PUBLIC ACCOUNTS COMMITTEE

DEPARTMENT OF HEALTH — RESPONSE TO AUDITOR GENERAL'S REPORT "OPERATING THEATRE EFFICIENCY"

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
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SESSION TWO

Members

Dr A.D. Buti (Chair)
Mr D.C. Nalder (Deputy Chair)
Mr V.A. Catania
Mr S.A. Millman
Mrs L.M. O'Malley

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Hearing commenced at 10.21 am

Dr DAVID RUSSELL-WEISZ
Director General of Health, Department of Health, examined:

Dr JODI GRAHAM
Medical Adviser, Department of Health, examined:

Mr ROB ANDERSON
Executive Director, Information and System Performance, Department of Health, examined:

The CHAIR: Welcome. Thank you for appearing today to discuss the department's response to the recommendations in audit report 25 of 2015, "Operating Theatre Efficiency". My name is Tony Buti and I am the committee Chairman and member for Armadale. To my left is Dean Nalder, the committee's Deputy Chair and member for Bateman, and to his left is Vince Catania, member for North West Central. To my right is Simon Millman, member for Mount Lawley, and to his right is Mrs Lisa O'Malley, member for Bicton. I would like to advise you that the committee has asked the Acting Deputy Auditor General and officers from the performance audit team to observe today's proceedings from the public gallery, which is behind you. Following the hearing, the committee may consult with the audit team for clarification on matters raised. I would also like to advise that today's hearing will be broadcast live over the Parliament House website. It is important that you understand that any deliberate misleading of this committee may be regarded as a contempt of Parliament. Your evidence is protected by parliamentary privilege; however, this privilege does not apply to anything you might say outside today's proceedings.

Do you have a brief opening statement you would like to make before questions?

Dr RUSSELL-WEISZ: I do, Dr Buti, if I can, just to sort of put it in context in what we have done.

The CHAIR: Yes.

Dr RUSSELL-WEISZ: Thank you very much. I will introduce the team again just to put this into some context. Jodi is also a consultant anaesthetist. She is working at the Department of Health at the moment in relation to the sustainable health review, but was intimately involved in the implementation of the Office of the Auditor General's report as the medical co-director of the surgical division at Sir Charles Gairdner Hospital, together with the theatre efficiency reform program, which I will refer to as TERP as the acronym we have become used to. Rob is the executive director of information and system performance in the Department of Health and oversees the performance management function, which ensures that the health service providers are achieving the level of service specified in service agreements.

Theatre efficiency is a key priority for WA Health for the delivery of safe, high-quality, patient-focused care and to meet value for money and public expectations. In WA, as well as in other states, maintaining efficiency across high-cost, high-utilisation operating theatres presents constant challenges. These include the complexity of theatre measurement for comparable performance, the complexity of scheduling requiring active management of emergency and elective theatre demands, resources required to maintain skills and time required for consistent data collection analysis, and collaboration and facilitation and sharing of innovative practices across different sites and across the nation to improve theatre performance.

The Office of the Auditor General completed an assessment of the theatre efficiency at five public hospitals in WA Health for the delivery of elective surgery from 2009 to 2014. The report highlights the need at that time for improvement in the way that we track, report and manage our operating theatres. Report recommendations included establishing performance monitoring and reporting, which we did not have before; improving ICT functionality; regular review of our schedules in operating theatres; and cross-site sharing of improvement strategies; and guidance and direction to the hospitals. Although WA Health had achieved significant improvements in patient access to surgical services by our WEST performance—or the WA elective surgery performance—and consistently performed well in elective surgery wait times in comparison to other states, we actually welcomed the OAG's report of improving performance monitoring in our theatres, access to patients for our theatres, better data analysis and working across sites.

What we did following the OAG's report, the TERP, or the program, was developed, including clinical services redesign principles. We used the same redesign principles as we did with the four-hour rule. We basically went back to basics to address the OAG's recommendations. We commenced in January 2016 and formally closed the program on 30 June 2017, having actioned each recommendation. If we may, I have got a summary sheet I would be happy to table here showing you which recommendations are complete and which ones are ongoing.

The CHAIR: That would be great, yes.

Dr RUSSELL-WEISZ: The program achieved a number of significant measurable improvements for the system, including the standard theatre efficiency performance monitoring and reporting framework. Now that is actually included in what we call our health service performance report, and we now have emergency surgery urgency categorisations and standardisation of performance indicators, definitions of targets; a new governance structure for surgical applications; and several site improvements, such as the clinical service redesign project at Sir Charles Gairdner Hospital, which Dr Graham can talk about. Program closure was approved with a number of follow-on activities, including further improvements in the technology which would be required, and work has since continued to achieve this since June 2017, partnering with health support services in the development of a practical technology-based solution, collaboration with the clinical excellence division in the Department of Health and other business intelligence units in the health service providers, and we have had a statewide symposium to provide a platform for talented WA Health theatre staff, as well as several interstate guest presenters to share our knowledge and experiences following this whole program. Finally, our next steps will be robust evaluation of what we call the emergency surgery urgency categorisation, and this was implemented in March 2017 and is now part of our performance reporting in January 2018.

A full review is underway also comparing us to other jurisdictions and comparing between the different health service providers; implementation of our emergency and elective booking and scheduling application; and progression of the endorsed proposal for the review of all surgical applications. The OAG led to a very robust program which has had benefits for us. We also should say that since then we have had the new governance changes in health. We have the Health Services Act. The health service providers—now north, south, east, WA country, and child and adolescent—are now responsible for meeting those performance indicators, and they get monitored by the Department of Health. But we also have a facilitation role, and we will learn from one area to another. What they have learnt at Charlie's will go towards Fiona Stanley et cetera. Bodies of work like the TERP or this program were designed to ensure we actually keep working together, and it has actually been a very effective program. Thank you.

The CHAIR: You mentioned about the new operation model with the five operation health service providers and also their governing bodies.

Dr RUSSELL-WEISZ: Yes.

The CHAIR: In regards to the recommendations, particularly 2(b), which talks about "share guidance and information strategies that have improved operating theatre performance at WA public hospitals", I think that becomes even more important now. Can you just talk to us about that and how you are meeting that recommendation?

[10.30 am]

Dr RUSSELL-WEISZ: I will talk a little bit from the department's perspective and then ask maybe Dr Graham to talk about how it has worked between the health service sites. When we put the governance model in place in 2016, we wanted to make sure we got clear roles and responsibilities. From a personal perspective, when I acted in this position in 2012, it was very much grey; everything was run through Royal Street. You cannot run everything through East Perth from Fitzroy Crossing to Fiona Stanley Hospital to Esperance. We have now got boards that are responsible and accountable for the services they deliver, so there are very clear accountabilities resting with those boards. The Department of Health's role is to lead, to steward, to performance manage, to assure and to regulate, but we are also here to facilitate. We are not stepping back and saying, "We've got nothing to do with what the health service providers do." We set down policies, we set down mandatory policies, we have service agreements with the health service providers, and one of our key roles is not to do clinical service provision, but is actually to facilitate, to say that if there is a program such as the four-hour rule, which was about emergency department performance, such as the operating theatre efficiency program—we are now starting on a program of outpatient reform—we will facilitate it; we will work with all the health service providers. We want everybody to succeed because if we succeed, patients get better care. Ultimately, when we do have a framework, it is up to the health services to actually deliver on those frameworks. It is a balance between performance management and facilitation, but we are not separating ourselves that we never cooperate. This was actually a great sign of cooperation.

The CHAIR: With regards to the operating theatre efficiency report, there is a systematic issue and then there is a specific site issue. That is even more so now when you look at the five separate health providers. What I am keen to know about those recommendations, because some are more systematic and some are more site specific, is this sharing of information. If the South Metropolitan Health Service is doing something, how is that information shared with the other providers? We could be looking at operating theatre issues here.

Dr RUSSELL-WEISZ: I will ask Jodi to answer that.

Dr GRAHAM: As part of the performance framework—actually Caitlin has this with her—we have a table that goes out to all the area health services and to the theatre managers, and it compares all the main hospitals in the state that are reporting to this. The beauty of that, and the way it helps us, is to drive the competition between the different area health services. It has kind of turned a light on to what we never saw with the other area health services before.

Mr S.A. MILLMAN: Facilitation is a qualitative exercise; like, how well are we sharing information? Is there some quantitative mechanism that you can apply to say King Edward Memorial Hospital has done a really good job sharing their skills, experience and expertise in this particular area with Fiona Stanley Hospital? Is there some rubric that you can put in place to measure that?

Dr RUSSELL-WEISZ: I think that is a role of the system manager and the department to make sure that, one, we facilitate that. Is there a measure? Do we measure how well hospitals share

qualitatively? I would have to say probably not. But what we did with this, because it was a program first that we ran for 18 months, we had representatives of every health service; every health service provider had skin in the game. Afterwards—Rob can talk about the performance reporting—Rob has performance meetings in his role with each of the chief executives once a month and will go through each of the indicators. What we have seen in other areas, for example—I will not pick the health service—if you look at one area, say in elective surgery performance, in one health service provider, we are saying they have made significant inroads into say urology or plastics. They will each share with us. There is not a formal way of doing that, but we still have a health executive that looks at the key issues that are affecting us. We will take that on notice. I do not know if we could actually measure it. We do not want to lose the fact that WA Health has operated as a family.

Mr S.A. MILLMAN: Do you have a mechanism in place for recognising good performance when people have shared their information?

Mr ANDERSON: Not particularly about when they have shared the information, but when they have good performance, we certainly recognise that. Similarly, when there is poor performance, we certainly raise that. As the director general said, we meet with the CEs and their executive team every month. This information is shared openly between the health services, so it is very transparent and the health services are accountable and they can see what they are doing well and what they are not doing so well. But what I would say is that one of the big advantages of this project was the standardisation of how information was collected and how it was categorised. Previous to this—this was part of the problem—you could not actually measure one health service or one individual site or potentially one surgeon against another because information was collected differently across sites. Now when we do this, it is not just a case of performance management good or bad; it is also a case of highlighting where there is variation. Why that is important is that as a system manager we cannot say, "You're clearly doing something wrong". What we can say is, "This looks different to this and this looks different to that. You tell us what's going on." That gets the clinicians to go away and look at the information and go, "Okay, there's a very good reason for this. A particular cohort of patients—whatever it was—caused these delays or a surgeon was off sick for a particular day or whatever it was." But it gets them looking at it and it gets them talking to each other and sharing the information to understand why they are different from each other.

Mr S.A. MILLMAN: In terms of the consistency of capturing the information, do you get any pushback as a result of the new management structure with different health services saying, "No, we don't have to measure our data in that particular way because we have our own managerial prerogative"?

Mr ANDERSON: No. We basically work on policy frameworks. Anything that sits in those policies is mandatory. Within a performance framework—I have used the wrong word—there is another document which sits off to the side and says, "In this year these are the indicators that we will be measuring you on", but, as we consistently tell them, we can measure them on anything we want. If we were to see something, we can raise it at any time we want. And so we should, because the reality is that we have—I do not know; I am making it up—30 or 40 key performance indicators and a lot of them will get skimmed across because by and large they are good or bad and they are generally good. It is when we start to see things that stick out that do not look right, we can then drill down—we can drill right down to individual sites—and say, "This isn't actually the issue. The issue is somewhere else." Then our analysts will go away and look at other indicators, which are supporting indicators—and we have stacks of those—and we can say, "The problem is actually in this area." So, they never have the ability to pushback and go, "You can't measure us on this." They certainly at times will tell us, "Can you give us a heads up before you bring it up", and we will try to

do that so we can have an informed conversation, but they cannot pushback and go, "No, you can't measure."

The CHAIR: You talk mandatory and non-mandatory—it appears the information is being shared—but specifically looking at the Auditor General's recommendation 2(b), do you mandate sharing of information?

Mr ANDERSON: We facilitate the sharing of information and we provide that information. It is very difficult at the moment to mandate that; that is an operational matter. I think what we have found is that they are sharing more information because they want to perform better.

The CHAIR: Do you provide guidance on how to do it?

Mr ANDERSON: We do. We also provide information so it is out there amongst the health services.

Mr D.C. NALDER: Is that across the five regions that we are talking about?

Dr RUSSELL-WEISZ: That is right.

Mr D.C. NALDER: You mentioned other jurisdictions earlier in your opening statement. Is there work occurring to compare how we are relative on certain measures? I know we are talking about the efficiency of operating theatres today.

Dr RUSSELL-WEISZ: Yes, very much so. Putting operating theatre efficiencies to one side at the moment, WA has led the nation with the four-hour rule, which was very much about emergency department patients being seen within four hours based on that patients do worse if they remain in emergency departments. A lot of the states have given that away but still report it, so we can compare ourselves, and we are still the best performing or the second best performing in the nation.

What probably concerns me the most at the moment is our elective surgery performance. That relates to this but it is more the patients coming on to our waitlist. I can measure at the moment how many patients we do within boundary. I can measure it in comparison with New South Wales and Queensland. I can also measure it between health services.

Mr D.C. NALDER: What do you mean by boundary?

Dr RUSSELL-WEISZ: Basically, elective surgery patients get classified as category 1, 2 or 3. In the public system, if you go to your surgeon, you have a condition, and he or she will make a clinical judgement—this is a category 1.

Mr D.C. NALDER: It is like triage.

[10.40 am]

Dr RUSSELL-WEISZ: Category 1 means you have to be operated on within 30 days; category 2, within 90; category 3 within 360. Category 3 is non-urgent, category 2 is semi-urgent and category 1 is urgent. If you have a major cancer, you would need to be operated on within 30 days.

If you take them altogether, we currently are doing 94 per cent within boundary, within the recommended time. I would love that to be 100 per cent, but if I said that to the health services, they will say to me that if they have a very complex patient who they need four surgeons for, or two or three, and they need to book them, sometimes that falls out of the 30 days. It could be 31 or 32. That is very reasonable because you want them to have safe care. My concern is now that patients are moving from private to public. It has been in the media recently. We are reaching, I think rapidly, a problem with private health insurance, when people are even not choosing their private health insurance. We have seen the waitlist in the public sector increase to—this is raw numbers—around 22 000, yet the public sector has still maintained its performance, which is great. I think in part that is due to this program, because what we are trying to do is do more patients. As the Auditor General

quite rightly said, "You should utilise the theatre time you have in the most effective manner, so you should not have these big delays." Yes, you should clean the theatres properly—clearly—but you should start on time and you should potentially finish on time. Although, we do think that if you can get an extra patient in, you should as well.

Mr D.C. NALDER: On the benchmarking, is there sharing of information with the private sector, like the St John of God hospitals, to understand where you are at relative to what they do and vice versa? Are there lessons to be learnt both ways?

Dr RUSSELL-WEISZ: Yes, there is more in our numbers. Oddly, I was actually talking to the chief executive of one of our large private partners today, and I think we were both concerned with where things potentially could go if more patients chose not to use their private health insurance. Do we compare their elective surgery performance—how many they do in boundary? No. But we do compare, certainly, with other public sector hospitals. I can easily compare Sir Charles Gairdner Hospital with Royal North Shore. I think on operating theatre efficiency, maybe Jodi can give you an example.

Dr GRAHAM: I was going to make a comment about private actually. They do not observe a triage system within the private sector, so there is no direct comparator. They are not working by the same kind of triage system that we have.

Mr D.C. NALDER: But operating theatre efficiencies, there should be —

Dr GRAHAM: Certainly, when we did the clinical services redesign, we went out to the private sector to see how they were doing it, because they measure everything down to a minute's worth of productivity and they are hugely focused on productivity. We did take some lessons from them and they have been taking some from us. For example, at Sir Charles Gairdner we almost share a site with Hollywood Hospital; they are just over a fence. We are pretty close to them and meet with them quite regularly to find out what they are doing.

Mr D.C. NALDER: I am aware that when you get someone who is looking at the dollar as much as the private sector can, they will go down to the minute. I am interested in whether you are benchmarking so that there are lessons learnt to deliver better efficiency outcomes.

Dr GRAHAM: When we looked at the metrics, we actually looked at all the private metrics as well and saw whether they would be applicable to us. A lot of them were not that applicable because we had to standardise across a range of different hospitals. Our tertiary hospitals are not like our country hospitals and we had to find metrics that sort of suited everybody and applied. A lot of the measures that the private sector uses—their main measure is productivity. So, we took some of that onboard but we did not find that the same metrics were going to be suitable for us. The things that we did try to take from them were the way that they measure and the way that they display data. They use it to drive performance.

Mr D.C. NALDER: You made the point that you have taken a generalist approach across the hospitals. Does that in itself leave potential gaps around productivity improvements you could actually deliver if you gave a more specific focus and you could segment your hospitals out to differentiate the services that they provide?

Dr RUSSELL-WEISZ: We actually can compare. We have our elective surgery performance—those that are over boundary and those in boundary—that we can compare between country hospitals. WA Country Health can compare Albany with Carnarvon. It can compare Kununurra with Geraldton. We can certainly compare our tertiary hospitals. We know where our hotspots are, we know where the difficulties are, and we know that the areas we potentially struggle in are urology and plastic surgery, because those are high demand.

I also want to come back to a point you made about private health. Private hospitals now do a lot of complex surgery, but obviously public hospitals do everything, so our big tertiary hospitals sometimes are not comparable. We also have to deal with private hospitals that do not have an emergency department. So, you are not comparing apples with apples. Yes, St John of God Murdoch has an emergency department, but Jodi in her role at Sir Charles Gairdner or the clinicians at Fiona Stanley who deal with emergency and elective have to balance. They all have a huge emergency load coming in who require surgery and at the same time an elective load as well, and that does not necessarily translate so much to private hospitals.

Mr V.A. CATANIA: With private patients going more towards the public side, is there a push from the public hospitals to say, "If you do have private health insurance and if you don't need emergency surgery"—is there a push to get them over there?

Mr ANDERSON: Not to push them back if that is what you are suggesting. Once they are in our system, we do not push them away.

Mr V.A. CATANIA: Is there a push? Push is probably not the right word.

Dr RUSSELL-WEISZ: Encouragement.

Mr V.A. CATANIA: An encouragement to go back to the private sector?

Mr ANDERSON: Once they are in, they are in, but we do encourage them to use their private health insurance.

Mr D.C. NALDER: Is that within the public system?

Dr RUSSELL-WEISZ: I think the private hospitals quite rightly—we have enough work with public patients. We do not actively go out there and tout for business. That would be absolutely wrong. Anybody who gets operated on gets operated on based on clinical need. It is clinical priority. We only have about seven per cent of patients in our public hospitals actually using private health insurance. That has grown from four per cent. So if you have it, we say, "Yes, you are able to use it." It is part of the Medicare principles. But if you look at where the federal government is going, they are seeing big increases, especially in New South Wales, where it has gone up to 20 per cent.

Mr D.C. NALDER: On that—I am digressing a little—do you think the system is a little flawed? If I enter the hospital system and I have a need to have an operation and I have private cover and I use the private cover, I generally end up with a bill myself or a gap, whereas if I put it on the public system, I do not pay a cent. It seems to me that we have it back to front. Is there a view that we ever try to deal with the federal government on this issue and if people use their private insurance, we should cover the gap, so that you are encouraging it up to 10 or 15 per cent or 20 per cent?

Dr RUSSELL-WEISZ: That is a great question because it has lots of answers to it. Can I ask Rob and Jodi to cover it from our perspective, but I think the major issue with private health insurance today is that gap. When you go to a private hospital or you see a private doctor—it is not only for surgery—you are left with a big gap. Not with everybody, but certainly there are some very large gaps. If you come to a public hospital, yes, there may be no gap, but we will not put you in front of somebody else. If you have a clinical condition, irrespective of whether you are public or you have private health insurance, you get triaged on your clinical condition. We do not treat you more favourably because you might have private health insurance.

Mr D.C. NALDER: Is there still a chance of a gap?

Dr GRAHAM: No.

Dr RUSSELL-WEISZ: No.

Mr ANDERSON: No, we cover the gaps. The state covers the gap.

Mr D.C. NALDER: I did not know that.

Dr GRAHAM: That is one of the reasons people come.

Mr ANDERSON: Potentially, it is an issue for the state in that the commonwealth will not fund us for private patients. They see that, so we then cover the gap.

Mr D.C. NALDER: As a layperson, my understanding was that if you go into the public system, do not tell them you have private insurance because you may have to pay a gap.

Mr ANDERSON: No.

Mr D.C. NALDER: There is maybe a misconception out there in the broad community—it is one that I have had—that I would have to pay a gap.

Mr ANDERSON: We have hospitals now that are the equivalent in terms of accommodation to private hospitals—in fact, better in some instances.

Dr GRAHAM: From an operational perspective, we have private patient liaison officers in the emergency departments. They actually explain to people all those misconceptions and they answer their questions at the time. I think most people are asked when they come in whether they have private health insurance, whether they would like to use it and they are afforded the opportunity to have their questions answered.

Dr RUSSELL-WEISZ: But they are actually not forced to use it. It is "Have you got private health insurance? This is what it will mean." A lot of people will say, "I don't get a single room." Although they have a good chance of getting one now at Fiona Stanley Hospital or Perth Children's Hospital, but if you are at Charlies or Royal Perth, you would not get a single room. Some people will say, "I've got private health insurance, but I am not going to use it." That is fine. Also, we do not want and we really could not cope with a huge onslaught of private patients coming into our public hospitals. We are there to make sure that we can actually deliver patients within boundary, that we actually have the right performance.

Mr V.A. CATANIA: Firstly, can I just say that I spent most of Sunday at Perth Children's Hospital after a football incident—very good.

Dr RUSSELL-WEISZ: To do with AFL.

Mr V.A. CATANIA: Yes. I just want to say that it is absolutely fantastic. My son loved it!

In your discussions with the private hospital sector, are they worried that they are missing out on that business, which ultimately has an effect on the delivery of health services and the—not quality—range of health services that those private hospitals can offer, which then ultimately keeps putting pressure on the public system? Are you talking to each other to try to make sure that they keep their financial viability going and the range of what they offer patients, as well as not putting pressure on the public system?

[10.50 am]

Dr RUSSELL-WEISZ: Very much so, and I think you have hit, again, the nail on the head here—it has got to be a balance. We are not out there looking for business. We are saying if you come up in as a patient who has private health insurance and you want to use it in the public hospital, you can use it, but you will be seen on clinical need, you will not be put first. Remember there are certain things that cannot be done in private hospitals. There are certain operations that can only be done in a public hospital here, though this is very super-specialised. We want the private hospitals to be viable. If I look at the waiting list going from 18 000 to 22 000, we do not want it increasing much

more because it will start to affect our performance. What other states have done is actually purchase activity from the private hospitals. We do purchase activity, as you would know, from Joondalup and Midland—they are private–public partnerships—but other states are very active, such as Queensland, in purchasing public activity from the private hospitals. They go to the equivalent of private and say, "We want you to do this group of public patients, and we'll pay you and the patient doesn't get a fee." There are other ways around it.

Mr V.A. CATANIA: Does that happen the other way as well, you will lend surgeons to go to the private hospital to do particular work?

Dr RUSSELL-WEISZ: No. I mean surgeons do work across both. A lot of our surgeons will have private and public capability or capacity anyway, don't they, Jodi?

Dr GRAHAM: Yes. I would say, if I look at our group of surgeons at Charlie's, we would only have about three or four full-time surgeons and everybody else is part-time and works most of the time in the private sector.

The CHAIR: Some of them do it as a community service. Dr Graham, you talked about the table that you have. Would you be able to provide us with a copy of that table?

Dr GRAHAM: Absolutely, yes.

The CHAIR: The audit did not have King Edward maternity hospital as one of the sample hospitals. Can you talk about the operating schedule there and if it has changed in light of the Auditor General's report?

Dr GRAHAM: One of the interesting things has been we have had responses back from all the other sites as to what they are doing. All of them are picking up on different points from the Auditor General's report. I think what we can safely say is that, with the Department of Health's support, we managed to do an entire project at Charlie's but King Edward was not part of that. Charlie's and Osborne Park were part of that. What I have seen is that all the other sites are picking up on pieces and they are starting to drive it on their own. The good thing is that for everything they have also filled this out for us, so we can see which recommendations they have achieved and which ones they are working towards. They actually have action plans next to all the ones that they had not achieved. I can say with King Edward, they are working on the on-time starts and looking at their schedule, but a lot of the schedule changes are becoming something that the hospitals want to do because of changes in activity and as it moves around the system—so with the opening of Midland and things like that—activity has moved, so it has become a need that the hospitals want to do because they have seen a change in their activity and their caseload. I think that is driving the behaviour as well, of them wanting to do it.

The CHAIR: I am just trying to get my head around the new system of the health providers. If you use an education analogy, they are like the IPS, independent public schools—right? How independent those public schools are though is very debatable, I must say. Can you tell how independent are they? I am a bit concerned if they are too independent, to tell you the truth.

Dr RUSSELL-WEISZ: No, they are not. They are established—I think this was going back to the governance changes. There was a decision at the time in 2015 to do it properly, and to do it properly you needed proper roles and responsibilities of what does the Department of Health do, what do the health service providers do—we did that—and also we needed legislation, so there was new legislation passed. The legislation is pretty clear. We did not want to use 1927 legislation that was clearly out of date. The new Health Services Act is very clear around that. They are not independent; the boards are appointed by the minister. The chief executive is appointed by me in conjunction with the chair of the board and there are certain levers that are within the act. There are service

agreements. The service agreement is really the bible and the service agreement goes out to them each year by 31 May. I send that to the board and that stipulates money, activity, health service performance reporting and any other initiatives, if there are other initiatives you want to do in the year, and that sets down, that is like their framework that they need to deliver to.

Mr S.A. MILLMAN: Just on the service agreement, is that like a contract negotiated or is that a set of requirements that they are to meet? Is it dictated from above or is it negotiated between the parties?

Dr RUSSELL-WEISZ: I am not a benevolent dictator, although, eventually what happens is a draft goes out. We start the process in January each year, so Rob's team will start that process with the health service providers. We will get together with the chief financial officer, with the safety and quality director and the chief executive of that health service and they put a draft out. By the time you get to May, I then meet with all the chief executives and the chairs and we go through any outstanding issues. By 30 May, we then need to issue. Looking at this month, I will get all the service agreements signed back from the chairs of the boards by 1 July. I think we have only had one come back where we have had to reissue because there was a minor error, so that gets reissued in June, and you can revise it. During the year if for some reason you get more activity from the commonwealth—there is an elective surgery blitz or something else we purchase via the commonwealth, knowing we get funded 45 per cent of our hospital activity by the commonwealth—then we can do a revised service agreement. That is the service agreement.

The other main lever is policies. The department has mandatory policies and these are policies that they do have to follow. But we have got out of the minutiae; we had about 1 500 what were called operational directives, some back from 1985 we have tried to modernise or get rid of because they are not contemporary. We have now gone down the mandatory policy arm knowing the health service providers themselves will have individual policies that their commissions will need to follow. We have gone back to around about 400 to 500 and we are trying to rationalise them further. There are other avenues that we can use which are directions, so I can direct a health service provider to do certain things. We have used that on a few occasions where we have had to do inquiries—the Ross inquiry in relation to PathWest, which was within north metro, which was tabled in Parliament—with either an inquiry through the powers of the director general or through the powers of the minister. We actually think we have quite good legislation and good levers to say this is what you need to do.

Mr S.A. MILLMAN: In terms of the rationalisation of the policies, and also just in terms of the negotiation and settling of the service agreements, are there checks in place to ensure an egalitarian delivery of service, so that you do not get developing disparities between, say, east or south metro and north metro, or between one of the metro regions and the WA Country Health Service? Because once you remove those policies that were universal and you say, "This can be left to the discretion of the board", you might lose some rights and obligations that were contained in the centralised system.

[11.00 am]

Dr RUSSELL-WEISZ: It is a great question. What we have tried to do—we have tried to learn from the eastern states. Victoria has 88 boards—we never wanted to go down that road—and New South Wales, I think, about 20 and we have very much gone down more the Queensland route where we have area health service boards. It goes to Dr Buti's point about King Edward. King Edward is part of the north metro family; they are not standalone, they are not independent. It is actually getting a little bit of healthy competition—that is not bad. I was at the south metro board on Monday and I actually said that I want every health service provider to be a success. But we know

that some health service providers have, say, got more financial challenges than others. For south metro, they had a financial challenge two years ago and we set them on a trajectory, and that was in their service agreement. They would have got some financial assistance but that would have come down each year. North metro health service has certainly been challenged this year financially, and we have intervened as well. That is the other avenue I forgot. I talked about service agreement, mandatory policies and directions, but we can intervene. With north metro, what happened this year is because of their financial performance, the Department of Health intervened. There are five levels of intervention; we got to a level three, because obviously we have to be more efficient and we have to keep within budget. The days of the bailout have gone. I would impress that we have to succeed as a family, a WA health family, but there will always be that inherent competition.

Mr S.A. MILLMAN: Sibling rivalry.

Mrs L.M. O'MALLEY: That is a really good segue as far as sharing and having that kind of collegiate approach. My question, I guess, comes to the ability to share that information; it comes back to what we were discussing earlier, and that is sharing information and strategies and the way in which you do that. I know this is kind of a big thing, but common platforms—common-user platforms between either the regions or the sites. Can you just explain a bit more about that and if there is consideration to developing something like that.

Dr RUSSELL-WEISZ: I will see if I am on the right track here. Let us say ICT platforms. We cannot have a health service provider on its own that says, "I'm going to go and change the radiology platform" and suddenly that makes the four health service providers fall over. There are certain things they cannot do on their own and, one, that is in the legislation, two, it is in policies. But we still have executive committees that sit at a whole-of-health level. There is an executive ICT committee. What we have done is basically said that if a health service has the money, needs to procure up to a certain level of money for an ICT platform that will have no effect on another health service provider, they can do that. But some of our big health ICT platforms are radiology, our laboratory information system—those things would all be procured at a system level. Also, they would not really have the money to be able do that. That sort of makes sure that one cannot go on its own. However, we might have one in the next two or three years who potentially wants to put an electronic medical record in. To be honest, we have done it; at Fiona Stanley there is an electronic medical record. It started off as a digital medical record and now is moving to an electronic one. I think the days of the big bang where you always went "one fits all" is potentially not the way to go, but we do have oversight. The system manager does—like we are putting a brand-new pathology information system in for the whole system. We would not want a number of those, and we have just got rid of three patient administration systems. When you go into a hospital, you could have gone with something called webPAS, TOPAS or HCARe but we now have one. We put one in and so there is very much that, I think, sensible approach that you do not get duplication where it would cost more money.

Mrs L.M. O'MALLEY: I think that also comes to the discussion around standardisation and benchmarking as well. I guess the ability to facilitate that sharing is key, but I definitely take your point that you cannot just necessarily change an entire system across the board because it would be far too expensive.

Dr RUSSELL-WEISZ: Rob can talk about this, but the performance measures are very similar across the board for every health service provider. There might be some slight differences in WA country.

Mr ANDERSON: They all have the same indicators, whether they are applicable to particular hospitals or health services varies. The Child and Adolescent Health Service, for example, is not going to get a lot of 80-year-old hips and knee replacements so we would not performance manage them

on something like that. But by and large, they have the same KPIs, the same definitions, they are aware of what they are. We try to align them to the annual reporting process as well, so that goes back into our outcome-based management framework, which obviously is used to acquit the appropriation back to government. We try to align it all so the definitions are standard, the data sources are standardised. The indicators are the same for all health services.

Going back to your previous point on the sharing of data and so forth, there are lots of clinical applications which are completely standardised and which clinicians—Jodi can talk to this—can log in and see the patient history across other services. From a clinical point of view, we are not perfect yet—I do not think any health service in the world is perfect—but we are certainly progressing. In terms of benchmarking, there are national benchmarking portals they can look at which open up every public hospital in Australia to a patient level so they can actually go down and look at clinical variation, particularly in the inpatient and emergency space, which is where you get most of your variation. They can certainly do that. Going back to my previous point, we facilitate, both in terms of indicators but also that sort of information that is fairly available to share between the health services. How they do it individually is entirely up to them from an operational point of view, but I know they do share this information, they do look at each other. That is the whole point of it. We do not mandate that, but they certainly do it.

Dr GRAHAM: Another thing that happened along the way is that the health department has invested in some visualisation software. Between north metro and south metro, for example, we are trialling some data visualisation software called Tableau. They have been building applications so we can now see. In theatre, the software we use is called the theatre management system, or TMS, and it has been used an awfully long time predating this project. There is lots of data in there, and we can see south metro's tableau. On an operational level, that kind of sharing makes a difference—and the same with the emergency department. They have standardised software called EDIS and, believe me, they watch each other all the time. That helps manage things on a state level. One of the advantages it gives us being able to see that is on an operational level, for example, if you have an overwhelming number of emergencies come in one weekend and you just cannot manage the load, we will get on the phone to the other hospital and say, "Can you take this many orthopaedic patients for this weekend so we can get them through?" otherwise these people are waiting for three and four days to get to the operating theatre. We are trying to get everyone within 24 hours when they come in through the emergency door so they do not wait long. That helps us facilitate it because we can see through the theatre management system what others are doing.

Mrs L.M. O'MALLEY: Following on from that, in recommendation 2 your response in the audit report indicated that an operational dashboard was under development to assist hospitals manage performance. Is the dashboard now in use?

Dr GRAHAM: Yes. That was the one I was talking about that Caitlin is going to send on for us. It is just a matrix that has all the hospitals lined up and you can see all performance measures. They are all colour coded in a traffic-light system so you can see how they all compare. They go out to all the hospitals. I certainly know at Charlie's what we do with it is we give it to all the departments—we give it to the anaesthetic department and theatre. We put it up and everyone hangs over it to see where they are in relation to everybody else—just basic competition.

Mr D.C. NALDER: I want to quickly go back to the subject we were talking about before about private health cover and capturing some of the information. How do we compare to other states on that measure?

Dr RUSSELL-WEISZ: We capture percentages of patients using private health insurance in our public hospitals. We are not a high user. I think we are the second bottom. It is quite interesting. The last

figure I saw—Rob will correct me if I am wrong—is that 55 per cent of people in WA have some sort of private health insurance, but in our public hospitals, only seven per cent of our patients actually use it.

Mr D.C. NALDER: Up from four.

Dr RUSSELL-WEISZ: Up from four a few years ago. But, again, I do not think that is a negative because we do not actually want to drag patients in from the private hospitals because our prime service is to public patients.

Mr D.C. NALDER: I get that, but if they are in there and they have got it, you want them to use it.

Dr RUSSELL-WEISZ: That is the effort and that is where we have jumped from four to seven per cent; we have actually moved. But you would not have 55 per cent of patients with private health insurance cover in our public hospitals. All we have done is invested—south metro has done this significantly and I know north metro has as well—in what we call private patient liaison officers. A lot of people want to know about the information. They say, "If I do come in privately, will I get a gap? What will I get? Do I get a choice of doctor? Do I do this? Do I do that?" They have lots of questions around that. The issue for the federal government—I think this is where the federal government is going at the moment—is looking at states that have very high numbers of private health insurance patients in their hospitals. New South Wales is one; it is up to 20 per cent. I understand that the federal health minister has made certain statements about the reform of private health insurance or looking more closely at it. I think it is about the growth in certain states, but it is not in WA.

Mr D.C. NALDER: My point is more about if we can get it off the state budget, we want to get it off the state expense line where possible, for the same work. If the work is being undertaken and there is an opportunity there to get it shifted, shift it. I am just trying to understand where we sit and whether or not there are opportunities there.

[11.10 am]

Dr RUSSELL-WEISZ: I could not agree more. This is probably a question for the Under Treasurer. We do get revenue targets that go up year on year. We get asked to find more in revenue, and a lot of it will come in private revenue. I think we are beginning to get to that limit, because we have really increased some of our revenue over the past two or three years—quite substantially in some area health services.

Mr ANDERSON: We do not go out and look for private patients—we do not advertise and promote—but once they are in the hospital, our priority is to make sure we have a conversion rate of those patients who have insurance to being privately insured so that we can bill the private insurer. There are some limitations to this. I do not want to misquote here, but one of the major health services does not allow us to look at, essentially, a register of which individuals have insurance and to what level they are insured. Just because somebody has insurance does not mean that they are insured for what they are coming in for. There is quite a lot of administration that goes behind this. Health services have invested in this. I cannot guarantee this, but one of the health services told us recently that their conversion rate is up to about 85 per cent, which is astounding given how poor we were in the past. There certainly is a push in doing this, but it is a lot of work. It is about asking the patient whether they have private health insurance and whether they are covered for the thing they are coming in for. Most patients do not know, particularly if it is an emergency situation, whether what they are going to have done is covered by their insurance. It is then another piece of work to get on the phone to the insurers if you cannot have access to a register that shows whether that patient is covered. There is a push now to try to get timely billing out, to get that to the patients in time. The

reality is that we have been fairly poor in that regard in the past years. We have improved out of sight in the last couple of years, but that is certainly a big push. As I say, we do not chase it, but once we have it in, our goal is to convert and to get that billing done.

Dr RUSSELL-WEISZ: That is not 85 per cent of patients in a hospital who are using private health insurance; it is 85 per cent of those who could potentially have private health insurance in a hospital.

Mr ANDERSON: That is the conversion rate. Remember, they do not all identify as having private health insurance; they do not have to.

Mr D.C. NALDER: I suppose it is just a broader question of efficiency in this space. For me, where we can save a dollar from the state, we want to save it because we can use it somewhere else. It does not generally get saved, it gets used elsewhere. The other point is the efficiency between the federal spend and the state spend and how we compare to other states.

Dr GRAHAM: I was just going to say that it is interesting to watch the private health insurers in this space because on a national level they are starting to object to how much they are paying to the public health system. We will have to watch that space into the future to see whether they continue to pay.

Mr ANDERSON: There are two things to that. One we touched on before, which is that there is no gap to the patient, so the state picks up that gap. I could not give you the exact numbers—we would have to go back and look at it—but the reality is that I think it is still less than what they would be out of pocket if they had to pay the full amount. I would have to go back and check that.

Mr S.A. MILLMAN: In terms of the health service that was not prepared to provide you with the full suite of data —

Mr ANDERSON: Sorry, health insurer.

Mr S.A. MILLMAN: That is what I was hoping you were going to say. I thought you said "health service" so I just wanted to clarify that.

Is there anything we can pick up from other states in terms of how they convert these public patients, perhaps using private insurance liaisons? I think that is a good initiative. Is there anything we can learn from other states about how we might be able to do this work even better?

Dr RUSSELL-WEISZ: I think the first thing is the information out there. We learnt, even when it was four per cent when I was at Sir Charles Gairdner Hospital 12 years ago, we did not have private patient liaison officers. It is actually people who come through the emergency department. You can get to elective patients probably a bit easier, but people coming through the emergency department have other things on their mind and they sometimes will want to use it and they just need to know what they need to do; what form they need to fill out and whether they will have a gap. That effort was significant. Are there any other efforts?

Dr GRAHAM: One of the most significant things the public patients get is parking. I think you have probably heard about that.

The CHAIR: That is important. Imagine the advertising campaign you could run: "Come to us and get free parking"!

Mr ANDERSON: We do performance manage our own source revenue reports. Own source revenue is not just private revenue; that is quite a small proportion. Own source revenue is any revenue that comes from outside of state appropriation. Commonwealth appropriation, for example, is included in that—veterans' affairs, private insurance, there is a whole range of things.

Mr V.A. CATANIA: If people do come through emergency and they have to fill out forms, can you not make it an offence that if they do not tick that they are private —

Dr RUSSELL-WEISZ: No, no, no. I would be in deep water if I did that, nor would I want to, no. As part of the Medicare principles, anybody who comes to an emergency department has the right to be treated publicly and free of charge. It is part of the Medicare principles, so it is very much that if you have got it and you want to use it, you can use it. Actually, we have been reasonably affected by that.

The CHAIR: When you talk about not wanting to advertise, you can imagine hospitals trying to get the increased clientele to their hospital. The enticer for me would be if you could provide a hospital where I could walk into the front door without inhaling smoke. At Armadale Hospital, as you probably know, it is a major problem, but you have limited powers in that area.

Dr RUSSELL-WEISZ: I could not agree more. We would like to try. We have Fiona Stanley and Sir Charles Gairdner. I am absolutely 100 per cent with you on that. If there was anything we could do to outlaw it in our hospitals, we should. When I stop people, they usually swear at me.

The CHAIR: Was there not a doctor in Melbourne who was killed when he asked a patient to stop smoking? It might also help if some of the health professionals did not go down to the bus station on Albany Highway and have a smoke either. It does not send a good message.

Dr RUSSELL-WEISZ: No, absolutely.

The CHAIR: We will leave that up to the individual health providers.

Thank you for the documents you provided us. Would you have any concerns if we decided to show them to the audit team?

Dr RUSSELL-WEISZ: Not at all.

The CHAIR: Okay. Thank you for the evidence you have provided before the committee today. We will forward a copy of the transcript of this hearing to you for the correction of transcription errors. Please make those corrections and return the transcript within 10 working days of receipt. If the transcript is not returned within this period it will be deemed to be correct. New material cannot be introduced via those corrections and the sense of your evidence cannot be altered. Should you wish to provide additional information or elaborate on particular points, please include a supplementary submission for the committee's consideration when you return your corrected transcript of evidence. Once again, thank you very much.

Hearing concluded at 11.17 am

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