Wednesday 24 June 2009 - Estimates Committee A (Giddings) - Part 1

LEGISLATIVE COUNCIL

ESTIMATES COMMITTEE A

Wednesday 24 June 2009

MEMBERS

Ms Forrest
Mr Hall (Chair)
Mr Harriss
Mr Martin
Mr Wilkinson

IN ATTENDANCE

Hon. Lara Giddings MP, Attorney General; Minister for Justice; Minister for Health

Department of Health and Human Services

Mr David Roberts, Secretary, Department of Health and Human Services
Ms Penny Egan, Chief Financial Officer
Ms Alice Burchill, Deputy Secretary, Care Reform
Ms Mary Bent, Deputy Secretary, Statewide System Development
Ms Catherine Katz, Deputy Secretary, Strategy, Planning and Performance
Mr Craig White, Chief Health Officer
Ms Fiona Stoker, Chief Nursing Officer
Ms Chrissie Pickin, Acting Director Public Health
Mr Simon Barnsley, Managing Director, Business Services Network
David Boadle, Chief Medical Officer
Mr Gary O'Keefe, Acting CEO, Tasmanian Ambulance Service
Ms Jane Holden, CEO, North West Area Health Service
Mr John Kirwan, CEO, Northern Area Health Service
Mr Michael Pervan, Acting CEO Southern Area Health Service
Mr John Crawshaw, CEO, Mental Health and Statewide Services
Ms Mary Blackwood, Director, Health and Wellbeing Service
Ms Pip Leedham, CEO, Primary Health Services

Department of Justice

Lisa Hutton, Secretary
Michael Stevens, Deputy Secretary
Chris Jacoora, Department Liaison Officer
Jim Connolly, Administrator, Magistrates Courts
Mark Cocker, Director, Monetary Penalties Enforcement Service
Len Armsby, Director, Office of Legislation Development and Review
Norman Reaburn, Director, Legal Aid Commission of Tasmania
Elizabeth Knight, Registrar, Supreme Court
Dale Webster, Project Manager
Stephen Morrison, Director, Finance

Ministerial Staff

David Nicholson, Senior Private Secretary
Margot Dawson, Adviser
Jessica Radford, Adviser
Ken Campbell, Senior Health Services Adviser
Cameron Lee, Attorney-General Adviser

The committee met at 9.30 a.m.

DIVISION 4
(Department of Health and Human Services)

CHAIR (Mr Hall) - Good morning, Minister, and welcome to your portfolios today. The order of business is health outputs first and then the Attorney-General adjusted outputs followed by the Ombudsman outputs.

We will do an overview first and ask some questions on that. I will lead off with the first question. The media reports this morning talked about the specialists in the Royal Hobart Hospital and other specialists around the State saying that they are underpaid as compared to their counterparts in other States, that that has become an issue with them and that the Government is not talking to them. Would you care to comment on that? What can you as minister do about that to sort out the situation?

Ms GIDDINGS - We are at the beginning of an industrial relations process of negotiation with the doctors. I do not intend to pre-empt any negotiations with the AMA on behalf of doctors. I do not think that is very helpful for anyone. There is a proper process to be followed through and it does not include ministerial comment at the very beginning of it. Having said that, obviously we respect our doctors and we understand the need to ensure that they are adequately remunerated and that they do provide a quality service in our State. Having also said that, it is very obvious to all of us that we are in a global financial crisis, there is a $1.5 billion black hole within the State Government's Budget and Health has its fair share of that burden to carry. We are also very much aware of the State Government's wages policy, which is all that the department is funded for for wage increases. That is not to say that we are not going in with an open negotiating

position but anything we negotiate above what we have been provided from Treasury will be another ask on the Health department budget.

Mr WILKINSON - I suppose one of the issues with that is that people are saying, 'The specialist doctors are warning that they will walk out', and the Tasmanian public do not want that to happen. You are between the devil and the deep blue sea, and we understand that. What there is a need for, I would imagine, is an assurance to the Tasmanian public that they are not going to be left without specialist doctors within the system.

Ms GIDDINGS - I would not like to see any situation evolve where people feel that they have to go on strike because they feel that there are no negotiations under way and that discussions are not happening. I would be very concerned if that was the case. My understanding is that there has already been some very basic discussions, including what was discussed with the AMA about having a facilitator help with these negotiations. So I was a little surprised by threats of strikes. I thought, 'We haven't really even started and they are already being' -

Ms FORREST - A pre-emptive strike.

Ms GIDDINGS - It is a bit of a pre-emptive strike. This is part of a negotiation and it will happen, we are coming to the table in good faith and we will be negotiating in good faith.

Mr WILKINSON - Are there any time limits in relation to these negotiations?

Ms GIDDINGS - Negotiations are negotiations and as we have seen on both sides there are times where a bit more time is required for the appropriate discussions to occur either with members from the unions' point of view or with Treasury from our own finance staff's point of view. I suspect that if we go back to Treasury they will tell us to go away. We have been given a wages policy amount in the Budget and that is it.

What is interesting is the recent release of the Australian hospital statistics 2007-08 report did say that the average salary for medical practitioners employed in public hospitals in 2007-08 was above the national average at $158 685 per annum compared to the national average of $151 211 per annum. So our doctors on average were paid above the national wages. So we certainly were not at the bottom of the pile.

Only Western Australia and Queensland had higher average salaries. It is not surprising that the Queensland salaries are the ones that are being referred to in media today because they are close to the top, if not the top, of that salary range. These are just natural parts of negotiation that parties put on the table. And considering t it is very early days, we have a long way to go yet.

Ms FORREST - According to the media article, a first-year level 1 specialist in Tasmanian public hospitals would get about $110 000 and it talks about $197 000 in Queensland and that Tasmania's closest rival is the Northern Territory, where the salary is about $128 000. So someone is not quite telling the truth here -

Ms GIDDINGS - No, no, no, because what I have just read out was an average and it is from the Institute -

Ms FORREST - They are suggesting that Tasmania is the lowest of the pile there unless they are selectively quoting, are they?

Ms GIDDINGS - I would have to check their figures, but I would presume that they are real figures. I would not doubt they are being honest there and that is one band that they are referring to, whereas the figures I have just referred to are across all the doctors in the sense that these are salaried medical practitioners as a whole.

CHAIR - Thank you that response, Minister.

Ms FORREST - It is the lowest level that first-year level 1?

Ms GIDDINGS - Yes, it is, and naturally you always pick your lowest paid as well to try to make an argument.

CHAIR - In these tight budgetary times it is something that you did not want to have to deal with but that is reality, isn't it.

Ms GIDDINGS - It is, it is a reality for the Health minister.

CHAIR - In 2009-10 the Health budget is $1.6474 billion. That is a 27 per cent increase I think in about three years and it is also expected that the Government's newly acquired financial stringency will stop any future blowouts. According to the budget papers, costs will increase by less than $50 million over the life of the forward Estimates and yet budget paper 1 includes a specific warning in the statements of risks and sensitivities in relation to them because we have such a large, complex department. What is the Government's strategy for preventing any further increases in the costs of the Health budget over the life of the forward Estimates?

Ms GIDDINGS - We have, as you know, been undertaking a lot of planning since I have been Health minister with Tasmania's Health Plan on the premise that what we know is that we have chronic disease increasing, an ageing population and demand pressures on the rise and for the foreseeable future those pressures are going to continue, which is why we said let's stop here for a minute, let's take stock of where we are at, let's plan for the future and let's start trying to make some structural changes to turn that around.

[9.45 a.m.]

There has been a number of areas where we have begun that process of trying to bring about structural change. At the same time we have been looking at how else we can make the system efficient. So in areas like IT investment for instance, in last year's Budget we invested some $18 million into IT. That investment is continuing; we have made no cuts in that respect to it. What we have tried to do, and I hasten to add this is not my portfolio area of Human Services now, but I certainly have been very supportive of the approach that has been taken this year by Mr Roberts and his team to ensure that we protect the reform moneys across Human Services and Health so we can keep those structural changes happening. We have tried to do that as best we can, and to put our budget management strategies across older areas basically we will have to take some pain because somewhere pain has to be felt to some degree.

I am happy, if you would like more detail around some of that structural reform change, for Mr Roberts to tell you more.

CHAIR - I understand that. How many positions might have to be abolished to meet the forecast savings over the life of the Estimates - that is something you might defer to the secretary - and from what areas might those jobs go?

Mr ROBERTS - We are just looking at the savings agenda for this year. Of course we are very mindful of the savings that we have to make in subsequent years, but I think it is right that we concentrate on the coming year. Of that, we have identified the need for up to 250 positions; that includes the five SES positions that were announced -

CHAIR - Five?

Mr ROBERTS - Five SES.

Ms FORREST - Have you identified five specific positions that are going to go?

Mr ROBERTS - Yes, and they will be gone by 30 June.

Ms FORREST - What positions are they?

Mr ROBERTS - Whilst we are looking for that brief, I will continue.

There is a contribution of 66 general management posts that we have also been asked to save and then the balance of the 250 will have to be found from within the entire services that we offer. What we have said, though, and we are in the process of working through what the financial implications are for all operational units, so the hospitals, Mental Health, Primary Health, and so on, is that we will look at any opportunity to make ourselves more efficient and effective to avoid major job losses. It is not up to number, and certainly the CEOs are very keen that they find always that they can make efficiencies and savings to avoid them.

In terms of how we will approach that, I think it is very much that an individual target will be given to an operational unit around how many positions they need to find and that they will then be able to work through sensible, sensitive, appropriate plans to reduce their headcount. What we have said is this is not about cutting jobs and giving other people the tasks or sharing out the burden. That is not going to work on a sustainable basis, we need to find things that are about reducing the overall tasks in the service. That is where the information technology, where the changes and reforms that we talked about all start to play their parts.

Mr WILKINSON - What is the type of thing you are looking at? We were told a couple of days ago that when you are looking at so-called voluntary redundancies, really what you are looking at on average is an FTE of $66 000. The Treasurer has said that each department has to find certain efficiencies, therefore they are saying it saves 10 positions, therefore you are getting $660 000 less than you would otherwise get, therefore you have to cut your cloth to suit your costs. In relation to Health, what types of areas are you looking at when you are endeavouring to cut your costs?

Mr ROBERTS - We have not taken quite the approach that the Treasurer took in that regard, we have looked a bit more sensitively at the areas where we need to reduce costs. So if we were to take just this is the amount of money we have to save times an average post, we would probably be looking at 400-plus posts, if not a little bit higher. We have not done that. We have

said no, there are efficiencies that we can expect the system to deliver, therefore we now need to look at this area, this area and this area to try to find headcount reductions.

Again, the department does not want to get too sensitive around that either, because we have moved to this devolved structure. It is about giving more autonomy to our front-line services, and they are the best people to determine which positions could in fact be lost or changed to make them work.

Mr WILKINSON - What type of efficiencies, though? We have heard it now for a couple of days, 'We are going to make efficiencies'. What I am wondering is, how can we make efficiencies? One would have expected that we have been working efficiently over the last three or four years. What further efficiencies can we make, especially when you look on the other side of the coin at the burgeoning costs of Health?

Mr ROBERTS - Our system is always changing and moving. To give you an example, this year alone the Royal Hobart Hospital has improved the productivity of its operating theatres by 20 per cent, and they think it can continue to improve as well. That is a really sizeable number.

Ms FORREST - How do they do that? What do they do to achieve that productivity increase?

Mr ROBERTS - They have been looking at the processes, the contributions of each member of staff, what stops the theatre from operating, what makes an operating theatre run smoothly and have all the goods and services they need on time, standardising the equipment, standardising the types of prosthesis they use. All of those sorts of things are where we go and look for efficiencies. We would apply those same principles and practices across all that we do. For instance, we are looking at some issues to do with making our ward spaces more productive, not that our wards are unproductive but there are processes in play there that we could look at to make them better. We will be talking a bit more about some of those things later.

CHAIR - Over the life of the Estimates $80 million is allocated for reviews, Minister. Given the size of the public sector, you would think that there would already be sufficient talent and capacity within the current public sector without requiring a further budget allocation.

Ms GIDDINGS - It is not about reviews, it is about implementation of the reviews that we have already been doing. It is across Health and Human Services. For instance, in my area it is the Banscott and Sharley reviews that were already done into patient transport and accommodation that we are now implementing. For Lin it is a disability review that she has now completed and is now implementing - the child protection reform.

CHAIR - So it is implementation rather than review?

Ms GIDDINGS - Yes. That was the point I was making, that we quarantined our reform processes in that sense internally so that we keep that going.

CHAIR - How much of that $80 million has gone out to external consultants?

Ms GIDDINGS - It is about the implementation of the reviews we have already done. In previous years we did the outside consultancies on disabilities and all of those.

CHAIR - So $80 million is for implementation?

Ms GIDDINGS - It is the implementation of our findings. In some of the reviews what they have recommended is that we go ahead and do further work in an area. Tasmania's Health Plan was the big review but within that came out a recommendation to do further work on patient transport and accommodation and that is what Sharley and Banscott were, so now we are implementing the recommendations of that. They have not asked us to do another review, that is it. We are doing all the implementation now. Bariatric surgery, for instance, is something that has been looked at out of the Health Plan. That is a review being done internally, I think. There is still work falling out of the larger plans, but we are very much now into the 'let's get on with the implementation' of it. It is not just sitting around talking.

Mr ROBERTS - Can I just give you the positions that will be gone by 30 June? There is a deputy secretary position for statewide system development, an SES level 4 - that individual leaves at the end of the month. There is a Department of Finance SES level 3, a corporate saving; a director of education and training SES 1 from Human Services; a director of youth justice SES 1 from Human Services; and a director of resource and system performance SES 1 from the department. Those positions are in process for being disestablished by 30 June.

Mr WILKINSON - And the savings would amount to?

Mr ROBERTS - We could calculate that for you. Could I take that on notice and perhaps come back to you? It is not a difficult one for us to work out.

Ms FORREST - When you made a decision about those positions how did you go about making sure that you do not diminish the service of that particular area by removing those positions?

Mr ROBERTS - That is a great question. What I think the committee will recognise - and we talked a little about this last year - when I came here I was asked to implement reform, implement the Tasmanian Health Plan and reform the department and that is exactly what we have been doing. We are able now to move to taking some of these positions out because we have created different tasks within the organisation. Some of these things have been devolved now to the operational units. The work that Statewide Services has been doing is now being done by the creation of new areas. It is right that they take on that responsibility. Regarding the integrated care centres, for instance, all the planning work has now been done for those and the LGH is taking on now the responsibility for that solution. There are many other things like that. We have also been reforming extensively the Human Services space and I am sure that we will talk a little bit about that in another committee. We have been streamlining that. We have now joined up Disability and Children and Family Services.

Those sorts of activities enable us to identify where positions are now longer required or they have changed or we have moved on to a different solution. That is how we have identified each and every one of these posts and been able to make a decision that we can now reduce that.

Ms FORREST - So we are not going to see the reduction of programs particularly. What we are looking at is basically input savings, taking out the input side of it. Suggestions have been made that there should be a greater look at output savings and whether you can remove or disband projects or programs that could be amalgamated or shelved or got rid of altogether. Is that an area that has been looked at as well?

Mr ROBERTS - I think it is always our job to continually look and review what we are doing. Things do pass on; they are no longer functions that we sometimes need to do. None of what we are doing here is about stopping any program or reform or anything that we are currently on with and that is not what we are mandated to do or what we want to do.

Quite the contrary, we want to continue with the reforms, we want to continue to add important programs so these are just natural changes in organisation. We have had to look a bit deeper this year, we have had to accelerate a number of things. For instance, in terms of the State-wide system development, in order to achieve that target, in order to be able to release that post we have had to accelerate a couple of things, which is what we have done. We have accelerated the implementation of the areas, for instance, to enable us to accelerate the pulling back of this program.

In many ways that is fine. As long as the system can cope with that, I think it is right and proper that we do that.

Ms FORREST - Last year, Mr Roberts, you stated that there would be 'a$50 million year-end budget overrun that would be covered through reserves within the department'. I have a couple of questions on that. Was this the case that the $50 million overrun was covered within the department or was transfer of funds from another area or department necessary? Is there expected to be a shortfall this year again and, if so, by how much and how will that be met?

Ms GIDDINGS - I am advised that there is no overrun for this year. We are not sure that it was a $50 million overrun at the end of last year. So perhaps if we take that on notice for you and we will give you the figures as they were at the end of the financial year. I am not aware that we had any problems anyway of finding ways of dealing with our budget at the end of the last financial year. We will get, as best we can, exact numbers for you and I understand that we are not expecting an overrun this year, which is full credit to the team of Dave Roberts and Penny Egan particularly and Eleanor and everyone else who have been supporting them in making sure that we come in on budget this year.

It also is a reflection of the fact that we did get a substantial increase in funding last year which enabled us to put sustainable budgets in place for our acute care hospitals where overruns have been a problem in the past.

Ms FORREST - So the major hospitals themselves are currently able to operate within their existing budgets now; they were not able to in past times.

Ms GIDDINGS - That was the key feature last year and when Dave arrived he was very definite that that is what he needed to do to put them on a sustainable footing. Now, having said that, we are in a position of global financial crisis where the generosity cannot be quite as it was in the past.

[10.00 a.m.]

Mr ROBERTS - All of our operational units come under a varying degree of pressure throughout the year. Patients do not naturally turn up in order so for our hospitals different challenges will hit them and face them at different times. We have been working on trying to gain consistency such that whether you are in the north, north-west or in the south you have, broadly speaking, common access rates to our services. With that it is inevitable that over a year or two

we will find that there will be more demand in one place than another. We may not have budgeted appropriately for that fluctuation in demand so we have to keep a really close eye on that and work with the hospitals where they get particular budget pressures. For instance, the LGH is under a little pressure financially at the moment because of increases in waiting lists. That is fine and that is a phenomenon that I am used to working with, the department is comfortable with. We work with each of the CEOs to identify that and try to fix those problems where they emerge. At this stage we are comfortable that all of the operating units are appropriately managing the constraints that they currently have.

Mr WILKINSON - A good mate of mine, who is unfortunately not here any more, was saying one of the ways of dealing with the hospital issue and the cost of hospital issues could be if hospitals had areas of expertise. The Launceston General has expertise in certain areas, the Royal Hobart has expertise in certain areas. There is always going to be an argument from the north if, say, heart is in Hobart and not up north, et cetera. It is always going to be a problem but do you believe that is a viable proposition?

Ms GIDDINGS - That is exactly what the Health Plan is about, ensuring that we have the appropriate services in the appropriate areas and that we do not just have a system which is enabling any hospital to grow services willy-nilly, that it has to be within a planned environment. It is important that there are certain services everywhere across all hospitals - even rural hospitals with basic medical support. As you go up the complexity of work you end up coming to a narrower and narrower base as to what hospital has what. As you rightly identify, cardiothoracic surgery or open heart surgery is only at the Royal Hobart Hospital. LGH has brachytherapy, which is a very specialised area of cancer therapy, and it is only at the LGH, and there are other areas like general medicine you would have across all your acute care hospitals.

We had to have a very close look at what was happening at the Mersey hospital and decided that it was not safe through that Health Plan process to have an ICU there so the ICU has not been re-established. There have been political ramifications around that decision and changes to the Mersey's management structure. That is what we have done. It has caused some concern in some quarters, but we believe we have had to do it for the long-term planning of our health system.

Mr WILKINSON - That is going to continue?

Ms GIDDINGS - It will continue. The Health Plan is a 20-year plan. In 20 years' time we expect you would need to have a really good look again at what you are doing but it is also an organic plan so it is constantly being looked at and in a sense revised or decisions made against the core principles of the plan. The fundamental part is that safety sustainability, quality of services, are the core principles of it.

Ms FORREST - Going back to budgetary matters, over the last few years there has been criticism of the late payment of accounts. I understand that Treasury created a fining system for late payment of accounts and any accounts beyond their term will incur a fine. Treasury informed us on Monday that that was going to be implemented on 31 May this year but I do not imagine that the department have had many fines as yet. However, can you inform us how many accounts have been paid within their terms over the last 12 months and if there are any outstanding at this time and by how many days?

Mr ROBERTS - We might not have it. I think we need to take that one on notice. We cannot tell you how many fines or if we have had any.

Ms EGAN- We do not record information. The creditor charges us interest and we pay the interest on the amount.

Ms GIDDINGS - From Treasury fines? We have not had any Treasury fines.

Ms FORREST - No, it was only on 31 May. So you will provide the information about the unpaid accounts?

Ms GIDDINGS - We will put that on notice for you.

Mr ROBERTS - It is 46 per cent -

Ms FORREST - It is still quite high, then.

Regarding the H1N1 virus and the impact on the State, we know what the health impacts are, but what are the cost impacts? How much is the publicity, the printing of all the information and all that? What cost has that imposed on the State Budget?

Ms GIDDINGS - It is probably best if we leave that one to the output group and we bring Dr Chrissie Pickin to the table, who has been responsible. That will fall under Population Health, and at this point I do not think those costs have been quantified because there is an element that will be Australian Government funded and some will be local government. Local government hopefully will be reimbursed by the Australian Government, and so on, but it is complex. We have freed up, I think, $1 million in our own capacity to help with the funding of it, but we can talk more about that.

Ms FORREST - Can you inform the committee in the last financial year how much has been spent on consultancies?

Ms GIDDINGS - We will take that on notice and give you the information - just for the sake of time. That is a standard question, if you like.

Ms FORREST - All right.

Ms GIDDINGS - We did that in the lower House yesterday, too.

Ms FORREST - Is this one of the areas, then, that has been targeted in the savings, or is this in your budget management strategy? Consultancy is being looked at as a cost-saving measure, not having consultant use?

Mr ROBERTS - We have not particularly looked at it to determine whether we should cut it. We always consider very carefully when we are going to add it, so we do not have a budget allocation for we will spend *x* amount on consultancies next year. That is not quite how we work. We may well find a need during the course of the year, or identify a need for a particular piece of consultancy. I think what is different is that all pieces of large expenditure like that now will be reviewed more carefully in terms of can we avoid making that expenditure in the coming year. We have not budgeted for large amounts of consultancy in coming years, with the exception of the capital areas where the $100 million on the LGH, the $100 million on the Royal where there will be consultancy-type contracts associated with them.

CHAIR - When redundancies are awarded to current members of the public service who are paid out, can you guarantee that those people that have become redundant will not then start picking up consultancies?

Ms GIDDINGS - It is a matter for DPAC- Treasury, I think. I think the Treasurer talked yesterday about bringing in a rule. I only read about that - a public servant not being able to return for five years, or something - through the media, so I have not even been briefed on that. I expect that is more a question for the Treasurer to give us instructions as to what we are able to do and not able to do.

CHAIR - We might, in that case, write to the Treasurer and ask him.

Ms GIDDINGS - Ask him has there been any thought behind that. Ultimately my gut reaction would be it should not really matter if they have private businesses that could compete with all other private businesses and tender for work, even though it is government work. The issue is people getting redundancies being paid out by government and then returning to government again 12 months later to be re-employed. That is where the issue is, which is what I think the Treasurer was trying to address.

CHAIR - That is right. It has happened in Education and other areas before to quite a large degree.

Ms GIDDINGS - But to put a restraint of trade effectively on someone for a period of time purely because they once worked for government, you would have an argument -

Mr WILKINSON - That would be crazy in my view. I would not have thought a government would have thought of that. If the consultant was the best person to do the job or to obtain a report from, surely that consultant should be able to provide that report because it would be in the best interests of everybody.

CHAIR - We might debate this in the House.

Ms FORREST - If I could go down a slightly different path but a similar line, I am interested in how much this last financial year was spent on advertising, and in what particular areas that was targeted.

Ms GIDDINGS - In the interests of time, do you want us to take that on notice for you or do you want to quiz us on it?

Ms FORREST - I guess we need to be sure that the breakdown includes things such as how much is spent on job vacancy advertising, promotional activities - I know a fair bit was spent in previous years advertising and promoting the Health Plan and that sort of thing. As long as we get a breakdown of where that advertising money has gone.

Ms GIDDINGS - That level of detail will definitely have to go on notice.

Ms FORREST - Is this an area that is going to be cut back on next year in light of the financial constraints?

Mr ROBERTS - In terms of publications and things?

Ms FORREST - Yes, and promotional advertising.

Mr ROBERTS - Yes, absolutely. What you have all probably already observed is that our annual plan has been very much reduced in printing costs, internally produced, all the stuff around Leading The Way. Recently we have made a lot of publication and done all of this work in-house using our own materials rather than sending them out for printing. We are trying very hard on advertising to streamline the way we advertise posts and look carefully at grouping them together, using the web more. We have a very major savings agenda around trying to reduce our printing and external marketing costs and that will be seen in the documents we produce. We are very happy with internally produced material but sometimes we do have to externally produce, but that will increasingly less.

Ms FORREST - It is more cost-effective to do it in volume.

Ms GIDDINGS - The other aspect is we have also been directed in some areas by Treasury to make sure there are reductions - so, mobile phones, vehicle usage, travel. Advertising is one of those areas. It is looking at where you can make cuts first that have the least impact ultimately on the department and service delivery.

Ms FORREST - Do you believe the proposed Federal Government changes to the private health insurance rebate - and this is an issue that was raised last year with different changes then - will have an impact on the public health standards in Tasmania? Have the previous changes had an impact?

Ms GIDDINGS - No, we do not. The last change had very little impact on us and we believe this one will have very little impact also. The initial introduction of the rebate only increased private health insurance take-up marginally between its introduction in January 1999 and March 2000. The rebate only increased health insurance take-up nationally by 2 percentage points and only by 1.3 percentage points in Tasmania. The largest increase in take-up was due to the introduction of Lifetime Health Cover in July 2000, which increased coverage by 13.5 percentage points nationally and 10.3 percentage points in Tasmania. As part of the Federal Budget the Australian Government is scaling back the health insurance rebate for high-income earners. It is unclear if there will be an impact of any significance due to these changes. Commonwealth Treasury has forecast a drop-out of less than 1 per cent due to the rebate reductions. We are more concerned about the global financial crisis, to be honest, that that might have an influence on private health insurance coverage. If people are losing jobs, one of the first things to go could well be private health insurance. That is more of an issue for us if employment continues to increase than the changes the Federal Government has made.

CHAIR - I have a couple of matters before I go back to Ms Forrest. We have collected up quite a few questions on notice already. I would like to say from the committee's point of view that last year some responses from Health were very slow; in fact I think there was one that stretched out to about August.

Ms GIDDINGS - Do you recall what that was about?

CHAIR - No, I cannot remember what it was about. We would appreciate if we could get those answers back -

Ms GIDDINGS - I do have information here on the consultancies that I can give you right now, but I am not just trying to save us time.

CHAIR - No, that is fine. If I could turn to the Launceston General Hospital and quickly talk about some capex there - and that is to do with the car park and the $15 million.

Ms GIDDINGS - Do you want to do that under the line item because we will have John Kerwan from the LGH with us. I am happy to cover capital programs while the CEO is at the table.

[10.15 a.m.]

CHAIR - I am a bit concerned about having the three-hour moratorium that we have here. Whereabouts -

Ms GIDDINGS - Output group 1, so the very first output group. I am quite happy, to help save time, to do it as an output group rather than to go line by line. So you can cross over any issue. If you want to talk about ambulance or hospitals -

Ms FORREST - It makes more sense.

Ms GIDDINGS - do it as an output group as a whole as a time-saving measure for you.

CHAIR - All right, as long as I can cover it.

Ms GIDDINGS - Absolutely. The sooner we get off overview the sooner we get on to output group 1 where the issues are.

CHAIR - So you could not answer? I had two or three questions about that.

Ms GIDDINGS - I can, it is just that he is project managing it. One of the things that we are doing is devolving these responsibilities to the hospitals so it is good if the CEOs answer.

CHAIR - Okay, all right I will accept that.

Mr HARRISS - Minister, going to the Consolidated Fund and the expected outcome for this year being $8 million under the Budget on the con fund and I have had a look at the explanation. There is an application of your budget management strategies but budget management strategies have only come in with the budget under review.

Ms GIDDINGS - No they haven't.

Mr HARRISS - There was a process after the midyear financial review, the preliminary last year, and there was a directive given for savings measures, efficiency dividends. Can you give some detail as to the impact of those efficiency dividends? What exactly have you put in place to ensure that you come in $8 million under budget, as projected in these papers?

Ms GIDDINGS - We had to find $16.7 million across the entire budget for both Health and Human Services, across both elements of the department in this current financial year. We have found that form of savings and it has been through the implementation of budget management

strategies like being careful with mobile phones, those basic ones, the core ones you would know of, as well as vacancy control and those sorts of things. In a budget that in total is around $1.3 billion nowadays, $16.7 million is not that difficult to find through just day-to-day operations. We spend almost $3 million a day on health care in Tasmania. So you are talking about two weeks' worth of looking for savings. You hate losing money at any point in time and particularly in Health. They have to wrench it off me. But having said that, when you have a problem that you have to deal with you deal with it. We have done that and we will do that in the next financial year, some $48 million we need to find in 2009-10 and we will find that too.

Mr HARRISS - Setting off against that there were extra funds flowing from the Federal Government in this current financial year, weren't there?

Ms GIDDINGS - Yes, there have been through election promises that they have been delivering on. An amount of $10 million, for instance, on patient transport and accommodation - promises and those sorts of things. We have had Federal money coming in.

Mr HARRISS - Is it too simplistic to suggest that without those extra revenues, which were unforeseen when you struck the Budget this time last year, that your $16 -odd million would have been much, much more than that - you would have had to generate much more saving than that?

Mr ROBERTS - We did get some money late in the year from the COAG Health Care Agreement funding and we used that to set against that target. At the beginning of the year we would have known that that was coming and planned to use that for a whole range of things that we just never allocated on the basis that until we got it we did not know. So some of that would have helped us out there.

Ms GIDDINGS - Our budgets are made up of a combination of Commonwealth and State funding. We have the Health Care Agreement that is a fundamental part of our funding. I think that they fund close to about 30 per cent of our health needs. There will always be that. We have had the elective surgery money come in in this financial year, the $8.1 million from the Commonwealth. So yes, there is money that comes in and it helps us with our cash flows and it helps us balance our budgets. But we still have to spend it and account for it so the $8.1 million has been accounted for back to the Commonwealth. The patient transport funding, the $10 million, will be accounted for to the Commonwealth. It helps us in managing our budget but you cannot necessarily use it to offset your own problems. Having said that, the ACA money, for instance, is money that is given to us to run our health system as a global budget and we will use it as we need to to assist us through these problems.

Mr ROBERTS - Just to confirm that number, we received $13.7 million additional in the 2008-09 year. We would have anticipated a proportion of that in terms of the money that we allocated out to our operational units and in fact did, so when we did the sustainable budgeting at the beginning of the year we anticipated that there would be some additional funds that came in. We managed the year through and so we have applied whatever was left of that $13.7 million to that $16.7 million target and they have had to find dollars in addition to that but we have not had to cut services or anything in order to achieve that target.

Mr WILKINSON - You might want to take it on notice, I do not know, but what I am looking at is private patients in public hospitals. In the year ending 30 June 2008 there were 12 193 acute patients with private health insurance admitted to Tasmanian public hospitals. That is up 12.8 per cent on the previous year and my understanding is that these patients occupied

42 263 bed days. On an average day there would be 115 private patients occupying beds in Tasmanian public hospitals and that does not include self-insured DVA and third party compensable patients. What are the current figures and how many privately insured patients in total were admitted in 2008-09 to date, how many at the RHH, the LGH and North West Regional and how many bed days in total do they take up?

Ms GIDDINGS - The details for each individual hospital we will take on notice for you. As to the issue that you have raised, it is raised every year. The effect of this is that the Health Care Agreement that we have with the Commonwealth says that whoever turns up to our door must be admitted into a public hospital. It does not matter if they have private health insurance or not, if they turn up they are admitted. It is part of our free health care.

The issue then is that yes, we do end up with some privately insured patients in our system and for the total number of patients treated in our public hospitals the up-to-date figures that I have here are 11.8 per cent of private patients, even though 43.2 per cent of our population have private health insurance.

Mr WILKINSON - There is 43.2 per cent?

Ms GIDDINGS - So 43.2 per cent are privately insured and 11.8 per cent of our patients are private patients so there is a huge number who either are not needing to access the health system or they are using the private health system.

Mr WILKINSON - If I asked how many people in Tasmania did not have private health insurance it would be about 57 per cent?

Ms GIDDINGS - It is 43.2 per cent so it is about 57 per cent in the other direction who do not. The only other issue is that we do have some patients come into our public hospital system who do not declare that they have private health insurance and therefore we cannot count them and they are not counted.

Ms FORREST - On that point, are they all asked, Minister, when they present?

Ms GIDDINGS - We will ask the CEOs when they come but it is a tricky one because you are not allowed, I believe, when they first arrive to say, 'Do you have private health insurance?' There is an issue there with it but of course it comes out. We will ask the CEOs directly how they do respond to that. The issue for us is that we do get some benefit from a private patient being there but their default benefit only covers about 22 per cent of the cost of their treatment. We are still covering the other 78 per cent of the cost of their treatment anyway and with medical pathology imaging and prothesis costs included, the total recoverable costs for private patients are only around 40 per cent of the cost of treatment. They can elect to be treated as a private patient in our system. I am advised that there is no incentive for public hospitals to chase private patients but there is an incentive to have privately-insured patients who are attending the public hospital for treatment anyway to elect to be treated as such.

CHAIR - With medical graduates there will 92 graduates in 2009, 100 in 2010 -

Ms GIDDINGS - Again, it might be best to go to output group 1 for that because I think Dr Craig White deals with interns.

Mr HARRISS - Minister, the out years for the department in terms of your total outputs are very modest indeed as against any historical analysis of the department. I am looking at the difference between 2009-10 and 2010-11, where there is an ever-so-modest downsize, the next year it is only a 2 per cent growth, the year after that it is not even 1 per cent growth. As I said, any historical analysis, as you would be aware since you have had the portfolio, shows that the department always has a growth factor of some substantial proportions. How can we be assured that those very modest projections for the out years can be met? Even in such a big budget, as you said a while ago of $1.3 billion or $1.4 billion and the millions per day, the squeak of an overrun amounts to millions. How confident can we be that all of that can be managed to deliver what is being projected not only for the coming year but the out years?

Ms GIDDINGS - As I said yesterday, none of us know what the impact of the global financial crisis is going to be up or down, which makes it very difficult for Treasury and for us to have some idea as to what is going to happen in the future. We have economic modelling which is the best that you can provide for us to have some idea, which is obviously what the out years are about, and to base your fiscal strategy on so that you ensure you come back out of deficit and do not go into any form of net debt through this process. It does have a role to play but my main interest is to ensure that the figures we do know for this coming financial year are very clear and that we put into place the strategies to deal with that. We have some idea as to what the next financial year is going to look like, so in our thinking we are also thinking about what we might need to do in the next financial year with further concerns around our revenues and expenditure costs that will need to be reined in and think about that in terms of our planning. It also gets back to why our structural planning is so critical.

There are areas where we can make efficiencies. I am thinking of my old portfolio of child protection. When I was minister they were still on paper files. I believe there has been a lot of investment in IT in that area, for instance, to try to start the process of getting them onto a proper IT-based system. Even in our own hospitals we have a lot still using paper file programs; even though we have had a program to put our medical records onto a digital system, it is still not an electronic patient record. We will continue to work with the Commonwealth as well around a digital medical record that will build efficiencies into our system for the future. If you start talking out years you start talking about those sorts of programs that we will continue to work on. I am really keen to concentrate on what we do know at this time, which is the 2009-10 year and how we are going to deal with the immediate budget problem we have.

[10.30 a.m.]

Mr HARRISS - We know that between 2008-09 and 2009-10 the expansion is 8 per cent, so even if we were to factor in -

Ms GIDDINGS - That is right, okay. That is the issue that came up yesterday as well. With this next financial year, 2009-10, we have a twenty-seventh pay period, so the budget is inflated slightly to take into account the fact that we have this pay period that we need to account for. Then we are back into a normal year the year after. So it gives you a wrong impression in a sense as to what is happening because of that.

Mr HARRISS - An aberration.

Ms GIDDINGS - It is an aberration because of that issue.

Mr HARRISS - My first grab at that was that I thought, 'Gee, 8 per cent in the coming year'. If you halve that, you would blow your budget by about $65 million even if it is only a 4 per cent expansion, so things really are extremely tight, but it goes for every agency, we understand that.

Ms GIDDINGS - Things are tight, and in Health you have inflationary pressures that other departments do not have. Health inflation is much higher.

Mr HARRISS - Pharmaceuticals and medical supplies are ones that come to mind.

Ms GIDDINGS - We have talked about that before, I think. Wages as well, doctors talk about wages already.

CHAIR - Mr Harris is being very agreeable this morning, is he not? Trying to help you out.

Mr HARRISS - Par for the course, the minister knows that.

CHAIR - It is early days yet. Any more questions on overview? If not, then I think, Minister, we will move into output group 1 and, as you say, we will do it in bulk.

Output group 1
Acute Health Services

Ms GIDDINGS - What I will do, then, is invite the three CEOs to come immediately to the table, and we can start around those issues. We have Ms Jane Holden, the CEO of the North West Regional Hospital and CEO of the North West Area Health Service; Mr Michael Pervan who is the CEO of the Royal Hobart Hospital, and will be responsible for the Area South when that is established. We also have the CEO of the Launceston General Hospital, Mr John Kirwan, who is also now responsible for the Northern Area Health Service.

CHAIR - Now we have Mr Kirwan at the table, I might ask that question regarding the LGH. Referring to the $15 million allocated to the car parking we could argue that it works out to 400 car spaces, $37 500 per car space, which becomes quite silvery. I am not saying that it is not needed, because it is. It is a dreadful place, as everybody knows, to try to get a park. How have you costed that $15 million, and have you considered a partnership with the private sector, a PPP?

Ms GIDDINGS - That aspect is mine, the first bit is his.

CHAIR - I beg your pardon. We will go to the first aspect then to Mr Kirwan.

Mr KIRWAN - Through you, Minister - the $15 million costing is based on the survey and quantity surveying work, and based on national standards through a consulting firm that we employed. That is what is still being worked out. We have a different set of architects and quantity surveyors working on that, and we will bring forward those costings to the Parliamentary Standing Committee on Public Works,. hopefully in July, with all the other capital works that are occurring, but we are confident that the original quantity surveying work -

CHAIR - Where might it be? Has a location been determined yet?

Mr KIRWAN - Yes. There were three options. The preferred option, which is also the cheapest rather than a tower block, because with a tower block would come a range of lifts and other issues. The preferred block is at the rear of the site down as a wrap-around from Franklin Street around to the back of the gardens, and it is currently proposed to be built in two stages. The first stage will be built on time by the middle of next year. It is reasonably straightforward. One of the discussions at the moment is in fact the size of the car parks because, interestingly enough, which I did not understand, the size of a car park for public fee paying is actually larger than for staff. There is a difference in the size so we are working through what that means at the moment and that will go forward, as I said, to the Parliamentary Standing Committee on Public Works. We are confident that that can be achieved. We currently have a shortage of about 200 spaces on site and the car parking will give us a net increase of 400.

CHAIR - How many levels?

Mr KIRWAN - It is wrap-around low density so it is actually three levels, using the natural fall of the land down Franklin Street. The advantage of that is there is not the need for lifts and when you look at the diagrammatics it is difficult to see the impact on the visual area because it is quite low impact.

CHAIR - You have had discussions with the Launceston City Council?

Mr KIRWAN - Yes, we are very grateful. The council has been very patient with us. Being in an inner city hospital, parking has been an issue and an aggravation and the minister can report on the announcement that she and the Premier made at the hospital, along with a whole range of very important clinical issues, which was the one that was the best received.

Ms GIDDINGS - Cheers , claps.

Mr KIRWAN - The frustration levels have been high but the advantage is that the way the architects and the quantity surveyors are now looking at it we can probably have a solution in there, as I said, by the middle of next year for the first stage but the second stage will take a bit longer.

CHAIR - I go back to the minister then about the question I asked on the funding.

Ms GIDDINGS - We have determined that we will be funding the capital expenditure ourselves through the State Budget and it is essentially a part of a stimulus package from the State in that sense, to ensure that we keep our building industry employed and the confidence in the economy up so that has been the reason we would want to do that.

In terms of the ongoing running of the car park, though, Treasury have been quite keen to ensure that we do look at other ways of operating the car park rather than it being operated by government. I expect that what will happen is that there will be a tender process for the actual operation of the car park but the building construction of it is very clearly government funded and an important part of our aims to keep the economy going.

CHAIR - If I could be the devil's advocate then, is it appropriate to spend $15 million on a car park at this stage given the spending cuts in other areas of the Budget, particularly with staffing levels? That is a balancing act but, as minister, you have to consider that.

Ms GIDDINGS - It is a fair question and most Tasmanians would ask the same question. The issue here is the difference between recurrent and capital expenditure. The capital expenditure is one-off expenditure so once the $15 million is gone it has gone, it is spent. So to actually shift the $15 million into recurrent expenditure and to boost services at the LGH for instance, we are employing more nurses and it is fantastic for the one year that you have the $15 million and then suddenly you have a big black hole and where do you go? I think that is important for the public to understand, that with capital expenditure it is one-off and it is gone once it has gone.

The car park, as John said, in terms of the frustrations of the staff and patients, has been one of the critical issues that has been raised with me time and time again and the response we received was quite phenomenal, I have never been cheered and clapped ever at an announcement that we have made - jeered, definitely but never cheered.

The other critical issue to this, too, is not only is it dealing with an issue that is needed right now but it has also very much become part of the infrastructure that is being developed around the Launceston ICC as well and the importance that if you are building another building with more services that you can accommodate the patients who will be using those services with appropriate car parking.

Ms FORREST - I want to ask a few questions about the funding arrangements for the Mersey hospital and I know it is part of the North West Area Health Service now, but the budget papers indicate there is an allocation of $60 million from the Federal Government to fund the Mersey Community Hospital and the total cost of the supplies and consumables is another line item there of $20.6 million. Can I have a breakdown of the actual costing to operate the Mersey - staff costs and other operating costs?

Ms GIDDINGS - I am happy to hand to Jane Holden who is in control of that area.

Ms HOLDEN - I want to be clear what the question was.

Ms FORREST - The Federal Government allocated $60 million per year for the funding of the Mersey. Can you provide a breakdown of where those costs are spent, what are staff costs, what are consumable costs, supplies?

Ms HOLDEN - I am not sure that I have that detail here today but I could get it.

Ms GIDDINGS - That is a level of detail that needs to go on notice. We can talk about the more general issues for you. We signed the agreement with the Commonwealth, that equates to $180 million over a three-year period. We then must have a budget that enables us to grow over that period within that envelope of $180 million. I have all the services listed. You do not need to know that, do you?

Ms FORREST - No.

Ms GIDDINGS - The Mersey has staffing of approximately 320 FTEs made up of medical practitioners, nurses, allied health, administration, clerical.

Ms FORREST - Have you a breakdown of the clinical staff as opposed to the administrative staff?

Ms GIDDINGS - The actual breakdown to that level is a detail that we will need to get back to you on.

Mr ROBERTS - We separately account for the Mersey as we have to and report to the Commonwealth regularly on separate accounts. Giving you any level of detail is not a problem; we have just not brought it with us today.

Ms FORREST - Does the Federal Government impose requirements under the agreement to provide - we know that they wanted an intensive care unit -

Ms GIDDINGS - The Federal Government did not, the community wanted it.

Ms FORREST - Are we providing a service here that could be more efficient if it was not in that model that required this extra accounting, extra reporting and that sort of thing because of that framework? I know the money sits outside the rest of the health funding, it is a separate bucket.

Ms GIDDINGS - We did not ever want this to happen. It is not of our making or our choosing. We want to ensure that we do integrate the Mersey as best we can into our State public health system. We do have to account for the funds separately but we have been working with the Commonwealth to ensure that the services provided are the right services for the Mersey hospital and for the north-west. I still have not let go of that view that there are operations that could be performed at the Mersey, that we may say to a southern person, 'If you want your operation sooner, you could go to the Mersey and have it'. That leads to an extent to what we are doing around elective surgery planning to look at how we can better coordinate our lists. We want to make sure we have consistency in the way lists are managed across the State so there is more ready information for that kind of decision to be made. Jane has done a lot of work around that.

Ms HOLDEN - Notwithstanding the fact that there was a heads of agreement, we have been working, as the minister has said, with the Commonwealth to enhance the integration of those roles. We have moved a number of short-stay surgical services across to the Mersey to the benefit of the whole of the north-west. In dental we take a northern north-west approach coming out of Mersey. We have created a state-of-the-art endoscopy service at the Mersey Community Hospital for the benefit of the north-west. We are taking every opportunity within the heads of agreement to ensure that Mersey is an integrated service and has a distinct and clear role in terms of all of the service providers on the north-west.

Ms FORREST - So what is the process? I know that there is a three-year agreement and that you do not wait until the end of that three years to start thinking about the future. What are you doing in that regard in relation to the future management and funding of the Mersey?

[10.45 a.m.]

Ms GIDDINGS - Right now, not much. What we have been doing is ensuring that we have the right mix of services there and getting that integration happening. That has been a concentrated effort there. But when we do need to start talking about any future negotiations of a new contract. Then we will start those discussions with the Commonwealth. But that is a way off yet. The other element that is overlaying this is the national reforms happening around the health system. We are still waiting for the National Health and Hospitals Reform Commission to provide us with their final report on the recommendations that they will put to the Federal Government as to how the health system should be funded or set up. Until we know more about

that direction - there has always been that thought, 'Would the Commonwealth take over all hospitals?'

Ms FORREST - Or is there a consideration of the State taking it back?

Ms GIDDINGS - No discussion is happening around that at all and I would not even be contemplating it. It has been far more important to get on with the job of running a hospital that is not our own that we have been asked to manage and to integrate it as best we can into the State system. That is the only issue there. As to what the future is of the Mersey hospital, that is really in the hands of the Australian Government as to what they want to do with it. It is their hospital; we manage it for them.

Ms FORREST - So the staff are employed by State or Federal?

Ms HOLDEN - They are State employees.

Ms FORREST - So any efficiencies required by the State budgetary strategies would be imposed across that hospital as well?

Ms GIDDINGS - No, because they are in a separate budget. Their funding is very separate from our own and, as Dave just said, we even have a separate accountant who is responsible for it. We have to report to the Commonwealth regularly on what is happening, how it is being spent, where it has been spent and those sorts of things. It is very different to how the rest of the health system operates.

Ms FORREST - Are you saying there will be no voluntary redundancies sought from that hospital?

Ms GIDDINGS - No.

Ms FORREST - If there were areas of efficiency that could be had there, you cannot effect those?

Ms GIDDINGS - Of course you are always looking for how you can do things better and the services we are providing, as Jane has said and she can talk more to it, some of them are across campus. If you are making efficiencies in the way you set a system up, then yes we will get efficiencies out of that as well. The money will not be reducing, we can use it better for other things. I think the Commonwealth would have a strong expectation that we would be spending their money in the best way possible. We have not had a cut from the Commonwealth on that $180 million; that has not been targeted by the Federal Budget. That is where you would see a cut, it would be from the Feds saying to us, 'Sorry, we can't provide you with that any more'. If they did that they would be breaking a contract, so I do not suspect that we will have that problem.

Ms HOLDEN - Where we can find productivity and efficiency gains across the north-west area we engage with Mersey. That is part of being integrated. The benefits of that would come to that budget, but it is quite unique and accounted for separately. As the minister says, any gains we can make in productivity are really an opportunity to develop services in that area. So whilst there are absolutely no cuts to the $60 million, there are no adjustments for inflation to that $60 million either . It is a capped figure over three years.

Mr WILKINSON - What is the financial commitment, if any, to the high-care dependency unit and 24-hour emergency services area at the Mersey hospital?

Ms HOLDEN - I do not have the specific budget with me, if that is what you mean. There is an ongoing commitment to both, the high-care dependency unit and the emergency department at the Mersey, for them to be sustained 24 hours a day, seven days a week.

Mr WILKINSON - Is the funding available to guarantee obstetrics and midwifery? Is that going to be available so that is retained at the Mersey given the recent development of this area in Burnie?

Ms HOLDEN - Yes, we have a commitment to maintain obstetric services 24 hours a day and we support a 24-hour anaesthetic service as well at the Mersey. Plans are to continue to provide those services for the foreseeable future, certainly for the length of this agreement we have with the Commonwealth.

Mr WILKINSON - I suppose all services really depend on what is going to happen at the end of the three-year period with the relationship with the Commonwealth. Would that be a fair assumption?

Ms GIDDINGS - That again comes back to our discussion that we were having with Ruth. Ultimately, no matter who owns a hospital it is about patient care that really matters. It does come back to the Health Plan. What I have been really pleased about is that the Commonwealth have worked with us. The independent review was started by Tony Abbott and the Feds who said they would abide by that independent review which came out with the same conclusion we had - an ICU was not appropriate for Mersey. So I do not think it mattered whether it was a Liberal or Labor government federally, the ICU was not going back to the Mersey.

The HDU is there, and maternity services are there, but we have also been able to move into and start the process of developing services as we intended under the Health Plan. This is a plan for 20 years so they are not services you are going to see immediately, but we are moving towards the ones that we know the community needs. I think we are improving our chemotherapy area, for instance; we are also looking -

Ms HOLDEN - We have reopened chemotherapy at Mersey since we started management of it.

Ms GIDDINGS - Right, and strokes -

Ms HOLDEN - That is the chemotherapy service. We re-established the chemotherapy unit at the Mersey Community Hospital about the second month we took over the management of the hospital, and that area was grown at the Mersey. We have grown it from establishing it at about three days a week to five days a week now, and looking to extend the afternoon sessions at the Mersey Community Hospital for the benefit of local residents.

Mr WILKINSON - Is there any funding for, is it planned to implement a dedicated palliative care unit at the Mersey, as was promised in 2005?

Ms HOLDEN - In terms of the role of the Mersey Community Hospital, and under the umbrella of the Tasmanian Health Plan, palliative care beds would fit into that role in the Mersey Community Hospital. There is an overview of palliative care services across the north-west under way. We need to think very carefully about where we put these beds in terms of the people that need them, so some might be at Mersey, some might be in the other places is a model that we are considering. But there is some significant support for looking to develop beds at the Mersey Community Hospital; we need to look at that in terms of the range of all the other services that that community needs within the funding that is capped at $180 million over three years.

Mr WILKINSON - What patient transport improvements are being funded when patients are being sent home in taxis?

Ms GIDDINGS - A whole lot of work has been going on in our patient transport area, and accommodation as well, as a result of the Sharley and the Banscott reviews. We were very pleased that the Commonwealth Government put some $10 million into that area, as this has assisted us in looking at those issues. One of the core issues is not just putting extra cars on the ground, which we have done in the north-west, but also ensuring we have central coordination of transport right from the community car through to the ambulance emergency services.

This is where we are progressing to, we have not achieved it just yet, but we will have a central coordination body here in Hobart that will look after all of those issues across the State. Of course at the local level, for community cars we are talking about a volunteer-based service, and they tend to operate within business hours. Outside of business hours, if we have the need to send a patient home and there is responsibility on us to do that, then I expect we will continue to use taxis unless our CEOs want to contradict me at all. That is partly because it would be that there would not be access there.

Ms HOLDEN - In the north-west, we have access to a range of services, and if there are no services we can use private ambulance, and we choose to do that. It is quite appropriate at times to use taxis. I do not want to say that we will never use taxis because they are quite appropriate transport vehicles to use at certain times for certain patients. But we do not use them because we cannot get some other services, the choice is made that this is felt to be the most appropriate form of transport for the patient.

CHAIR - I understand there will be 92 medical graduates this year, in 2009, rising to 100 in 2010, yet in 2009 there were only 58 intern places for the 83 graduating in 2008. Tasmania is a party to a national agreement to increase this so why have you not?

Ms GIDDINGS - The first point to make is that you never ever have a situation where all graduates want to stay in Tasmania for their internship. As in law and other areas students like to go off and they apply for various areas and they leave. My understanding is that in recent years, including this year, we have not had a problem in placing the interns who have wanted to stay in Tasmania. In terms of future planning I will ask Dr Boadle to speak to that.

Dr BOADLE - We work with the medical students, the Postgraduate Medical Institute, the hospitals and the AMA to look at the future situation for Tasmanian medical graduates, recognising they are a precious resource for Tasmania. We do, however, recognise that we are competing in a national marketplace. Therefore, in looking at the forward projections, we have looked at the future intern positions around the nation and the future medical graduate numbers across the nation. The projections do not suggest that there will be a shortfall of intern positions

in Australia until 2012. For example, for next year, the 2010 clinical year, which will look after our 2009 graduates, there is going to be a surplus of 392 intern positions over and above the Australian domestic resident graduates.

Based on past experience a number of our graduates choose to move interstate for three main reasons. The first main reason is they have come from interstate to study in Tasmania, they have got a position in our medical school, and so naturally some of them will take the earliest opportunity to go back home. The second group is Tasmanian residents, Tasmanians who want to explore the world for social and personal reasons, and the third group is those who wish to explore another career opportunity interstate, if they want to do microsurgery or some particular thing they move interstate to position themselves for that.

Out of last year's graduating cohort of domestic resident graduates there were 65 and of those 32 chose to remain in Tasmania. We actually had to import graduates from elsewhere to make up our inter-cohort last year. What we have planned for next year, and we need to work with the hospitals now they know what their budget is, is to increase the number of intern positions across the State to keep pace with the domestic resident graduates. That was the basis of the COAG agreement, that domestic resident graduates not be international fee-paying students. The university is telling us that they plan to graduate 83 domestic resident Australian HECS-funded students at the end of this year. We will work with the hospitals to see if we can increase the number of intern positions next year by 10. That will take us up to 68, recognising that there will still be a gap of about 15 but we know that at least 15 will want to go and work elsewhere and almost certainly we will be in a position of having to import graduates.

[11.00 a.m.]

CHAIR - In an Australia-wide perspective then do you think that we are seeing enough people going through medical school and graduating to meet the needs of Australia, bearing in mind that you talked about the transfer between States? Is it a question you can answer?

Dr BOADLE - No, I do not know that anyone can answer that. It is a very imprecise science in terms of work-force planning. It is difficult to get a handle on. The people graduating today will be fully-fledged GPs or specialists in perhaps 10 or 15 years' time. It is hard to predict what the community is expecting of medicos in 15 years' time. With the move to using other skilled practitioners, particularly nurse practitioners, and rearranging the way we do things, it is hard to be emphatic and say, 'Yes, we will have enough'.

CHAIR - There is an ongoing concern with rural GPs and the shortages that occur from time to time. Despite all the best efforts and getting overseas-trained doctors in - and I know of two or three areas in my electorate at the moment that are really under the pump, there are GPs leaving, and I know that it is somewhat of a Federal matter as well.

Ms GIDDINGS - It is a Federal matter largely in terms of GPs. The work-force issue worry all of us, State and Federal. Part of the problem is not just the numbers of graduates we have going through the system, which we have now increased - and full credit to Nicola Roxon for doing that, even though it will put pressure on us to train them up - the problem is the fact that there is a cultural change, a lifestyle issue, that is coming in here. We have more women now training to be doctors, and particularly GPs, than ever before. They are having families and wanting to work part time, but also you have men in the system who are saying they are not prepared to do the 24/7 any longer, that they want to work hours that fit for them, family-friendly hours. Even though in one respect we have more GPs in the system than we have had before, they

are working less FTEs, so we have a reduction in a sense. We also have the added problem of the ageing work force, where we have fewer younger people coming into the system - and this is across all areas of life, teaching, health, nurses, whatever. This is our problem and this is what the demographic council, which the Treasurer has been running, has been trying to grapple with. Some reports around the health work-force issues have gone to that council that have been released, they are out in the public talking about these very bigger pressure issues of 10, 15, 20 years down the track that are thinking about now.

CHAIR - Certainly, where there is enough economy of scale, the managed practices have alleviated that. This has given those GPs in rural areas, the flexibility of work hours. But where you get a smaller place such as Oatlands and others where there is not enough economy of scale to institute or to put in a managed practice, that is where there are problems. There must be some solution to that, whether they can perhaps link up with urban surgeries or practices.

Ms GIDDINGS - It is not necessarily a problem in that sense. What we have done for the east coast and the west coast, for instance, is work with a management company that ensures that we have GPs on the west coast and GPs at St Helens. Just because you are in Oatlands, Campbell Town or some small country town does not mean that you cannot be part of a management structure already. That is happening.

CHAIR - Part of the problem, though, might I suggest - and it has been put to me by rural GPs - is the cost of the locums. It really puts the pressure on those smaller practices.

Ms GIDDINGS - That is where it is useful being part of a management company because they take on the responsibility of finding the locums. I do not know enough about the way they structure it but, as I understand it, they take on that management issue on behalf of the GP. I am not sure if we know the details of how they do it, if they are able to move their own GPs around to fill in and do locum work at a different cost. I do not know, but it is their issue. They are private companies, they are private businesses and they run the show. It comes down to an individual GP as to whether or not what is offered by a management company is what they are prepared to accept. That is their own private business as to whether or not they do that. We have provided some $300 000 to General Practice Workforce, which is a federally-funded organisation to help recruit GPs into rural areas.

CHAIR - That is in this coming forward Estimate.

Ms GIDDINGS - Yes, it is in this year's Budget but I think that it was in last year's Budget as well, it is funding over three years that we provided. . It was the first time we have actually given some funding to a Federally-funded organisation in recognition that the State Government requires recruitment of GPs to service our hospitals. That is where we are concerned.

Local government tends to take on more of the responsibility about looking after their local community. Huon Valley Council, for instance, has helped to recruit GPs to Geeveston in recent times that I am aware off. Glamorgan-Spring Bay have done a lot to keep their doctor at Triabunna. We are peripheral to that aspect of it except where we need to contract GP services to keep our facilities operational.

CHAIR - Thank you for that.

The committee suspended from 11.09 a.m. to 11.28 a.m.

Ms FORREST - I want to go to elective surgery. I know there are some reforms planned in this area but when we look at the progress chart of May 2009 we are still seeing longer waiting times in most areas than in previous months. In view of the Federal Government's elective surgery waiting list improvement funding of $8 million can you provide a breakdown of how that was spent. What sort of surgery was conducted, in what part of the State and how are the reforms supposed to be fixing this waiting list problem?

Ms GIDDINGS - Absolutely. There are a number of issues. I will ask each CEO to talk about what surgery happened in their own hospitals. One of the key things here is that both the Commonwealth and our own reforms are aimed at trying to deal with the over-boundary cases, those who waited outside of their clinically recommended time. The result of that will be that our median waiting times that we report on will in fact blow out. It is a positive turned into a negative in a figure because in fact it looks bad that suddenly Tasmania's median waiting time is blowing out but the reason that is happening is that we are in fact operating on the people who have been waiting a long time.

As soon as they operated on they are counted into that statistic so the median waiting time blows out. While they are sitting there waiting for their elective surgery they are not actually counted in that figure. The minute you count them in the figure it blows it out for us because it is about how long people waited for their surgery; that is why they are counted then. Once you have had your surgery we then ask, 'How long did you wait for that surgery?' The perverse aspect to that sort of reporting is that governments might say, 'To look good what we will do is do all the surgery of the category 1s and those with the shortest time waiting because that will make the median waiting time come down and we will forget about the long terms'.

[11.15 a.m.]

Mr MARTIN - Minister, on that point, is there any way you can measure the people who are waiting now?

Ms GIDDINGS - Yes. We also have a waiting list and we know how many people are over boundary and we know how long they have been on the list. In terms of that public reporting that is in the AIHW report, for instance, when they talk about medians that is what they are talking about, how long it took someone to go on the list to have the surgery.

Mr MARTIN - Does the other one get published?

Ms GIDDINGS - Yes, in the progress chart we publish the waiting list data. Whenever I publish that I always hasten to add to people that the pure waiting list data is not that useful because every day you have more people going on the waiting list. Even though they are dropping off the other end, with the ageing population we expect that list to continue to grow. What is important is the waiting times that people are there. When you are reporting on the waiting times this problem occurs; you count from the date they went onto the list until the actual surgery. All of that is on the progress chart.

Ms FORREST - But the information that is not on the progress chart is the number of people who are waiting in various categories longer. Are you able to provide that information?

Ms GIDDINGS - Yes, there is information we can provide on that. What we are looking at doing further in our reforms around elective surgery is getting more information out into the public arena. We have not got to that point yet but we intend to set up a web site that will have more information on it around elective surgery. There is further consultation that we need to do with our own clinicians and staff before we make final decisions around exactly what information will be available. At the moment we are in a conversation with people. Already we are looking at perhaps having to adjust slightly what we thought we would do originally. Originally we thought you would go straight out there and list surgeons and how many people are on their individual waiting lists and everybody could see that. There is some resistance, for reasons, for that information to be so publicly available at this point in time.

Ms FORREST - This has only just been on the north-west to a degree.

Ms GIDDINGS - I will ask each CEO to address the issue pertaining to their own area and they can talk about this more then. What we may well do - and we are still in consultation so there is nothing set in stone - is provide that information to GPs so that when they are referring their patient to a surgeon they can make that decision then, 'Dr such and such has a lower list so I'll refer you to him or her, rather than the one you will be waiting far too long to get your operation done by'. That is where we are heading in being more open, but having this coordinated statewide process so that we know what is happening with all of our surgeons around the State and across all the hospitals rather than what has happened now, where it is managed in a very local way and in some respects managed list by list. There may be better ways that we can do that.

Ms HOLDEN - We have had a 17.5 per cent growth in elective service throughput at the North West Regional Hospital from May 2008 to May 2009. Although the percentage drops from 54 per cent to 48 per cent, the actual volume of day cases that have gone through has risen by 2 per cent. So it is the volume that we are doing that has influenced that negative position in the day surgery, not that fewer people have accessed day surgical interventions. We do not have any over-boundary patients in ENT and by 30 June, subject to the last few patients not cancelling, we will not have any over-boundaries in cataract surgery either in the north-west. There is a major focus in the north-west to eliminate all over-boundary cases by the end of December this year. That will not mean that there are not waiting lists, it means that we will be focusing to eliminate that. The only challenge that we see in that will be in relation to major joint replacements. We have begun a program. Every second month we produce a general practice newsletter and in that newsletter, as you are aware, we publish our waiting times for outpatient clinics by specialist and for waiting times for surgery by discipline and then by hospital. In effect the specialist are understood as well. We have agreed a pooled waiting-list strategy for general surgery and orthopaedics in the north-west at this point.

We are very small and that is a good place to look at, at what are some of the benefits and some of the risks in developing those kinds of strategies. To date it has worked in the north-west but it is an ongoing program of looking to pool other lists together as well.

Ms GIDDINGS - Mike.

Mr PERVAN - The Royal is going through a process of substantial reform in surgery beginning with the appointment of a whole new management team last November who in the six months from November to the end of April were able to increase elective surgery throughput across the board by 11 per net. One of the unfortunate things about the way that the activity

around waiting lists is reported, as the minister said, is that it is all done on medians and averages; you do not actually get to see the raw increases in productivity or in fact the stories that are not as good as that.

While we have increased activity by 11 per cent, so for the six months comparable to the previous year that is 3 770 elective surgery episodes compared to 3 405 for the comparable six months of the year before, while there has been that improvement we still have a number of patients who have been waiting too long, particularly in orthopaedics for complex joint replacement. Over the next 12 months we are targeting those areas and cardio-thoracic to try to increase our throughput there and get those cases dealt with.

At one stage for all sorts of reasons that have been dealt with now, the Royal was only managing to do one joint a week. That was the case for nearly 18 months. It is now up around 10 joint replacements being done per week.

Ms FORREST - Was that a problem with the theatres or a problem with the beds in the ICU and the wards?

Mr PERVAN - Everything from the initial clinic appointment right through to beds. It was just a series of management breakdowns from one point to the next - the changeover times for theatre, how the sessions were being managed and staffed, just about every point where things could be improved needed improvement, and certainly we have been working very hard at doing so.

The orthopaedic area is up to 10 a week at the moment and that is building. Similarly, we have been working away at the cardio-thoracic list although due to pressure on our ICU that has had to slow down for the last couple of weeks, but we are building that back up.

Ms FORREST - What sort of pressures in the ICU?

Mr PERVAN - It has been full. Immediately after cardio-thoracic surgery you need an ICU bed before they can go to HCU and without a bed being available and a guarantee of a bed being available we do not start the surgery. We have had to bump a couple of cases over the last three weeks, which we were very unhappy about, but we are addressing that now. Over the next 12 months we will be targeting orthopaedics, cardio-thoracic although there are not many long waits there and ENT is our other area that we will be targeting over the next 12 months to try to get rid of all the outstanding cases.

Mr KIRWAN - Through you, Minister, last calendar year our base level was 4 600 elective surgery cases. We actually achieved 5 200. Interestingly enough, the same time last year we would have done 1 894 cases and to date we have actually done 2 159. What is interesting is that there are some cataracts in that but at the early part of the year we were not doing additional cataract work. We are tracking. As with the other two hospitals we are doing considerably more activity through elective surgery through a range of areas. In respect to our current waiting lists, May 2009 versus May 2008, at the end of May 2009 we had 2 650 on our waiting list. Last year we had 2 711. Regarding overdue patients or the over-boundary patients, which are the ones that we focus on for obvious reasons, we currently have 875 which is 33 per cent of our list. Last year we had 996 which was 36.7 per cent. The median waiting days currently at the end of May are 152 and last year they were 183 so you see that reduction.

The other qualification I would make, which the minister has alluded to in other discussions, of our current 875, about 100 of those are cases that we locally call category 4 but are surgery that have waited well over the one year and are categories of about 20 categories of work that we are unlikely to do at the moment because they are a range of cosmetic and other surgery. If you take those out, both the numbers of about 100 but also particularly the waiting time, given that some of those waiting times are quite extraordinary, you would see those averages come down quite significantly.

Ms FORREST - There is work being done, obviously, and improvements being made but we still have a long way to go in some areas with people waiting beyond the times recommended. What other measures are being taken to address this?

Ms GIDDINGS - I will ask Dave to talk to you about the overall elective surgery strategy that we are pursuing here and also to touch on, just to give you a flavour of those programs, the sorts of surgery we have been touching on, which really go from hips, gynaecology, ENT, opthalmology, orthopaedics, neurology - the elective surgery plan, both Commonwealth and now our own, has really been across a spectrum of surgery. Under our own, though, we have also put a very strong emphasis on cataracts as a first area to try to get the waiting list into some form of proper management. I think the analogy you have used before that comes from the UK is 'draining the lake', getting rid of the people in the middle who have been waiting far too long but understanding that there will always be a flow of people getting surgery out one end and a flow coming into the lake on the other, but you want to get it down into a management process.

The figure of $8.4 million is going into our own elective surgery strategy, $2 million is going into cataracts, $2 million is going into other forms of surgery similar to what I have just mentioned and there is $4 million going into another area and so on to help us to get some of the basic structural work right with elective surgery. I will ask Dave to give you that bigger discussion around where we are heading with the reforms.

Mr ROBERTS - Thank you, Minister. As you have heard, you have some fantastic work and achievements already emerging. I think the fact that a CEO can sit here and say to you there are no over-boundary cases in these areas is evidence that that is the case and Jane is really targeting now to get to no over-boundary by the end of this calendar year, which is fantastic. However, when we look at the number of cases that we have in the other hospitals we have some slightly different problems to overcome. It is a challenge, and that is why I think changing the whole system is important.

Again, what Michael has done in terms of improving productivity is vital to that because it is not just one procedure like a cataract, it is actually a whole series of things that are going on in the LGH and at the Royal, as the minister has described. What we do have now, though, is a very clear understanding of what our waiting lists look like. We know where they are in each of the categories and we are increasingly building a system which is capable of dealing with those urgent cases, those not-so-urgent cases and those that are okay to wait for a little bit longer and structure that appropriately. That is where quite sophisticated data and statistical analysis is coming in.

Each CEO now has on their desk something called a 'check list', which is a tool that shows every patient on their waiting list and where they are. It draws a graph for them and shows them that they actually should, as an organisation, be looking at those individual patients. Highly

sophisticated work is now taking place with our clinicians and our managers to understand where a patient is in the system and how we move those forward.

For next year we are really very clear that we have to move through this process in a very pragmatic and staged way. Nobody who sat along this table would say to you that we can solve waiting times or waiting problems instantly; this is something we will have to work on over many years. It is something about how we work with the system to enable it to deliver more patient care, and that is truly happening. The work that John is doing with the ED, the emergency assessment unit, and patients getting through the system in terms of people coming out of the beds at the end is really important. He will also address the availability of beds and staff for elective surgery.

[11.45 a.m.]

Ms FORREST - At the LGH that has been a huge problem with bed blockages and people who have been ACAT-assessed for aged-care beds, sitting in beds and impacting on the flow of patients through the DEM, but also for elective surgery. What has been done to address that?

Mr KIRWAN - Quite a number of things. I would like to be able to say we have it beaten, but I do not think I would be that clever or that brave at the moment. But it has improved significantly. When we started having really significant problems in winter last year and in January this year we were having bed blocking through the Emergency Department of 50 per cent-plus, and on some days higher than that. On the worst days we would have 15 or 16 people in the Emergency Department waiting for beds and them not being available. We have had some difficulty on an occasional day since then but nothing like that. Now we are running sometimes up to 50 to 55 patients who are ACAT-assessed ready for placement, predominantly high care, and not being able to be placed. We had more than 1 000 extra nursing-home-type patient days in the hospital last year and that showed a significant inability for access, access block and equity of access issues for other patients. We now have only 17 ACAT-assessed patients, as of Friday - they are a majority of high-care patient beds - and the average length of stay has reduced from 75 to 76 days down to 45 days. So we are seeing a significant improvement in that throughput.

Ms FORREST - What have you done to achieve it?

Mr KIRWAN - We are working closer with the ACAT assessors, we have purchased eight transitional-care beds from OneCare, the old Manor, and we are using those off-site - and they are included in those 17 patients; eight of them are off-site.

Ms FORREST - So the ones at the Manor are still included in your numbers?

Mr KIRWAN - Yes, included in the 17. By increasing our transitional-care packages from effectively five from just after I started to now 25 and by the opening of eight rehabilitation beds, we have effectively created another ward of capacity within the hospital. For normal day business that seems to be working well. It does not help us on our peaks on weekends, and Mondays and Tuesdays on occasions.

In respect to elective surgery, what is now emerging as a bigger issue for us rather than bed block is our ICU size and capacity. That is now a real problem for us because it is basically the same size as it was 20 years ago. It is a combined ICU-CCU. The Acute Medical Unit that David has referred to is very important for us because the 26-28 beds that will come with that - and it is still being configured - will allow us to remove the CCU patients out of ICU and expand that and

that will give us an immediate resolution for some capacity early to mid next year. The redevelopment on levels 4 and 5, which will come a year or 18 months later, will allow us to expand the capacity in what is an overcrowded and currently not-well-designed ICU because of its age and its original design has not kept up with contemporary standards, particularly infection control and a few areas like that. It is okay but it is not flash. ICU is where we probably have our biggest bed blocking and cancelling at the moment for elective surgery because the beds are not available. That is a problem across the island, unfortunately.

The other initiatives are the Acute Medical Unit will deal far more up-front in the hospital with patients, medical patients with co-morbidities, which are anything between 40-60 per cent of our emergency department workload will be allowed to be dealt with in that unit with up to a three-day stay and then discharged back into the community. They will be dealing with senior physicians, senior allied health, senior nursing and other support staff. That model of care is being rolled out as we speak. We already have a paediatrician working in the Emergency Department, improved mental health access, improved allied health access.

Ms FORREST - Minister, with the changes that are being made here, the separation of the CCU and the ICU and the short-stay unit, obviously that requires staffing. You cannot open these units without nursing staff - and that is why we have had problems with bed closures, particularly at the LGH. We now have this employment freeze and the new position freeze, so how are we going to manage that with the current staffing allocation? We have had to have beds closed at the LGH on a rotational basis for as long as I can remember because of lack of staff for beds.

Mr KIRWAN - Through you, Minister - we do not have any beds closed through lack of staff, and have not since I have been there. We have quite intentionally kept beds opened either through the use of locum staff, which is another issue which was raised in the other House. In particular in respect to theatre staff where there is a problem and a national shortage, and while we also then help to train the EN pre-operative nurses to come on stream, we use locum staff to keep the theatres open. Also in one of our surgical wards we have had a difficulty recruiting, in the rest of the hospital generally it is not too bad.

We currently only run eight beds that are closed, which are not funded rather than not staffed; we do not have the capacity to open them. I have to say that of the eight beds that are closed, four are on the surgical ward which we use in a rotating clean to terminal clean, so that is an efficiency issue, and probably even if we had the funding we would not be all that keen on opening them. The other four are on the medical ward which we use as an overflow for the Emergency Department, and more often than not are open during the day, so they are open on regular occurrences.

Apart from that, we have opened the eight new rehab beds on site, which the minister and the Premier opened, we have the transitional care packages and we are buying the eight beds from OneCare, and we will go to the private sector to see what other capacity there is there, particularly for winter periods and peak periods.

Ms FORREST - Have you looked at the north-west where they have a fair bit of capacity?

Mr KIRWAN - I am aware of comments made in the Legislative Council inquiry -

Ms FORREST - And in this place.

Mr KIRWAN - And this place. The movement of patients is an issue that is sensitive in respect to their willingness to move, and the Tasmanians' issue of travelling. As someone who comes from Western Australia -

Ms FORREST - People from the far north-west do not have an issue because they do not have any choice.

Mr KIRWAN - Yes, but 35 per cent of our patients come from outside Launceston, so we are a true regional hospital. Obviously we are fairly keen to move them back closer to home as quickly as possible, as is clinically safe and appropriate. The issue of people moving to nursing homes in particular, which have vacancies in the north-west, when they and their families come from the north is a separate issue. As you would appreciate, the Commonwealth regulations are that you have a choice of three nursing homes, and we have vacant beds within Launceston, but they are seen to be less desirable nursing homes to go to. That is a mismatch issue.

We are doing something in that area in that we are looking at an integrated aged care service which will allow us to combine the State Government areas together, and we will change the model of care which is fundamentally at the moment in a process design - terminology and jargon - we have a push model, that is we push people out. What we need is to move to a pull model so we have people working with our patients and our clients in the community and their family and their friends to help massage them and encourage them into different models of care.

Ms FORREST - It is called coercion.

Mr KIRWAN - No, no. What we have seen is, particularly for the high dependency, particularly for the psycho-geriatric areas, it is not easy and a lot of the facilities are not there. So we need good case management that works with our bed allocation and other people in discharge planning, as with the nursing homes because they have a funding issue for them. We just need to be complementary to that.

Mr MARTIN - What is the situation in Hobart with ACAT-assessed people blocking beds in Hobart?

Mr PERVAN - We do not have nearly the difficulties that Launceston had in the recent past, and it is largely attributable to one person, and that would be Dr Jane Tolman. The reason we have fewer ACAT-assessed nursing home-type patients in the Royal is that Jane and her team work very closely with the nursing homes to get them out of the Royal and into appropriate care. That is a process that commences with their admission or their arrival in the Emergency Department, so they are not trawling the wards looking for people after they have already been in the hospital for a considerable length of stay. They manage them from their arrival through their surgical or medical episode, whatever they are in for, and then into alternative care, be that home, a nursing home or an alternative location.

Mr MARTIN - So there is no problem with the supply of nursing beds?

Mr PERVAN - There is a problem, but Jane is a fairly convincing woman with respect to the nursing homes and getting them to be very accepting of -

CHAIR - A force, no doubt.

Mr PERVAN - She is a force.

Ms FORREST - I have one other question in relation to bariatric surgery, lap banding. There has been some recent media surrounding that and whether the State should pay for it. Can you tell us what the Government's view and policy is regarding that broader area of obesity and lap band surgery?

Ms GIDDINGS - Some work has been done not just around bariatric but also on what other procedures should be performed in a public hospital. You might have noticed today's media reporting on what we discussed yesterday around that very issue. Part of our elective surgery strategy is to ensure that clinicians are aware of what is acceptable to put on the public waiting list. There will always be exceptions to that. No matter what procedure we are talking about there may well be the need for a medical reason to perform that procedure. So breast enlargements, reductions whatever there might be reasons for it. So there is that proviso. Once we get through our consultation phase we hope to produce a list of procedures concerning which we can say to Tasmanians, 'Do not expect that you can have these procedures performed'.

Bariatric surgery is one of those that is a little bit more topical around where we are heading. Tasmania has been the only State, or one of very few, that has provided bariatric surgery on the waiting list. But with the obesity issue taking off as a national problem, other States are now thinking about putting bariatric surgery onto their public lists.

At one point we were talking about the fact that if no-one else was doing it we should not be doing it either. Now others are starting to consider doing it we have said that maybe we should not rush into a decision around bariatric. For some very obese people it is beneficial, but it is a very risky piece of surgery. In one respect people say it is a simple procedure therefore why don't we do more of it. But the kinds of patients we are dealing in fact make it high risk. They have co-morbidity problems and putting someone under anaesthetic for any surgery who is very obese is a huge risk to them and their life.

Ms FORREST - Not an anaesthetist's best patients.

Ms GIDDINGS - It is not a decision that you take lightly in terms of any form of surgery for someone who is morbidly obese. We have recently conducted a review of the scope and operational arrangements for bariatric surgery in our hospitals. The findings of that review will help inform this other work that we are doing and the future arrangements there. But should we continue, which I believe we will to some extent, there will be clear guidelines around who should have it.

Ms FORREST - When is that review to finish?

Ms GIDDINGS - The review is being done, as I understand it, but it is helping to inform this next stage of work we are undertaking around what operations should be provided and under what circumstances they can be provided. The most important aspect for us is to ensure that whatever we do is safe and is effective. For bariatric surgery it is also important to ensure that the surgery is not seen as the solution. In fact there is a lot of work that needs to happen around that patient with a team-based approach. We are looking at bringing in dieticians to work with that patient and also psychologists.

Ms FORREST - How will that be actioned? That was my next question and that is probably the most important part of this if the surgery is to be a success. How is that framework going to be established?

Ms GIDDINGS - We are working on what that framework will be now. It is very clear that just doing the operation and seeing that as a means to an end is not satisfactory and should not be seen that way. There are anecdotal stories about people who have had lap banding and then ask for that lap band to be expanded for Christmas so that they can enjoy a big Christmas dinner. I have also been told of instances where we have people who have had lap banding who then, because they are desperate for a Tim Tam biscuit, crush it up in milk and have a milkshake Tim Tam biscuit thing.

Ms FORREST - Some people do the same with Mars bars.

[12.00 p.m.]

Ms GIDDINGS - You name it. Obesity of that nature I describe as a form of addiction. It is an addiction to food, an unhealthy addiction to food. If you are desiring your packet of Tim Tams you will find a way to have your packet of Tim Tams regardless of the fact that you have a lap band. That is why the team approach, the dietitian and the psychologist - and I actually think the psychologist element is quite critical in that - is really important. It is not just about putting a band around someone's stomach and saying that we can dust that one off, we have solved their obesity problem.

CHAIR - Mr Harriss is feeling a bit embarrassed when you start talking about Tim Tams because he consumes a packet a day.

Laughter.

Ms GIDDINGS - He is one of the addicts. He is lucky he does all the exercise to go with it. Dave has some comments to add to this.

Mr ROBERTS - As the minister has said, we clearly need some guidance as a department to give on bariatric surgery. We think there is absolutely a place for bariatric surgery against a predetermined protocol which must include, we believe, all those extra items the minister has just said. But importantly, our assessment shows that there are over 13 000 morbidly obese clients in Tasmania. The current cost of a procedure under the model we are talking about is $15 000 and if we were to pick up the entire burden of 13 000 clients in Tasmania that would be a very large sum indeed.

Ms FORREST - Is that $15 000 just for the procedure and not all the other things?

Mr ROBERTS - The procedure is around $11 000 to $12 000 but adding into it what we believe to be a more appropriate package for a client of this type it would be of the order of $15 000. I think that would have the support of our clinicians. But the point I wish to make here is not about the 400 or so clients currently waiting for bariatric surgery. We must recognise that obesity is becoming a problem within our society and that the health-care system could not possibly deal with all of that burden and shoulder it on its own. This is much more a whole-of-government issue, it is a societal issue and it is about the way we see and react to an eating disorder, or however we wish to describe it.

We are very cognisant that there are 13 000 people who would benefit from a range of advice, guidance and support as we move forward, not just those people that are currently waiting for bariatric surgery, which is of course the extreme end of that.

Mr WILKINSON - How much are we spending in total at this stage to directly combat the problem of obesity?

Mr ROBERTS - Across government?

Mr WILKINSON - Yes.

Ms GIDDINGS - When we get into output group 2 we will go into Population Health which is where our programs are and we can talk more about that there.

Mr WILKINSON - What I was looking at was how much we are spending now to combat it and what is the estimated cost of obesity within Tasmania at present?

Ms GIDDINGS - As part of our whole Tasmanian Health Plan we want to shift focus and resources from just the acute end into the preventative and primary health end of the health system to help us deal with these chronic diseases that are almost a tsunami coming our way. There is work happening there. It is one of those areas where we and future governments will need to look at how they can put more resources into the preventative health end of the health system. It is very difficult when you have the other end sucking it up, but that is certainly what we are trying to do.

We are also working with the Commonwealth in these areas, such as in the Measure Up initiative, a national television campaign to get people thinking about their weight issues. There is a whole lot of work we do. When we get to that output group, we will probably be able to provide you with more information supporting the campaigns around encouraging people to eat a lot more vegetables - the three-two-one campaign or something, the Eat Well Tasmania group that we also help support, the work across Government, the canteen programs in schools. These are some of the ways we are trying to get messages across.

It is an area where we need to do more. We are fortunate, and Paul would be aware of this, that in the Huon Valley we have a set of community funds unique to the Huon Valley due to the closure of the hospital at Franklin some years ago. In my time as minister we have managed to get a fund set up to spend money in the Huon Valley. I said to the community group that are running that fund my priority, as a provider of the funding, is to concentrate on community initiatives that look at preventative health programs. There is $200 000-odd that we have, let us spend it and let us use the Huon Valley as a pilot in a sense to see whether or not by putting anti-smoking campaigns out there, by supporting local initiatives and positive health programs, messages and the like we cannot turn around or make a difference in the community like the Huon Valley in their health outcomes. I have a list that we can talk about later on - I do not want to waste too much time right now - around the projects that have already been funded through that program.

Mr WILKINSON - If somebody wanted to point me to a good study, either in a State, country or wherever, in relation to how the obesity problem is being tackled, where would you point me?

Ms GIDDINGS - Ask the question when we go to output group 2 and we will talk more in detail about that. I do not think anyone has the perfect solution. All of these issues we are looking at at the national level - the Food Regulation Ministerial Council meeting, for instance. The UK have gone into traffic light symbols on food to give people a better understanding as to whether this is a danger food in terms of sugar, fat and salt. Our own industries are concerned about going into the traffic light signals. I think they realise that it does impact on purchasing power and what consumers do so they are trying to stop that happening. There is a whole lot of things going on there that I am happy to expand on later.

Before we move onto something else, I want to give you some more information around the invoices issue that was raised earlier, otherwise I am concerned that people will head off thinking that we have a big story here when there is an explanation. The response on invoices paid outside terms used information drawn from data contained within the DHHS accounting system. In the eyes of creditors it is likely that the payment within terms is at least 90 per cent so there is a difference between what we have been doing internally with our accounting and what creditors actually see. From the creditors' perspective, we are paying within terms at the level of about 90 per cent.

There are no complaints to the department or any ministerials to me on the issue. Any complaint that has been made has been dealt with immediately. As I said, I have not had any complaints to my office about it at all. There is no budget reason to hold payments. In fact, the department is best served by ensuring invoices are paid rapidly and within terms. If the department is to have a sustainable budget then it must pay its obligations on time. That is a firm message that I would be providing to them.

The difference relates to accounting system processes. The reported 46 per cent late is a technical measure only. A late payment arises from either an invoice getting lost in the system, which is rare but it is a risk, or the invoice is disputed. So at times we do say that the invoice was not correct and we challenge it. There are other factors that give unrealistically high measures given the system rules, for example, all one-off creditors, PTAS, many small creditors and child welfare claims are set to be paid on either one-day terms, that is immediately, or seven to 14 days. The transit of documents from the claimant to the department via mail means that the payment for one-day terms will be overdue even before it arrives, given approval and processing these will show as late.

For creditors on seven to 14 days the flow of documentation is such that there is receipt of the invoice and it will already be one or two days into the seven-day term. A referral to the business area to secure certification that goods or services were received, approval by delegate and then data entry, this can mean that achieving seven days is challenging. Even a day late again will show as being outside terms, yet for the respective creditor they will be satisfied with a payment. That is where we are saying on our accounting terms it is 46 per cent but from a creditor's perspective, if they get it on day eight or day nine they are not seeing it as an over-late payment. Payment dates can also fall on weekends so if that happens it goes over. A large portion of invoices are processed as a batch. If there is an error in setting the correct finance one terms for the batch then they are all seen as being overdue even if they are not.

I just wanted to clarify that so people did not think that 54 per cent of the invoices of the department are not being paid on time.

Mr MARTIN - It sounded bad.

Ms GIDDINGS - It did sound bad. That is the explanation and it would be about 90 per cent from the creditors' perspective but our internal accounting looks at it differently.

CHAIR - Do you think the media have changed their story by now?

Ms GIDDINGS - I hope so. That was for the benefit of the media.

Laughter.

CHAIR - Thanks for that, Minister.

Mr MARTIN - Chair, there are two areas under output group 1 that I want touch on and I have been holding back, mindful of the tag-teaming stuff. The two areas are speech pathology and ADARDS. Does that require a change of team?

Ms GIDDINGS - Yes, it will. Are there any other questions for our CEOs?

Ms FORREST - I have a couple. It may just be a case of tabling some of this information. You were possibly asked it yesterday but I would not have a clue what went on downstairs except for what was in the media today. I am interested in the amount of overtime that is worked by nursing and medical staff not related to recalls - those staff that are on call and then called in; I think that needs to be kept separately -

Ms GIDDINGS - I will put that on notice.

Ms FORREST - the cost of the overtime to the department, broken down into the various regions, the cost of locum medical staff and agency nursing staff over the last 12 months.

Ms GIDDINGS - Regionally for each?

Ms FORREST - Yes. How does that compare to previous years? Do you know that off-hand, whether we have had an increase in those lines?

Ms GIDDINGS - I have information right here with the LGH but I think that it is probably best we give it to you. We will collate that. And you want the previous year as well?

Ms FORREST - Just a comparison of where that is tracking.

Ms GIDDINGS - I could go through it right now but because of the time I will put it on notice.

Ms FORREST - I do have another question in relation to women and children related to the Royal. I know that there have been significant issues in the past with the antenatal clinic at the Royal and now that the new Royal Hobart Hospital is somewhere else other than in immediate forward planning, is there work being done? What planning is being done to address those issues? There were serious problems with heavily pregnant women having stand waiting for hours.

Mr PERVAN - Some minor works to gut out the area which the antenatal clinics are is provided by are about to get under way. The area they are currently in is actually a converted cupboard and corridor and it is abysmal so what we are doing is relocating the clinics for a short period of time to the new paediatric clinics in the basement.

The area that they are currently being provided from will be gutted out and is being completely remodelled. The design of the new clinics is being done with the staff including the clinical staff who deliver those services so it is quite a good-news story and will be a very significant improvement. As well as remodelling what we have on the site, we are now delivering antenatal clinics in Clarence, Glenorchy and Kingston to all the low-risk mums.

Basically the only people that are still coming into Liverpool Street for their antenatal care are the ones identified as high risk who might need an ultrasound or a blood test or something else that cannot be provided as an outreach. More and more we are trying to push the services from the Royal out into the community.

Ms FORREST - Also in relation to women and children, do you believe that there is adequate reporting to the department from Healthe Care, the operators of the North West Private Hospital, for the provision of the public maternity services unde contract, and adequate reporting regarding outcomes and service delivery? If not, how could this improve?

Ms HOLDEN - That whole area is under review right now and I have taken over the chair of the management committee that is the interface between the North West Area Health Service and the North West Private Hospital in that regard. We are also looking to introduce a perinatal database cross the whole of the State, which the North West Private Hospital will contribute to.

Ms FORREST - That is good news.

[12.15 p.m.]

Ms HOLDEN - That will provide a number of reporting issues. The Perinatal Mortality and Morbidity Committee is a separate committee and that does report on pretty standard lines as any other would in the State at this time. The management committee is looking at just that issue in terms of enhancing the timeliness of the reporting as opposed to the breadth of the reporting. We do get pretty comprehensive monthly reports that relate to the invoice in terms of what work has been done in the volume, complexity by a case weight - how complex was this care, therefore how much did it cost. So it is more about how regular it is and the timeliness of it than the breadth of it, with the exception of the perinatal database.

Ms FORREST - Do you believe we are getting value for money there under that contract?

Ms GIDDINGS - I think it is important that if the review is under way then through that review process we will be able to analyse better what we have paid for and what services we have got back for that.

Ms FORREST - They will look at the antenatal services, the post-natal services, the extended care and all those things?

Ms HOLDEN - The extended midwifery program, the Know Your Own Midwife program. We are looking at that whole package.

Ms GIDDINGS - I presume if there are concerns that arise out of that review we will then be talking to the company to ensure that they can be rectified in the future so that we are comfortable with the service they are providing for us.

Ms FORREST - Which brings me to my next very important question. What is the Government's response to Kelly Madden's report establishing a case load midwifery practice? It is not just in the North West Regional Hospital area.

Ms HOLDEN - That information has gone into part of the whole review of the maternity services in the north-west which has picked up services at the Mersey as well. That model is one that is quite contemporary and looking to what bits of that fit well and are easily imported into our system where there is the competence to manage those case loads and now we will look at that. It is important to what we are thinking about for the future.

Ms GIDDINGS - Rather than ask the other two CEOs to speak to this, I will bring to the table Fiona Stoker, our chief nursing officer, who is looking at this from a whole-of-department point of view. She may be able to address that issue for you.

Ms STOKER - Through you, Minister - we have received Kelly Madden's report and are currently going through it. At the moment we are providing a response through the minister's office to Kelly Madden regarding that. The report has been circulated through our system. We now have the agency midwifery reference group, which consists of senior midwives in the State, and they also have the report. We are doing an analysis of that and undertaking a review.

Ms FORREST - It is also noted in this place as well. We had a motion to note it here.

Ms STOKER - Yes, that is right. There is some work that is currently being undertaken to have a look at case load midwifery within the State from that strategic perspective in the first instance.

Mr WILKINSON - Assaults on staff within hospitals has been a disturbing happening over probably the last 10 years now, or even more. Are they increasing? What measures are there in place in relation to those assaults, or to security problems?

Mr PERVAN - There has no significant increase in physical assaults on staff but threats and verbal assaults have been something that seem to happen in clusters more than a steady increase in the incidents. What we do have, though, is increased training with our orderly staff around the management of code blacks, which is the code that would be called if staff are under personal threat, as well as working very closely with Dyson Corporate Security and around targeting a response to those areas where a code black is called.

The management of disruptive people in the Emergency Department is becoming quite a challenge, as a designated place of safety. The police occasionally drop off an aggravated intoxicated person who does not actually require clinical or medical treatment but ends up being a security issue and an assault threat, if you like, to the staff but we manage those very strictly and very quickly now. Before things escalate we tend to get security and the orderlies involved and have them put into a seclusion room if we can.

Mr WILKINSON - Are we able to get approximate numbers at all?

Mr PERVAN - I do not have them to hand.

CHAIR - We will take that on notice.

Mr WILKINSON - Is it the same throughout the north-west and the north as well?

Ms HOLDEN - Yes, it is an area that is really important to us, as far as safety. As Michael has pointed out, we are focusing on training and we have increased our training because of the incidence of this issue in the north-west so that we can enhance people's competence to respond and to reduce the likelihood of the grievance. I cannot remember the official term but it is to really de-escalate the whole process. We are looking at some changes to our Emergency Department at the North West Regional Hospital so that we can create a safe environment that is low stimulus for these patients. Most of our code blacks generate from patients coming under Mental Health Services.

Mr KIRWAN - In respect to the Launceston General Hospital we are not seeing any significant increase at the moment; however, just a little bit of background. We train all our staff in aggression management and the majority of that is that our Emergency Department staff, predominantly nurses and medical orderlies as well as nurses in other departments of the hospital, and particularly our Northside Ward 1E mental health area, which is not directly our area but a part of that code black response team.

Just a comment, in October 2007, the Auditor-General's Report on Public Building Safety concluded in respect to the LGH that while there were some areas of concern, the standard of security at the Department of Emergency Medicine was satisfactory. We have recently increased the amount of video surveillance in the hospital and it is constantly under review from our Occupational Health and Safety Committee. There are some issues on occasions on response times, particularly out of hours, but that is the nature of a general hospital working 24/7.

Mr WILKINSON - Are you able to put any figures on how many present relating to either drug overdoses or drug-related matters?

CHAIR - We will take that on notice.

Ms FORREST - In regard to hospital infection rates, do you publish the infection rates, obviously the major MRSA, VRE and there is no CDI still?

Ms GIDDINGS - We publish those rates globally not per hospital. There is a whole care reform agenda that we are pursuing and there is a whole lot around quality and safety which Alice Burchill, the Deputy Secretary, Care Reform, is helping to progress and we are going through a phase right now of consulting with hospitals and clinicians and the like around a whole agenda - some of these issues are being discussed as well - about what we do put out to the public arena and when. My view is always to try to be as open about these issues as possible but we do need to work through how and when that information is put out and more of a site specific way.

Ms FORREST - Do you have any global figures now?

Ms GIDDINGS - We do have global figures, I believe, that we could have access to but we would have to take it on notice.

Mr HARRISS - I was interested in the number of resignations of doctors or surgeons over the past year. You may like to home in on whether there have been any in the last month or so and whether reasons have been given and whether those reasons can be provided to the committee.

Ms GIDDINGS - We do not have the information so we will have to take it on notice and supply you with that information.

Ms HOLDEN - Minister, I could say that we have none in the last month.

Mr HARRISS - So year to date, please, and then in addition to that how many unfilled positions there are.

Ms GIDDINGS - That is fine, we will supply you with that.

We are moving on to Mr Martin's issues. What is the question with speech pathology?

Mr MARTIN - There are a number of them, the level of service and so on.

Ms GIDDINGS - Speech pathologists are employed by DHHS as well as the Education department and within the private sector. We employ speech pathologists in both inpatient, outpatient and community settings and they work in the areas of acute care, rehabilitation, disability and community care with children and adults.

The specialist children's therapy services, which I think really are Lin Thorp's area, are provided through a contract by Calvary Healthcare Tasmania Incorporated in the south, St Giles Incorporated at Launceston General Hospital and the Child Development Unit in the north, and North West Regional Hospital and Child Development Unit in the north- west.

Funding for inpatient rehabilitation services has been increased significantly across the north and north-west with additional positions being funded for speech pathology. However, adequate staff resources for outpatient community and paediatric clients have been flagged as an area of need in some regions. Recruitment of qualified speech pathologists to vacant positions in Tasmania has been difficult over the past two years. As this has resulted in staff moving around existing vacancies, filling one vacancy therefore often creates another vacancy in that area.

That is a national problem for us. We are trying to recruit right now to fill current vacancies. At present there is one FTE vacancy in the south for community health speech pathology, 0.3 of a vacancy in the north-west for paediatric speech pathology services and in the north the Child Development Unit has 0.8 speech pathology position vacant.

Mr MARTIN - Minister, tapping into some of those issues that you mentioned with paediatric speech pathology services, as you said they are run by a variety of people from Acute, Primary Health, Department of Education, NGA services, which from the industry point of view leads to a fractured approach. This was identified in the children's therapy improvement project 2006 which made a number of recommendations to improve the access to the therapy services, including speech therapy.

I understand the Government has actioned several of these recommendations this year, however, the fractured services has not been addressed.

Ms GIDDINGS - That is where it falls into Lin Thorp's area. The Children's Therapy Services and particularly the contract with Calvary and the other services with St Giles and the services we provide are in her portfolio responsibility. Mine are much more about what we would provide through the hospitals for rehabilitation and the acute care setting for speech pathology.

Mr MARTIN - Anything to do with children's is Lin's, is it?

Ms LEEDHAM - It is more Human Services because they manage the Children's Services contract. However, I am aware that this issue you are talking about, the fragmentation of access to services, is a southern issue and there is work going on between the providers which involves the Royal Hobart Hospital, Primary Health and the contract with Calvary. We are trying to work through all of that so that we can address this fragmentation of services.

Ms FORREST - It is not just confined to the south.

Ms LEEDHAM - The particular big issue around fragmentation is more a southern issue and there is a whole lot of work that is occurring there.

Mr MARTIN - Okay. The statewide autism assessment team is that you or -

Ms GIDDINGS - Lin Thorp.

[12.30 p.m.]

Ms FORREST - I wanted to ask for the figures for all those vacancies. That can be tabled if you have the figures for all the allied health vacancies.

Ms GIDDINGS - We will provide you with the table with that information.

Mr MARTIN - A number of adults in Tasmania who require speech pathology rehabilitation or maintenance post an acute hospital admission, or people who live in our community with chronic and complex conditions such as MS, motor neurone disease, Parkinson's et cetera, are in some circumstances, I understand, waiting to access speech pathology services for up to nine months and in other cases not being referred to speech pathology services. Referents are despondent at the lack of access to services. Both of these situations create the potential for hospital admission or readmission, social isolation and a host of other problems. Is anything being done to address that?

Ms GIDDINGS - I will ask Pip to talk more to this. The problem is that speech pathologists are pretty thin on the ground and we have trouble filling our vacancies in this area, as we do with some other allied health areas. For the south of the State, for instance, there is one full FTE vacancy that we are trying to recruit now, as well as vacancies elsewhere around the State. In terms of services we provide, perhaps Pip can expand a bit more on that.

Ms LEEDHAM - The clients are prioritised as to the availability of access to services according to need. We have fluctuations of where we have had real challenges in recruiting speech pathologists. When I look at the information that is here at the moment around the vacancies I think that has been the best it has been in a long time. We have had far more vacant speech pathology positions than we have at the moment. We may see some increase in access to

services as a result of being able to fill positions. That is not saying we do not have vacant positions because we do, but the staffing levels just look better than they have been.

Mr MARTIN - My information is - and you might correct me - that there is a misperception that the recruitment of speech pathologists to the DHHS in Tasmania is the reason for staff shortages in the speech pathology area, that since Tasmania achieved pay parity for speech pathologists with mainland counterparts recruitment to DHHS has improved vastly.

Ms LEEDHAM - That is reflecting what I am saying. What I am saying to you is that the vacancies we have at the moment look as though they are the least number of vacancies in speech pathology that we have had in a long time.

Mr MARTIN - There is a concern that it might get tougher if we lose pay parity. Is there a danger of that?

Ms GIDDINGS - There is always a concern and it is always part of the arguments put forward through a negotiation process around wages of all people involved in the medical profession, and I would say across all areas of government. If there is too much of a wage differentiation then it is harder to recruit teachers, police or whoever. It is always a factor that you consider but we also have to consider balancing all these things as to how much we put into salaries and how much we put into service delivery to provide services to people on the ground. The problem I have is that with huge wage increases you are not having any more staff, you are just paying the existing staff better, which does help to recruit and to retain, and no-one would argue about that. It is always a balancing act in all of these areas of trying to ensure that we do enough to recruit and retain but not too much that we end up not being able to provide services because the funding is all tied up in wages.

Mr MARTIN - Do you think there are enough FTEs working in speech pathology to cope with the demand in Tasmania?

Ms GIDDINGS - I think the problem for us is getting the speech pathologists. There is probably never enough of any speciality area to cater for demand. I do not think in health you will ever cater for demand. It is a matter of managing demand and ensuring that those with the highest clinical need get access to services of any kind, whether it is speech pathology or open-heart surgery. I think that is an almost impossible question to answer because there will never be a position where you cater for all demand. What that highlights is the fact that we do not have speech pathologists knocking on our door asking for work. We still have vacancies in the State even though we have had an improvement in that area. Even if I allocated more resources to Pip's area to employ more speech pathologists, unless the work force is there it makes no difference.

Mr MARTIN - Just as an example, I understand that at the North West Regional Hospital there has been a 462 per cent increase in speech pathology referrals over the past 14 years yet there has been no increase in staffing.

Ms GIDDINGS - We have a vacancy at the North West. At the moment it is a 0.3 vacancy in the paediatric inpatient area. We have six speech pathologists in the acute area, including one supernumerary. In the community we have one, so in total we have seven FTEs and one in the Child Development Unit. I have not been lobbied for another speech pathologist on the north-west coast.

Ms FORREST - There has been a lot of unmet demand in times past so when you get an increase it could be related to part of that.

Ms LEEDHAM - I think part of the problem was there were a period where we had extended vacancies in this area and we had some maternity leave of the existing speech pathologists. There is a shortage of speech pathologists nationally anyway, so that adds to the challenge of recruiting to the vacant positions and recruiting to cover the maternity leave that occurred. We are back to nearly full establishment in the North West, which is really good.

Mr MARTIN - There are case studies I can mention in the kid's area, but we cannot go into that. The performance indicators in this area focus on the waiting lists, but there is concern amongst the professionals that that should not be the only performance indicator because clinicians are often under pressure to push people through and that the quality service can drop and inadequate service can be provided to get people through the waiting list. Apparently there is some work going on to look at other KPIs. Has that been progressed anywhere?

Ms GIDDINGS - Not that we are aware of.

Ms LEEDHAM - We do not record the speech pathology waiting lists at this stage. There are so many different providers in the services.

Mr MARTIN - So no waiting list has been kept?

Ms LEEDHAM - For individual services would probably keep waiting lists because that is how they would prioritise their clients. That is managed at a service level; it is not rolled up and reported from a whole-of-State perspective.

Mr MARTIN - Do you think it should be?

Mr ROBERTS - I think it should probably come into the area management now that we are starting to see the overlap between the hospitals and the community provision. And as we are so good at managing waiting lists within our hospitals then we probably should look towards that. Catherine's team within the department is looking at where we should have performance indicators for a range of primary care activity, which we currently do not have, but thus far we have not done that.

Ms GIDDINGS - I am also informed that part of our problem is that we would require IT infrastructure that at this point we do not have in the State. I am not sure that it is part of the priorities of the $18 million that we are spending right now on IT. As I said, there is a very strong commitment to improve IT across the entire department.

Mr MARTIN - Just a final question, given the time. Since we have been acknowledging the problem about the lack of professionals, is anything being done at the national level to see more people trained in this area?

Ms GIDDINGS - I am not sure what is being done there, but we have -

Ms LEEDHAM - There are some changes going on in some of the universities that train allied health professionals such that they do a generic degree and then specialise in a particular area. They are also certainly looking at the training of therapy assistants to actually help

supplement the work force such that the therapist can actually prescribe the program of work that needs to be done, and then it can be overseen by a therapy assistant. There is a specific project occurring in the Launceston General Hospital with the therapists and therapy assistants, and being worked through with whatever TAFE is now called in Launceston, to get a certificate for therapy assistant workers to supplement the work force. That is another way of starting to address this issue.

CHAIR - Minister, I have a general question I am sure you will be able to answer. It basically falls under medical services, I think. It has been put to me in a very succinct e-mail on the subject of medical and nursing staff. It goes like this:

> 'Probably the greatest threat to health delivery in rural and remote areas is recruitment and retention of medical and nursing staff. Recruitment of nursing staff in particular is a problem, with increasing reliance on agency nurses at significant financial cost, often blowing out budgets in small rural hospitals. A small departmental task force with innovative leadership' -

this is a proposition that is being put -

> 'could look at recruitment and retention issues, targeting permanent non-agency staff. This would require extra financial inducements to compete with mainland States and address accommodation issues, etc, but would still be cheaper than employing agency staff.'

Further it goes on:

> 'Escalating paperwork is overwhelming nursing staff in all rural hospitals. This is a national, not local problem, but any sensible approach to streamlining this would free up nursing staff to attend to their hands-on clinical duties.'

I just put that proposition to you; it makes eminent sense to me from somebody who is operating in that field.

Ms GIDDINGS - We try not to use agency staff if we can avoid it because they are expensive and they are not the safest in terms of safety and quality. When you are moving around different hospitals, you do not necessarily know, certainly when you arrive, where all the medication is or where certain equipment is you might require, and all of those. We are very aware that just bringing in agency nursing staff is not necessarily the safest system you can provide, so we try to recruit our own. Inevitably there are areas where we just have to use them.

Ms LEEDHAM - We are doing everything we can and looking at all sorts of options. Part of the nurses enterprise bargaining agreement that there is a rural nursing allowance that is paid at a tiered level has actually helped add to the recruitment issues. One of the things that is occurring with the creation of the Northern Area Health Service is that they have put a project together around rotating major hospital nursing staff out to the rural areas, and also for the rural nurses to actually spend some time in the major hospital. They have called for expressions of interest, and there has been a significant number of nurses out of the LGH that are interested in going to the rural facilities in the north, and there are a range of -

CHAIR - To -

Ms LEEDHAM - The rural hospitals in the north, so it is being led by the north. I know Jane is looking at the same proposal for the north-west, and I am sure Michael, seeing the success of it in the north and the north-west, would be looking at the same proposal with the creation of the Southern Area Health Service. The other thing is, what that has done is enabled the rural nurses to actually have a rotation in the major hospitals, and that is the bit about maintaining their skills and exposure to case loads. One of the challenges of working in a rural hospital is that you do not get exposure to significant numbers of cases, and you get random events of cases which makes it very difficult to maintain their skills.

CHAIR - So you have had expressions of interest, but the program -

Ms LEEDHAM - It has started in the north and -

[12.45 p.m.]

CHAIR - It has just started. Okay. It is going to expand to the other two regions, and you expect that to alleviate some of those issues that I just put forward.

[12.45 p.m.]

Ms LEEDHAM - The challenges of recruiting nurses to rural areas are multi-faceted and it can be the type of work that is there, the throughput, the expectations. It is not one size fits all in actually solving the problem because of the challenges. It could be a site thing, people do not want to go and live in certain communities. It could be anything. When you look at our rural sites across the State, there are some that are more challenging than others and sometimes it is difficult to work out why it is.

CHAIR - I just want to be reassured, as a member, that the department is seriously looking at this and taking this matter on board.

Ms LEEDHAM -We have to, Greg, because the challenge in all of this is that the cost of the agency nurses is far in excess of the budgets that are allocated to us. We have this obligation to ensure that we have two nursing staff, whether they are an RN or an EN, but we have to have one RN on every shift, three shifts a day, in a rural facility.

Ms GIDDINGS - Some of these issues go more broadly into what we are trying to do in developing the nursing work force as well - giving career opportunities, progression with roles like the nurse practitioner's role, looking at how we can reform the nursing work force and what we can do to expand the scope of practice of registered nurses who do not necessarily become nurse practitioners or nurse consultants or the like, but who, perhaps, might have other roles like nurse consultants who actually have prescribing rights as well. They are the sorts of things that could happen in the future. We are also looking at the role of paramedics and an expanded scope of practices with extended roles for them in order to boost our work force. In fact in 15 minutes' time we will be receiving a report called Leading the Way which has come out of an overseas study tour last year of about 20 staff, most of whom were nurses but also there were some allied health professionals and one doctor, I think. We told them to go and have a look at the US and the UK to see what they are doing around these very same demand pressure and work force issues to see if there are things that we can learn from them about more efficient ways of practising the disciplines in wards as well as the different roles that might make up a health work force. There is a lot in all of this that I recommend and once I have formally received a copy of this report I am

happy to bring copies to the table and to table them. I encourage you to have a look at it in terms of a more in-depth look at what we are trying to achieve.

Ms STOKER - I just wanted to also say that with the extended roles there are a number of really innovative roles around which do not go to the same level as the nurse practitioner role. We are currently looking at the role of the rural and remote nurse and one of the things in the rural and remote areas is that we need a highly competent, well trained nurse that can take on a range of different roles in different areas of their practice but they do not necessarily need to be working at the level of a nurse practitioner.

One of the really exciting things that we are looking at is whether we can extend some of that and that we have people working at a very high level and not necessarily having to undergo all the rigours that is required for a nurse practitioner. I think that will probably be a role that is going to attract people to the State to work in some of those areas.

CHAIR - Thank you very much for that. Minister, I have here a raft of questions from the ANF Tasmanian Branch, and they will require quite a bit of homework for somebody so rather than soak up any time here, I might pass those across to you and you, no doubt will give them to somebody else, and those responses might come back to the committee.

Ms GIDDINGS - If we are criticised for being too slow in providing the responses -

CHAIR - There are no more than about 50 there.

Ms GIDDINGS - Yes, I know. It might be better if you do not put them on notice in this budget Estimates process but put them on notice through the Legislative Council, or just provide them to me and I undertake that we will respond to you and the ANF in regard to the issues.

CHAIR - I am happy with that.

Ms FORREST - They could be broadly put into categories, I do not know.

Ms GIDDINGS - What they have probably done is provide you with a whole lot for you to determine which ones you are comfortable in raising. I do not know if they would expect you to have asked every single question that is part of this. It is your call in that, but I am happy to accept it outside of the budget Estimates process so that we do not have to give you an answer within 24 hours or 48 hours, but we will undertake to provide you with a response.

CHAIR - I would be very happy with that.

One question I have regarding medical services is community defibrillators. Do you have a health strategy that includes a community defibrillator plan at all?

Ms. LEEDHAM - Yes, we have been doing some work in relation to that and there are a number of sites across the State that need to either have their defibrillators replaced or ones purchased. We also know that Tas Ambulance Service is going through a process to procure defibrillators as well. We have joined that process because it makes a lot of sense. When you think of retrieval of patients from rural areas common equipment is used between the rural site and the Tas Ambulance Service, so its how the equipment can actually go with the patient.

CHAIR - Yes. It was just brought to my attention that the Queensland Department of Emergency Services has a policy for the development of Community First Responder programs in rural and isolated communities and work places. There is legislation passed, I think, to make it mandatory for schools and sporting events to have access to those. Obviously that is a capital -

Ms. LEEDHAM.-. This is more to do with schools and other areas. That has been a process that Tas Ambulance has worked on with community groups because you need to ensure that they have the right type of defibrillator in the right situation. Some of them have bells and whistles and some are what they call idiot-proof.

CHAIR - Not one size fits all.

Ms GIDDINGS - I can bring Gary O'Keefe from Tas Ambulance to the table who might have something else to add to that.

CHAIR - Thank you

Mr MARTIN - Lions International have been doing a lot in that area.

Ms. LEEDHAM.-. Yes, and the National Quality and Safety Council have released some stuff on consistent signage around defibrillators in public places and advice around the types of equipment that is more appropriate for a public place as opposed to the types of equipment that is used in an emergency situation.

Mr O'KEEFE.-.That is quite correct. Certainly we have found that when we are talking about automatic defibrillators or semi-automatic defibrillators there are different levels. In the community and in public places, there is the idea that you need to have something where you break glass in the old context of the fire and remove the item and put it out and it goes. Of course the current models actually talk you through it, in an American voice, through the defibrillation process. It is very much a follow the menu that is in front of you. Those types of models are being placed in areas like Cradle Mountain, Port Arthur, the Tahune Airwalk. We also have community groups that have got involved in the first responder program, which we really support, and we are working with St John in moving forward with that. Regarding those groups that have now started up, there is one at Westbury, Poatina, Port Sorell, Longford and just recently at South Arm. All the communities are getting behind these and we support that too because quite clearly these people are really the ones that are going to save lives.

CHAIR - Who is providing the capex for those at this stage? Are you saying the community are doing that?

Mr O'KEEFE - I understand St John's have had a negotiated position with the Federal Government. Some of the capital equipment is being provided by that. The other capital equipment which we like to think that defibrillation is only part of is being provided by the Government through a program where we are providing them with resuscitators so that it can aid as a total package.

CHAIR - What is an average defibrillator worth?

Mr O'KEEFE - The ones that go out into the community would be in the vicinity of about $4 000. The ones that have more bells and whistles associated with them but can still be used in the community would go up to $7 500.

CHAIR - It is an important issue in the minds of a lot of people. The figure that I had there were about 500 Tasmanians die each from out-of-hospital cardiac arrest. It is a matter of importance but bearing in mind the cost of them and where do you strategically put them?

Mr O'KEEFE - Often the communities are the best placed to work that out. It is through the community that we actually have the resolve in having these placed. If I remember correctly, about six years ago the cheapest units were between $10 000 and $20 000. They are now down to $3 500 which means that as technology is evolving, the cost is coming down for these units. You see them on airlines now. I think that every aircraft has one on board and I would like to think that in the future we will see these right down to the school level and to community areas. That will provide the immediate answer. We understand there are golden time rules in regard to the capacity, as Ruth would know, in regard to resuscitation and every minute that passes the chance of resuscitating that person is decreased by about 10 per cent.

Ms FORREST - You have also got to remember that some people are going to die no matter where they have their cardiac arrest. They can be in ICU and have a cardiac arrest and still not survive.

Mr O'KEEFE - That is quite correct and that is always the position.

CHAIR - I appreciate that answer. I think that it is important that the department has a strategy of a sort to communicate with all areas in Tasmania so that these things are rolled out. Technology improves, the price comes down so that they become more affordable.

Mr O'KEEFE - Yes, that is certainly the case.

CHAIR - I know that the minister is taking that on board.

The committee suspended from 1 p.m. to 2 p.m.