Wednesday 25 June 2008 - Estimates Committee A (Giddings) - Part 1

LEGISLATIVE COUNCIL

ESTIMATES COMMITTEE A

Wednesday 25 June 2008

MEMBERS

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

SUBSTITUTE MEMBERS

IN ATTENDANCE

Hon. Lara Giddings, Minister for Health and Human Services

Department of Health and Human Services

Mr David Roberts, Secretary, Department of Health and Human Services
Mr Simon Barnsley, Deputy Secretary, Corporate Governance
Mr Wayne de Gruchy, Chief Financial Officer, Finance and Business Performance
Ms Alison Jacob, Deputy Secretary, Human Services
Ms Mary Bent, Deputy Secretary, Statewide System Development
Ms Catherine Katz, Deputy Secretary, Health Services
Dr Roscoe Taylor, Director, Population Health

David Boadle, Chief Medical Officer
Dr Craig White, Chief Executive Officer, Royal Hobart Hospital
Mr John Kirwan, Chief Executive Officer, Launceston General Hospital
Ms Jane Holden, Chief Executive Officer, North-West Regional Hospital
Ms Fiona Stoker, Chief Nursing Officer
Mr Grant Lennox, Chief Executive Officer, Ambulance and Health Transport

Ms Pip Leedham, Chief Executive Officer, Primary Health Services
Ms Mary Blackwood, Director, Health and Wellbeing Services
Mr John Crawshaw, Chief Executive Officer, Mental Health Services

Mr Mark Byrne, Director, Children and Family Services
Mr Michael Plaister, Director, Youth Justice Services
Ms Ingrid Ganley, Acting Director, Disability Services
Ms Mercia Bresnehan, Director, Housing Tasmania
Mr Scott Marston, Director, Affordable Housing Innovations Unit

Ministerial Staff

David Nicholson, Head of Office
Margot Dawson, Adviser
Stuart Beswick, Adviser
Jessica Radford, Adviser
Sheree Bennie, Adviser
Dr Sujata Trivedi, Senior Medical Adviser

The committee met at 9.30 a.m.

CHAIR (Mr Hall) - Thank you and good morning everybody. We are going to do all of the health matters first and then we would like to spend an hour on housing at the end of the day. It is our intention to not have a break, an evening meal and then come back. If we can slide past 5 p.m. for a little while and we can complete everything else that is the way we would like to do it.

Before I open it up to other members I will just ask one general question and that is a little bit of comment to start off with. Last week it was reported that Australia has become the most obese nation on earth. I think we passed the Americans which is most unfortunate. I think that here in Tasmania we have further problems and a lot of those issues relate to lifestyle and lack of exercise and all those issues. Our Health budgets on an annual basis have become larger and larger, and if it is not for more infrastructure it is for new technology that is available. Because of the obesity problems and diabetes it seems to me that in Australia we are going to have this enormous issue of cost blow-outs in Health.

So I was just a little bit surprised when I noticed the $3.3 million budgeted for the public sector to be spent on health and activity programs. I am just a bit concerned that maybe there are other community groups that ought to be targeted with that $3.3 million rather than the public sector who, one could argue, could be in better positions to access these types of programs anyway.

Ms GIDDINGS - I welcome your question and it is a very good one in terms of actually giving you a bit of an overview as to what is happening in Health and Human Services as well. What you have there is a specific initiative that has been put forward in this Budget, one that I wholeheartedly agree with, considering that the State government is the largest employer of any group of people in this State. To target the entire public service is the most effective way to reach many Tasmanian families. This is about leadership in that sense. If you have a public servant who is going home and incorporating the benefits of what they are learning through that program into their own family life then you are in fact touching a lot more people that the 23 000 or so public servants that we have. Double that just with their partners, and with children you have quite a number of Tasmanians that you are touching. It is about building up. You cannot ever have a whole population-wide program to touch absolutely every person, but this one does touch a significant number..

As you quite rightly say, every year we are putting more and more funding into our Health and Human Services portfolio. People would be aware of the comments that I have made since being Health minister about the challenges in the Health and Human Services portfolio and why, even with increased funding, we have seen the growth in obesity, in people dying of cancer and those indicators which are not good here in Tasmania. That is why I have said let us stop; what we are doing is not working. Throwing money into the existing system is not working. We actually need to try to change the system. That is true of hospitals and that is why we have done the Tasmanian Health Plan. It is true of disabilities and that is why we have just announced disabilities reform. It is true of Children and Families and that is why we have just done a huge reform with Family Support Services as well our own child protection system. It is true of alcohol and drugs and that is why we have done a review and we still have work to do in that area. We have already done the work primarily in Mental Health Services, although we are in that phase of actually looking back on the changes we have made, seeing whether or not they are working. We have a lot more work to do across the other elements of the agency.

This year's Budget invests $153 million more again into Health and Human Services and that is a 11.2 per cent increase. We have now hit over $1.5 billion for this portfolio, which is a huge amount. I think the whole State Budget now has hit $4 billion and we are $1.52 billion of that. I did want to note that we have been progressing, particularly in hospitals where these challenges are the greatest, and health outcomes in primary health and preventative health are really critical. With the Tasmanian Health Plan we have in fact been doing the lot since we released that plan in May of last year to get the structures right, to start setting this up for a different way of delivering services into the future and helping us deal with those issues like obesity - while working with GPs.

A lot of this is working in tandem with the Commonwealth Government as well. For instance, a care plan has come in with GPs now able to use practice nurses to help them deliver some of those clinics for diabetes and things like that. All of these things are linking in together. The particular strategy you pointed out I see as just another piece of the overall puzzle, and a very important piece because it hits so many Tasmanians.

CHAIR - Might it be that that $3.3 million in future is extended to more programs for preventative health? Are there any other jurisdictions, particularly in the western world, that have really made some inroads into combating these issues which have the compounding effect into the future.

Ms GIDDINGS - Yes. When we get the likes of Dr Roscoe Taylor to the table when we get to the outputs, you will be able to have a much more in-depth analysis of some of the work that has been done in these areas. As the Health minister it was the first issue that hit my table; I think it was within 48 hours and I was at my first ministerial council meeting in New Zealand. The issues around obesity were right there at the table. We were looking at some of the programs that New Zealand had undertaken with success. The problem is that to deal with issues around obesity, or we prefer to talk of 'healthy weight', you really do need a lot of one-on-one work with people. That is where the work with the GPs and care plans is so important, having that contact with the patient on a one-on-one level. The programs that work in New Zealand that we were told about were directed at overweight children. They were really intensive programs, and they are very expensive programs that deal with a small group; they do not actually deal with the population-wide issue. You are always trying to get enough initiatives that work with groups that actually hit the whole community. Nationally again we are part of a whole campaign to get out

information across the entire country about healthy weight and obesity issues. There is a fair bit happening, both at the local and national level.

CHAIR - How do we really get the message out about eating non-processed foods, healthy foods and exercise? They are fundamentally basic things.

Ms GIDDINGS - They are. We do have programs with things like the 2 fruit and 5 vegetable campaign. We have posters up in a number of places advertising that. We have our healthy eating people who work with schools as well about nutrition issues. As someone whose weight fluctuates a lot, I do sympathise and understand the difficulties that many Australians have in maintaining their weight, even when they do predominantly eat a good healthy diet.

CHAIR - Yes, I know.

Ms GIDDINGS - We all probably know to some extent, some less than others.

Ms FORREST - There is some evidence to suggest that people who are a little bit overweight but have a healthy lifestyle and exercise are in better health than some people who are underweight.

Ms GIDDINGS - That is why Dr Taylor has been saying to me many times that talking about healthy weight is more important than talking about obesity. Obesity has a very negative connotation. In fact you can be very thin and not do any exercise and be less healthy than someone who is technically overweight but is fit and well. So it is a complex thing. Again, we do not want to perpetuate those mythologies in the community that being overweight is really bad and being underweight is good because it is not true in this sense. It is about being healthy all around and fit. Exercise is critical.

[9.45 a.m.]

Mr WILKINSON - Obesity is a big thing at the moment. How we are going to improve it? We were told only last week that Australia is now the fattest nation in the world; it has surpassed America. So it is a huge problem. The costs that flow on from that into the medical sphere are significant. What are we going to do?

How much money are we putting towards it? What are the outcomes that we are looking for? How are we going to have the KPI's, for want of another word, of whether our programs are being successful or not?

Ms GIDDINGS - Again, if we can do a lot of that analysis in the output group with Dr Roscoe Taylor, it would be far better to get that in-depth level of questioning you have there answered by him at the table. We do acknowledge it as one of our chronic disease issues and at a chronic disease level we need to do more, which is what the whole Tasmanian Health Plan is about. We have our own strategies in place, which, again, I am happy to go through what we are doing with the Tasmanian Health Plan.

But here is not one single easy solution to these issues. They tend to be different programs at different areas. So in preventative health there are strategies we have in place. In primary health, in the health plan we are trying to deal with those issues through care planning with GPs and the like as well. We have partnerships with Diabetes Tasmania, for instance, around trying to assist people with diabetic issues which are often obesity-related as well. It is such an intricate area that

it is not easy to provide you with the one simple solution. But these strategies, like getting the public servants involved, are key to touching 22-23 000 people around Tasmanian plus their connections that they make within the community.

But it is frightening. And have a growing problem here in Tasmania as much as anywhere else. We are having to buy bigger beds to accommodate people within our hospital systems, our surgical beds so that they can have the surgery done, even though it is at huge risk to their lives being so obese. This is extreme obesity that we are talking about - ambulances, those sorts of things. It has an impact on the equipment that we require to support these people in the hospital system.

Ms FORREST - You are more likely to have complications that cost more.

Ms GIDDINGS - Yes, exactly.

Ms FORREST - I mentioned to the Treasurer about the budget papers not containing a breakdown of the expenses. I wonder if it is possible to have a table with the breakdown of the expenses. Last year's budget paper looked at things like consultants, advertising, travel costs and those sorts of things. All we have this year is expenses and it makes it a little bit difficult to look at where the changes have been, where the upwards or downwards have been in costs. I wonder if it possible to have that tabled.

Ms GIDDINGS - I am sure that is possible for us to table that for you.

Ms FORREST - It will make it a little bit easier to move through the output groups.

Ms GIDDINGS - We might take it on notice at this moment and try to get it to you before too long.

Ms FORREST - In a broad question - and without the breakdown of those figures it is a bit hard to see if there has been much change - how much has been spent in the last two financial years on advertising, in what areas has that advertising been conducted and how much was spent on each area? The reason I ask it here is because it goes across all output groups; it is not just one area.

Ms GIDDINGS - The overview does tap into our shared services so you are quite within your rights to ask those questions. We will have to take that on notice for you; it is not right here.

Ms FORREST - Okay. How do you measure the value and outcomes of that advertising?

Ms GIDDINGS - It is a little bit too broad, which is why I am gulping. I am not quite sure in that sense because probably it is better for you to target your question as to which advertising you are thinking about because there are different levels of advertising that you do against your outcomes. If, say, we are advertising for jobs and we fill jobs, we know that advertising has worked. If you are talking about public information, that is just getting out there providing information to the public; what concerns me is when the public say, 'We did not know', and so we put information out there - from ads in the newspapers to brochures in the community health centres. Numerous times I have been criticised for putting information out, which I think is a real shame. Even though I have used appropriate ways of advertising different things that are going on within Health and Human Services, I still get people saying 'Oh, but I did not know'. It is a bit

anecdotal in that sense - I am not spending money on doing surveys of the community to work out whether or not my inserts on the Tasmanian Health Plan, for instance, were effective. However, I did get a handful of responses from people who were very angry about elements of the health plan telling me that they did not appreciate me spending public money on telling them something that they were very angry about.

For the broader community who did not ever tell me how they felt about it, I do not know. You would know as well as I do as to whether they appreciated having an insert on the Tasmanian Health Plan. I would still stick by that, saying that is critical to get your information out and to ensure the community has as much as it can. As it is, we use the Internet for virtually everything in terms of information putting reports up on the web, but not everyone has access to the Internet so we advertise and we will continue to advertise.

Ms FORREST - The point is, I mentioned how much has been spent on the advertising surrounding the health plan over its life so far. There has been criticism in the community not just from people who are unhappy with aspects of the health plan and how it might impact on them but seeing this as a way of spending money to tell them what some of what they already know. And then you give me the feedback that people say 'Well, I did not know'. You spent all this hundreds of thousands of dollars in advertising and people still do not know. So the question is - you stand by your decision to do it?

Ms GIDDINGS - Absolutely.

Ms FORREST - But how do you really justify that expense if people still claim that they did not know?

Ms GIDDINGS - As I said, unless you go and spend money on doing a survey of finding out whether people did or did not appreciate having information provided to them I think it is an anecdotal discussion that you and I are having. I think the problem is is that the community would probably be even more outraged if I then spent money on doing a survey. My belief is that it is important in a democracy that people have information available to them. Unfortunately, what I find is that in politics you often have, as you would know, and not just in Health but across the whole of Government, people who disagree with certain issues and go out of their way to ensure that their view of the world is heard loudly and clearly. I never hear any sort of criticism of that but when the government comes out to try to balance the wager a bit and say 'There is an alternative view to the one that you are hearing', we get criticised for doing that. Normally, it is from the people who are waging the other side of the debate. They do not want government to get involved. I do not think that this government has spent extraordinary amounts of money, unlike what we have seen at the Federal level where hundreds of millions of dollars was spent on the WorkChoices campaign. Hundreds of millions of dollars were spent on numerous campaigns federally to get various policies up, and I would say in a political sense, not in an information sense.

Ms FORREST - We can make the decision when we see the figures.

Ms GIDDINGS - Absolutely; we will get figures for you. For instance, we have spent $50 000 promoting the abuse-in-care round and that was because we had to go national with that. So that has paid for advertisements in six interstate publications: the *Northern Herald Sun*, the *Brisbane Courier Mail*, the *Adelaide Advertiser*, the *Daily Telegraph*, the *West Australian* and the *Northern Territory News*, as well as all the posters. We have flooded Tasmania. You could not

say that you did not know about the abuse in care round 4. I think we spent that $50 000 extremely well ensuring that people know that this round is occurring right now. So that is an example.

I do not know if we have anything on the health plan. We are getting that for you as well. I think that it is very important that people have access to that information. I am also told the prevention campaigns have some evaluation. Quit, for example, get some evaluation of their ads from the callers who ring the Quit line following a television campaign. In February-March we provided $50 000 for Quit Tasmania's antismoking campaign.

Ms FORREST - Quit's program, is a positive step in assisting people to make a life change that will have a benefit on their health. Most people do not see direct benefit in only being informed.

Ms GIDDINGS - I do not know how you can say 'most people' because I think this is just anecdotal. I could say most people do not care because most people have not contacted me about it. But a handful of people, mostly those who are part of a campaign against elements of the plan, were against it. They were against it because they thought that they were being attacked, even though I was not attacking. With the LGH, for instance, there was a political campaign around the Launceston General Hospital in council elections, where suddenly these candidates were using the hospital to gain publicity over it. So you go out there and you say to the community, your hospital is under threat, your hospital has been downgraded and you are losing services. Was any of that true? No, not one bit of it. That hospital was not under threat. That hospital did not lose one service. That hospital is still the very same hospital it was prior to the health plan. So, when I put out a media information sheet to northern Tasmanians to tell them the facts about the LGH, I received some criticism from people who were part of the campaign on the LGH. Why they do that? You would need to talk and ask them. But the vast majority of northern Tasmanians did not contact me.

Ms FORREST - Possibly because they do not care.

Ms GIDDINGS - Either they do not care or they are quite happy to have the information presented to them.

Ms FORREST - I will move on to the question of consultants and how much is being paid to consultants in the last year and the total cost of the consultants who work today, associated with the Tasmanian Health Plan.

Ms GIDDINGS - I can tell you about consultants generally in relation to this. We have entered into 97 contracts for the procurement of goods and services with the value of $50 000 and over and the total value of these contracts is approximately $89.6 million. Of these contracts, 10 relate to consultancies with a total value of around $2.4 million. A number of other contracts have been recommended for awarding, however contracts are yet to be formalised with suppliers. The engagement of contractors and consultants is undertaken in accordance with the Treasurer's instructions and local suppliers are actively encouraged to participate in the services of the industry capability network used to identify local suppliers. Tasmanian suppliers are successful in approximately 52 per cent of all contracts awarded by my department. This figure is generally lower than for other departments due to the specialised nature of many of our departments' requirements, particularly in areas of medical equipment and pharmaceuticals.

[10.00 a.m.]

I am happy to table the list of the consultants that we have which covers all those consultancies of which some would be of the Tasmanian Health Plan. I think some of the Tasmanian Health Plan we have not got through yet. We are still waiting for the invoices on the clinical services plan to complete the latest update of that. So I cannot today provide you with the latest cost of the Wellington update report. I am happy to table the other consultancies for you.

Ms FORREST - Just before we move on, what was the financial budget overrun for the whole department for last year; where is it tracking to be at this stage? I know that we are not at the end of the financial year quite.

Ms GIDDINGS - This is a copy that I am happy to table for you on consultancies. The final budget position. Before we go onto that other question there are some more here that relate to acute services where we have used consultants to provide advice on the Clinical Services Plan, the Tasmanian medical retrieval review, which fell out of the THP, as did the bone marrow transplant review. There are also engineering and architectural issues and various other reviews and evaluations.

As of 30 April a total of $599 222 has been expended on consultancy fees over $2 000. So just under $600 000 for health. This excludes consultancy costs relating to the transfer of the Mersey Community Hospital which were reimbursed by the Australian Government. It includes $50 000 for John Kirwan for the Clinical Services Plan; he is now the acting CEO of the Launceston General Hospital. I am happy to table that information for you which should relate to the other information we have provided.

There is mental health here as well. During 2007-08 Mental Health Services have engaged expert consultants to progress a range of reform issues around services development and review, including a review of the implementation of the Bridging the Gap-funded recommendations. Consultants have been engaged to augment the efforts of Mental Health Services staff by providing expertise which does not exist within Mental Health Services or my department.

At the end of April 2008 for the 2007-08 financial year Mental Health Services expended $101 743 on consultants. Key consultancies have been provided in the Huntington's disease service review, Bridging the Gap evaluation and Ward 1E. These reviews are critical to our ongoing reforms of Mental Health Services. To break that down for you: $10 820 paid to Lea McInerney, a specialist provider of health sector reform consultancy services to review Huntington's disease, $51 270 paid to KPMG to evaluate the Bridging the Gap, $8 301 for architectural services, $14 917 was paid to Peter Santangelo for Ward 1E's review and specialist clinical supervision, $2 945 was paid to the Queensland Government for review of a serious incident at Ward 1E, $8 976 was paid to PDF Management for community consultancy services with the Mental Health Act review.

We had the appointment and selection of Lynette Pearce as a senior consumer carer liaison consultant with Mental Health Services as well. There is not a figure for that. She was a State Service employee so that is probably not relevant to what you want to know.

In relation to the budget outcome, as you would know it is premature to be talking about the specific budget outcome at this stage of the year because it is not yet 30 June. However, I can say with confidence that the Health and Human Service portfolio budget is not at risk and it is under control. The remainder of the year will see tight control over expenditure, as is normally the case

every year. There is always pressure to spend more money in this portfolio, and firm control is needed to keep spending within limits.

The continuing message for Tasmanians is that the Government has made and continues to make significant investment in Health and Human Services. There has been real growth in spending over the last few years. The appropriation from the Consolidated Fund has risen from $751.1 million in 2003-04, to $1.136 billion in 2007-08, a 50 per cent increase or $378.9 million increase over four years. It is a substantial increase.

Over the same period, budgeted spending has risen from $960.1 million to $1.369 billion. The portfolio has significant expenses funded by sources other than the appropriation from the Consolidated Fund, and when discussing the portfolio we have to have regard to the total spending, not just the appropriation. But again, we remain very focused on managing a sustainable health system, and while we do normally have those tight short-term budget control measures that we use to get over the end of year, we have everything under control.

Ms FORREST - Last year it was estimated at being $27.5 million over budget, a figure that was given to us in last year's Estimates. Your general report stated just recently when it was released, that $58.9 million was expected for this financial year.

Ms GIDDINGS - Overrun?

Ms FORREST - Yes.

Mr ROBERTS - I have projected a year-end overrun on operating costs will be $50 million, which we will cover through reserves within the department, so balancing at the end of the year within our reserves.

Ms FORREST - A question that was asked last year, too, was in relation to the amount of unpaid accounts. I know you have the structures in place you just described to manage the situation into this year. Are you able to provide the number of accounts that remain unpaid at 45 and 90 days to date?

Ms GIDDINGS - I understand all of our accounts have been paid within the appropriate time.

Ms FORREST - So there are none that have extended beyond their terms of trade?

Ms GIDDINGS - No, none. We have been very good this year. We have put a huge effort into getting a sustainable budget in Health and Human Services, and this latest injection of funds is part of our strategy to ensure that we do have a sustainable budget that is ongoing across the portfolio. So I am pleased to say that we have put in a huge effort, and part of that effort, I might say, that will be ongoing are the strategies that we are putting in place, for instance, in putting finance officers into all of our hospitals so that there is no excuse in that sense from our hospitals of not managing their budgets effectively and efficiently in the sense of the actual numbers.

Ms FORREST - When you say finance officers, are they qualified accountants? That was an issue with the North West Regional Hospital last year, that the finance manager there was not an accountant.

Ms GIDDINGS - They will be appropriately qualified individuals for the financial officer positions within our hospitals.

Mr ROBERTS - That is correct. It is part of the financial regime that we are implementing - finance directors in each of the major business units; it is a program of investment that we started this year. We have appointed to the LGH and we have made one attempt at the Royal; we will be following that up now with the North West Regional Hospital, the Ambulance Service and our primary services this year, along with a CFO within the department. This is a program of implementation of qualified accountants running the business functions of all our major operational units.

CHAIR - Minister, just while we are talking about budgets, one thing that may well have a significant impact is the last Federal Budget with the change in the Medicare thresholds. How much effect do you think that is going to have? Have you talked to the Federal Government about that? Is there any chance of getting any compensation out of the whole system, because a lot of people are obviously going to drop out of the private system, and we are going to have them presenting to hospitals and surgeries.

Ms GIDDINGS - It is an interesting issue. Certainly when it came out I welcomed it in one sense. I think it is important to try to alleviate pressures on working families and I support that in that sense. However, I have also said to the Commonwealth very publicly - and it was even printed in *The Australian,* with the Honourable Jim McGinty - that should there be a negative impact on the public health system, we would expect that in the negotiations for the new Australian Health Care Agreement, the AHCA, we would get compensation for any flow-on effect to the public hospital system. This is a much bigger issue for the bigger States than it is for Tasmania. Yes, there could be some flow-on, but evidence shows that, when the surcharge was first brought into place, there was only a 0.2 increase in Tasmania of people taking up private health insurance. So, even with the stick, it only had a 0.2 per cent effect. We have a relatively small private health insurance system in Tasmania and it is a fragile one. I am very conscious of that in terms of how we work in the private sector with our public system but I believe that the impact will be felt much more in NSW and Victoria where they have a far more robust and larger private health system with a lot more people who have taken up the insurance. I think you will find here in Tasmania, because we have lower socioeconomic status than the rest of Australia, that we have fewer people who can afford private health insurance in the first place.

I have had private health insurers or their industry bodies write to me and say dramatic numbers are going to fall out of the private system and into the public. If we saw that happen in Tasmania, I would be very concerned that we would have a private system at all. I do not believe that this one decision of the Commonwealth Government is going to create that catastrophe.

CHAIR - You are not expecting any change on the bottom line of your budget this year through this measure?

Ms GIDDINGS - There could be; we are going to monitor it. It is a bit like trying to look into a crystal ball to work out exactly what the effect is going to be. That is why I have said that I do not expect that we are going to see a dramatic effect from this decision, so I am not going to be pulled into the Federal Liberal Opposition's argument, which Richard Colbeck and others have tried to do already. Equally, I will be watching to see if there is an effect here in Tasmania and if there is then I will certainly draw that to the attention of the Federal minister and ask that we be compensated for that flow-on to the public system.

As I said, we only had a 0.2 per cent increase in private health insurance coverage in Tasmania as a result of the surcharge being put in the first place, so I do not think it will be dramatic, but of course we will monitor it and that is why it is in the budget papers that we are going to do that.

Ms FORREST - Further to that, have you done any risk analysis of that event? Like how many people go through the private sector here, and how many people would drop health insurance, particularly in light of the rising living costs at the moment?

Ms GIDDINGS - That is the bigger issue - not the surcharge. The bigger issue is private health per se and what is happening with private health insurance every year. I do not think that this will be a trigger. As I said, 0.2 per cent were taking it up when that was a stick, so I do not think that you are going to see a huge exodus. People join private health insurance for their own individual reasons and -

Mr MARTIN - Do you know what percentage of Tasmanian that have private insurance?

Ms GIDDINGS - I do not know; we have only rough per capita basis figures. The information I have here is that with the introduction of the 30 per cent rebate for private health insurance from 1 January 1999 in lifetime health cover from June 2000, Tasmania's level of private health insurance coverage initially increased by 11.5 per cent from 33.1 per cent to 44.6 per cent. It has since decreased to 43 per cent in December 2007 which is below the national average of 44.4 per cent. I understand that the lifetime health cover was the main driver of the increase.

[10.15 a.m.]

Ms FORREST - It was getting people to join up before they were 30, wasn't it?

Ms GIDDINGS - Yes.

Mr WILKINSON - I note, Minister, you were saying it is going to mean a 0.2 per cent difference?

Ms GIDDINGS - I was saying that was the effect of people taking it on because of it.

Mr WILKINSON - Sure. But I also note the footnote on page 6.12, where it says, 'There was a significant increase in the waiting list for 2007-08' - due to bed closures. It further said, 'It is anticipated demand will further increase as a result of the recent changes in the Medicare Levy Surcharge threshold'. So it would seem, on the facts that we have before us, we are saying that as a result of this Medicare threshold change there is going to be, definitely, an increase in the waiting lists. If that is the case, what do the Government believe that increase is going to be? How far are the waiting lists going to expand as a result of it?

Ms GIDDINGS - I think I have spoken about all of that in my comments just now. I even referred to the fact that there has been that mention in the budget papers because it is almost impossible to quantify what it may or may not be. It is a crystal ball you are looking into here. The health insurance people have certainly given us what they believe will happen, which seemed like a huge impact for Tasmania. I do not think that we will see that impact here. It is almost impossible for us, though, to predict what the consumer behaviour will be. That is why I have

said to you that we are going to monitor it. You are quite right; there has been an increase in demand over 2007-08. There was in 2006-07 and so on. We are on a threshold increase here and the Tasmanian Health Plan is about trying to level out that demand growth, not necessarily drop it. I do not know if we can do that for many decades.

We will be monitoring what is happening to our patterns there, what impact the plan is having and whether or not we can pick up any change with the Medicare surcharge issue. Believe you me, if there is an impact on the Tasmanian health system I will be using that to gain extra dollars for the Tasmanian health system from the Commonwealth.

Mr WILKINSON - I understand that. But what I am saying is that you must have information, I would think, in relation to how much it is going to increase, and if you have that information then that is what I am after.

Ms GIDDINGS - The national health insurance people have said they think about 10 000 people in Tasmania. That is what they are saying, but it is almost impossible to predict that. So I would argue that they are pretty rubbery figures in that sense. I am not basing anything, at this point in time, on their view of the world. They are coming from a particular point of view because they are trying to protect their industry and I support them in that. That is what they are there for. From my position as a health minister in Tasmania, we will be monitoring it because if there is an impact on the Tasmanian health system that we can say was a direct result then we will be going to the Commonwealth, but I do not believe there will be.

Mr WILKINSON - And you would be asking for, I would imagine, compensation for that?

Ms GIDDINGS - Absolutely.

Mr WILKINSON - Do I understand that the health insurance body that you have mentioned are saying there is going to be an increase in waiting lists within Tasmania of 10 000 as a result of this change? Is that what you are saying?

Ms GIDDINGS - No. That is people dropping out of private health insurance, not on waiting lists.

Mr WILKINSON - Okay. Can you transfer that into waiting lists at all and have there been any figures done in relation to an increase in waiting lists as a result?

Mr ROBERTS - No, there has not been at this point in time. There is a jurisdictional working group around the COAG reforms and which is looking at this very issue. There is a belief on the part of the large jurisdictions that this will have an impact on demand. I would like to clarify something slightly. Just because people may come out of health insurance that does not mean waiting lists will grow. It does mean that the demand on the public system may well increase in certain areas. I would also agree with you that there is a tendency for private medicine to be waiting-list related; that is, patients coming in for elective surgery. The two thing do not necessarily correlate in the way that you describe. I think we have to wait for the jurisdictional working groups to come up with a formula of what they think the impact of that movement will be.

Mr WILKINSON - When will that be?

Mr ROBERTS - The jurisdictional working groups go up to Christmas

Ms KATZ - The COAG working groups are delivering some information around October. That is an estimated arrival date.

Mr WILKINSON - So in October this year we will get some understanding of how it has changed?

Mr ROBERTS - From the joint work with the insurance industry and with the jurisdictions we will have a better understanding of the effects of that change. Again, I would emphasise that it does not mean to say that waiting lists would increase as a result. Demand on the system may increase but not necessarily waiting lists.

Mr WILKINSON - Are you going to take any figures as to whether the waiting list has increased as a result? Without asking people, when they are waiting for surgery, whether they have dropped out of a fund there will be no other way of understanding whether it has made a change.

Mr ROBERTS - Sure, and monitoring this will be a very key thing. For the jurisdictions to be able to demonstrate to the Commonwealth that a change that they have instigated has resulted in this will be part of the monitoring we will have to put in place.

Ms KATZ - Also you have to be aware that for most people with health insurance only a very small percentage use their health insurance in public hospitals, so it is more complicated than watching the privately insured people come into hospitals.

Ms GIDDINGS - I have asked the national insurance group to give me some breakdown as to how they have come up with their analysis and why they believe the numbers that they have given us. So I wait with interest to see what they come back to me with.

Ms FORREST - There is $20 million allocated per year for the next four years to be spent on reviews and reforms. I am just wondering what percentage will be on reviews, since we have had a lot of reviews of late, and what reviews are actually planned?

Ms GIDDINGS - It is mostly about the reforms that we have already put out there. There is $80 million to support the implementation of reforms and to develop the new services models which include $20.1 million for clinical services, $4.5 million for primary health services, $6 million for out of home care, $6 million for family support services, $17.1 million for alcohol, tobacco and other drug services and $26.3 million for disability services. There is also a further $29.5 million for family support services, which will also go to supporting the reform and the expansion of family support services. The Tasmanian Health Plan reform has generated reviews like the patient-transport review, the accommodation review, the bone marrow transplant review and the medical retrieval review. You are continuing your reform process through those reviews. A lot of those are underway already and perhaps when we get to the output groups we can actually go through what the forward plan is.

I have just been told that the money is really for implementing the reviews but if the review recommends another review then we will be implementing that recommendation.

Ms FORREST - It was not clear from the budget papers that was the case that is why I asked the question.

Ms GIDDINGS - It is actually a very exciting Budget for us because to have so much resourcing provided in one year to put behind the numerous reviews that we have been undertaking in that reform process is really welcome.

Output group 1
Acute Health Services

1.1 Clinical Support Services -

Ms FORREST - I am interested to know how many allied health positions remain unfilled around the State, what professions they are in, and what locations.

Ms GIDDINGS - I am not sure if this will cover everything you want, but we will go through it and see. Total paid allied health full-time equivalent positions at the LGH, including overtime and call-back, have increased by 12.3 FTEs, or approximately 11 per cent since June 2005, compared with April 2008. It does not appear that we have the numbers of our advertised positions there for allied health. I have here that the total paid allied health full-time equivalents at the LGH, including overtime and call-back was increased by 12.3 FTEs, or 10.83 per cent since June 2005. It is only related to the LGH, not across all allied health, that is the only thing. As you know, there are difficulties in recruiting within allied health professional areas.

Ms FORREST - That is why I asked the question, Minister.

Ms GIDDINGS - Yes - how many people we are looking for. I am told across the whole agency as at 2 May 2008, there were 103 casual fixed-term or permanent vacancies advertised across my department, but we would need to breakdown for you the breakup of that for allied health. This is allied health. We have increased our FTEs. From 2000, we had 740 average paid FTEs, and now we have 1 051 on average paid FTEs. So we have been on very much a growth continuum here; I have a graph that you might find interesting - the trend is up. We do hit times where we have had some drop in the number of allied health people available to us, but our trend has been right up. We can table that information for you; I am more than happy to do that.

Ms FORREST - Will you also provide a breakdown of the unfilled positions and where they are?

Ms GIDDINGS - We will have to take that on notice.

Ms FORREST - Can you explain some of the measures you have taken to try to recruit? I know there are challenges, and you identified that in a number of areas, but a lot of our remote areas and regional areas are sadly lacking in allied health professionals at the moment.

Ms GIDDINGS - Yes, it is a real problem for us, that is for sure.

Ms FORREST - Can you outline what you are doing to address it?

Ms GIDDINGS - We are trying to recruit allied health professionals, and we do have some strategies in place. In oral health, because we do not train our own dentists in Tasmania, we have formed a relationship with the University of Adelaide to get some of the undergraduate training and postgraduate training of dentists done in Tasmania to try to attract people to our State. That has been working; we are now doing very well, but I will wait until we get to oral health to go into the details.

We are also been doing is starting to use that strategy in allied health as well, because other than in pharmacy and social work, we do not other allied health professionals in this State. My understanding is that we are developing a partnership with Monash University to work with some of our specific allied health areas.

[10.30 a.m.]

Ms BENT - We have an agreement with Monash to take students on clinical placements from the physiotherapy school at Monash. They will work with our hospitals and community-based services and provide funding to us to enable us to provide appropriate, supervised clinical placements on the basis that often students who come for clinical placement then decide to stay. This has been a program that has been going for some time with other universities. We have arrangements with Latrobe and Charles Sturt and the University of Adelaide, among others, for a range of allied health clinical placements. But Monash is the first one that is offering us a package which will include having a clinical lecturer on-site in Tasmania to support them. As well as that we are doing other work with the University of Tasmania.

Mr WILKINSON - Is this the first year for that?

Ms BENT - This is the first year for the Monash one, yes, and we are hoping to expand that over the next couple of years.

Ms GIDDINGS - The areas that we are really concentrating on too, are physiotherapy, nutrition, dietetics, further development of a degree course for environment health officers as there is severe shortage of those in the State, and increasing workplace clinical psychology training across the department.

Ms FORREST - Speech pathology is a really big area and there is a big lack on the north-west coast particularly. Is speech pathology being considered in this mix?

Ms BENT - Speech pathology have very small numbers. So when we look at what students we can train in Tasmania we have to do a balance between what is viable in terms of the university course - the ones that the minister spoke of - and which ones we might support through arrangements such as clinical placements. My understanding is that we do have arrangements around speech pathology clinical placement but I do not have the details here.

Ms FORREST - The Department of Education use speech pathologists as well under a separate structure.

Ms BENT - They do, but the numbers are still very small across the whole of Tasmania. They do not warrant us training our own.

Ms GIDDINGS - In terms of recruitment, though, it might be of interest to you to see the things that we do and to show you that we are out there trying to promote ourselves as being a

good place to come. This is a kit that we use, Health Careers in Tasmania. I am still yet to be convinced about the colour blue but apparently it works really well. Someone said that. There must be marketing analysis on that on, Ruth, because every time I try to change the colour I am told 'no'.

Ms FORREST - What would you prefer, Minister?

Ms GIDDINGS - I would prefer a soft red with purple tonings.

Laughter.

Ms FORREST - A little bit of gold as well.

Ms GIDDINGS - Yes, a bit of gold, lovely. Now we are in this upper House surrounded by gold, gilt and red.

Ms FORREST - Red, yes. I think she is on the right track.

Ms GIDDINGS - Anyway, we do have some really good information that we provide to attract people to our hospital and health system to work with us.

Ms FORREST - Are you able to table that, Minister?

Ms GIDDINGS - I am sure we can table that, if you want to have a look at. But we might have it back if you do not want to use it. It is a good resource. I am looking after my pennies

Ms FORREST - For my benefit I think it would be helpful to show constituents in my areas or others that this is what the Government is doing because, when we have such trouble filling positions, I have to explain to people why this position remains unfilled, not from the lack of trying. It is good to have some evidence.

Ms GIDDINGS - I am more than happy to give that to you if it going to be used.

Ms FORREST - It will not be on my desk gathering dust.

1.2 Medical services -

Ms FORREST - Will the time frames for action according to the monitoring Gantt chart be met in view of the recent variation of the situation at the Mersey Hospital? If not, what changes have been made and when can the people of the north-west see some clear direction and action to ensure a safe, quality, accessible and sustainable health service?

Ms GIDDINGS - The answer is yes and, in fact, we launched the Gantt chart at the same time that we launched the revised Clinical Services Plan. I can assure you that we will be endeavouring to stick to those time lines. In terms of the services on the north-west coast, as you would know this has been a bit of a moveable feast in the last two to three weeks since the Commonwealth contacted us to tell us that their tender process had fallen through.

Ms FORREST - That was a surprise.

Ms GIDDINGS - I was interested to see whether they would get any tenders at all. I thought that it might fall over at the first hurdle but it did not. They did actually get people to participate through the process. It backs up a lot of what we have been saying about the services on the north-west coast for some time. We are right now in negotiations with the Commonwealth.

The deadline for them in the tender process was 1 July to get a new operator at the Mersey Hospital operating. We are working with them and we are trying to get to that deadline as close as we can as far as we can in terms of agreeing on the services that we will be providing there, agreeing on ongoing employment arrangements, agreeing on the costs that it will take to run the hospital. Whether we get to heads of agreement by 30 June or whether we can get beyond that is yet to be seen and we still have some negotiating to do.

So we are being as helpful as we possibly can through that process and we are not trying to do anything to stall it but at the same time there are some areas that we do need to negotiate with the Commonwealth and I cannot predict how long that will take. But the sooner that we can get things happening on the north-west coast the better for all of us.

Ms FORREST - Is it fair to suggest that you will be pursuing services as planned under the original Clinical Services Plan?

Ms GIDDINGS - Under the 'revised' Clinical Services Plan that we released in May 2008, we softened the model for the Mersey Hospital. For instance we now have medical overnight stays, which were not in our original model. We also incorporated the high-dependency unit, which was not in our original model either.

We are currently negotiating with the Commonwealth about other elements like the 23-hour elective day surgery centre But we have been very clear that if we were asked to take back the hospital, the revised plan is the one we would want to implement.

Mr MARTIN - Were those revisions medically classified, not just political?

Ms GIDDINGS - Yes. Dr Heather Wellington in preparing the revised plan talked to all the relevant clinicians and went through a thorough consultation process again. She felt that with those adjustments to our original plan it was still within the parameters of the health plan as being safe and sustainable.

There are still some concerns, and this again is why we are talking through these issues with the Commonwealth, about the services because we do not want to have services there that are locum dependent. We have been there and done that and that is not a safe way of running services. Hopefully we will be able to come to an agreement so that we can start operating the hospital as close to 1 July as possible.

Ms FORREST - So will the administration be joined and managed from one site?

Ms GIDDINGS - That is part of the discussions that are going on. I think that it is important that there is some management at the Mersey but it is also important to have some management that is across the health services on the north-west coast as well to ensure we get that integrated system. What is interesting is that out of all this, when you have these hand grenades thrown in your foundation shifts and you then have to change according to that. We think the LGH may

have a more important role in management cooperation and supporting the services in the north-west than we first envisaged.

I do not know if there is anything else that needs to be added. It is a bit hard to go too much into detail for you right now; we have probably gone too far already when we are actively in negotiations.

Ms FORREST - With the implementation of the health plan, you have the Gantt chart giving some direction to that so when do you realistically expect to see reductions in waiting lists?

Ms GIDDINGS - Let us get away from the waiting lists.

Ms FORREST - This is what people see when they are waiting, though.

Ms GIDDINGS - This is where you and I need to educate them. Waiting lists per se are not the issue. The issue is waiting times. For those people, you as their representative want to be able to say that they will be seen within the clinically recommended time. We have been pleased to have the Commonwealth Government come on board this year with the $8.1 million that they have put into elective surgery plus the $3 million for the capital program to support elective surgery. There may be more that we can work on with the Commonwealth down the track as well as our own investment in elective surgery. We see this as critical but the problem we have currently is that there are far too many Tasmanians on our waiting list who are outside the clinically recommended time. That is the aspect that we are driving, not the waiting list. Every year more and more older people come into our health system with various conditions and there are waiting lists for hips, eyes and heart conditions. But that is not a problem - the problem is the waiting time.

Ms FORREST - How will this $8 million - that is from the State and Federal governments - be targeted directly at waiting lists? That is what it is aimed at. That is what the budget papers tell us. So how will that be spent to address the issue of waiting lists and times?

Ms GIDDINGS - We have already come to an agreement with the Commonwealth on the details of the elective surgery that we are targeting under their strategy.

Ms KATZ - We have three responsibilities under that program. One is to deliver 895 over-boundary cases as measured from the end of last year. We have to spend the $8.1 million by, I think, March or May next year. We must exceed the 2007-baseline activity. Last report we were well on the way to delivering the long waits. We had done 532 - that is the last report I had. There might be some more by now. The full-year equivalent of that is 1 063. We are expecting to increase the baseline.

Ms FORREST - This does not really answer my question. I hear the numbers. I hear that you are actually moving people through. How are you doing it? Is the money going to be spent employing more theatre nurses, more general surgeons? How is it going to be spent that it will actually make an impact?

Mr ROBERTS - Can I just pitch in? There is a series of things we will have to do to manage waiting lists, not least having a much clearer focus statewide management of waiting lists in all of our infrastructure and capacity to make sure we get best value from it. It is also a case that we need to target those out-of-boundary cases to bring them down to a conservative and

appropriate level. We need to have a strategy for ensuring that appropriate demand enters the appropriate part of the system. Waiting list initiatives are not just about treating more and more people. That is actually a recipe for disaster. It will not achieve what you need it to achieve. This year is about strategy of elective management as well as actual productivity. We need to tackle all of those together. It is a discussion that we are presently having as part of next year's budget with each of the individual provider units. That work not be complete for a number more weeks yet.

CHAIR - Just a couple of questions I had, Minister, in regard to the LGH specifically. One was that I am informed just very recently a woman who had been allegedly sexually assaulted was admitted. However, there was nobody available at the time to make an examination because apparently the person was on leave. As a consequence of that the police were very restricted in their investigations. In fact it would seem that they will not be able to press charges. The question is: that would obviously have to come from somebody from the hospital, so why did that happen? It was obviously very distressing to the person involved.

Ms GIDDINGS - Yes, here is John Kirwan the CEO of the Launceston General Hospital. I will just give some brief facts first, John, and then you might want to add to that.

[10.45 a.m.]

That was a tragic circumstance. I think you would probably be aware that I apologised in the Parliament and also publicly to that victim who was involved, because it should not have happened. She was seen, mind you, at the Royal Hobart Hospital, I believe, so the evidence that was required was collected from her. To try to ensure that we improve we have provided $214 000 that will be spent on medical services for sexual assault victims in the north and the north-west. That is going to provide a 24-hour a day, year-round roster for sexual assault forensic services at the LGH. It will also include more training and appropriate reimbursement for staff. We had a system in Launceston that relied, I think, on two GPs who did it for many years. They did it because they really felt that it was the right thing to do, not because the correct incentives or the reimbursement were there. In the end they got burnt out by it and they left the service in that sense; that is when it fell on the LGH to provide the service. The LGH have been trying to do their best to do that. I do not know if they are actually the appropriate people to be doing it, but that is another discussion.

We will be ensuring that there is adequate reimbursement for staff who are involved in it, for not only their time undertaking the evidence collection but also should they then have to go to court. They are reimbursed for their time as part of that court process as well. We are committed to recruiting and training additional medical practitioners at the LGH to hopefully reduce that demand on the one or two people who are there doing it at the moment. That is exactly what we have been talking about with the health plan. Services that rely on one or two people are unsustainable and will fall over, as we saw in that particular case.

The funding will allow a formal on-call roster of trained medical practitioners in forensic sexual assault examinations. There will be better coordination of the roster, eliminating any gaps in cover. There will be the appropriate reimbursement that I have mentioned. The training and ongoing professional development will also be provided in twice yearly educational sessions to local GPs free of charge to try to encourage GPs to get back involved in the process as well. Of course we will be providing them with cover for any cost they incur in taking time out to do that training as well.

The Launceston General Hospital is currently continuing its efforts to recruit an extra registrar to help with the workload. Then in the longer term we will develop a whole statewide service so that we actually connect our people who are involved in that area. Should there be gaps in the system they can back each other up when those gaps occur, so you do not have someone turn up to a hospital when there is nobody available to do the procedure.

Mr WILKINSON - I cannot understand why you are saying the evidence was not available. I hear what you say that a person was not available at the LGH, but certainly there would have been other people within an hour or two hours away to carry out examinations required to get the evidence that was needed.

Ms GIDDINGS - No. The problem is that we do not have enough people in that region to do the work. At the moment it is about two people, I think. .

Mr KIRWAN - The issue was very unfortunate, and we also apologise. In respect to the Monday night, there were just no trained staff available. It was late on a Monday long weekend during school holidays. Staff were interstate, overseas, on sick leave, or were not able to come back to the hospital given the time of night and other issues. The staff in the emergency department rang through all of our available staff that had been trained in the area. In this case that was unfortunate for the person concerned. We should have been able to provide the service on the Tuesday and we accept that responsibility.

Just for a little bit of clarification, although they present at the emergency department, they are not actually emergency department patients as such. What we provide in emergency department is a counselling room that the very good counsellors at Laurel House can use because, particularly out of hours and particularly given the type of instance, it is secure. Our security are there, our staff are there and our services are there to then follow through in that instance, so they are not admitted as an emergency department case. We did have a registrar who was available but unfortunately he was in theatre with two very complicated deliveries and had worked 20 hours. So we just literally ran out of people.

What we are now doing is bringing in training from Victoria so we will train up house staff and GPs, make the remuneration equitable for general practitioners if they will do it, and provide better coordination across our services. If we cannot do it then we will use Hobart. The long-term solution is, as the Minister has suggested, the provision of a statewide service as envisioned by the KPNG report. Preferably, and I am talking about our end of the business, which is the forensic medical examination, that may well be delivered by nurse practitioners or others in the future, where they go to the client and which probably provides a better women's health service. We are doing that forensic end, and if we increase our numbers and provide another registrar we will have the cover and would like to say it will never happen again.

Mr WILKINSON - I sympathise with the patient but what I cannot understand is why it happens time and again. Evidence can be obtained two hours after an incident or after presentation, therefore that person could have been taken to Hobart.

Ms GIDDINGS - She was.

Mr WILKINSON - Therefore that same evidence that could have been obtained can be still obtained.

Ms GIDDINGS - It was. I did say that at the beginning. You are quite right; she was brought to the Royal Hobart Hospital and the evidence was collected, so we did not lose the evidence. It was a very unfortunate situation for someone who is obviously distressed. They are taken to a hospital, have to wait and then find there is no-one to help them and they are sent home again. I think you have 72 hours to collect the evidence, so she was assisted.

Mr KIRWAN - In respect to having people trained and keeping in practice, I should say that we are dealing with a couple of dozen referrals a year, so the numbers are not great. It means that you have to have the staff on call and trained because for someone who is not doing it too frequently I am advised by our clinicians it takes about three hours to go through it. That is for some of the ones who are not experienced with the paperwork, making sure everything is done because it is for evidence. Those who do it more frequently will move through it a lot quicker than that. That is a bit of the critical-mass issue, but it is also about being available on call. At the moment our obstetricians and gynaecologists are on call to do it as part of their being on call. Others, like some of our anaesthetists, are trained as the second on call, not the primary on call, because on primary on call they are in the hospital and are busy anyway. So there is just that balancing act and coordination. It is a reality for us to hopefully get the general practitioners back in, training them, paying for their training and then using them so we have a comprehensive service.

Mr WILKINSON - The hiccup was when that person was sent home instead of being sent to the Royal Hobart Hospital.

Ms GIDDINGS - That is right and that is where the statewide service link would be critical because we have those connections so that if one hospital cannot look after someone they are immediately in contact with the others. In theory it should happen anyway but the reality is that people get on with their jobs where they are. However, once we have the clinical networks up and going there will be that structure in place to allow that to happen. It is about filling the gaps I think in the existing system.

CHAIR - My understanding is that the LGH is not funded as a referral hospital; it is funded as a base hospital. Is that correct?

Ms GIDDINGS - No. It is a teaching and referral hospital for the north and north-west and it is funded according the services it has. As with all of our hospitals it is appropriately funded, I would argue. We have had to try to get our hospitals onto a sustainable footing. That is what we are trying to achieve out of this Budget with the increased funding that we have received.

CHAIR - Yes, I can understand that. The scenario was put to me that its funding was a bit insufficient, and 20 per cent of the patients that come to the LGH come from outside the 63 area, which puts therefore more pressure on the system.

Ms GIDDINGS - That is the whole reason we have the Tasmanian Health Plan. For the first time we have a coordinated approach around how all of our hospitals work together within one health system. We are not three health systems; we are one health system, ensuring that each hospital backs each other up. The Launceston General Hospital does brachiotherapy, which no other hospital in the State does. So we have patients travelling around the State to Launceston to get that treatment.

The Royal Hobart Hospital does a lot more of the other high level things, like open heart surgery, which you can only have at one hospital. The Royal cares for patients with severe burns, they have the neo-natal and paediatric ICU, high-risk obstetrics, paediatric and gynaecological oncology, complex paediatric, vascular, neuro- and cardio-thoracic surgery, and hyperbaric medicine. The ICU provides care to statewide cardio-thoracic and neurosurgery and also at times critical transfers for vascular and major trauma.

We also provide a fair bit of support for infectious diseases at the Royal Hobart Hospital. The Launceston General Hospital does brachiotherapy as its specialised service but it also has a number of other services that are sustainable - some oncology and a number of different areas. In the health plan they are the teaching and referral hospital for the north and the north-west.

CHAIR - I have three questions on hospitals on which you may like to table the information. What are the individual operating budgets for the Royal Hobart Hospital, the LGH and the North West Regional Hospital for 2008-09?

Ms GIDDINGS - We cannot give you 2008-09 because in the next week or so we will be negotiating with the CEOs what their operating budgets will be.

CHAIR - Okay, that will all come out in the fullness of time. The same for Ouse, St Marys, Rosebery and St Helens hospitals?

Ms GIDDINGS - It would be the same issue. What we have is the global budget that we have provided to the agency and, once we are through this budget process, the agency goes back and discusses with the individual business units what their allocation is.

CHAIR - Staff currently employed at each of these hospitals and anticipated numbers for 2008-09: is it possible to provide that information? Or to have it tabled if you take it on notice?

Ms GIDDINGS - We can give you existing staff; we can put that on notice. Across all hospitals?

CHAIR - Yes, please.

Ms GIDDINGS - You would not want to favour one, would you, so all three hospitals. I knew that there would not be any parochialism at this table.

CHAIR - And anticipated numbers for 2008-09?

Ms GIDDINGS - No, you cannot do anticipated numbers. We do not work that way at all. For instance, under the enterprise bargaining agreement struck at the end of last year we put in an extra 75 nurses but I do not have another process like that which will throw more nurses on the table. We have negotiations around the Commonwealth with the various strategies they are putting in place; they may have staff implications but at this point in time I have no idea. It is crystal ball gazing again. I do not go in for crystal ball gazing but I am more than happy to tell you what we have in existing staff. I might even be able to tell you some right now.

As at the pay day 23 April 2008, the department had 10 534 paid staff, which equates to 8 699.58 FTEs - exclusive of the Mersey Community Hospital. I can do a little bit of crystal ball gazing and tell you that we are expecting a few more to come to the Mersey. Of these, 2 886.14

were nurses; 1 943.8 were administrative and clerical support staff, that is ward clerks, administrative assistants, customer service officers, reception staff, managers, project officers, child protection case workers, medical records assistants, clinical coding staff, information technology professionals, records staff, finance service officers, payroll officers and various other support roles.

[11.00 a.m.]

Some 1 649.06 were operational staff, that is hospital aides, cleaners, home helps etc; 1 007.27 were allied health professionals; 623.72 were medical staff; 243.84 were ambulance officers; 115.05 were technical staff; 62.93 were computer systems officers; 46.76 were youth workers; 7 were graduate trainees; 40.58 were radiation therapists; 46 were senior executive service; and 21.45 were dentists. As at 30 June 2007 my department had 10 843 paid staff or, as I said, 8 992.58 in full-time equivalents.

For comparison purposes to 2007-08, this number needs to be discounted to 10 425 paid staff or 8 663.87 full-time equivalents for the transfer of the Mersey Community Hospital to the Australian Government. To April 2008 there has been a net increase of 35.71 full-time equivalents. Major full-time equivalent increases from June 2007 have been 47.64 in nursing - I think that has even increased now that we have had further recruitment as part of our 75 nurses - 34.6 in medical staff; and 13.89 in ambulance officers, with a significant decrease in operational staff - 102.68 - due mainly to the transfer of group homes within Community Health Services to non-government organisations. The majority of full-time equivalent increases have occurred within acute health services with an increase of 153.65.

I might take this opportunity, since I do not have any of my colleagues here to ask me a question on these issues, because it is very relevant to that question, to take a minute to look at the fact that these are not bureaucrats. We are often told that we have a whole lot of fat-cat bureaucrats and there is this attack on the health and human services system, saying that we need to get rid of the bureaucracy and everything would be all right. The reality is - the 2007-08 data shows - that 522 of 550 employees who earned more than $100 000 were doctors, nurses, ambulance officers, allied health staff or dentists. So, of 550 employees who earn more than $100 000, 522 were physically there on the job doing the work of the services you would expect from us. The remaining 5 percent were senior executive service managers or the heads of agency. So we are really investing in our coalface; we are investing in our employees with 95 per cent of our high-earning staff being professionals. This should, I hope, get rid of that fat-cat bureaucrat myth that continues to be peddled at various times in the community.

Eighty-seven of our employees earn between $150 000 and $200 000 and that includes 75 doctors and six senior executive service managers, including hospital CEOs. We have 167 employees who earned over $200 000 and they were doctors. The other element that I think is really important is that the growth in our staff has been in the clinical services area. Operational and administrative staffing has declined by 29.4 FTEs since June 2007, with overall staff numbers for nurses having risen by 57, medical staff by 29, ambulance staff by 12.5 and dentists by 2.7. We have also converted around 800 people from their fixed-term positions to give them permanency as well, which I know the unions have been particularly keen to see happen and of those: 64 are allied health professionals, 227 are nurses and five are dentists.

I hope that in providing that information to the committee I am providing it not just to you but to the broader community about exactly how the Health and Human Services department

operates. The vast majority of our employees are at that service delivery end; they are not at head office. In fact we have had a decrease.

Mr MARTIN - Minister, do you know the ratio at the coal face?

Ms GIDDINGS - I have given you some percentages there. For instance, in high level earning it is only 5 per cent against 95 per cent, so 95:5 is the ratio for them.

Mr MARTIN - But of the total DHHS staff. Do you know what percentage are at the coal face?

Ms GIDDINGS - I think Dave Roberts himself has announced a target of getting that total administrative bureaucracy down to 3 per cent.

The committee suspended from 11.06 a.m. to 11.20 a.m.

Ms GIDDINGS - We wanted to clarify for a point to make sure people were very clear that the 5 per cent I was talking about are senior executive officers, with 95 per cent of people being at the coalface. In fact we have an agenda to drive that down to 3 per cent. I was going to ask Dave Roberts who has set that target to talk a bit more about it.

Mr ROBERTS - Of course. Can I just clarify the question that you are asking?

Mr MARTIN - The ratio between those at the coalface and overall DHHS staff.

Mr ROBERTS - I am happy to answer that. There are 8 736 FTEs across the whole of the agency. In the group of clinical staff that you would recognise nurses, allied health professionals, medical and dental, ambulance officers and the like. They categorise to about 4 870, which is 56 per cent of the total work force. There is another category of operational staff: ward attendants, cleaners, personal carers, other people who are supporting the operations of each of the individual units - amounting to 1 668 people. There is a category of administrative and clerical staff which amount to 2 038 people. That is broken down in a variety of ways. Effectively 17 per cent of the administrative and clerical staff of the total agency operate within the business unit.

So they support the individual hospitals, primary care and the like. Four per cent of the total work force is corralled in the human services, finance, information services within the shared services. To my mind this is a category of staff that I have moved to be much more aligned with the operational units. So I would see them as part of delivering day-to-day front-line services. Then we are left with just under 3 per cent for what is increasingly becoming the head-office function - the Department of Health as you would know it. They are percentages. Far and away the largest proportion are at the coalface - 56 per cent - and they are supported by a range of people - 21 per cent - who are administrative in nature but who are supporting the clinicians delivering front-line services.

Ms FORREST - A broad question initially in relation to the Department of Emergency Medicine Services. It may be different in each hospital, that is why it might need to be a separately asked question, but what procedures and policies are in place to ensure adequate

assessment of any person who presents there, assess their capacity to manage on discharge and an appropriate setting for their discharge? What measures are there to ensure that that actually happens and does it happen?

Ms GIDDINGS - We might ask Craig White from the Royal Hobart Hospital to talk about that hospital. What I can say is that we have had instances where there has not been adequate communication between the acute health sector and the primary health sector about some patients. Some of that is related to the IT systems that have not communicated well enough, and when you have systems that rely on human beings to fax medical records or to do those sorts of things, you do have a higher risk of some human error occurring. That is actually one of the reasons why we are investing $18 million into IT this year, to try to help our hospitals as well as other parts of our agency, and have far better information technology within them to assist with those sorts of issues, as well as building up towards having electronic patient records, and those sorts of things.

There have been gaps in the system, but we are trying, through our clinical networks and through the Tasmanian Health Plan to get better connection between the hospitals and the primary health system so that people are not just discharged to nothing. That if they require ongoing medical care, there is that follow-up there.

Dr WHITE - I might ask you to repeat the question so I answer the right thing.

Ms FORREST - I am asking what policies and procedures are in place for when a person who presents to DEM does not need admitting and is discharged; what assessment is made of that person's capacity to manage on discharge? I will be more specific in particular cases, but I do not have one related to the Royal.

Dr WHITE - The assessment of patients of course is very important, but we make sure that when they leave the hospital they are going to be okay. The assessment process depends on what the person presents with, and what their general state is like. If someone is assessed as able to go home, certainly there is some discussion about who is going to take them, how they are going to get there. I think most of the time that works very well, and occasionally it seems not to and we certainly occasionally have to deal with some feedback about that, that helps us improve our processes.

For many hours of the week, every patient who comes to the emergency department at the Royal Hobart Hospital who is over the age of 65 is assessed in terms of their wider needs, not just the immediate medical needs to see what is the best solution for them in terms of coming into the hospital or being discharged. Of course discharge assessment is something that is even more important if someone has had to spend some time in hospital. What we are working on over the coming months - we have already made a start - is a much more comprehensive risk assessment on arrival at the hospital as part of the admission process, which will be comprehensive and includes skin integrity, including discharge risk, to make the appropriate referrals early to make sure that things are in place for when the person is able to leave hospital clinically.

I think the minister presaged some important reform issues as the system integrates more fully. We will have to get better at exchanging information. One of the innovations over the last 12 months that will help us move in that direction has been the care-point trial, which means that there is a one point referral for the hospitals to send information to access community-based support. So I think there is quite a lot happening, and of course there is more work to do.

Ms FORREST - Is that practice common across all DEMs in the State, or can't you speak for the others?

Dr WHITE - I am not able to speak for the others.

Ms GIDDINGS - I can call each one up if you would like me to.

Ms FORREST - I would, because there have been instances at the other two

[11.30 a.m.]

Ms GIDDINGS - The other aspect to that in terms of my involvement at a reform level is also the patient transport reform that we have been doing as well because, again, what we want to ensure is that if you are discharging someone from the north-west coast who is at the Royal Hobart hospital, for instance, that they do have adequate transport to get back again.

Ms HOLDEN - Thank you. The North West Regional Hospital electronically discharges patients from the DEM back to the general practitioner, so that is real time.

Ms FORREST - What I am referring to are people who are discharged. For example, there is a recent case where a young person from King Island was brought over by air ambulance; it was the only way to get there. He was assessed, deemed to be able to be released and was discharged around midnight and there are no flights back to King Island at that time. And so what happens in these situations? Are people assessed before leaving the DEM as to where they are going to go, how they are going to get home, all those sorts of issues?

Ms HOLDEN - As a result of that case we have reviewed all of those processes and yes, a full social impact is taken. We can either hold them in a ward or in DEM overnight if we cannot arrange transport or we can work with them to put them in an assisted motel, again awaiting transport, so they are assessed as to how to get back to their homes.

Ms FORREST - So the accommodation units are used up on the hill as well?

Ms HOLDEN - Yes.

Ms FORREST - From that comment, can I be reassured that people that come from the outlying areas in that sort of circumstance will not be discharged at midnight with no avenue to get home?

Ms HOLDEN - Yes, that is our intent and that is the process that we are working on to make sure that they will not be.

Mr KIRWAN - We get over 100 patients aged over 70 attending the AED per week, but just to put it into context, for those people who are already in programs, be they in various Commonwealth programs or one fully run with or on behalf of the Commonwealth, there is a reasonably defined service. When they are presented, then, if they are a new patient and not on one of the programs, there will be a social assessment taken by the emergency department staff. If there is an issue in respect of referral during the day the social worker will be called in - and out of hours an on-call social worker can be called in - to help arrange accommodation and transport.

Launceston is relatively fortunate in that, with a couple of exceptions, there is normally accommodation and other services available. There are some exceptions to that but they are relatively rare, I am advised. What does occur though is that, if the patient is discharged and insists on going home, we do not second-guess them. If there is a requirement in the emergency department where they would deal with the transport, accommodation and other services themselves, the social worker will be called in and will assist in those programs. It does depend a bit on what their personal choice is. If they wish to go back home, it would be fair to say that we do not second-guess them as to what is available.

Ms FORREST - You do assess their home situation to some extent?

Mr KIRWAN - As much as can be done. For example, if they say 'No, I am okay to go home and someone will look after me', we have no way of knowing whether that is correct or not but they are advised of the various services, particularly those being looked after in nursing homes and other areas. If they have identified that they have a GP, the GP will be told as well in respect to the exercise for both in-patients and emergency.

Ms FORREST - You made some comment about other accommodation for these people to go to; is that a like a transitional care type arrangement?

Mr KIRWAN - Just normal patient accommodation in other services. There is a range but with respite or other services, we would not, unless they are an in-patient going through the ACAT process. An emergency patient would not be admitted back if they said 'Oh, my son or my brother or my mother will look after me' - that would be the end of it. But if they did ask for assistance, they would be referred to our ACAT teams or social worker.

Ms FORREST - This is a routine assessment for everyone over 70, you said?

Mr KIRWAN - No, no, I am just putting it into context. What we have been seeing is a lot of older people, particularly elderly people in the north who are still living at home. So we are aware of the issues. As I said, particularly for those travelling in - and I picked up your earlier question about discharging people at different times of the night - we still do that, particularly given that we are running at close to 100 per cent occupancy. So if someone is ready to go home and it seems that there is transport ineligibility, we will discharge them because we do need those beds, particularly for emergency admissions. It is normally done - that is not to say that some cases do not fall between the cracks, they occasionally will - but normally they will have transport or local accommodation. If there are other follow-up referral services, we will either arrange that or refer them to their local GP or other providers.

Mr WILKINSON - The new Royal: there has been plenty of press from time to time in relation to it. I understand there is a business case presently in process. Can I ask when that is going to be finalised? Is it on track?

Ms GIDDINGS - Yes, everything is on track and the business case will be finalised by the end of this year, December. That is when I believe it will be presented to Cabinet. When it becomes a public document might be after that. But we expect it to be presented to Cabinet in December.

Mr WILKINSON - Is that going to be an all-encompassing business case in relation to how many people are expected to be there, what services is new Royal going to provide et cetera?

Ms GIDDINGS - Yes, it will be. It will have all of that. We have already been consulting with our clinicians and nurses and others to look at those issues now. You might be aware of some of the debates that have been coming out of that already - around birthing suites, for instance, one of those issues which I know Ms Forrest has an interest in as well.

Mr WILKINSON - Is she expecting?

Laughter.

Ms FORREST - I might ask the secretary's wife to assist me.

Ms GIDDINGS - I have a brief here that I can read from, just as a global, general position on this first. The new Royal project is in the planning and evaluation stage and, as I said, is on schedule to deliver a detailed business case to Cabinet in December of this year. The business case will enable Cabinet to make an informed decision about whether to commit the substantial capital and appropriate recurrent funding for the construction of the new hospital. Supporting the business case will a master plan study, assessing a range of possible development options and recommending the preferred option. The preferred option will be developed further to refine its scope, study its feasibility and to enable to preparation of accurate cost and program estimates suitable for budgeting purposes.

The required investigations are being progressed by a large project planning team consisting of government employees and consultants providing local, national and international expertise in the field of health planning, architecture, engineering, sustainable design, cost estimating and financial analysis. Subject to Cabinet's endorsement of the business case, the project will proceed into the detailed design and documentation stage in 2009.

Mr WILKINSON - Would it be fair to say that the decision has been made that there is going to be a new hospital built and, if that is the case, what is going to happen to the present site?

Ms GIDDINGS - Certainly the Government has made a decision that a new hospital is required and we are now going through that process of ensuring that what we believe and need is right; we are going through proper process for that. I expect a business case and the master planning process will also provide us with additional information around why the current site is not an appropriate site to continue using as a major hospital. We have already had a fair bit of that work done, which is what led to the Government making the decision in the first place to progress a new hospital in Hobart. But I am aware that there is more work happening as well around that.

As for what will happen to the current site should we build elsewhere, at this point in time we do not have a plan for that. We will be a fair way down the track yet before we need to have a plan for that. We need to get the business case done and we need to get that next step approved by the Government. We need to start that whole process of building the new one.

Mr MARTIN - Is this part of the work that is being done? What happens to the current site?

Ms GIDDINGS - No, not at this point in time. The current site is a prime piece of real estate in the CBD of Hobart and Government will want to make decisions around that. Whether or not they want to put other government offices or institutions on that site as part of the waterfront

precinct, whether or not it should be a mixture of commercial, whether or not there should be affordable housing for instance, all of those decisions around what you would do with that prime piece of real estate are yet to be made. You would also want consideration for what is going to help the CBD of Hobart in using that land.

At the moment we are still going proper processes of establishing the business case for the new Royal Hobart Hospital. I do not anticipate that anything is going to be thrown at us which will take us off course but you go through these processes to ensure that what you are doing is the right thing, that you are investing in the right way and that this is required. So in theory there is still room that you might not go for a new Royal Hobart Hospital, but I think in practice it is very unlikely from all the information that we have had leading up to the decision and the information that I have been shown as we have been progressing the business case.

Mr WILKINSON - The new emergency department has just been completed at significant expense. I understand there has been a lot of excellent reports in relation to that. It is an interesting question. After all the expense paid on that, what is going to happen with it, especially considering al the good reports that have been flowing back.

Ms GIDDINGS - We had this discussion last year as well because we had the discussion around why the Government is spending money on the in-fill building for the expanded neonatal intensive care, paediatric intensive care and the new theatres. The reality is that even though you are going to build a new hospital, hospitals take years to develop and be operational. In the meantime there was a desperate need for those new facilities. We could not have kept going with our neonatal intensive care area that we had; it was appalling. That has been a great success. The old department of emergency medicine was not up to modern standards; it was very cramped and crowded and not dealing with the rapid growth in demand. So we had no choice but to reinvest in the existing building to ensure we could keep up with the services that we require at the Royal Hobart Hospital.

People have some interesting ideas about what would happen to that building once we vacate it. It is excellent underground space and could be used for numerous things I am sure. At this point in time we have not exercised our brains that much, other than saying it is quite an exciting opportunity.

Mr MARTIN - Is the chosen site the only site upon which a new hospital could be built?

Ms GIDDINGS - In February of this year I released the site assessment report that was undertaken to look at the new Royal project. It looked at a number of the issues around where, how and why you would put a hospital on the waterfront area, and against other areas as well. It quite clearly came out in favour of the waterfront as being the appropriate place - for a number of reasons. I am happy to provide you with a copy of that report.

[11.45 a.m.]

Mr MALONEY - There were probably two public reports which cover the site selection assessment. There was a report released I believe around April of 2007 which went through looking at a range of site options within or close to the CBD. That process identified that the rail yards was a preferred site. It recommended further assessment of that site, looking at things such as the geological conditions, heritage and a range of other activities. The report that the minister has tabled, which was released in February, is that additional site assessment. We have looked into things such as water levels in the future, the sea level rise, geo-technical conditions and the

like. That is quite a detailed assessment of the site. It has indicated that there are no impediments to the development of a hospital on that site that are so significant that you would need to look at alternative sites.

Ms FORREST - Can I ask a couple of questions in relation to the current Royal, as opposed to the new Royal? You mentioned yesterday you are challenged for space at times and the NICU was remodelled as part of that. I understand that space for the antenatal clinics is similarly challenged and that women are having to stand for up to two hours waiting to see their doctors or midwives at the antenatal clinics. There has been a look at this recently, I understand, with the paediatric office nearby. It seems that, as this stage, there is very little opportunity for expansion within this area to enable women to be seated while they wait up to two hours to be seen. Is there some way that we can look at that important issue?

Ms GIDDINGS - There are certainly crowding issues in various outpatient areas of the existing Royal Hobart Hospital, which is just another reason why we need a new hospital.

Ms FORREST - The Treasurer did say we are having quite a good birth-rate at the moment, too.

Ms GIDDINGS - We are.

Ms FORREST - Which is no doubt compounding the problem.

Ms GIDDINGS - My office is doing quite well in that area In fact I should just mention that we have a proud new father beside me - Lucy Claire Nicholson has arrived.

Dr WHITE - The antenatal clinic area is probably the most visited part of the Royal Hobart Hospital by VIPs. I take anyone I can find through it, don't I, Minister?

Ms GIDDINGS - You do.

Dr WHITE - Including the current Federal Health Minister when she was in Opposition and visiting Hobart. It is, from our perspective as well as the clients' perspective, completely inadequate. It is something that we want to fix when we do the paediatric redevelopment through the course of the next 12 months - which is already funded within our plans and is ready to go. We want to improve the environment for the women's clinics as well.

Ms FORREST - There is nothing that can be done in the interim to relieve discomfort for women who are visiting this centre?

Mr WHITELEY - Within the confines of the current space, no. I will happily take you through and show you how tiny the spaces are, including the need to queue in a corridor because there is not anywhere else for people to go.

Ms FORREST - Stand queuing in a corridor.

Dr WHITE - To stand queuing in the corridor for young mums who are pregnant, often with kids with them, is very difficult. We do know about it and we plan to deal with that.

Mr HARRISS - Have you had any discussions with the Federal Government about potential funding assistance by them for the Royal?

Ms GIDDINGS - I have mentioned it to them but we have not had any serious conversations at this point. Right now our aim is to negotiate a good outcome through the next Australian Health Care Agreement for Tasmania. Should we be able to gain assistance with the new Royal we will gladly receive it. I have mooted the point at the Commonwealth level but at this particular time we have to be very careful. We have a lot at stake in relation to the overall health system around the negotiation of the new AHCA. So it is about playing your cards right at the right time, Mr Harriss, as I am sure you would understand.

Mr HARRISS - You addressed the possibility of the Infrastructure Australia Fund being a possible funding stream?

Ms GIDDINGS - At this very point in time, no, because at the moment we are just pulling together our business case and working through how much it will actually cost and how that will be funded. The Treasurer has a keen issue in the funding side of it. That is an idea that we can look at. I expect the Commonwealth are going to be a little bit careful about getting too involved, because every State is building billion-dollar hospitals at the moment. I doubt that infrastructure fund will go very far if we all dip into it for health alone. I am interested to hear your ideas and I am happy to explore them at the Federal level.

CHAIR - I did raise a question with the Treasurer the other day about PPPs. The new Gold Coast hospital and the one on the Sunshine Coast are being built on those financial models. Have you a view on that, or do you prefer to leave that to Mr Aird to work it out?

Ms GIDDINGS - Primarily they are Treasury issues because it is such a huge amount of funding. What you would know, though, from your Estimates with the Treasurer is that $900 million has been put aside in our own hospital fund. The vast majority of that would be going to the new hospital, but there is also funding in there for the requirements of the other hospitals - funding for the new Department of Emergency Medicine, the master planning process that the LGH is currently going through, and the North West Regional Hospital. We understand the need for further large capital injections in other hospitals, but that is our forward planning in terms of getting the vast majority of the funding together ourselves. If the budget is over the amount that we have been able to budget for, then I think the Treasurer has indicated we will look at other funding mechanisms to ensure we get the hospital we require. Whether that is PPPs, getting some debt funding or going through other infrastructure funds, with the Commonwealth putting their bit in, it is too early to say.

I should just say very clearly, though, because I do not want anyone thinking there are any political options, we have ruled out selling Hydro Tasmania, dams, Aurora, or Transend to fund the hospital, so we can be very clear about that.

Mr WILKINSON - We spoke about the new emergency department, which is going well. Do we have any breakdown for the reasons people are presenting to the emergency department?

Dr WHITE - I can certainly explain the classification model, which is the Australian Triage Scale. It is applied by a specially trained registered nurse when a person arrives and registers as wanting to be seen. There is an interview that takes place to assign a triage category. There are five categories of triage: 1 is classified as life-threatening, and those patients are to be seen

immediately. There are various grades through to the least urgent, which is category 5, and each has a corresponding time frame. Category 2 is to be seen within 10 minutes.

Over the last 12 months our numbers have increased. Typically we were seeing 109 patients a day in the emergency department. Recently that has been up to 144 on some days, which is clearly quite a strain. In spite of that, through streamlining processes, including the order in which we see categories 3, 4 and 5, which is now in order of arrival, we have quite drastically improved our performance. We have halved the number of patients who did not wait to be seen.

The fewest patients are in category 1, a few more in category 2, and most are 3, 4 and 5.

Mr WILKINSON - Can you give me an example of a 3?

Dr WHITE - It can be somebody who is quite unwell; they might have pneumonia but they are not at immediate risk of cardiac arrest or some other immediate complication. There is a lot of debate about 4s and 5s, but many of them are believed to be patients who could have been seen in a general practice if one was available.

Ms FORREST - These figures are available for all three hospitals?

Dr WHITE - They will be. I do not have them for all three hospitals.

Ms GIDDINGS - I do have some DEM presentation figures here for year-to-date for the Royal Hobart Hospital. It does not break it down to categories, though. For instance, in 2001-02 we had 31 606. Comparison for this year is 34 073. That is a year to date figure. Generally, there is a trend up on presentations. It does vary slightly from year to year but the trend is certainly on the way up. But that is for the Royal Hobart Hospital. I have figures for all hospitals: in 2002-03 it was 69 668 compared with year to date now 85 115. That is quite a rise. That is without the Mersey, though, for all of those. Burnie, we had in 2001-02, 5974; now 6103, year-to-date.

In Launceston - the LGH - in 2001-02 it was 20 413 - that is ward separations, sorry, not DEMs. DEM presentations for the LGH 2001-02 was 23 515 and in 2007-08, 30 276. For Burnie 2001-02 was 16 149 and in 2007-08 is now 20 766. That is quite a growth there as well, which again is an example of what happens when you do not have enough GPs in your communities, so there is more and more demand pressure growing on our departments of emergency medicine. Or there are not the after-hours services in the community.

Mr WILKINSON - It would be fair to say now, if you took into account the Mersey as well, we would be having about 100 000 people presenting this year in the emergency department.

Ms GIDDINGS - Not quite 100 000, no, but not far off.

Mr WILKINSON - Are we able to put a figure on how many present in relation to drug overdoses of some sort?

Ms GIDDINGS - I do not have that breakdown with me. No, we do not have that information. I am not sure whether it would be possible to get it.

Dr WHITE - If we were going to look at the data, we would probably want to define the question because people presenting with drug overdoses as a suicide attempt would be a different group than patients who had misused recreational substances.

Mr WILKINSON - So you would not have those figures available?

Dr WHITE - They would be available. We just need to make sure we ask the right question carefully.

Mr HARRISS - I guess we need to determine whether you want both those components, as Craig has said.

Mr WILKINSON - If you can present those to us in the next day or two.

Mr HARRISS - As a suicide attempt and as recreational drug abuse.

Ms GIDDINGS - We will take that on notice and we will do what we can. We have to be careful about anything around suicide numbers, though, so I would ask you that you give us some leeway to look at what we can provide to you. It might not be appropriate to provide information that could be around what may or may not be a suicide. It is very difficult at times to determine that. I know from a mental health point of view there is always a lot of concern around that sort of information.

Mr WILKINSON - As you are aware, we can take it in camera. If it is in camera it can be locked away; it does not see the light of day, if that is the case.

Ms GIDDINGS - We will see what we can provide to you and we may then put an in camera stamp on that information should there be sensitivities around it. It is a very sensitive area.

Mr WILKINSON - I would like the information but if there are areas that you wish to be in camera, please mark it as in camera and we will treat it accordingly.

Ms GIDDINGS - We will mark those 'confidential'. Thank you. I appreciate that.

Ms FORREST - I wanted to pursue a matter regarding overtime and staff working hours. Mr Kirwan, I think, made the comment on that unfortunate incident that happened to the sexual assault victim. The doctor was in involved with two complicated births and had been working 20 hours at that time. How often are we seeing this sort of thing happen for our medical professionals? I would like to look at the nursing staff overtime as well.

[12.00 p.m.]

Ms GIDDINGS - I will give you some general information first but around specifics on a hospital I would have to ask each CEO to address that for you. Overtime levels were lower for the pay period of 23 April 2008 with the equivalent of 253.18 FTEs, which represents 2.91 per cent of my department's work force, compared to 25 April 2007 with overtime equivalent of 284.41 FTEs and 3.14 per cent of the work force. So there has been a lower level of overtime this year.

For the three major acute health services hospitals medical practitioners have the greatest percentage of overtime-to-paid FTE of 21.93 per cent as at 23 April 2008. For the same period

nursing were 1.6 per cent and community health services award 1.27 per cent. Allied health professionals were 0.54 per cent and radiation therapists 0.23 per cent for acute health services hospitals.

CEO's and business unit managers are accountable for monitoring the level of overtime and call-back having regard to service needs, available funding, staff occupational health and safety and effective use of budget resources.

Call-back paid hours for the period 23 April 2008 were 5 386 with 6 007 call-back paid hours for the period 25 April 2007. Salaried medical practitioners are the highest utilisers of call-back hours with 49.67 per cent, followed by allied health professionals, 15.07 per cent; nursing 14.97 per cent; and visiting medical officers with 11.41 per cent of the total call-back hours. If a medical practitioner has been working on a patient the night before, they might actually choose to come back the next day to check on that patient and that could be a call-back as well. It would not necessarily mean overtime.

Dr WHITE - It is probably useful to note there are two types of overtime. There is overtime that is rostered because that is what you need to do to fulfil the training requirements of the junior doctors, for example, combined with the need to cover the hospital 24/7 with the right number of people with the available work force. You often do that in the face of what you would like to do from the budget perspective because the equation just does not work any other way.

Then the recall work is for doctors, typically, who are on-call to provide specialty cover. If a patient comes in, say, with a plastic surgery problem and their treatment needs to be immediate out-of-hours, that would trigger a call-back. So they are the hours that the minister is referring to, or we need to call a doctor back in to do a complex procedure.

Ms FORREST - As far as the number of hours of overtime worked in the last year in nursing, do you have that information and the actual cost of that overtime?

Ms GIDDINGS - We have these sorts of comparisons: in overtime paid, we had in April 2007 for enrolled nurses 19.99 paid FTEs - that was at 25 April; as a comparison, 23 April of this year is 18.08, so it is down. But that is equivalent paid FTEs; for registered nurses it was 608.1 in 2007 and it has gone up to 628.85 in 2008.

Ms FORREST - Do you have the cost that overtime has been to the department?

Ms GIDDINGS - No, sorry I have read the wrong thing here, it is actually the overtime paid FTE - that is just the Launceston General hospital and the Royal - I had better go through each of these for you so it is clear.

So for the Launceston General Hospital - the figures I just read out to you were the paid FTEs - the overtime for enrolled nurses in 2007 was zero and in 2008 it is zero. With registered nurses the overtime equivalent paid FTE was 6.43 and in 2008 it is 7.58 so there has been an increase but there has also been an increase in the number of paid FTEs, so the original figure I read out of 608.1 was the paid FTEs and now we have got 628.85 paid FTEs at the LGH. There has been an increase of overtime from 6.43 to 7.58 with registered nurses.

With the Royal Hobart hospital, the equivalent figures there with enrolled nurses, we had 87.85 FTEs and we now have 89.62 FTEs. For overtime there was 1.11 FTEs in 2007 and 1.14 in

2008. With registered nurses had 956.35 FTEs compared with 974.13 FTEs. Overtime was 14.38 in 2007 and 15.49 in 2008. So there has been an increase there and there has also been an increase in the number of nurses.

The North West Regional Hospital: we had enrolled nurse FTEs of 37.98 in 2007 and in 2008 it is 27.6. Overtime in 2007 was 0.52 and that has gone up to 0.57. With registered nurses we had 346.41 FTEs in 2007 and without the Mersey now it is has gone down to 199.98 so that would be with just the Burnie campus. Overtime: in 2007 it was 6.43 and now it is 6.16 so it is down.

Ms FORREST - Do you have a dollar value?

Ms GIDDINGS - Okay, for nurses the year to date cost of the overtime is $5 667 227.

Ms FORREST - You do not have that figure broken down within the regions?

Ms GIDDINGS - No.

Ms FORREST - Are you able to provide the breakdown of the overtime costs?

Ms GIDDINGS - We can, we will take that on notice for you.

CHAIR - Anything else?

Ms FORREST - Last year the department was looking at a nursing and work force strategy. I am wondering where that is at, what progress has been made and what outcomes have been achieved.

Ms STOKER - We proposed a nursing/midwifery work force strategy last year and since we have moved into a new structure within the agency and also have a new secretary we have had some further discussions about how we can make the strategy more patient-focused or client-focused. The actual nursing and midwifery work force strategy is now changing more towards a care strategy so we will be looking at how we deliver care and what is required for those components of care and then the work force required in order to deliver that. So it has slightly changed in that we are directing it more around client care rather than on the components of the nursing work force at this time.

Ms FORREST - When can we expect to see a definitive plan, for want of a better word?

Ms STOKER - The time that we have looked at for publishing the care strategy is November or early December.

Ms FORREST - What engagement of key stakeholders occurred during the process, particularly since the changes of direction?

Ms STOKER - The key stakeholders will be involved and at the moment we are revitalising the paper to start the discussions and then key stakeholders will be involved across the State in that process.

Mr ROBERTS - It is a very helpful question. I think there is a lot that we are doing and need to do around our work force in general, in particular with nursing in midwifery as you described. I am very keen that we see a care strategy which sets out what we think the future of our nursing midwifery and allied health professional work force is and how their roles will inevitably change with a shrinking work force, with a growing and ageing population and with a growing and ageing demographic. Very many things will need to change for us.

We have already kicked that process off by asking Professor Dame Catherine Elcoat from the United Kingdom to help work with us. She has been over twice now. She is working with stakeholders, like the ANF and the other unions, with our staff and with our directors of nursing in the individual hospitals and with colleagues at the AMA. We are planning a study tour to understand how our work force, midwifery and allied health professional work forces can move, over coming years, toward more contemporary models of delivering services, respecting the needs of our patients and the service provision through the Tasmanian Health Plan. It is changing quite dramatically with specialist nurses, nurse practitioners and a whole range of other opportunities for our nurses.

We do believe that this is about encouraging our work force to engage us also in the debate for change as well as the union representation and, of course, Fiona has some very tight time scales to get both the work force assessment and the strategy for care reform up and running, such that we have tangible things coming out of that by Christmas of this year which is a pretty tall order. But I am really quite determined that we do that.

Ms FORREST - So where will your study tour take you?

Mr ROBERTS - The United States and the United Kingdom.

Ms FORREST - Not New Zealand?

Mr ROBERTS - There is no plan for that, but there is no reason why we cannot use the knowledge and expertise of New Zealand's routine in any way. They do participate in the national work force principal committee, which I chair. We have already made contacts through the committee that Fiona chairs in terms of nurse directors, including New Zealand.

Ms GIDDINGS - They are also part of the Health Ministerial Council as well. So we have the New Zealand health minister at the table there too. It might be appropriate perhaps next time Dame Catherine is here for Ruth to meet her.

Ms FORREST - I would appreciate that opportunity, thank you.

Ms GIDDINGS - I would be happy to link you up.

Ms STOKER - Ruth, one of the areas that we are keen to have a look at in the UK is midwifery and we have made a specific request to have a look at that.

Ms FORREST - New Zealand has a good model of care surrounding midwifery as well. That is why I particularly suggested New Zealand.

Mr WILKINSON - A couple of years ago there was a significant amount of press in relation to resignations. In the past year, how many, if any, resignations have you had in relation to medical practitioners?

Ms GIDDINGS - I think we have had a reasonable rate of stability in the last couple of years which has been good. I do not think there has been anything abnormal in relation to that. In fact, this is a little bit more generic in the first instance, but total staff turnover for my department has remained steady over the previous two financial years with a turnover rate of 10.2 per cent in 2005-06, 10.74 per cent in 2006-07 and 10.63 per cent year to date, as at 23 April 2008. The largest area of turnover in my department is within the medical stream, with 42.46 per cent in 2005-06, 35.6 per cent in 2006-07 and 31.74 per cent year to date to 23 April. So, as you can see, there has been more stability, even within the medical stream where it is not unusual to have a higher turnover of staff.

[12.15 p.m.]

Mr WILKINSON - How does that equate to numbers in the past year, 31.4 per cent was it not? While you are looking, I would not mind knowing the numbers and the breakdown as to the areas as well.

Ms GIDDINGS - Medical practitioners, we had separation in 2005-06 of 13.28; in 2006-07, 9.81, and 2007-08, 16.53.

Mr WILKINSON - That is percentage, though. I was wondering if you had numbers.

Ms GIDDINGS - That is actual FTEs.

Mr WILKINSON - Oh, FTEs. Okay. And a breakdown of areas?

Ms GIDDINGS - I do not have that with me, that is across the whole -

Mr ROBERTS - Do you mean across the individual hospitals?

Mr WILKINSON - Yes.

Mr ROBERTS - We do not have that here.

Ms GIDDINGS - I can also give you the medical specialist, medical practitioner figures, which in 2005-06 were 26.74 FTEs; 2006-07, 20.39, and 2007-08, 16.25.

Mr WILKINSON - So it seems to be tracking down.

Ms GIDDINGS - That is tracking down, yes. There has been generally a lot more stability in the system, and also with our CEOs, which has been good.

Mr WILKINSON - Could we have a breakdown across the hospitals? If you have that figure that would be helpful.

Ms GIDDINGS - I will take that on notice for you.

Mr HARRISS - Minister, can I come to the matter of issues like bed closures and bed blockages due to non-urgent aged care patients and the like. Can I first of all ask what is the total number for bed closures this financial year to date, and whether that could be broken down for each of the hospitals in your jurisdiction, please?

Ms GIDDINGS - I might call each CEO up to the table again to go through each hospital for you, so Craig, if we could start with you.

Mr HARRISS - And you might go to aged care beds and blockages while we have each one here.

Dr WHITE - One of the hardest things you can do in a hospital is try to count what a bed is, and what a closed bed is, because the physical capacity of your building has to accommodate your current and anticipated future needs. There are physical beds at the Royal Hobart Hospital which are not currently staffed, which I need to keep in reserve so that as demand grows, as observed by the clinical services plan that it will, it would be out of the question to bring those beds back on line.

So with that sort of background context, we are running at the moment 522 overnight and day treatment places, given that models of care in recent years have become increasingly dependent on ward-based care, that increasingly people either sleep in their own beds and come in to get treatment on a day basis, even if they come back for several days. There are 522 overall treatment places, comprising 417 in-patient beds; 97 day-service places of different types; three day treatment spaces in the hyperbaric unit, and there are eight short-stay assessment beds in the emergency department and maternity unit.

Ms GIDDINGS - And how many beds do you have that would have ACAT assessed people in them?

Dr WHITE - I would have to take the actual number at the moment on notice, because it does fluctuate. We have had some improvement in that in recent years, although it does fluctuate from week to week and month to month. It depends which part of the hospital we are talking about. The bit that really causes the most grief is when they are in an acute bed without an acute problem. We have been able to make some good inroads in that at the Royal Hobart Hospital, but there are still numbers that we can get back to you on who are in acute. We will, of course, expect to have in TCU, GEM and critical beds those who are ACAT assessed. That is a not inappropriate place for them to be if there is some potential that they may be able to receive some improvement in functional state to actually go home. We have had some good success with that in TCU. So patients who were initially ACAT assessed have ended up going home.

Mr KIRWAN - In respect to the turnover rates in our medical profession, given that we are also a training hospital the rates are quite high and they vary each year between 30 to 40 per cent. But on the permanent staff, which is our full-time staff specialists, they are around 1 to 2 per cent per annum so they are quite low in respect to our medical staff.

Mr WILKINSON - This is in the Launceston General Hospital?

Mr KIRWAN - This is the LGH. You do need to understand that with a training/teaching component there will be high turnover in those areas. You have to look at what is your permanent

establishment versus your training registrar and others. Because there is a natural turnover built into that.

Mr WILKINSON - Would that be the better statistic to take if you could break it down into those two categories - your FTEs and your training staff?

Mr KIRWAN - Yes. The figures are quite low. In respect to our beds, as of today we have 322 beds which include, I should qualify, 20 beds in ward 1E, which is the mental health ward and which is not actually part of LGH. It is co-located with us. That constitutes 276 which are in-patient beds and 46 which are day beds. I think Dr White has explained how that is split. With the announcement on Saturday by the minister, an additional eight rehabilitation beds will be built and opened. In respect to the question as I understand it, we have eight beds that are closed. Four of those were closed last year, so technically we would say we have only had four this year. We have eight beds which we could reopen based on staffing and need so we are currently running with eight beds that are closed. Four of those have been closed for some period of time. As we can we will reopen those as 23-hour beds in the surgical ward.

Ms FORREST - I just wanted to clarify that point because last year it was a bigger issue, particularly with the LGH with their closures and bed blockages. It was a moving feast. Every day there were a variety of beds closed in a variety of areas depending on staffing needs, which is obviously the way to operate to an extent. So are you giving the beds that are permanently closed at the moment. Are there extra beds closed on an as-needs basis? Are they reflected in that figure?

Mr KIRWAN - For the last six or so months we have had quite a stable situation. That is substantially due to the extra nursing positions that came through the EBA. There were 29 FTEs which were created into 40 positions and I think all but one or two of those have been filled now. That allowed us to open the beds that had been closed through not having enough nursing staff and moving some nursing staff into DEM to satisfy the EBA outcomes. So we now only have eight beds that are closed, which we could open if need be and if we had the available staffing.

I forgot to address the issue of bed-blocking. We have an average between 20 and 30 care-awaiting and long-stay patients that we would like to see not in the hospital. We are in the process of addressing that. There is a range of reasons for this. These are people who are assessed and ready to move but they do not have position places to go to.

There is a range of issues around that. The Department of Medicine is in the process of re-configuring its medical wards to allow a three-phase modelling so we can bring together those that are on that longer-stay area all together - not as a nursing home-type ward because, to be perfectly frank, nursing home-type patients are not best cared for in an acute setting. But we will work very hard. We have done as much at our end. It is not a discharge planning problem, it is not enough places in the ward at this stage for them to go to. There are places, but it is often not where they come from or where their family comes from. Sending someone to the east when they come from the west is not a fair outcome either.

Ms GIDDINGS - I do have some figures that I can actually provide to you rather than having to take them on notice, which will be helpful. Clients awaiting aged care services as of 1 May 2008 with high care, waiting in a hospital: in the south we have 38, in the north we have 36, in the north-west we have 5. Low care: seven in the south, five in the north and four in the north-west. Those with the community aged care packages: in the south there are three, in the

north there are four and in the north-west there is none. Those waiting in the hospital for an EACH package: there are six in the south, one in the north and none in the north-west. Those waiting for an EACH dementia package: there is one in the south, none in the north and none in the north-west.

Ms HOLDEN - One hundred and twenty beds are open at the North West Regional Hospital and we flex an additional four and move between surgery and medicine depending on where the demand for the patients actually is. We have the potential to open other beds in terms of the facility; we do not require them at this stage. The bed-block issues are managed by and large by improving our discharge planning processes, discharging on admission as opposed to towards the end of an admission so that we are planning. We have been supported recently as well with the extension of a local rest home and that has really created some flexibility for us.

Mr HARRISS - Minister, I think that my question fits into this overarching medical services area and that is the initiative identifying the budget papers of the new health information technology. I think it goes across this issue. What are the main improvements that you are looking for as a result of this initiative which would then flow through our health information system and how do you see it improving the health of Tasmanians as a major initiative? I want to go to specific matters related to technology matters if I can.

Ms GIDDINGS - I will do a combination here. There are examples like one in the ambulance system where we have been trialling the Toughbooks and that has been about getting rid of the big A3 pages that they currently have to manually fill out on a patient as they are travelling to the hospital and then have that whole process of transferring information. So one of the initiatives that will come out of the $18.5 million will be going to ambulance to spread Toughbooks around the State.

In the coming four years the $18.5 million will be invested in developing our information technology systems to support service delivery. In 2008-2009 it will be $5.4 million which is directed towards this initiative. A key project is the completion of the installation of a patient administration system at a cost of $3.5 million to replace the ageing system that has been provided for the last twenty years. This is provided in addition to $5 million that was invested in the 2007-2008 project and the new system will improve patient management within hospitals and provides the foundation for a range of clinical information systems. What I also understand that to be as you may well know that at the Royal Hobart hospital we have had a whole IT strategy to get our old paper patient records on to a digital system and now we have been able to free up space at the Royal by getting rid of many of our paper records. At the moment those patient records, as I understand it, are not interactive in the sense that you cannot take them to the bed of the patient and add information but you can take it to the bed of a patient and review their past medical history. I think that is right and this funding helps fill the blocks that we need to eventually get to the point where you will have a fully electronic patient record which will then be able to flow across the health system - as long as we get our privacy laws sorted out - potentially back to your GP and maybe even stick with yourself. They are the sort of issues that are being looked at at the national level, like whether or not you can actually carry your own patient record with you. Three million dollars will be invested in an enterprise storage solution to replace the current piecemeal storage approach with silos of data storage across the system. This is a vital part of an effective ICT infrastructure for a large health organisation in which there are enormous volumes of data to be stored. The project will include purchase of hardware and software to manage back-up and recovery of data.

Local area network upgrade and infrastructure investment will be a focus for a further investment of $4 million to provide a robust and reliable network across all departmental sites, allowing rapid access to information assistance. Some $700 000 will be invested in phase 2 of the child protection information system which we can talk about more later. Some $3.7 million will be invested in the medical imaging project to provide a picture archiving computer system at both the LGH and RHH, with a statewide system capable of receiving and viewing medical images across the State. This allows electronic transfer and viewing of medical images by clinical staff across the departmental network.

Some $2 million will be invested in continuing developing of messaging and identified systems. This capability allows flow of information between disparate system and enables linkage of systems between providers within and outside the departmental system. This is a critical element in developing integrated approaches to health care delivery. There will also be $1.6 million invested in a mental health services electronic client management and reporting system which we can talk about later as well.

The committee suspended from 12.33 p.m. to 1.30 p.m.