T R A N S C R I P T

STANDING COMMITTEE ON THE ECONOMY AND INFRASTRUCTURE

Inquiry into infrastructure projects

Melbourne — 18 October 2016

Members

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Mr Khalil Eideh — Deputy Chair
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Mr Nazih Elasmar
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Ms Colleen Hartland
Mr Shaun Leane
Mr Craig Ondarchie

Participating member

Ms Samantha Dunn

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Witnesses

Ms Frances Mirabelli, chief executive officer, and

Dr Roderick McRae, chairman of council, Australian Medical Association Victoria.

The CHAIR — I declare open the Standing Committee on the Economy and Infrastructure public hearing and thank our witnesses who are present here this afternoon. Today we are hearing evidence in relation to our infrastructure inquiry, and the evidence today is being recorded. This hearing is to inform the third of at least six reports into infrastructure projects, and witnesses present may well be invited to attend future hearings as the inquiry continues. All evidence taken today is protected by parliamentary privilege. Therefore you are protected for what you say here today, but if you go outside and repeat the same things, those comments may not be protected by this same privilege.

Once again, thank you for your attendance here this afternoon. I might get you to introduce yourselves and give your roles at your organisation, then move into any introductory comments, and then we will have some questions from the committee from there.

Dr McRAE — My name is Roderick McRae. I am a medical practitioner. I work in the public hospital system, currently employed at Monash Medical Centre at Clayton. I am a consultant anaesthetist and intensive care physician. I am also a lawyer. I have a masters of bioethics, so I am very engaged in many things, and through this organisation, which is AMA Victoria, I am the chairman of its council.

Ms MIRABELLI — I am Frances Mirabelli, and I do not have a CV anywhere near that long. I am the chief executive officer at the AMA.

The CHAIR — Very good, and any introductory comments you might like to make to kick things off?

Dr McRAE — Thank you very much for the invitation to present to you. We were not entirely clear on what it was you were specifically looking for. We have lots of ideas on lots of things. With the word 'infrastructure' sitting in the title of the committee we figured it is more at the bricks and mortar end of things, but we welcome any commentary that you might have. We are pleased to hear that there appear to be budgetary surpluses and things are going very well within Treasury in Victoria, and we think we can assist you to spend your money wisely.

In a nutshell there has been a massive growth in the community population, in particular in the metropolitan areas. There is at least three designated growth corridors, and I am experienced with the south-eastern one where I work, as I mentioned, in the public hospital there. There is the northern one and the western one, and I do not think anybody needs their eyes opened to that fact. The population is moving very rapidly, and the infrastructure investment has not matched that.

Within medicine and the broader public hospital communities we have looked to be as efficient as we possibly can. We can produce data should you require it that indicates that we have had this great increase in productivity. What we cannot do is make people heal any faster. So your 95-year-old mother-in-law who may have to come from the other side of Shepparton to have a massive operation at a tertiary hospital would still be invited to rock up at 5 in the morning, not having eaten, got there somehow — perhaps stayed with a relative nearby — come in, have a massive operation, use the resources and away she would go. Married with all of that is the fact that we have more complex illnesses, elderly people and obesity is a big thing. So that is kind of the physical illness, if you like, in the hospital.

Then we need the consideration of mental health issues. That also is going to require some infrastructure, and funnily enough there is a big overlap between the two areas. So you do not just have a mental illness, you do not just have a physical illness; often the two are combined and they may increase the likelihood of one or the other occurring. As it happens at the moment if a mental health patient requires intravenous fluids — just a needle in a vein — they have got to get out of their mental health facility and go somewhere else, which is usually into an acute bed in an acute care hospital, and that has its flow-on effect onto waiting lists and somebody else having some procedure.

With the ageing and greater obesity you may think, 'We can do that operation in an hour', using an operating theatre facility; it can go to 2½ hours, and I had that very experience this morning — unpredictable. That means if you were budgeting to have two operations done, only one can get done. If the person requires an intensive care bed, if we do not have an intensive care bed available for something like open-heart surgery, for example, then the operation is cancelled, and even if they have come at 5 in the morning, prepared socially and worked it all out that they are going to have that operation, it will not commence. So there are abundant requirements for the bricks and mortar, as you have spoken about, and we know that there is some investment going there, but it

is just lagging behind the community requirement. We are interested in outcomes. We like to perform high-quality medicine, and sometimes it gets pretty hard. We cut corners. We perhaps discharge people too early when they may benefit from some more.

Then if we consider obstetrics, there is an increase in that area of health care. A plan needs to be put in place. We could be talking about outside of the Geelong, Ballarat, Bendigo resources — the old bush nursing homes — whether or not they are adequately resourced in order to let local-type people have a normal gestational experience.

At the other end I mentioned that we have got the ageing population. There is the requirement for palliative care as a consequence of that, and that requires some sort of facilities and infrastructure support. Whether it is going to be a standalone building — one of the high-rises here in town that everyone in Victoria can come to on the one or two occasions — or we have some sort of system go out to meet the community's demand will need some thought, but it will all require investment.

Within even the existing hospitals we can do an awful lot better with respect to communication, how results are communicated. We can look at saving money on unnecessarily repeated investigations, whether it is medical imaging, pathology, blood tests — anything along that sort of line. If it has been done in the morning, it does not need to be done by another person in the afternoon. So it is very likely to require a massive investment in IT support. We have done away with carrier pigeons. We seem to be relying heavily on fax machines, and even the AMA does not really rely on faxes to communicate one way or the other; it is all electronic technology. We can have the investment in infrastructure for video consultations perhaps in some areas — mental health comes to mind, but it may be other things, post-operative follow-up, you name it. Now I will take a breath.

Ms MIRABELLI — He is actually not joking about the fax machines. That is the preferred form of communication between hospitals and GP clinics.

Mr ONDARCHIE — There is a new thing called email; I am not sure if you have heard about it.

Ms MIRABELLI — I know, but it is not secure, so we have actually been lobbying for that for some time.

Mr ONDARCHIE — We will talk about that.

Ms MIRABELLI — A secure messaging system needs to be installed. So that was not actually a joke. That is exactly what happens, and it is the 21st century.

Dr McRAE — It is very interesting, because on many occasions there is almost nothing much more personal than your healthcare information. If you bump into somebody from school or you have not seen for 25 years and you say, 'I've had the hernia and the appendix out and that sort of thing'. Most people at that level of privacy are relatively friendly and open about it, but there is some stuff that you just do not want to have go off to the wrong fax machine, and we are very concerned about that.

The CHAIR — Indeed, nor inbox if it was to be emailed.

Ms MIRABELLI — That is right, and that is why it needs to be secure.

Dr McRAE — That is right. It goes into all of that.

The CHAIR — Indeed. Ms Mirabelli, is there anything else you would like to add to any of that?

Ms MIRABELLI — No, he has covered it all.

The CHAIR — Obviously you went through a lot of infrastructure priorities there. I am just wondering if you could pick, say, the top three, if you had a magic wand in terms of infrastructure needs here in the state of Victoria, are there a couple or three that really jump out at you as these are the no-brainers that really should be done?

Dr McRAE — Yes, I would highlight the support around mental health issues. They seem to be a little bit different between metropolitan and the more rural and remote areas. A large play is off the back of illicit drug use, but the ability to access acute care of somebody in a psychotic extreme episode — often it is a younger

person. It would be worth the investment, because with rehabilitation they should get back to the workforce and be productive, which is kind of what it is all about.

Then I would also support the IT infrastructure requirement. Regrettably it is invisible, it is very hard to cut the ribbon on it, and all that sort of stuff, but the brutal fact is the benefits that could be obtained are likely to be unimaginable — while we sit around and think about it.

The next is just keeping up. Often you have to spend an awful lot of money on infrastructure just to stand still, and then we do need to expand. So there is a big capacity requirement. For some out in the more remote areas, but even around the metropolitan areas I would say a lot of people would need to think very hard if you had planned a hospital at the Royal Melbourne Hospital site in a city like Melbourne, but we sure need trauma services out on the fringes. It seems with environmental changes we are going to have more natural disasters. A bit of an emotional word perhaps and overcalling it, but we need to be able to deal at short notice with mass casualties from something like an extreme bushfire. With drought there is usually a bit more of a warning, but it still needs to be planned and played out.

The CHAIR — Of course. Obviously we are talking about investment into infrastructure, and we are saying that the Infrastructure Victoria plan says that at least one of the Alfred, Royal Melbourne and Footscray hospitals will need to be rebuilt in the next 10 years. I am just wondering: would you have a prioritisation of those types of investments, or is there anything else you would add to the list?

Dr McRAE — As in prioritise those three?

The CHAIR — Yes.

Dr McRAE — Probably the western direction. That is a growth corridor.

The CHAIR — Footscray. You would be pleased to hear that, Ms Hartland.

Dr McRAE — I have worked there in the past, and it was not an oil painting then.

Ms HARTLAND — It is still not.

Dr McRAE — Yes. It is pretty easy to turn your back to that side of town, and it is not right. The people there have their own issues and then entitlement to getting the best quality health care that they can, so if you had to pick one of those three, I think that would be it. I have worked at all of those institutions actually, and there is also a lot of capacity for private fundraising at the Melbourne hospital and the Alfred hospital which is not experienced out in the west.

Mr ONDARCHIE — Apparently not. At the VCCC there is not.

The CHAIR — I am hoping to move on to health IT. Obviously you have spoken about the importance of that investment, and as you said, it is hard. The minister does not get to cut the ribbon as visibly as they do on a brand-new hospital. Obviously you have been advocates for investment into Victorian health IT infrastructure. I am just wondering again: what is the most urgent need in terms of IT infrastructure in Victoria?

Dr McRAE — It is really the ability to communicate in that cleft between primary care and I will use the word tertiary care — and maybe secondary care, but it is easiest probably to think about the tertiary care model — and just get the messages back. There is an awful lot of lag and delay when the primary care practitioner has no idea that their favourite patient has actually spent two and a half weeks in a tertiary hospital and has no idea why the medications that have been going nicely for 12 years are now completely changed. It might be completely appropriate, so there is no comment about that — moving with the times and that sort of thing, or a new opportunity to manage a condition.

But if they do not know, and again falling back to the potential confusion that anybody on a good day can have around their personal healthcare issues — and you can overlay that with ageing and perhaps some mental deterioration, not getting it right and going, 'I know they changed my pills; I don't have the blue one anymore', having clearly no idea what is going on — it is something as simple as that and just improving the communication from a discharge from a tertiary hospital to the primary care physician. In my model everyone has a primary care practitioner, and again the brutal reality is not everybody does or many people have six of

them, trying to get the message for the right one, but they would nominate who would be told or something along those lines.

The CHAIR — On the electronic medical records, I am wondering if you have an idea of what would be an appropriate time line for rolling that out statewide?

Dr McRAE — I think we need to be able to crawl and walk and run, so it has to be done very, very sensibly. I would see that really overlapping with a lot of what I have just discussed in terms of the communication. I would be concerned if we have a lot of healthcare networks — and even, I guess, it is the federal investment in primary healthcare networks — each coming up with their own things, so that the VHS does not talk to the Beta videos and all that sort of thing.

The CHAIR — The railway gauges again, yes.

Dr McRAE — Very good. Yes, that is exactly right. That would probably become more of a problem than what it is trying to address. I can see that in starting around the large metropolitan teaching hospitals, where there are a large number of younger, newer graduates, on the one hand they are more savvy with all that IT sort of stuff than a person of my distinguished appearance. They would grow through the system, so there is just a hidden benefit in those people also experiencing it and spreading the word. Then they seed out into everything else. They would be rotating out to more peripherally located hospitals within Victoria and also transferring to primary care training and then occupation as well.

The CHAIR — I am just wondering if the AMA has done any work on what the cost might be to roll out EMRs across the state.

Dr McRAE — I do not think we have.

The CHAIR — No? It would be a big job, I would imagine.

Dr McRAE — I expect that it would be, and I expect that any number of providers will come globally to you with an offer you just cannot refuse.

The CHAIR — With an idea of what that might be. Indeed. In terms of best practice of rolling out EMR across Australia or the world, are you aware of any places of best practice where it has been done and been done really well?

Dr McRAE — Not really. I am aware of where it has been done. I think Canada shot $4 billion and it came to nothing, and the UK have had a somewhat negative experience, and then the federal government have also had a disappointing response to the investment that they undertook.

On the approach in Australia, I might say I was involved a little bit in some of the committee meetings, but the concept was always very good. There was concern about the patient controlling the information, and that is something that needs to be worked through, rather than just polarised views coming on it. Then I think interested parties captured the agenda, and we started worrying about individual identifiers and forgetting what the whole point was, which really goes right back to when I turn up unconscious and someone wants to be able to find out what my blood group is perhaps. What is my kidney function? Am I waiting for a kidney transplant on dialysis or never wanted this treatment in the first place? Should I be in this horrible circumstance?

The CHAIR — Indeed. I note that your policy submission suggests that an effective EMR would reduce patient readmission. I am just wondering how it is that that might come about.

Dr McRAE — It is particularly the unexpected readmission. In part it is what I said. Somebody says, 'I've still got that little bit of a pain'. Somebody is not sure. They might have an appointment for 6 minutes, a person does not quite get it and calls an ambulance — 'Look, they just left'. I will use Monash, my employing body. 'They've just left there four days ago. Send them back and get them to check it out'. Then people are not quite sure. We do not have access to the records, and there is no access to the plans. It is a completely different team of medical practitioners who are going to be meeting that individual — 'Not quite sure. Let's get a bed, and we'll cancel the four operations that we were going to cycle through that bed tomorrow'. That is sort of the concept, by having the communication.

The other thing is that when a person is put in the bed, instead of perhaps another team picking it up — and it might be from general physician to gastroenterologist, as an example — them repeating everything that was done 10 days ago is unlikely to be rewarding.

The CHAIR — Indeed. I suppose my next question is probably answered in part by that. What are the risks to patients if an EMR is not delivered? I am assuming that is what we are seeing. We are going to see more tests and the like.

Dr McRAE — When you say not delivered — —

The CHAIR — If we were to, you know, just put a halt to — —

Dr McRAE — It is like every time you turn up, it is a brand-new episode as if you never existed before.

The CHAIR — Yes.

Dr McRAE — There are some tests out there that carry a morbidity. Every time you have a chest X-ray, you get radiation exposure a bit like flying to Sydney, which we do often because it is a holiday or to see a show or relatives. But every time somebody like me orders a test, I am weighing up the exposure of electronic radiation versus the information and benefit that I am going to receive from it. Then if you get into coronary angiograms, we are talking glow-in-the-dark country, so some serious radiation and potential morbidity. I do not think that anybody has actually been tipped into an anaemia that has precipitated a coronary infarction as a consequence of a 20-millilitre blood specimen, but there are some people who have nutritional problems, malabsorption problems, and it is not in their interests to have an unnecessary test. And of course we are all paying for it in the same way.

Mr LEANE — Thanks for your evidence. In your submission you said that psych patients may have to be moved to maybe get an intravenous drip.

Dr McRAE — Yes, if there is a requirement. A very simple thing if somebody has a mental health issue — a simple thing that affects a lot of people, probably under-recognised — is depression. If they are institutionalised for the management of depression, it is pretty serious depression to start with, and then they get pneumonia for whatever reason and need intravenous antibiotics. They are not able to stay in the psychiatric area, because it is an acute medicine intervention.

Mr LEANE — Is that your experience across the board? I am only asking this because I just happened to be at Maroondah Hospital last week and had discussions with some medical experts there about their new PAPU — psychiatric assessment and planning unit — where in the ED people get identified. Maybe a flag comes up when someone goes to the front desk that that person has been a psychiatric patient before, or someone arrives in the ED where they show signs of maybe having an episode, and so there is a separate entrance into that PAPU from where I might go if I turned up with a broken arm and showed no signs similar to that. Then integrated with that is a quite sophisticated psychiatric care ward. So I am surprised that in that sort of scenario at that hospital a patient would have to be moved to somewhere else. I am no expert either, but you see all the equipment behind the beds in the patients' rooms, so I am surprised they would not be able to perform those sorts of functions in that case.

Dr McRAE — Right. I am not familiar with Maroondah Hospital and the specific things. Do you want to say something?

Ms MIRABELLI — I was just going to say in this particular case, I am not familiar with it either, but it sounds like it is co-located with the hospital, so in that instance they probably would be able to access the services, but at Southern Health where they are on the Kingston site — —

Mr LEANE — So that is a dedicated psychiatric care site.

Ms MIRABELLI — Yes.

Mr LEANE — So Maroondah is a — —

Dr McRAE — It is complex. Where I work there is a co-located psychiatric facility. It is actually a standalone building connected by a corridor, not unlike the facility here, but my experience is if somebody has a high requirement as a consequence of physical illness — say, pneumonia requiring intravenous antibodies — they have got to come out and go into the general medical ward, and maybe require additional nursing resources, special one-to-one nursing, in a general ward. I am sure there will be a policy approach in each institution. It is as simple as a policy saying, 'You will not do this', so somewhere in the past there has been harm to a person. The general nursing staff are not psychiatric nurses, and as a consequence they might not manage the psychiatric condition so well but might be great in applying antibiotics intravenously.

It is always an issue having an intravenous access in a psychiatric patient in a ward, because one never knows what they might do. You know, particularly when they are admitted, they are there because there is something not quite right. So I, with my anaesthetic role, will often provide anaesthesia when a patient has electroconvulsive therapy. Every time they have it, an IV access has to go in and then it has to be removed before they go back to the general ward — and it is often through self-harm.

Mr LEANE — I was just there last week and they seemed to have that. It is obviously experts like you that have actually advocated for this sort of system at that hospital. I think they believed it was a good template to have it in that form. Accepting that we can find more sophisticated ways to communicate from hospital to hospital and provide real-time data, does the AMA include that position with real-time prescriptions? At the moment the doctor can scribble on a piece of paper and the piece of paper can find its way to a number of doctors through unscrupulous individuals, and prescription drug abuse is a huge issue in the community. It is probably bigger than most people would understand. If there was a system between the networks and the hospitals, would you advocate that that should be part of it as well?

Dr McRAE — Look, I think I understand the concept that you are discussing, and we would be supportive of it because we are interested in the health and wellbeing of the citizens. Regrettably what you have described does occur. I will just check. This is to say that somebody cannot get the same prescription three times in 2 hours.

Mr LEANE — Yes.

Dr McRAE — Yes, we are very supportive.

Ms HARTLAND — I would like to go back to IT. I can remember 10 years ago when I worked in a community health centre and we were looking at HealthSMART, so that is how long ago that was. It seems to me there have been a number of attempts to do this, and it is really critical for it to be fixed. I have GPs talking to me about the fax coming a week after the discharge, or the pharmacist talking about someone turning up, especially someone who is elderly and confused anyway, and them not having any knowledge of what that discharge plan is. If we were to have a proper IT system that worked across the state, is there any sense about what that would cost? Do we need to start it in one of the major hospitals, test it and then send it out? Has it been the problem in the past that it was attempted too widely and that it should be trialled in one place and then sent out?

Dr McRAE — That latter suggestion is appealing because it appears that whatever has gone before has not quite translated through to the outcome anyone was intending, and as a consequence it is reasonable to try something else. It is interesting that, as I said, the Barwon area is often used for experiments and that sort of thing because it is big enough and it is kind of metropolitan/kind of rural and would provide a mix of experience. I do not think we have actually discussed it as such, but I do not think there would be terrible opposition to that sort of suggestion.

Ms HARTLAND — The other thing is, has anybody done that kind of economic comparative work? If you had a good IT system within hospitals, what would that actually save in the long run, especially in terms of multiple tests, wrong medication and so on? I know last year or earlier this year the Auditor-General did a report on the issue around CAT scans and the fact that hospitals do not speak to each other and so there may be four appointments available at Footscray but Melbourne, which is completely overloaded, does not know that — so that kind of thing, and also conversation between hospitals.

Dr McRAE — Yes. I do not think anyone has really sat down and done it. You can almost pick little points and make an argument, and organisations like the Grattan Institute try to do that every so often. In terms of the

access and space, there are notionally friendly arrangements in referral networks, but then we come down to the issue of full-time medical practitioners in one centre or healthcare service, and they have all been structured so they are independent. I think going back to the Kennett government, the concept was, 'We're going to have all of these businesses and they should compete', so if open heart surgery is done brilliantly at Monash, then everyone gets done there, colorectal surgery is done at Melbourne and something else is done somewhere else; and that has never really come back.

It may be that you have the same medical practitioner visiting at several health services — several different employers, if you like — on a part-time type of basis, plus the management of their own private practice and everything is trying to work piecemeal, and there is no mechanism to have that information shared. There is no ill will about sharing it; it is just that it is not there, it is not done, it is not encouraged and there is no mechanism of knowing.

But equally, patients contribute a little bit in their own way. I have met several who live next door to the Alfred Hospital — I have attended there — and they did not like what they got told. Often, regrettably, we have to tell people bad news some of the time, and so then they move to another institution, do not tell anybody that they have had all of those investigations and then they all go and get repeated. Now, we tolerate that because it is the patient's right to do that and to choose.

Ms HARTLAND — Yes, but if their records could follow them — —

Dr McRAE — Their records do not follow them. If I am very clever and I want my hernia fixed as soon as possible, I will attend five major metropolitan facilities, get my name put on the waiting list and then see which one comes up first.

Ms HARTLAND — If I can just give another example, we are about to do legislation on advance care directives. I am totally supportive of this concept, but one of the things that is in my mind is, if someone has an advance care directive and they are in a car accident and do not go to the hospital where their records are, unless they have it tattooed on their forehead that hospital is not going to know.

Dr McRAE — Correct.

Ms HARTLAND — So they could be aggressively treated when it is everything that they did not want.

Ms MIRABELLI — That has certainly been something that we have raised.

Dr McRAE — That is absolutely correct, and I think it has occurred on plenty of occasions. It is difficult to know that there is a system around that, because you still have to identify the person. Frankly, the correct decision is to aggressively resuscitate until proven otherwise. Another example is a Jehovah's Witness. When they are devout, they just do not want blood transfusions. If you commence one, it is all done in good faith. As soon as you know, it has got to come down. That would be the same. But we would be very supportive of a mechanism to provide that.

Ms HARTLAND — It almost feels like our committee or a committee should actually do an inquiry just into IT within hospitals, because it has always felt like it is so huge but so fundamental to getting a number of things right, especially around bad medication decisions. It is all those kinds of issues. I can imagine that it would be a great money saver. It would cost a lot to install, but in the end it would save a lot of money.

Mr ONDARCHIE — I am interested, Frances and Roderick, in your comments about private funding when you talked about the south-east corridor. What is AMA's view on the current government's rejection of the $20 million of private funding for the VCCC?

Dr McRAE — I am personally not all that informed about what went in the background to it. My understanding is that it was a political decision. We are always supportive of having infrastructure capacity made available. I was not clear how it was going to be used or how it was envisaged to have been used, but when it occurred it had a lot of medical practitioners' eyebrows raised, particularly because at that time there was knowledge of the difficulty of getting investment in infrastructure. It was a bit like, 'Well, that's some infrastructure, and we can do it'. Then in the background my understanding is that it was purely a private facility, but my level of detail there is so scant that it is probably dangerous for me to go too much further.

Mr ONDARCHIE — My understanding was that this facility would take patients out of the public system, freeing up more capacity. So I was just interested, Frances or Roderick, in your view about creating more capacity and why you would withdraw that facility.

Ms MIRABELLI — As Roderick said, it is political. As long as the money is put back into the system, we are okay.

Mr ONDARCHIE — I will have to go begging for that private money that has gone missing now.

Let me just touch on something else, then, around your obvious focus on and passion for service delivery and patient care, particularly when you talk about anaesthetists and specialist services. I am aware that the specialists EBA expires in March next year. How are those negotiations going?

Dr McRAE — They are moving along. Formal negotiations have not commenced, but we are interested in having them.

Mr ONDARCHIE — What are your priorities in that EBA?

Dr McRAE — I mentioned earlier that we can demonstrate that we have increased productivity in the public hospital system. That is the famous 'doing more with less' and producing the outcomes. In the background people are remarkably cheesed off because there has been an alteration in the financial remuneration arrangements which has resulted in a real decrease in income. That is predominantly affecting people salaried in the public sector. They are hurting, annoyed and angry. They are interested in having a redress of that. It is a commonwealth government contribution related to fringe benefits tax which has been markedly reduced. As a consequence the morale is low, so they are looking for some sort of tangible replacement for that and will be active to try to achieve it.

Mr ONDARCHIE — It is interesting that in your very opening comments today you talked about — and I am paraphrasing what you said — there being a bit of money around. The government have just sold the lease of the port for $9.7 billion, which was well over what they thought they were going to get. Also there has been a significant increase in tax taken over the last 12 months. It is well and truly over what they budgeted for, so now is a good time, I guess, for the AMA to put their hand up for a clip of that ticket that helps patient care. What are some of the things you would be looking for?

Dr McRAE — In terms of just a pure pay rise or to make — —

Mr ONDARCHIE — No, as part of your EBA negotiations and the infrastructure things you are looking for. What would you say are the things you are looking for?

Ms MIRABELLI — I brought a copy of our budget submission.

The CHAIR — Look at that. Very good. You have got it on hand.

Ms HARTLAND — Can I again make a statement that this is an infrastructure inquiry; it is not an EBA inquiry. I know the Chair will rule me out of order, but we have just had the same discussion with the nurses. I do not believe that the EBA was in this referral. It was about infrastructure.

Mr ONDARCHIE — On the point of order, the witnesses did introduce discussion around specialist services, and that is what led me to that.

Ms HARTLAND — They did not introduce the topic of the EBA; you did.

The CHAIR — Again, going by my previous ruling, Ms Hartland, if the witness would like to answer the question, that would be great.

Mr ONDARCHIE — Give us your list.

Ms MIRABELLI — Do you want to start at the top, then?

Dr McRAE — Yes. There is a large increase in graduating medical students, and that is a good thing. They are going to require teaching and training. Some will want to participate in research, which is also a good thing

down the track. All of these are going to require infrastructure. In many ways everything I have discussed has been infrastructure thinking around the hospital bed for a patient. But even in order to educate, it is typically the full-time salaried employees in the large metropolitan quaternary and tertiary-type public hospital institutions who do the training on the ground in the public hospitals, so they require facilities which are modern, up to date and all those sorts of things as well.

We need to be able to provide them with a career path. We are educating them, so then they need to have somewhere to go. We need to support them in primary care as well as into specialist care. We require relevant capacity and everything there in order to support that. Sometimes that is more bricks and mortar. We are getting to the stage where there are large queues — 22 people around grandma in a hospital bed — trying to observe how to practise medicine. It is not terribly satisfactory for anybody. So those are the things.

In terms of other issues it is all along the lines of what I spoke about in terms of the infrastructure and all of that. We are very interested in supporting all medical practitioners at every level in maintaining information and maintaining standards. That could be another use of electronic communication means and providing them with the facilities to be able to do that. For example, I do not have a computer at work. Maybe I do not need one as I am mainly a anaesthetist, but I have got to get my pay sheet somehow, so it is often done when I can find one. We tend to think every medical practitioner probably should have something like an iPad. It does not have to be a desktop PC or anything along those lines. That also lets them say, 'Gosh, I've never heard of that condition. How do I look after somebody with it?', and they can have a quick search. Again it is to the community's benefit when it is something along those lines.

Mr ONDARCHIE — I have one final question, if that is okay. I know, Roderick, you are familiar with the south-east corridor of Melbourne, but you also mentioned the other growth corridors, the west and the north. Can I use Northern Hospital as an example? It is very stretched. The City of Whittlesea, for example, attracts 173 new residents every week. It is a hugely multicultural area containing people of various backgrounds who are not familiar with authority and English et cetera. I asked the Australian Nursing and Midwifery Federation this exact question. The previous coalition government committed $100 million to expand that hospital. That money was taken away by the current government. Given the pressures on the health system, do you think the Northern Hospital needs more money?

Dr McRAE — Yes. In one word, yes. In fact you have touched on a further point. It requires the expansion of the capacity, patients and clinicians, as I have described, but there are also the ancillary services and translation units, preadmission clinics. One thing that is a disaster — well, 'disaster' is again over the top — is to have somebody come in, ready to have their operation at 10 o'clock of a morning, and they go, 'Oh, actually, we didn't know that you were at a high risk of having a heart attack. Why? Because we didn't have an interpreter. Your brother-in-law, in good faith, was just sort of answering questions, and we couldn't get the information from you'. Even that is another spend, if you like — just providing adequate translation services, right down to things like a consent form. But your original question there was about expansion, and in fact the amount that was cut out will probably not be sufficient now.

The CHAIR — I was hoping to touch on training. You mentioned the need for additional training here in Victoria. I believe there are currently not enough intern positions for the number of medical graduates in Victoria.

Dr McRAE — Yes, that has been the case. It is relatively lineball. Just by way of background, the intern placement is a necessary adjunct to allow a medical practitioner to move from provisional to full general medical registration, and there are expectations from the Medical Board of Australia that they will canvass certain areas. Yes, the positions have become reduced with what I would describe as a smoke-and-mirrors technique. There has been an ability to find an intern position such that nobody will miss out. That has occurred to date. Each year there is a concern that 1, or 10 or 15 will miss out into the future. That is a community investment which will go nowhere. This is replicated across Australia, so it is not like, 'Oh well, I'll go over to Tasmania or go to South Australia'. It is just at that individual's level in the community deliverable on their investment.

What has occurred is, if you can imagine a traditional pyramidal structure or triangular structure, you might have — I will use simple numbers — 100 interns; 50 second-year residents in prevocational training, still looking around, periscopes up; and 20 in the next year. There would be a natural attrition and fallout and all that sort of thing. You might say I did not follow my own maths, but if that is 170 people, what has tended to occur

is we have drawn down and expanded the 100 to 135 so that every medical graduate got an intern position but at the price of there being no second and third-year position or further advanced fellowship training positions, for intervocational training.

At the moment there are not many roles around where you can just sit in the job for 40 years and just do the same thing, so be an orthopaedic surgical assistant or fill in X-ray forms or whatever it might be. That may be something that occurs in the future. What has occurred is those jobs have come down to ensure that everyone gets their internship, they get their general medical registration and, 'Good luck, sunshine — you're on your own'. So the price of losing those jobs is that they are the stepping stones into further advanced training and exposure.

The other thing is that it is just a brutal reality that an intern, almost by definition, is less experienced. It used to be that the more complex hospital jobs would go to a second-year hospital medical officer as opposed to a first-year or intern hospital resident. There is just a bit more street sense, smarts — 'I've seen this 10 times', rather than, 'This is the first time that I've seen it'. Those jobs were typically in the more complex type of medical and surgical unit, moving a little bit more into the psychiatry field, obstetrics, paediatrics. So we are losing those jobs, and there will be a price to pay; it is difficult to know exactly when. Again, that is sort of a budgetary expansion to ensure that there are adequate positions, because it is not so much for December this year or even December next year, but it is for December in five years time.

The CHAIR — So when we are looking at the gaps in terms of those opportunities for interns to move up, is it more expertise based rather than location based per se? We are not saying, 'We need additional capacity here', necessarily; it is more about having the opportunity to progress in expert — —

Dr McRAE — It is a little bit of both. I do not think that you can achieve a good, high-quality medical practitioner via a simulation exercise sitting in a factory out there somewhere. It really does require not only the hands-on experience and ability to interact with patients and get to understand their experience but also the ability to trade off the knowledge and experience of typically senior medical practitioners — sometimes it is peer-level medical practitioners — and just to train and provide that. So what we need to do is sort of think, 'Okay, in 20 years from now where do we want to be?'. As a community, how many neurosurgeons do we want, how many heart surgeons do we want, how many psychiatrists? And things like palliative care physicians and practitioners and the infrastructure around all of that would be required as well. It is definitely a long game.

The CHAIR — Obviously it is a difficult question to answer, but in terms of the cost of the additional internships that are required, do you have any idea what they might cost? If we were to be doing what you referred to there — looking into the future and saying, 'This is what we need' — what are the additional costs that we might be facing?

Dr McRAE — It will be a function of providing correct payments on entitlements for the number of people that are employed in that field. The style of employment is likely to modify it. People senior to me talk about these horrible experiences of starting work at 8.00 a.m. or 7.00 a.m. on Friday and working through to Monday night. I did that a few times — probably a handful. It is horrible, and I am sure that my performance was not fantastic through the Monday and the Sunday.

Also the younger people — while I have been advocating for them — have different life interests themselves. There is a different gender mix, and there is a different expectation of how their own lives are going to go. With their peers, say from high school, and the sort of employment and career paths that they are following, they tend to marry up, so the desire to do 168 hours nonstop is removed. It may well be that we are moving to a great deal of shift-type work, so they are socially inconvenient hours; that requires adequate compensation.

So to come right back to your question, it may cost nothing, because if you do not pay anybody any overtime but people are doing a 38-hour week at a higher hourly rate with some compensatory components for lousy shifts — starting work at 10.00 p.m. and going through to 8, for example — it may be very cost neutral. Like everything, I think there will have to be an injection of funds, but it may not be as horrible as it actually looks.

Then in addition to that another benefit there will be an increase in skills in the handover process. I remember — I am around 55 years of old — thinking how surprising it is that women tolerate another obstetrician coming in and assisting them in their delivery, but they did — rather than their obstetrician. That is just the way it is going. Now, particularly in the public sector, there is no comprehension that this one medical

practitioner is going to be with me nonstop. Of course nursing is much the same — it is not one nurse with one patient; it is a shift-based change. There may be continuity, and there may not be.

So that is another movement. We need to have the infrastructure and investment to ensure that people can undertake good, sensible handovers, point out somebody is allergic to something, or that they do not want that sort of treatment but will have the other — all that sort of thing. So it is a difference in the nature of the practice of medicine, but the bottom line is we want good, healthy patients at the end, so satisfactory outcomes on any investment.

The CHAIR — Just one final one from me. In terms of those students who are not staying on in Victoria, do we have any idea of where they are going — where they are moving to?

Dr McRAE — Some have come from somewhere else — Canada comes to mind and maybe South-East Asian nations — and they go back there.

Mr LEANE — That is not a bad thing, though, is it?

Dr McRAE — It depends on how we want to contemplate that. If we were exporting education, that is okay. If we compromise the ability of a Victorian to obtain an education, that is something that requires a thought process. The junior end of the medical practitioners and in particular medical students are very altruistic and really want the people that they have been sitting next to in the lecture theatres to have the same opportunities and get the full Australian medical registration that they are going to get or expect to get, but there are consequences, and I am not sure that they are completely familiar with what they are. One of them is that — I will use Canadian, why not — if that Canadian gets that internship and then gets that second-year job, then they will not be able to get it. I wonder if that was so smart back then. It is something that we need. It is just workforce planning and how we want to do it.

The CHAIR — Any other questions from committee members? If not, thank you both very much for your testimony today. You will receive a copy of the transcript of evidence in the coming days or weeks for proofreading, and it will ultimately make its way to the committee's website. Once again, thank you very much for your attendance today.

Dr McRAE — Thank you. Nice to meet you. Thank you for your time, everybody.

Committee adjourned.