It is against all principles of quality management. You have somebody looking over somebody else's shoulder. In private enterprise, anybody who worked on that business would go out of business. You do it right the first time, and if somebody does not do it right, then you make sure that they know they are not doing it right and fix it. That is a current example, and all players other than the federal department are paying because of that divide.

I have given you just one example. There are lots of things we could give you, but that is a very current one that will cost a lot of money. An extra couple of days for every patient who is having an ACAT assessment at $500 a day in a private hospital or $700 or $800 a day in a public hospital is a lot of money. Somebody should cost it out and take it back to the minister. We will do that because I think they need to know, but whether that will make any difference we do not know.

Ms HALL—I think that is a good issue to raise.

CHAIR—Would you give that to us as a supplementary submission.

Dr Clark—We can do that. We can do it as a joint a submission with the health funds.

CHAIR—Would you include those figures you have been quoting, and we can have it as an exhibit or something.

Dr Clark—Yes. But I have to say that there are lots of examples like that. I do not think it is possible to calculate it because the examples are not all known. The majority of people who would look into it would not know about it.

Mr Toemoe—On that point, there is a fairly simple solution. Nurses in aged care interview a potential resident, and they have the right expertise and they can very quickly determine whether a person is a level 1, 2, 3, 4, 5, 6, 7 or 8. When post-audits are done on ACAT, or on what we call our residential classification scheme audits, most of those classifications stay as they are—on occasions they go slightly upwards and on occasions they go down. What I am saying is that you have the people at the coalface who are the gatekeepers who can readily assess those people, so why not take that assessment as the first-step assessment, and then if you want to you can check it later on? That would certainly be shorter, and would at least eliminate these transitional types of arrangements.

Dr Clark—There is at least one large private hospital in Victoria, and there may be more, who pay their own ACAT assessors. It pays them to do it, because the delays are so long that the cost is huge.

Mr Greenman—We have a full-time gerontologist at our hospital just to get this sort of thing through, to move people through, and it is not only for ACAT assessments but also for the elderly patient who needs to go elsewhere for other therapies. It is very difficult to move the older medical patient in particular. There are all sorts of blockages.

Dr Clark—Then you have the problem of nursing home availability, and, once again, there you have a different jurisdiction. At any one time in our hospital, which has 329 beds, we would have between 30 and 50 patients waiting to go to nursing homes.

Ms HALL—These are people who should be in residential care?

Dr Clark—Yes.

Ms HALL—I hear that it is the same in the public hospital system. There is a large number of people waiting for a nursing home or hostel care.

Dr Clark—Yes, it is a similar percentage. That is something that could be improved with the stroke of a pen. The issue of the supply of nursing home beds is a much bigger and more expensive problem. It needs to be addressed, but the incentives are not right there either.

Ms HALL—Maybe that is one area where, if the Commonwealth had responsibility for the hospitals, it may lead to people being assessed and placed in nursing homes more quickly because the Commonwealth would be bearing the cost as opposed to the states.

Mr Toemoe—At a federal level it is already there; it is called the Department of Health and Ageing.

Mr TURNBULL—As a general rule is it right that most procedures are more cheaply delivered in private hospitals rather than in public hospitals? That seems to be what you are saying.

Dr Clark—There was not any argument about that. It depends on what your basic philosophy is. We have pretty good evidence that it is cheaper in private hospitals. But you will get people who are academics with a particular philosophy who will put up arguments, which I think are quite contorted and based on a wrong premise.

Mr TURNBULL—There is a complexity of procedures and infrastructure and so forth that public hospitals have to provide, which would add to their cost base, that may not be allocated to a given procedure.

Dr Clark—There are specific examples of that, but if you look at the demographic—and this is something that is not well understood but it is in our submission—in both private and public hospitals it is almost identical. In fact, in some age groups over 65 there are more people as a percentage of the total in the private than in the public hospitals.

Mr TURNBULL—I am coming back to Michael Coglin's point about the DVA type of approach. For example, take the Aboriginal gentleman in Darwin that he mentioned who was second in the queue behind the chap you met at the drinking hole. If there was available capacity at your private hospital, why would the Commonwealth not contract, other than for financial reasons? Medicare is the insurer, for all intents and purposes. It is just that he does not contribute directly to his insurance in the way a privately insured person does. Why would the Commonwealth not contract directly if you were a private hospital?

Dr Coglin—Absolutely. Can I share an observation with you which I think you will find interesting. In 1995, Healthscope contracted with the government of South Australia—I am sorry your colleague left at the psychological moment—to manage a public hospital. The bare bones are that the South Australian government retained the asset, and Healthscope managed the facility, employed the staff, paid the bills and was paid by the South Australian government to treat the public patients. That contract was catastrophic, from the point of view of a commercial hospital operator, so this was not our finest hour as a private hospital group.

However, one fascinating sideline of that show was that we demonstrated, particularly in the early years of that contract, that we could treat a public patient in Adelaide without compromising access, quality, clinical outcomes, waiting times or anything you can measure. The cost of our inputs in treating the clientele of the public hospital using a private, for-profit operator's approach to management and cost control was 10 per cent less than was being spent in the other public hospitals of Adelaide under public ownership and management. Just by applying some of the disciplines that we live and die by in the private sector, we have proven that we can run a public hospital 10 per cent cheaper than traditional public hospital management, without compromising the product.

CHAIR—Can I ask Mary to comment on that because she has run both.

Ms Foley—We do run both. They are such different products, but because we are the organisation that we are—we are not the government—we do look at how it can cross-fertilise,

so we have introduced in our public hospital some of the cross-discipline measurements and so on that the private sector uses, particularly around nursing work hours per patient day and things like that, as a way of measuring the nursing inputs. That has been very beneficial in finding savings, and finetuning the allocation of nursing and nursing costs to relate to patient demand.

In terms of our public teaching hospital, using the benchmarks in New South Wales, we have the most acute patients per case at St Vincent's and we are right on the benchmark cost for that level of public hospital, so we manage our costs very well in the public hospital. But the cost structures are different. You have a front end; we are the trauma centre for the CBD. That puts on an enormous pressure, with a very high level of admissions from the emergency department. The stand-by costs you have to have for health personnel to deal with the trauma load coming through is different to operating a hospital where most of your input comes from people booking for a procedure and coming into the hospital when they expect to. They are different.

CHAIR—Can you measure the cost of a hip replacement in one of your hospitals, compared with a private hospital?

Ms Foley—You can do that. It is quite a complex exercise, because the private product does not include the medical cost; that sits separately. The patient pays for it separately and the health fund, to the extent that they have an arrangement with a doctor, pays for some of it and the Commonwealth pays for some of that medical bed. Not all the medical inputs are in the hospital bill. We can tell you exactly what it costs the private hospital to deliver a hip for the hospital, but we do not know what the doctor charges, for example. In the public hospital you meet all the costs. There are no other bits covered from anywhere else, so you can cost the whole lot in there. You can do that exercise—and it will vary.

CHAIR—Mr Greenman, you also run both, don't you?

Mr Greenman—No, we do not. Private.

CHAIR—Sorry.

Mr Roff—There are other issues. Where you are looking at a genuinely public hospital, as opposed to the St Vincent's model, the costs of capital and depreciation, for example, are not transparent in the public sector as opposed to the private. So that does make those sorts of direct cost comparisons difficult. I would just like to use this opportunity to once again call for the refunding by the Commonwealth of the National Hospital Cost Data Collection in relation to the private sector, which will help in this sort of exercise. We did a little bit of work a while back looking at this using some proxies for cost. You would expect this if you looked at comparative efficiency, but that actually found that the private sector, with its much stronger surgical focus—remember we do 56 per cent of all surgery—was more efficient when it came to surgical cases and the public sector was marginally more efficient when it came to medical cases in general on average across the sectors.

I have got some figures here that I have pulled out of a submission that AHIA made to an inquiry on mental health. I am sure that Russell will put in some supplementary information to this committee if I have misinterpreted them. It looked at the average cost per separation for mental diseases and disorders across the public and private sectors. That found that the cost per

separation is approximately 28 per cent lower in the private sector for overnight episodes and around 150 per cent lower for same-day admissions. There are obviously a number of factors that come into play there, but once again it is another indication.

Ms Foley—I cannot let that go by, I am sorry. I wear both hats. But my experience would back up that a private hospital is very geared about doing surgery efficiently. A public hospital, especially with a major trauma function, has to be ready to deal with whatever comes through the door and then manage the booked surgery in its spare capacity. So that is a different exercise. But, in terms of using those numbers, in mental health the private sector does not deal with involuntary mental health patients, for the most part, to the level that the public sector does, and the most disadvantaged, most seriously mentally ill people end up in public mental health care. So I think comparisons between those two sectors are very difficult.

Mr Roff—I did make the point that there were a number of factors coming into it.

CHAIR—We have to wind up shortly. An issue I raised yesterday, and a matter that keeps getting raised in our electorates, the media and our party room, is mental health. We spoke about this yesterday. I wondered if you would quickly give us a view of the role of the private sector in treating mental health patients. We hear this story that because of the lack of facilities at the state level people are finishing up in prisons and jails, whereas they should be getting treatment. Does anyone want to make a quick comment on that?

Dr Coglin—There are 23 specialised psychiatric hospitals in the private sector in Australia—that is, private hospitals that do nothing other than psychiatry. The admission criteria for a public psychiatric unit, which Ms Foley just referred to, are set very high. That is, the public units tend to specialise in acute psychoses, high-level suicide risk, and high levels of disorders which involve risk to the community at large. For the less acutely well, it is extremely difficult to gain access to a public psychiatric facility, notwithstanding the clinical necessity for in-patient care. I am particularly talking about mood disorders, depression, anxiety and eating disorders affecting younger people. The private sector has a major role in catering to that sector of the disease spectrum.

Regrettably, in recent times some health insurers have taken what I would believe to be a discriminatory attitude towards their members who suffer from mental health disorders. I am happy to elaborate on that, but it strikes me that, as with other diseases such as diabetes, congestive cardiac failure and rheumatoid arthritis, many forms of mental illness are incurable. There is no magic bullet or operation or tablet that will make it go away forever, just as with diabetes and the other things I mentioned.

Similarly, the course of those mental illnesses is characterised by periods of wellness punctuated by periods of exacerbation of the disease, just like your heart failure gets out of control. If you are an elderly person with heart failure, you need to go into hospital to get that fixed. Why some health insurers—and I use my words advisedly—regard people with one form of chronic relapsing incurable disease in a way that distinguishes it from how they look at other people with chronic relapsing incurable diseases is inexplicable to me. It certainly, in my view, reflects an underlying prejudice and stigma held towards people with mental illness.

CHAIR—I appreciate that comment.

Ms HALL—Mr Toemoe was going to make a supplementary comment on the nursing work force issue.

Mr Toemoe—One thing that I think should also be mentioned about the nursing work force is what I would call an uneven playing field in terms of attracting nurses from overseas. Australia does try to attract nurses from overseas—such as the backpackers, so to speak, from the UK, Ireland and other places—but there are restrictions in Australia on the length of stay that is available to them, which is 12 months. A further restriction is three months with one particular employer. And how that one employer for three months works is open to conjecture. So there is a 12-month restriction on how long the visas are that they are given—

Mr CADMAN—That is working holiday makers?

Mr Toemoe—Yes, but you can extend that to the others—and the three-month restriction. When our nurses go overseas to the UK, for instance, they get a two-year visa with no restrictions on who they work for and for how long. We are getting ships passing in the night, nurses going back and forth. One way to further attract nurses to Australia is for the immigration department or the federal government or whatever to look at relaxing that rule and making it similar to the others, because some of those nurses want to stay with one employer for more than three months. The dichotomy of it is that if they register with an employer on 1 January and want to work on 1 April, they have blown their three months and never worked. So there are things like that. They may want to stay longer with one organisation, they may want to stay longer in Australia and some of them may even want to stay permanently, which is another issue, but they are very restricted in what is available to them compared to what is available overseas.

CHAIR—The rest of the people here would support that concept?

Ms Foley—Definitely.

CHAIR—There are a myriad of issues that we could talk about but I think we have pretty well covered private health today.

Mr CADMAN—With regard to nurse education, what capacity do you have to influence the direction of medical education or fields within the universities? Are there avenues for discussion? Is there regular exchange?

Dr Clark—I happen to be representing the Australian Private Hospitals Association on a group that is now in discussion that was initiated by Brendan Nelson. I think that will have some impact. But it is not really about work force; it is about training and it is about how they train.

Mr CADMAN—Education.

Dr Clark—It is about education, yes, in medical schools.

Mr CADMAN—I am pleased that that is in place. It seemed rather slow coming in light of some of the comments made earlier.

Dr Coglin—I would like to make one more remark. We mentioned this off the record at the break. The regulatory environment in which private hospitals operate is a state jurisdictional matter. Each state has a governing act and, typically, significant regulations which govern the operations of private hospitals. At one extreme—the Northern Territory—there is a brief act which says that the chief health officer can license a hospital on any conditions he sees fit, full stop. There are no regulations.

CHAIR—What a good law!

Dr Coglin—There are conditions, but they are not onerous. In New South Wales there are hundreds and hundreds of regulatory requirements placed on the operator of a private hospital. One of them says something like: the curtain around your bed shall be at least 450 millimetres above the floor and not more than 1,800 millimetres above the floor and 450 millimetres below the ceiling. There are hundreds more like it.

CHAIR—What is the penalty for the breach?

Dr Coglin—I will not go into that. Suffice it to say that, from the point of view of an operator who is operating across jurisdictions, the efficiency and gain—in the public interest, not in the interests of hospital operators or state bureaucracies—in standardising the regulatory environment in which private hospitals operate, and having it based on the same evidence based approach that leads to quality of hospital care, would be a huge advantage in this industry.

Ms HALL—I think that was raised yesterday. As a committee, we are very keen to look at that. It is a very important issue and one which we really need to address.

CHAIR—Mr Turnbull raised that some time ago with regard to nursing homes in his electorate, where there is a shortage of land for buildings to go upwards rather than outwards. I have a totally different problem on the Sunshine Coast, in Noosa, in trying to convince the local government to zone land in advance for retirement purposes. So we have looked at those areas before.

Dr Clark—And there are different standards for public and private hospitals—surprise, surprise. In public hospitals, if they set certain standards they have to pay for them. In the private system they can just make a regulation and ultimately the client pays.

Ms Foley—I agree that the regulations are very excessive in New South Wales. The height of handbasins have had to be changed on final inspection.

Dr Clark—It is ludicrous.

Dr Coglin—We had an inspector demand that we place a Disney mural on a wall in our hospital in Dubbo, under pain of retribution by the state. These are our taxes at work.

Mr Tobin—On the big picture, we have advocated a rationalisation for funding arrangements but obviously, if the regulations do not follow, you could have at the end of the day the Commonwealth taking responsibility for funding and then each state government having regulations, which costs money. I think we need to align both.

CHAIR—I thank everybody for attending today.

Resolved (on motion by **Ms Hall**):

That this committee authorises publication, including publication on the parliamentary database, of the transcript of the evidence given before it at public hearing this day.

Committee adjourned at 12.32 pm