Ms GIDDINGS - Just while we wait for the other members to come, I will formally table the additional information that Ms Forrest asked for.

In relation to the advertising costs, I have the outputs broken down across the different parts. In 2007-08, in output group 1, in acute health we spent $263 000 on advertising. I expect your real question is around the Tasmanian Health Plan. The Tasmanian Health Plan element was $211 243. All components of marketing are in that. So that includes printing of the reports and the three elements: the Clinical Services Plan, the Primary Health Plan and also the overarching document. As well there was print advertising and advertising that people saw in the newspapers and so on.

Ms FORREST - Television?

Ms GIDDINGS - Yes, that would include television advertising as well. We did television advertising in 2006-07. We will double check that element, but all of our costs are within that $211 243.

In Community Health Services, $156 000 was spent. In Humans Services, $218 000. In the independent children's review service, that is output group 4, $3 000. Capital investment program, $9 000. The Royal Hobart Hospital redevelopment fund, $18 000. The Special Capital Investment Fund, $5 000. In total we spent $672 000 on advertising - around 0.05 per my entire budget. In fact I believe it is 0.04 per cent of my entire budget. So it is pretty much a drop in the ocean in terms of the work that is done in Health and Human Services.

1.4 women's and children services -

Ms FORREST - I commend the target in the budget papers for reducing caesarean-section rates. In 2008-09 the target is 25.4 per cent, down from 27.4 per cent in 2006-07. How do you plan to achieve it?

Dr WHITE - Caesarean-section rates are an important issue to be discussed. The advice that I had from the outgoing professor and head of department at Royal Hobart Hospital was that he believed that the caesarean rate at the Royal Hobart Hospital was reasonable, but I am aware that it is something to be monitored on an ongoing basis to make sure that it is being done for appropriate indications.

At the Royal Hobart we are actually looking at models of midwifery care which will, as far as I am concerned, involve discussions about appropriate Caesarean-section rates. That will be something that gets addressed as the discussions progress.

Ms FORREST - So there is not a particular plan to reduce the numbers?

Dr WHITE - Not at the moment.

Ms HOLDEN - In the terms of the north-west we actually contract out our public maternity services. The kinds of strategies that we have just begun to talk about are things like much closer

liaisons with GPs and midwives, talking to women earlier in the pregnancy about the options that are available to them, and increasing the partnership relationship between midwives, obstetricians and gynaecologists. So a lot of our strategy is around actual communication between the health professionals and the women around those options.

We have also considered getting a consumer group together for women to talk to about what sorts of options there are in childbirth, why some like some and some like others and whether we want more of one and less of the other.

Ms FORREST - So do we actually know what the caesarean rate is at the North West Private Hospital in the public patients?

Ms HOLDEN - I do not know it right now but I have seen it.

Ms GIDDINGS - Yes, we can get that information. We will take that on notice.

Mr ROBERTS - I think it is an important area for us to think carefully about. We do run a very medical model of midwifery or obstetrics. There are other countries that use a much more midwifery-led model. I think that we have to come up with some decisions locally about what we expect to see in the future. The rate is high, not as high as other States but it is going in the direction of other States.

I do not know that we explain well enough within the system the complexities of caesarean section. It is almost seen as a piece of care with no complexity. I am afraid it does have ongoing complications so we do need to explain much more to women the options available to them and put those options before them at an early stage. Perhaps we will start to embed a more midwifery model within our system, as much as the medical model.

Ms FORREST - Will the government consider case-load models of midwifery care as one of the options?

Ms GIDDINGS - We are establishing the women's and children's clinical network. I am informed that this is one of the issues that they will be addressing across all hospitals. So those sorts of things would be considered by them - the appropriate models and how you get the rates down.

Ms FORREST - So they will brings recommendations forward to the Government?

Ms GIDDINGS - If that is required. What they will be doing as the experts across that system is working through the solutions themselves and then implementing those solutions at their hospitals. They will be working as a statewide network in that sense. So we would get consistency across all three hospitals according to the policy procedures that enable us to get caesareans down.

Ms FORREST - Can you provide details of who is involved in the network?

Ms GIDDINGS - It is not yet established. We have established the cancer network and I can provide you with details of who is on the cancer network. The next one to be rolled off is the aged-care and rehab clinical network. The women's and children's network is down the line a little bit but the work is being done now to establish those other clinical networks.

Ms FORREST - So when do you expect the women's and children's network to be established?

Ms GIDDINGS - By December we hope to get the first consultative meetings on women and children up and running. We have these consultative meetings first and out of that we would hope that the network will evolve and grow and will support that process. The time line for when it is actually established I cannot give you but we will have the first of those meetings by December of this year.

Mr ROBERTS - We have the establishment of the Clinical Advisory Council which will be a forum of all the chairs of all the networks as they become established. We have programmed three to be established this year in addition to the council one and, as you have just heard, for the following year, there are a number more, which includes the obstetrics agenda. The Clinical Advisory Council will be taking matters to do with all clinical practice across the whole of the State and it will consider these issues at its earliest convenience and whenever we can deal with it. Remember also the care strategy will be reflecting on the midwifery model as well that we wish to use and that will be from Christmas.

Ms FORREST - I noticed in this budget estimate an increase of $13.2 million for the next financial year and then it is reduced to $3.3 million and $4.8 million. Why is there such a big increase in the next financial year, and where is that money going in women and children's services?

Mr ROBERTS - We have a breakdown for the increase of $13 million. There is clearly a salary and non-salary indexation at $3.523 million and in 2008-09 there will be more staff at the Royal to the tune of $2.5 million. Internal adjustments following the transferred Mersey funding, so some issues of relocation of staffing there coming in at $2.338 million. Internal reallocation in 2007, which gains more staff - a general trend coming into this service. Expenditure from increased revenue projections, budget of $1.371 million. Budget priority clinical service plan - so these are things from clinical services plan that we are expecting to invest that service in the coming year. Some technical adjustments, again as a result of the Mersey write-offs and other issues, to the tune of $1 million. Fifthly, Australian Health Care agreement funding which will be a proportion of the additional funds that we have secured - $658 000. A minus figure for internal reallocation of highly specialised drugs and interstate charging - a reduction of $1.5 million giving a net $13 million increase in that service.

Ms FORREST - So will not a lot of those increases continue in the forward Estimates? The 2009-10 financial year is only a $3.3 million increase, which really only accounts for the indexation of wage increases, according to the figures this year that you have just given to me.

[1.45 p.m.]

Mr ROBERTS - Are you asking the question why is it so small?

Ms FORREST - Why is there a bigger chunk for the next one, actually, then it drops away significantly. Only a $3.3 million increase in 2009-10.

Mr ROBERTS - What you have there is, there is an adjustment in terms of one year it is bearing a higher cost, but that is not around indexation. So in 2009-10, you have the indexation

coming in. The adjustments that we have talked about here continue to roll through, but we have not profiled more investments in those subsequent years. It is like your comment, we have not -

Ms FORREST - It does not appear that you have, in the sense that -

Ms GIDDINGS - Normally there are 26 pays in a year but in one of those years there would be 27 pays.

Mr ROBERTS - It looks slightly odd.

Ms FORREST - There is information there about the implementation of a statewide perinatal database. I would like a bit more information about how it is planned to roll that out. Will there be direct entry into a database at the site, and which hospitals will be included in that? Will North West Private Hospital be included in that as well, particularly for the public births but ideally all of them?

Dr WHITE - The need to provide accurate information about peri-natal care is acknowledged as very important, and the minister has supported the acquisition of a perinatal database to be included across the State. So obviously there needs to be involvement, which is yet to take place, of providers across the State. It has happened informally to date, but needs to be done in a more structured way to make sure that we scope the system properly and it will give us the information that we need in a way that is acceptable to all concerned. At this stage we do not know exactly how it will operate, but there is certainly a commitment that it will happen, and I would anticipate that happening within the next 12 months.

Ms FORREST - So this includes the data that is collected on every birth but now is manually completed, manually tracked and put into a system that mainly takes about three years to get a result?

Dr WHITE - That is my understanding.

Ms KATZ - This will be an electronic database collection.

Dr WHITE - This will be an electronic database.

Ms FORREST - So the data will be entered immediately into the system when the birth occurs.

Ms KATZ - It will be the same form.

Ms FORREST - The same form, but electronically entered.

Ms KATZ - Yes, that is my understanding.

Ms FORREST - And at all hospitals where births occur?

Ms KATZ - Across the State, it is a statewide database.

Mr HARRISS - You mentioned matters related to communication between the hospitals and GPs and a broad range. I understood that there was some process called ReferralNet. Is that an IT bit of software, or is that a sort of program which is available?

My further understanding was that there may have been Federal funding to progress such an initiative, and that then, as I understand it, allows that sort of communication between hospitals, what they might have been doing in treating patients while they are in, and the medication they are on, and so on. That could be immediately electronically communicated to GPs when the patient is discharged, but at the moment my understanding is GPs and the like can wait for anything up to six weeks to get that information from the hospital once their mutual patient is discharged. I just want to understand a bit more about that, if I can.

Ms GIDDINGS - My gut reaction is that six weeks is far too long, and I doubt that that is a normal process. My understanding is that the information is faxed pretty quickly to GPs on discharge of a patient, so I think six weeks would be out of the ordinary, if that has happened that you are aware of. From the looks around that I am seeing with people here, we are not aware of ReferralNet as an IT program, but there are many different programs in the e-health area which different States are taking on board. We are looking at what would be the right strategy for us in Tasmania and learning from other parts of the world. But it is the tricky part of information technology that you have so many options to choose from. I do not think there has ever been a perfect system. So it is a bit like our mobile phones, you buy what you think is the best you can get, but not one of them is 100 per cent good. I do not know if there is anything else that David Roberts or Simon Barnsley might like to add to that.

Mr ROBERTS - I can add a little to that. The problem that you refer to around discharge information is an all too common one for every health care system and, as you will recall, I recently came from the United Kingdom where exactly the same problem existed as exists here in Australia.

The issue to which you are referring is a HealthConnect pilot project that we are doing in the north of the State around that very issue and electronic discharge information going very quickly to a general practitioner. It is not the full discharge letter, it is a discharge summary which seeks to tell the GP the drugs the patient received when they were discharged and the issues that they encountered. Broadly speaking, that is what a GP needs in order to be able to take over the care from somebody immediately; just to know that they have left the hospital is an important piece of information for them. That is encompassed in the national e-health agenda - which is called NEHTA - and it is one of the pilots that the Commonwealth are pushing through this national program. It is hoped that this, plus other examples of this around Australia will prove that electronic discharge is a worthy thing to do and that would be part of the national rollout of electronic transmission data to GPs.

Ms GIDDINGS - If you would like any further information on that, Mr Harriss, I also have another person here who was closely involved with HealthConnect who could give you more information around that patient discharge model. If you would like, I can bring her to the table.

Mr HARRISS - Yes please.

Ms BLACKWOOD - The patient discharge medication record was initiated as a pilot project in the north, as the secretary said. But it rolled out from the Launceston General Hospital, starting in 2005 and subsequently, from other sites, 2006 and 2007. So it is now really through the system

pretty much. It generates a discharge summary which is either faxed or sent to the GP's e-mail, immediately on discharge. So, if there was a six-week delay that you were referring to, that was pretty much an anomaly.

Mr HARRISS - The six weeks that you refer to is with regard to transferring paper information?

Ms BLACKWOOD - Yes.

Mr HARRISS - Not electronic?

Ms BLACKWOOD - Not all GPs have computers on their desks and so some of the summaries certainly go by fax.

Ms GIDDINGS - Again, my understanding, though, is that even with paper that these things are faxed to GPs and, in fact, I am told that it would normally be faxed the day before a patient is discharged or on the day of discharge. So even if you are not hooked up electronically I think it would be rare to have a GP surgery that did not have a fax machine. So, again, regardless of whether it is electronic or paper, I think it is an anomaly if that is a six week wait that you are aware of.

Mr HARRISS - I take that at face value. But you would appreciate that I have not raised it for no cause - that there are people who have raised the matter with me.

Ms GIDDINGS - Yes.

Mr HARRISS - You would be aware, Minister, that gynaecological oncologists in Tasmania are a rare breed.

Ms GIDDINGS - They are rare around the whole of Australia.

Mr HARRISS - Yes. My understanding is that Penny Blomfield is one of very few, if not the only one around Tasmania or the south -

Ms GIDDINGS - No, she is not the only one.

Mr HARRISS - and very much overworked. Are you aware of that challenged circumstance within that component of health care? If that is the case, what can or is the Government doing in terms of attracting suitable replacements in the event that Ms Blomfield does not continue practice.

Ms GIDDINGS - I sincerely hope Ms Blomfield does. She is a well respected gynaecological oncologist at the Royal Hobart Hospital and does a tremendous job for us. I have had some contact, not personally, with her but through my office, and certainly through the CEO of the Royal with Ms Blomfield over the recent issues around the gynaecology ward and so on. The issue of gynaecologist oncologists is a problem in Australia. I am told that we have 35 for the entire country.

So to have one on a per capita basis pretty much our share and if we can get more that that we will certainly be trying. I am aware that the CEO has been trying to recruit another gynaecologist

oncologist. But as you can understand when you have 35 it is not about advertising in newspapers it is about virtually knowing every individual in the country in that profession.

It is about the one-on-one discussions, trying to get to reasons why, if someone has shown some interest to come to Tasmania, what is holding them back from coming and trying to delicately negotiate around that. But it is a problem and from my perspective as a minister in control of a budget is another example of the issues of that we face in health, because with 35 around the country the market is their own.

In order to get another here we have to pay market rate and market rate is going up all the time. It is a difficulty, particularly for a small jurisdiction, to be able to compete with the Sydneys, Melbournes and Brisbanes of the world in attracting and then retaining highly specialised people. That is why, again, we would like to ensure that we can keep the staff that we have and we will continue to do what we can to try to recruit backup support in line with the health plan, in line with what we know are sustainable services. Craig might be able to add to that for me.

Dr WHITE - I support all the comments the minister has made. Gynaecological oncology is a statewide service based at the Royal Hobart Hospital and it is being run by a sole practitioner. There are obviously some pressures that arise from that as the service grows. We have been funding for most of this year a locum person to provide some support for clinics in Launceston to reduce the pressure on the incumbent and that was a new arrangement to make her working life more manageable and we continue to talk with her about what we do in the meantime.

She is working on a statement of duties for a second gynaecological oncologist and we will be looking at how we might be able to progress that over the coming year, but the minister's comments about them being a rare breed are absolutely true. There are vacancies all over the country. I suppose, in Tasmania's favour, they did have their national event, get together, at the Henry Jones Art Hotel and a few other prime Tasmanian locations only about six to eight weeks ago. So they have all had a taste of the best that Tasmanian has to offer. I hope that will be encouraging to them.

Ms FORREST - We will be fighting them off with a stick then. We can only hope.

Dr WHITE - I was looking for some balls and chains but -

Ms FORREST - They are up in the north-west if you are looking for those.

Laughter.

Dr WHITE - We are very conscious of the issues and the concerns and we are actively trying to improve the situation.

Mr HARRISS - You might know whether Dr Rob Beattie, who is a widely respected general physician, has retired or not? My last communication was that he was on the cusp of retirement.

Dr WHITE - I am nodding because he lived over my back fence before we moved. Most of our conversations were about my barking dog. I saw him in the shop the other day and he said 'You know, you have taken your dog but the new people have a barking dog too'. Dr Beattie was a very well regarded physician who worked in private practice; he and another practitioner retired

around Christmas time and the private sector is working very hard to fill the obvious gap that they left.

[2.00 p.m.]

The minister has alerted us to the work force demands by mismatch that exists across speciality, including general medicine which of itself has been an unfashionable speciality over the last decade in many bits of Australia although alive and well at the Royal Hobart. To date it is fair to say that all the gaps left by the retiring general physicians have not been filled and they are effectively the private sector gaps. Some work has flowed as a result from the private sector to the public sector and we have had in the last 12 months about a 15 per cent increase in medical work at the Royal Hobart hospital which we have effectively absorbed. Some of that, at least, is due to changes in the employment prospects in the private sector. There is a lot of work out there but the feedback that I get when I talk to people is that the young doctors do not choose to work the same way as they see those retiring doctors who worked very hard - so there is a great employment opportunity. So it is really quite a challenge for us because there is a fragile ecology between the private and public sector. For more than 12 months I have been doing everything I can from the public side to try and support the private sector and we are looking at a series of quite innovative things including a cardiology registrar at the Hobart Private - he would be rotating out. We have already organised a registrar to go to Calvary so that would provide some in-hospital backup to support the physicians in private practice. There are a few other things that we are looking at as well so I believe we are playing our part in trying to ensure the viability of the private sector.

Mr HARRISS - Is the public sector able to handle the sort of demand that was in the private sector? You have indicated, and I understand that it is not a government issue personally, but I would understand that the minister would do all that she can to advance the industry but can the public sector handle the demand?

Dr WHITE - Well, we have to date. However it has also been very difficult; we have seen a rise in our emergency presentations and our emergency medical admissions. More complex elective surgery is being referred into the public as well so it is also having an effect and it is one of the drivers of the growth in the waiting lists. It is not just numerical it is also bringing complexity with it. It is something that we will need to look at as we look at the data about what is happening about the future and do our forward planning to do with funding growth. I think some of the changes that have been made in the hospital in terms of improving productivity have buffered us and we have been able to do more work without an equivalent amount of additional funding to date.

Ms GIDDINGS - These things are really complex and that is why Craig is bringing efficiency models to try to move patients through the hospital system faster as well. Even talking of maternity services there is a growing trend worldwide that, once you have given birth, it could be within six hours you are back home again but you do not actually have these week-long stays in hospital to recover and have a bit of supportive in-time.

Ms FORREST - The Canadian model is very good in that.

Ms GIDDINGS - Yes. These are not pressures just in Tasmania and just on one hospital because of one physician leaving, these are trends across the whole of the developed world, in that sense and, as a result, we are seeing different ways of treating patients. It is also why we are talking more about new models of care like hospital in the home, aged care in the home, respite in

the home, palliative care in the home - all of these things have been developed in response to the growing demand on our hospital systems.

1.5 Diagnostic and pharmacy services -

Ms FORREST - I just noticed that there is again a significant budget estimate increase of $11.2 million for the next financial year but then it drops down significantly again. I wonder why there is a significant increase in the next financial year. Is there to be some significant outlay in this area?

Mr ROBERTS - The same principle will apply, that 27-week issue will be in there so we are asking some of the 2009-10 from the indexation.

Ms FORREST - You would not have that many employees in that area, would you, not in the acute health services or women's services.

Ms GIDDINGS - We were just determining whether or not it has the allocation for the PET scan as well.

Ms FORREST - That could make the difference.

Ms GIDDINGS - Yes. We are just clarifying that.

Mr ROBERTS - There appears to be a rebasing exercise taking place around highly specialised drugs, so it is all being brought into next year being redistributed. So that is why there is a step-up in costs, it is being rebased for future years. That is $4.4 million, so it is quite a large number.

1.6 Ambulance services -

Mr HARRISS - Minister, whilst I and other members would clearly appreciate the policy divide with regard the ambulance levy, and the Treasurer has said clearly that his intention and the Government's intention is to put the ambulance service onto a sustainable basis, that suggests it is not currently. What is the present status of consultation with regard a proposed levy of whatever sort it might be?

Ms GIDDINGS - You would need to ask the Treasurer that aspect or detailed questions around the levy, because it has been run through Treasury. Treasury have taken on board that we do need to put ambulance onto a much more sustainable footing, and they are driving the changes to enable that to happen. So the discussions and consultation around an ambulance service fee originally were undertaken by the Treasurer.

He responded to the consultation by withdrawing the ambulance service fee, and is now looking at an ambulance levy. Where he is at in that consultation at this point in time, I am not fully aware, but they do anticipate that the new ambulance funding arrangements will be applicable from 1 July 2009, and they have provided us with a $5 million one-off payment for this financial year to assist us as they move forward to finding an alternative means of putting ambulance onto a sustainable footing.

Mr HARRISS - In terms of getting the ambulance service into a sustainable framework, previously it has been identified that you would need an extra $30 million. That was the Treasurer's contention.

Ms GIDDINGS - No. That $30 million would have been to cover the entire costs of the Ambulance Service today as it is, and then you would have the Consolidated Revenue. It would have freed up $30 million within the Consolidated Revenue for us to spend on other activities within Health around patient transport, and so on. It would depend on what your model is as to how much funding you can get from outside sources, as to how much then has to go in Consolidated Revenue to maintain that budget or provide additional resources on top of that.

Certainly it would be fantastic if we could get the entire ambulance budget funded through another means, but we do not know that we can do that, and it would not look particularly as if there would be a means to do that. I think you will find that no matter what system you put in place you will have some Consolidated Revenue going into ambulance, supplemented by the outside revenue.

Mr HARRISS - Your budget for the emerging year is $44.4 million. That is a lift of a bit over $8 million. Is the $5 million to which you referred included in that or that something sitting off to the side?

Ms GIDDINGS - Yes, I believe it is the one-off with that as well as the other increases that we had come in on-line. So it does include the $5 million. It also includes $1.312 million for the Australian Health Care Agreement funding, $1.138 million for the salary and non-salary indexation and $645 000 for accruals, adjustment for wages and depreciation expenses.

Mr HARRISS - If I cast my mind back pre the 2006 election, am I right in recalling that David Llewellyn made the announcement that there would be no ambulance levy?

Ms GIDDINGS - Not that I recall. He may have said that at that time. I am not aware of that statement being made. But it is very clear that the Government has decided to look at an alternative means of raising revenue because we are the only State in Australia not to have outside funding coming into ambulance services. We know that demand is growing every and that we do need to ensure that, not just that we can deal with the demand today, but we are able to continue to do so well into the future and that we have the training that is available or required and that we are able to attract and retain paramedics into the system. So all of those things mean that we do need additional resources into ambulance and the best way and the most reasonable way, I think, to do that is to do what every other State around Australia is doing.

Mr HARRISS - I accept that you cannot recall Mr Llewellyn, as the then minister, making the statement. But if, in fact, he did, then by the introduction of a levy of some kind, that would constitute a broken pre-election promise?

Ms GIDDINGS - I do not know there was an election promise. I do not recall it being an election promise at all. It may well have been a statement that he made as minister during his time as minister for Health and Human Service, but times do change, as you would be very aware and you have to re-assess decisions of the past to ensure that you are providing the best quality service you can possibly provide today. I am certainly not aware of that being an election promise. So, no, I would not say that was that was a broken election promise at all.

Mr HARRISS - You have indicated that there is in effect a funding shortfall because you need to free up the funds by raising revenue through a levy of some sort. Can I have an indication as to what streams of revenue are raised from fee paying exercises? For instance, I think of the horse races where I presume there is a fee for service paid by the racing fraternity to have an ambulance on site. I think of other functions like the Supercars and things like that. Could I have the detail of those revenue streams please?

Mr LENNOX - Roughly speaking, only 5 per cent of ambulance cases generate revenue. Those cases are motor vehicle accidents where the people are insured and licensed drivers are not breaking the law, the Department of Veterans' Affairs beneficiaries, some overseas patients and contracts. The ambulance fee regulations, which have been through this House, specify the fees for contracts and the fees vary, depending on whether there is a paramedic on a crew or whether it is a wholly volunteer crew. The fee level for volunteer crews is based on presuming that they are paid a salary so they do not disadvantage the private operator. Generally speaking, the ambulance service does not market itself whatsoever to do contracts. The contracts that we do are ones where there is a requirement by different regulatory authorities for a level. So in the case of motor sport the Confederation of Motor Sport sets a level of skill for a particular type of event and in motor sport there might be 15 types of events right down to the bottom level where they are doing time trials and a vehicle is going through a course and it is closed versus cars racing against each other on a track.

[2.15 p.m.]

They specify what other States call intensive care paramedics, and what we call paramedics at the top of the range of motor sport and motorcycle racing and the police department regulates that. They issue police permits for some events, so speedway racing has been determined as being a significant risk and there have been some deaths from that in Tasmania so the Ambulance Service does not market those. They are under a police permit system so we are required to be there or they do not get a police permit.

In the case of horse racing, the horse racing community desire us to be there and that comes to an issue of jockeys pursuing their safety; they have reinforced that through injuries to prominent people like Beverley Buckingham where her spinal injury treatment enabled her to substantially recover. So the racing industry, through the jockeys, sought and demand that we be there; it is not something that we go out and market. The only other events would be the Falls Festival where the organisers come to us and they go to St John Ambulance. Of all the caseload it is five per cent and it basically boils down to top of the range motor sport where a police permit requires us to have intensive care paramedics. There would be a few minor events in rural areas where a volunteer crew, to raise their profile in the community, might sit at the football at Triabunna or Swansea; they are not there under contract but they are there as part of showing the flag, that they are interested in their community etc.

Ms GIDDINGS - Encourage volunteers to join up. Part of our marketing campaign.

Mr HARRISS - Flowing on from that what I would like to be provided - and I appreciate the overview and the 5 per cent - I would like the actual revenue which is generated from those areas that Grant mentioned, the claimable insurance et cetera. If we can have that and if you need to take that on notice, that is fine. But if you have it at your fingertips that would be even better.

Ms GIDDINGS - We will; take that on notice and provide that to you.

Mr LENNOX - Some of them are easy to provide, like the Department of Veterans' Affairs or Motor Accident Insurance Board because they are the one payer when you get down to analysing how much is the speedway organisation paying or whoever was the event organiser. We will be able to get that for you.

Mr HARRISS - With things like the MAIB and those type of areas. I am thinking of another stream to all of that. When the service provides an ambulance with a paramedic, I presume, at functions like horse races, is that on a contractual basis or a tender basis or is it annual contract which you enter into? The further question then would be is it a cost effective exercise or do the wages for the paramedics outstrip the revenue generated?

Ms GIDDINGS - Is this in line with we have a private ambulance and whether or not it might be more efficient to use private ambulance?

Mr HARRISS - Not at all. I appreciate the fact that paramedics are required, and my understanding is that the private ambulance service does not have a paramedic service.

Ms GIDDINGS - That is the problem. You would not go out to tender for something if you are the only person who provides the service.

Mr LENNOX - There is no contract with the horse racing industry. As I said, the horse racing industry internally demand that we be there and the prices are set by regulation. KPMG signed off on the fees, including an element of profit, all of the departmental overheads, capital and depreciation costs and adjustments if the private sector was providing, including adjustments to taxation, and better differentials between the public and private sector. Since they were signed off by KPMG and went through the subordinate legislation process, then the Fee Units Act adjustments bring them into place. We are looking at, during the course of this year, doing a revision of those to see whether there is a need for an adjustment beyond the adjustments that go across all government fee units in the fee unit legislation.

Going back to the central point, there is no contract with the horse racing industry. I have raised this with the horse racing industry. Did they want to consider other alternatives, and their answer was no. I think the jockeys in particular have been part of that desire for safety, and you might recall that from time to time there are issues about jockey safety.

Mr HARRISS - I appreciate the fee structure, as you said, through regulatory process. Does that cover the cost of providing the service?

Mr LENNOX - When they were set, it covered all of the costs, all of the overhead costs and a profit margin, and they have been adjusted by the fee unit process. During the course of this year we are going to go back to first principles and examine them in the context of whether there have been any movements in our costs over and above the movements in the fee unit adjustments. For example, if the wage rises factored in have come into play, do they outstrip the wage component of the fee unit adjustments that Treasury do across all government services?

Mr HARRISS - What is the current feeling within the service? Is it looking positive or will you need to revisit it?

Mr LENNOX - We will need to revisit it. I expect it would be within a margin of a few per cent from what they are now, bearing in mind they have been adjusted through the fee unit

process by - I do not have the figures, but Treasury can supply them - roughly 2.5 per cent in some years; 3 per cent in other years that have been continually adjusted.

Ms GIDDINGS - Generally speaking, getting ambulance on a sustainable footing and having some form of ambulance levy has been welcomed by most of our employees; I would not be able to say by all. Through the Health and Community Services Union, they have joined with others within ambulance and call themselves Ambulance 2020. They have been lobbying the Government very hard for some form of levy which would put ambulance on a sustainable footing, so in relation to that broader issue that you have been asking about, I think there is a lot of support to do something in this area.

Mr HARRISS - What is the process under which the Tasmanian Ambulance Service is required to operate with regard to reporting your commercial income? Is there a legislative provision which mandates a level of reporting?

Ms GIDDINGS - It is just reporting alongside our budget; all revenue across hospital, ambulance or any other part of the department is reported alongside our budget, or in our budget. It becomes a very important part, for hospitals it is important, too, in terms of we do get some funding from private patients who were part of the public system, or the services that we might provide to the private sector. There are revenue streams for Health, just not enough.

Mr LENNOX - Under the Ambulance Service Act, which was established at a time when ambulance was almost a stand-alone entity, there is a statutory requirement to have audited statements each year. So under the umbrella of the Department of Health and Human Services, there are a couple of areas, of which ambulance is one, where there need to be audited statements, and they are prepared by the department's finance section and audited by the Auditor-General. The Auditor-General's staff have been in our office in the last week as part of their processes, and they will examine and sign off on the audited statements for our services, as they do each year.

Mr HARRISS - What is the impact of that? Is there a trade-off in the Consolidated Revenue as a result of that? Is there anything that then means you move to consolidate a component of Consolidated Revenue to offset your commercial revenue raise?

Mr LENNOX - That is basically a matter for Government policy to -

Ms GIDDINGS - The budget is set at the beginning of every year, as I understand the process; with each business unit, their budget is set. If they were to get more revenue in over that period I would presume that that stays with the ambulance service but 5 per cent of the ambulance budget is not a huge amount. They have increased activity, so it is going into to helping them sustain their business. We have some figures here which Dave can go through with you.

Mr ROBERTS - The accounts for the ambulance service are independently audited, so for the 2006-2007 budget the current revenue from Government is $28.18 million. There is an additional sum of user charges which is the subject we are talking about here of $2.968 million and other revenue - a small amount of $172 000 making up the budget there.

Ms GIDDINGS - Each year they have had an increase in their revenue. If you start in 2004-2005 there was $19.922 million in recurrent from the consolidated fund; that increased to $23 million, to $26 million and so on, and so each year we have been putting additional resources into ambulance.

Mr LENNOX - Effectively, since you have come to Government, there has been a growth of 87 new positions before the ones introduced this year, so there are only seven additional staff employed in the ambulance service. They have gone into new stations, volunteer educators and so on.

Ms GIDDINGS - The other side to that is that our user charges have been going down. In 2004-2005 it is $3.614 million, then $3.115 million, down to $3.299 million, so it fluctuates year to year as to what revenue we get in but I can assure you that the revenue is not big enough to have any impact on how policy and our budgeting for ambulance. That is exactly why we need to get an ambulance levy in place so that we can get some additional revenue in.

Mr HARRISS - Yes, and those figures you just referred to will come out more fully in the information which you provide for user-pay services.

Mr LENNOX - This year there will be a spike in revenue because the Department of Veterans' Affairs for the first time has agreed to pay us as they started to pay other States for cases where we go to the Department of Veterans' Affairs client and they do not need to go to hospital. In the past, they have not paid for those and we kept giving them information and this year they will be paying for about four years of those. So it is a one-off, as most of the early ambulance services identified costs for attendance and treatment and assessment but then they might not decide that you need to go to hospital.

Mr ROBERTS - We do have the breakdown here for you now. I am going to ask Grant to read it because it has some abbreviations in here and he understands them.

Mr LENNOX - So there is fees from the Department of Veterans' Affairs of just over $1.8 million; the other fees, $2.174 million; when we sell vehicles, $169 000.

[2.30 p.m.]

There is a need to explain how they treat workers compensation moneys. It is treated as revenue to us in the way they do adjustments from the risk management fund, so it is internal. It is just the way that the insurance goes. It also links to the Department of Veterans Affairs - the $498 000. But in terms of true revenue, with some of these figures about workers compensation recoveries, you pay out in salaries and then you get an adjustment back through the risk management fund. So that will give you clarity on that.

Ms GIDDINGS - I will table the information we said we would provide on overtime to nurses.

Mr HARRISS - That sheet to which Grant just referred, there did not seem to be much detail there at all.

Mr LENNOX - I will give you the detail of the split up between horse racing and -

Mr HARRISS - So we are still going to need that, Minister. You have indicated that is the information which I was seeking and I do not think it is.

Mr LENNOX - That is it in a lump sum - all grouped up.

Ms GIDDINGS - So you want more information on horse racing versus racing cars?

Mr HARRISS - Yes, the split-up. With regard to overtime, is overtime somewhere from a separate budget or is it all within the ambulance service budget entirely?

Mr LENNOX - It is all within the ambulance service budget. The biggest source of overtime in the ambulance service links to 12 stations where the service delivery model is that all cases at night generate overtime because the staff members are on a salary during the day and an on-call allowance with overtime call-backs at night. So 12 stations in the State have that service delivery model. In this year's Budget, as the minister has indicated, three of those 12 stations will be getting staff on duty at night, one of which is in your electorate, I am sure you would be pleased to know. The others are at Sorell and New Norfolk. So they will then decrease in overtime expenditure. That is the number-one cause of overtime. Others come up when we have mandatory requirements to progress training for students by a set time ahead of exams, replacement of staff on sick leave, workers compensation absences and short-term absences. Most ambulance services in Australia have very high proportions of overtime, particularly in the rural service delivery where common models around Australia are on-call staffing and overtime call-back at night.

Mr HARRISS - Historically, about 50 per cent, or just a bit over, of responses by ambulances are with regard to emergency calls. Would the Government consider the possibility of the transfer of the ambulance services to emergency services because of that? It is an emergency response unit.

Ms GIDDINGS - This is an interesting topic of debate which I think has been discussed over many years at Estimates as well. It is one where, at different times, the arguments have been stronger towards amalgamating all emergency services together. Now I do not think it does sway that far at all in terms of putting police, fire and ambulance together. In fact, I would argue that ambulance is a key part of the entire health system and to remove them from the Health department would be a backward step because they are the first response on a medical issue, which is then part of a continuum of care for that patient through the system. The last thing that I would want to see is a silo effect because you pull one element of the health system away. It is then under the control of another bureaucracy, another minister and all that goes with that. So while in the 1980s and 1990s there was a fair argument to perhaps look at bringing all three together, I think now that would be the wrong thing to do.

Having said that, of course, cooperation between all emergency services is critical, particularly dealing with a road accident or the like where you have fire, ambulance and police all working together. In fact, since the last Estimates I have had the opportunity of going out and doing a night-shift with a Hobart crew, seeing how important it is for police and ambulance to work hand-in-hand on a Friday or Saturday night dealing with different people under alcoholic or other effects. The police were integral in two occasions that I was involved in - one which was related to alcohol and the other an attempted suicide. So to see that level of cooperation is really critical but it is not critical to have them under the same operational banner.

Mr LENNOX - Can I add a perspective nationally? There are two jurisdictions that are not in the health area. There were three. The South Australian Government has just reviewed theirs and put it into the Health portfolio. In Queensland it is in the Department of Emergency Services and it is in the Bureau of Emergency Services in the ACT. As the minister said, the importance of the service is working cooperatively together. Tasmania probably has more examples of the

emergency services working together. Almost every ambulance station built in recent times has been a shared one because we share common factors where we site the station. There is one in Mr Martin's electorate, where ambulance went there first. It proved that it had more response effectiveness in the northern suburbs and then fire moved in and we did it together.

So we have a number of shared stations. Five of the six stations in Hobart are shared with fire, but we share with police, with country hospitals, with the State Emergency Service. We are in business of giving cost-effective facilities and services, but once we go out the door we are going out to give a health service. We share a radio system with the fire service - a paging dispatch system. We have their mechanics decommission our vehicles. We share critical incidence stress debriefing across police, fire, ambulance and SES. In terms of the actual service we deliver it is overwhelmingly a health service and that is where our training is.

Mr HARRISS - Can I address the matter of ramping, particularly at the Royal? Has the incidence of ramping become more prevalent in, say, the last two to three years or is it one of a fairly static nature?

Ms GIDDINGS - My understanding is that the Department of Emergency Medicine at the Royal Hobart Hospital have been undertaking a fair bit of work to try to improve the problems of ramping. There certainly have been some problems in recent times at the Royal Hobart Hospital. In fact I am told that on some days more than 20 hours of emergency crewing has been lost while emergency crews are ramped there. Work has been done within the Department of Emergency Medicine to try to deal with that.

Dr WHITE - Ramping is one of the things we have discussed today which is also not unique to Tasmania. Probably we have greater risk of it because each of the hospitals in Tasmania is really the only show in town when it comes to where you have to be taken if there is an emergency. If that facility is, for some reason, unable to take that patient immediately, then there is always the risk of ramping. In the larger jurisdictions there are all sorts of systems of bypass where the ambulances are directed to the hospital which has available capacity. In Tasmania we do not have that ability. So we will at times have ramping. Ramping is not something that does not have consequences. It means that the vehicle and staff will be held up which could otherwise be out on the road doing other work. So it is in the interest of both the hospital as well as the ambulance service that we all work together very closely to minimise the time that ambulance crews are actually held up at the hospital off-loading patients. Over the last year, from my end anyway, I think that we have done a lot of work with the ambulance service on practices at both ends to try to streamline the handover as well as to provide safer, better and more workable arrangements when that handover cannot take place as well as to reduce the overall number of hours that ambulance crews are held up.

My understanding is that we have seen significant improvements but ramping is still part of the reality of life for the foreseeable future.

Ms GIDDINGS - This leads to another work force issue in the sense that some of the debate coming pout of these issues around ramping - what is the role of the paramedic once they hit the hospital? At the moment once a paramedic hits a hospital they do not actually do much more care. That is the problem with ramping; they are standing around with a patient waiting for someone to come but they are not actually providing the ongoing medical treatment as I understand it. Correct me if I am wrong.

Mr LENNOX - Sometimes they are.

Ms GIDDINGS - Sometimes they are but there is a role there that could be more formalised as I understand it - that a paramedic could then come into a department of emergency medicine arena and continue some of that care as an appropriate part of their work. That is where I understand the debate has been moving to. But some emergency specialists are not comfortable with that, similar to some doctors who are not comfortable with nurse practitioners because they see it as moving the scope of practice.

These are issues that as these demands increase on our hospital systems across Australia that we are going to have to start talking more about - what is the role of the paramedic? They are very highly trained individuals; can they provide a lot more of the medical care than they are currently allowed to do?

Dr WHITE - Even, indeed, the roles of emergency departments in the future - they can become over time a bit of a one-stop shop. I understand that recent research shows that in the 20-30 years olds it is actually the first place they think of when they are unwell. They do not see it desirable to have your own GP. So one of the reasons that we will at times have ambulance ramping is because you are treating people who could have been in another bit of the health system if only they went there and if only the capacity was there. There is really quite a lot of reform work to be done there.

Mr LENNOX - As Craig said, the hospital and the ambulance service are working very positively together to minimise the effects and it has been trending down, but we get the occasional blip and you have raised questions today about how those blips occur with more and more presentations to the emergency department but also flow-through problems with aged care people awaiting placements in the nursing homes being in the hospital.

At the other end in ambulance we are also trying to direct some of the people away from emergency departments. We are in the top two or three ambulance services in Australia in terms of not bringing people to hospital, giving the crews the skill base to what we call TNR - assess a patient as not needing an ambulance. In the next three months we are going to be building an electronic interface between us and GP Assist so that we can electronically transfer calls coming into ambulance right from the word go; before we even send a crew we are convinced they do not need an ambulance response and they will go to GP Assist.

Ms GIDDINGS - There is now a formal written agreement between the Tasmanian Ambulance Service and the emergency department. That is now in place to clarify the roles and responsibilities of each service during times of peak demand when ambulances are ramped. There is also an area in the emergency department that that ensures patient safety and privacy as being designated for use by ambulance crews providing care for patients while waiting for handover to emergency department staff.

This area is resourced with emergency drugs, cardiac monitors and defibrillators. Ambulance crews can also rapidly initiate an emergency medical response by activating emergency alarms for immediate assistance from the hospital's emergency department staff. But again, we want ambulance crew to be back out on the road, so that is one way of trying to assist in that issue at the hospital and we are working on it.

[2.45 a.m.]

Mr HARRISS - I understand that if you do have three, four or five crews around, then there will need to be adjustments made with coverage of those areas from which the ambulances come, and then there may be a compromise to consumer safety, or health and wellbeing. My advice is that this is a tragic situation such that when ramping has occurred, and ambulances have had to be relocated from areas, deaths most likely have occurred which may have been preventable if the ambulance could have been in its own area very close to the emergency call. If that is the case clearly, then, minister, you would be very concerned about something of that magnitude.

Ms GIDDINGS - Absolutely, and if there is -

Mr HARRISS - Sorry. Just before you answer, can I add or ask a further question as to what records are kept as to the time ambulances are ramped, and then what call-outs or what emergency calls are made from their area if somebody else has had to be covering for them?

Ms GIDDINGS - I will get Grant to answer that aspect, but what I would say before answering it, that of course that is of any concern if anybody's health and wellbeing is put at risk. If there have been deaths of any suspicious nature or of any real concern to a coroner, there is a coronial inquest. Should a coronial inquest point to ambulance being part of the problem, we always go back and double check what we have done and look at how the system can be improved through that as well.

Grant might be able to give you some more information in regard to the information we do collect, but I believe we also have reasonable response times which would be the other side of the equation here. Our response times are pretty good.

Mr LENNOX - As we said, this issue of ramping is not a Tasmanian issue, it is Australia-wide and an international issue. In the ambulance service we try to deflect some cases; we keep the time record for every case, time-stamped by a computer to hundredths of a second from when the call is received to when we allocate the crew, the crew go out the door, to when they arrive at the scene, leave the scene and get to hospital. We track that for every case so we can audit any individual case.

We also track, for every station, the number of times that we do a coverage move on what we call a standby. We do standbys when there is no ramping; if we have a spate of emergency cases in an area, say in Hobart, then the people of Hobart will occasionally see an ambulance sitting by the side of the road near the Bridgewater Bridge or the top of the Southern Outlet, and what that means is we have had a peak in demand and then we strategically move crews to minimise the risk to the public on a risk matrix. We will bring the crew from Kingston, for example, to sit at the top of the Southern Outlet so they can get back to Kingston but, if the next emergency arises in Hobart where it is statistically more likely, they can get to that.

We track every case, and we track the number of movements, and one of the things that will improve the situation is where we are doing single responses because of lack of volunteers. We have recruited more volunteers to support the paramedics in some areas, so they are not being backed up. A member of the staff of this House joined our service as a volunteer, and is doing a great job. That was another factor why we were having movements, two crews going to a case rather than one, because we had a single responder. We recruited and trained more volunteers so that is another dimension, but we can track any individual case with its time stamping.

Ms GIDDINGS - There are two other points I want to make quickly for the committee in relation to that, as it is quite a serious point you have made. The median response time to urgent ambulance cases in Tasmania for the 2006-07 financial year was 10 minutes 30 seconds. For the period ending 31 March 2008, the median response time for emergency ambulance cases was also 10 minutes 30 seconds, so that, as I understand, is a pretty reasonable response time. I believe the statistics are not easily comparable around the States because we do measure it slightly differently from State to State, but that is a pretty good response time.

The other element is that we have, as a government, recognised the growing demand on ambulance, which is why we have increased ambulance staffing by some 30 positions. This has enabled a new 24-hour crew to begin operating in both Launceston and Hobart. So in recognition of those concerns we have put additional resources into ambulance and in fact this $5 million will also be helping with further training of new paramedics and the rest, as well as looking at the patient transport issue. It is an issue we take very seriously from all elements of the system - from the ambulance right through to our department of emergency medicines.

Mr HARRISS - With the changed operation process at the Mersey Community Hospital, has the department been providing a continued patient transport service for the hospital?

Ms GIDDINGS - Our ambulance crew were based at the Mersey hospital and they were continuing to be based at the Mersey hospital regardless of who was taking over the Mersey hospital. We would have the protocols in places as to where an emergency patient should be taken regardless of who owned that hospital. It was going to be part of the public health system regardless of it being operated by a third party. Now that is it coming back to the State that certainly guarantees the fact that it is part of the public health system and an integrated part of the Tasmanian health system. So I do not see that there will be any problems around ambulance. Again, we will be taking patients to the most appropriate hospital for the condition that they have.

Mr HARRISS - Have there been dedicated PTS staff?

Ms GIDDINGS - It has been our own ambulance crews there. The hospital itself did not -

Mr LENNOX - The hospital employs patient transport officers in addition to the emergency crew. So the Government increased ambulance staffing by 25 positions in the north-west, opened a new station in Latrobe in the hospital, opened a new station at Sheffield, added staffing into Devonport and Ulverstone and to Burnie. The hospital has patient transport officers for non-urgent cases.

Mr HARRISS - I do not understand the staffing arrangements up there nor the hierarchy for payment, money and everything. When you say 'the hospital' are we talking about the State Government?

Mr LENNOX - The State Government, and so do hospitals in a number of other places around Australia and overseas. One of the reforms the secretary is bringing in is to consolidate ambulance and health transport in the one area.

Mr HARRISS - So do I understand clearly then that there have been specifically identified PTS staff employed by the hospital?

Ms GIDDINGS - Yes, but there have been our own ambulance crews as I understand it.

Mr LENNOX - So there are emergency crews in Smithton and Wynyard and -

Ms GIDDINGS - Yes, our emergency crews have been based there, haven't they?

Mr LENNOX - Burnie, Ulverstone, Devonport, Latrobe and Sheffield and Zeehan and a lot of volunteer-only crews. The hospital employs patient transport officers to provide a non-urgent patient transport service for routine movements of patients including patients who are on discharge and patients on transfer where they are clinically deemed stable for non-urgent transport. They have been doing that in the order of 20 years.

Ms FORREST - I want some clarity on this point. I just want to see if you are referring to patients who need to travel between the Mersey and Burnie hospitals but do not necessarily need an ambulance.

Mr HARRISS - Non-urgent patient transport.

Ms FORREST - Your non-urgent patient transport, that is what you are talking about?

Mr HARRISS - I want to understand clearly what the staffing arrangements are. If we have dedicated PTS staff who are doing not much -

Ms HOLDEN - We have retained the role of managing the non-urgent patient transport services for the whole of the north-west driven out of Burnie at Parkside. The State has done that on behalf of the Mersey Hospital seamlessly and clearly now we will continue to do that. The staffing are actually employed by the North West Regional Hospital and they support that work throughout the north-west.

Mr HARRISS - I keep coming back to the dedicated staff for PTS services.

Ms HOLDEN - Yes.

Mr HARRISS - Do they have any other allocated functions or, if I can be bold about it, do they sit around waiting for the need to transfer patients on a non-urgent basis?

Ms HOLDEN - The reality is that it is the latter, however the demand is such that we are rostering them to respond to needs that are projected 24 to 48 hours in advance so these are planned transfers. I do not think that we have reserves sitting there without things to do.

Mr LENNOX - I can add historically that the transport staff at the hospital have also moved goods and services - they have moved the department's mail between different facilities. The manager for the area also manages patient travel and the assistance scheme which is the financial subsidies for people to access specialists and hospital service if unavailable in the region and he manages the hospital's air travel, so there is a range of other duties that -

Ms FORREST - That is only the coordinator?

Mr LENNOX - Yes, that is the coordinator.

Ms HOLDEN - So the coordinator of PTS also coordinates a number of other duties but the drivers who transport non-urgent patients do just that.

Mr HARRISS - And that is at all hours.

Ms HOLDEN - Yes, it is, so long as they are planned so it is not an urgent emergency response but if someone needs to be in Hobart from Smithton for either some sort of intervention that is done down there, they would leave from Smithton obviously fairly early in the morning and we plan for that patient to be transported.

Mr MARTIN - Most of my questions have been asked and answered. Just in relation to the performance indicators, Minister, that you have mentioned about the response times. It was 10.2 minutes in 2005-06, it went up to 10 minutes and 30 seconds in 2006-07 and apparently it is the same for this year?

Ms GIDDINGS - For the year to date it is the same.

Mr MARTIN - I was going to ask what it was this year because the target was to reduce it to 10 minutes - obviously it failed to meet the target. What is the target for next year?

Ms GIDDINGS - The performance target for next year is 10 minutes - so we are still aiming to get there. In this year's Budget we have, in fact, put more money into ambulance which will employ additional paramedics on the west coast, New Norfolk, Sorell, and the east coast and the Tasman peninsula and of course by putting more paramedics in we are actually boosting the numbers available within areas which helps to bring down response times as well.

Mr MARTIN - There are still the issues like ramping which was going to be my main area. Until you fix that it is going to be very hard to reduce the times, is that not the case?

Ms GIDDINGS - It is also to do with the number of crews that you have on the ground out there as well so if there is a crew ramped that you have got another crew to actually respond that keeps the response times down. I think that the additional investment that we are putting into actual ambulance officers in this year's Budget will help in some respects to do that but also things like the protocols that have been put into place with the Royal Hobart hospital, for instance, with ambulance, I think it was a relatively new agreement. I am getting nods, so those sorts of things would also, we would hope, help to impact on the ramping issue that might then be reflected in response times as well.

Mr LENNOX - There are two other things that will impact positively. One is that as the Government has increased the staffing in Sorell, New Norfolk and Huonville they will not be staff responding from on call and the case loads of those stations have gone up so much that every so often when they work for days and nights in a row they are so fatigued that we stand them down and then have a response compromise where we have to look at how we manage into New Norfolk or Huonville. So the Government putting those services on so that we will not have that issue of losing crews to cover fatigue will also have significantly less single response cases that will be backed up because we have recruited substantially more volunteers working with paramedics at Kingston and Bridgewater so they don't have to be backed up and losing two crews to do one job. So there are two positives. Ramping is an issue that is on the other side of the equation but we are working on that. Extra crewing and single responders may minimise both of which will have a positive impact.

[3.00 p.m.]

Mr MARTIN - My only other question relates to the staffing. You are budgeted to employ 15 extra paramedics for 2008-09. Do you anticipate any problems filling those positions?

Ms GIDDINGS - We have training already under way of additional paramedics, don't we, Grant? Recruitment of paramedics was the question.

Mr LENNOX - We have recruited some in advance. They are being carried supernumerary because they have to go through their training processes. We are picking up a few from interstate and we will have another student intake next February of some significant size. We are progressing more people through their training so that we can keep expanding the service and strengthen the rural service delivery.

Ms FORREST - Do we have some of those people who are committed to going to Smithton, which has been difficult to fill, and Queenstown which I am sure will not be an easy one to fill? It is okay to have these positions, but you have to have someone in them.

Mr LENNOX - There are two issues here. One is that when we start a new station or when we have a station like Smithton we cover it every day. There is a difference between having people who are willing to be there all the time and those willing to get more money by being a reliever. There are award conditions for those who relieve, where they will earn more money - in the order of $15 000. We cover Smithton every day, and I am pleased to see that one of our volunteers is in the Chamber. We strengthen and cover those services once we start them.

One of the issues which is being looked at by the Government in the career structure negotiations is the salaries and benefits of those who are substantively in a position in a rural area versus those who come in and relieve, because those who come in and relieve currently get more money. So they can say, 'I will not take the Smithton job', but they will work there for the next six months and get paid more for relieving. That is one of the award issues to be examined.

Ms GIDDINGS - If I can put some information on the table about the caesarean sections just while I have it here in front of me. In 2005-06 at the private hospital in the north-west 23.8 per cent were caesarean sections; in 2006-07 that dropped to 21.32 per cent; and year to date, that is to May 2008 for 2007-08, it is down to 20.83 per cent. In actual figures, in 2006-07 that was 145 caesarean sections and for this year 135 caesarean sections.

Ms FORREST - Is that public and private or just the public patients?

Ms GIDDINGS - That is the public patients. There were 535 normal births in 2006-07 and in 2007-08 there have so far been 513 normal births.

CHAIR - Do you want that tabled, Ruth?

Ms FORREST - If that is all the information - it is on *Hansard* now.

Ms GIDDINGS - Yes, it is on *Hansard*. The rest is just the total births of 680 in 2006-07 and 648 to date, but all the figures are there.

Ms FORREST - So maybe we need to talk to the North West Private Hospital to see what they are doing there to keep their rates below the rest of the State.

Ms GIDDINGS - At least they are trending down, so that is great.

Mr WILKINSON - If I can ask a question in relation to the ambulance officers doing a great job. To get to their jobs they often have to drive at excessive speeds. By doing that, they go through the speed cameras and they are then served with an infringement notice. One of the problems that I am hearing - and it is a problem because it is a significant amount of money that would seem to be lost - is that if the person in the ambulance office does not say who the driver of that ambulance was, it goes to court and they are charged $600 a pop. In court approximately a month ago, I am advised by people who were involved that four of these went through without the name of the driver being provided. So that is $2 400 in one day. Is it a policy of the ambulance department not to say what the name of driver was? Because it is easy for them to say they were driving to carry out their normal duties and nothing would occur. I just wondered if it was a policy within the ambulance department not to name the driver.

Mr LENNOX - No. It was very great news to me that we had an issue where we had been fined for not providing the details and the person who was handling that matter, who did not process some paperwork, is currently in the care of Her Majesty's prison. But the general rule is that, when an infringement notice comes in, we identify first of all whether it was an emergency, because if it is an emergency case the police withdraw the infringement notice. If it is not an emergency then the crew have to identify who the driver is. I can only recall one case where the two members for the crew could not recall which of the two of them was not the driver, but categorically we have a policy of identifying the driver and telling the crews that they must identify who is driving and who is doing patient care. We had a number of fines on paperwork which was never processed to me or to any of the regional superintendents. No notices came in to us and we went through some fine processes for failing to identify some drivers. So we have had some discussions with Justice and with police to try to bring in a system where they all come to one point, and from that one point we account for first of all whether the infringement should be withdrawn and, if not, who is the driver and time stamping so that we report by the due time to meet that requirement, which we think is fairly fundamental.

Mr WILKINSON - Are you able to advise how much the ambulance department has been fined as a result of that default over the last 12 months? The advice from my last conversations with people involved was that it happened approximately one month ago.

Mr LENNOX - It is in the order of $9 500, from memory.

Ms GIDDINGS - And that is related to that one individual, isn't it?

Mr LENNOX - It goes back. As I said, we were unaware of them altogether until after they had been processed. Some of them go back four and five years ago. From memory there were eight or nine cases that had gone through several steps without coming back to us. The person who handles them had never got them. We went through searching for them and we found them in amongst the papers of the staff member who was found guilty of fraud. There was not any fraud involved in this case, but he certainly did not fulfil his administrative requirements to identify and track those vehicles.

Mr WILKINSON - Could I be provided with the exact figure say over the last 12 months and when the courts imposed the penalty?

Mr LENNOX - Yes.

Mr WILKINSON - I understand that the police have been endeavouring to make contact with relevant people within the ambulance board in recent times and have been asking whether this matter could be sorted out but there has not been a reply. Is that the case as you know it?

Mr LENNOX - I am aware of one case where a crew member was arguing that he should not subject to an infringement and he has been told in no uncertain terms that, yes, he is responsible for that. I initiated contact with the police and I initiated contact with Justice because it was an enormous surprise to me to find that we had been fined for cases that had not been processed properly.

Mr WILKINSON - When was the last time that either you or others made contact with police prosecutions in relation to that?

Mr LENNOX - My last contacts was on 30 May this year. I was in contact with the justice department and the police. I was talking to Inspector Michael Grant from the police department and I can't remember the name of the person in Justice. I have sought a meeting and I have tasked some people to bring about some systemic changes to make sure that this does not occur again.

Mr WILKINSON - Have you spoken with the justices themselves. They are tongue tied, they cannot do it, their hands are behind their back, they have to impose the penalties because it is form them as well.

Mr LENNOX - I have not been talking to them. It was complete news to me until the fines had been imposed. So we were completely oblivious - I, the executive officer administration, the regional superintendents - until the fines had been imposed. So we paid the fines tried to unravel how that came about and tried to focus on system improvements and I have sought a meeting with police and justice to go through how they have arisen and to prevent their recurrence.

Ms GIDDINGS - Which is a critical point I think. That when things go wrong in the system you must go back and ensure that you close that gap and that is what Grant has been doing. Fortunately the incident has happened and we are now dealing with that and ensuring it does not happen again.

Mr WILKINSON - But if we can please be provided with that information.

Ms GIDDINGS - I have undertaken to do that for you.

Ms FORREST - The north-west coast has 15 students, which is half the state intake for this current year, and 10 of them need to undertake nine case management exercises before September, and none of the Burnie officers are supernumary - the CSO is not supernumerary. What consideration would be given to providing supernumerary CSOs to enable the freeing up of these people to ensure that these students could be able to get the attention they need because they are often tied up with crew work?

Mr LENNOX - That is one of the issues being looked at as a priority amongst the new money being provided by the Government for this year. Having said that, I would also draw your attention to the fact that the staffing in Burnie is about five times the extent of staffing in Bridgewater or Kingston, which have the same case loads. So there are issues in terms of comparative salaried staffing for case load. They are significantly more highly staffed, but within that staffing they have a lot more students, and we are addressing that issue.

Ms FORREST - The student load is what I am talking about here, not the staffing levels. Devonport have two supernumary CSOs, but Burnie does not have any, and it is difficult to provide that training.

Mr LENNOX - The case load link to supernumerary is also a factor; if those people are not on cases, they are able to do some of that in their normal jobs. That was the point I was making. But, yes, that issue is a priority to be addressed with the new money allocated by the Government.

Ms FORREST - One other thing in the north-west is the $50 000 mannequin still sitting in its box from lack of a place to set it up to be used in training. Is that a priority as well, giving some space for that to be put out to be used?

Ms GIDDINGS - It certainly would be, we paid for it.

Ms FORREST - I know, it is still in the box. It has been in the box for some time now.

Mr LENNOX - The staff then have to be trained to use it by the equipment manufacturer.

Ms FORREST - That is good, because they cannot be trained until it is unpacked out of the box and set up.

Mr LENNOX - No. Someone will come from interstate to train them; this is not a simple matter of just opening the box and reading a few instructions. This is high technology.

Ms FORREST - No, I am not suggesting that. The question is, is there going to be room made available somewhere for this to be -

Mr LENNOX - There is a training room in Devonport and a training room in Burnie, and what we have to look at in terms of Catherine's commission is some information to try to strengthen education and training. One of the things we are trying to do is build up the equipment base and the staffing base to give greater emphasis to education and training of staff so that there will be additional staff directed to education in the north-west, and purchase of more equipment so that they have the equipment to do more of the training on site. We have two training rooms -

Ms FORREST - It is not as though we need more equipment, we have a mannequin there that is not being used for lack of a space to put it in.

Mr LENNOX - There is space.

Ms GIDDINGS - We have space.

Mr LENNOX - There is a training room in Burnie and a training room in Devonport. Whether or not because of the value of the mannequin, they do not want to put it out there and

have it damaged, because we are talking about a $50 000 mannequin which is hooked to a computer where the staff members can give the mannequin a cardiac arrest or a stroke.

Ms FORREST - We also need a room that can set up that allows the instructors to be out of sight, adjusting the functions of the mannequin so they can assess the responses of the trainees.

Mr LENNOX - That is the ultimate, but it does not mean you cannot use it without having a two-way mirror.

Ms KATZ - We have recently undertaken a review of training needs across the service on three points: professional development; paramedic training after post-graduate training within the service; and student training. There is a number of recommendations coming out with quite a sensible short term and long term implementation plan. One of those is simulation centres across the State so that we can have a proper training system throughout the State. We do have rooms for that simulation mannequin at the moment, but we need better rooms, and that is part of the plan.

Mr LENNOX - It may well be that the solution is to join forces with the University, who have a simulation centre in Burnie. We will go through all those options.

Ms KATZ - We have set aside some money in the budget for the coming financial year for the first part of that training program and the implementation of the priority items. That is part of the implementation plans.

1.7 Forensic medical services -

Mr WILKINSON - It is a fairly small line item compared to the rest of the output group 1. I just wonder, the figures seem to be static over the next five years. What does the output entail? Is it just employment? Is it anything else other than employment?

[3.15 p.m.]

Ms GIDDINGS - I will get the figures for you: We will take that on notice for you as we do not have the breakdown with us right here. Catherine might have something to add to that.

Ms KATZ - No, I do not. I think you need the detail. But they do have two highly trained individuals working for that service. That would count for a lot of them.

Mr WILKINSON - That includes, what, two medical practitioners? Is that what you are saying?

Ms KATZ - Yes, they are forensic pathologists.

Mr WILKINSON - Forensic pathologists.

Ms KATZ - Yes. We have recently recruited. We used to have one but now we have two. Obviously we need two to support each other. So there has been an increase.

Mr WILKINSON - Forensic pathologists have always been a bit difficult to get in Tasmania for the last 20 or 30 years. There have been some difficulties in relation to some of the people also that have come down.

Ms KATZ - Absolutely. We have been very fortunate in recruiting another forensic pathologist during the last calendar year. He has passed his exams and he is here with us now.

Mr WILKINSON - This line item specifically relates to those two forensic pathologists?

Ms KATZ - I would have to get the detail of that.

Mr ROBERTS - Can I just check, are you asking me for the difference between the two years?

Mr WILKINSON - No, just a breakdown of the budget.

Mr ROBERTS - A breakdown of 1.7 which you do not have.

Ms KATZ - No, I do not have the details.

Mr WILKINSON - In all the budget documents there are major initiatives. It would seem to me that there is no major initiative in relation to this. It would just be to do the work and to do it the best they can and as swiftly as possible.

Ms KATZ - Yes.

Mr ROBERTS - Absolutely.

Mr WILKINSON - Is that fair?

Ms KATZ - Yes.

Output group 2
Community health services

2.1 Primary health services -

Ms FORREST - A leading question first. In view of our ageing population and the increase in numbers of people with chronic disease such as diabetes and all the associated complications that go with diabetes, why is there a planned reduction in the occasions of service in community nursing and a reduction of rural hospital separations predicted?

Ms GIDDINGS - There are two parts to that. Might I start by saying that the Tasmanian Health Plan looks a lot around the chronic disease issue with diabetes particularly. We are boosting our funding in the area of diabetes. There is some funding going to Diabetes Australia in order to work with them on monitoring and providing advisory services that give lifestyle information, nutrition and physical activity advice, as well as having a telephone monitoring service for people at risk or merely diagnosed with the condition.

Also, the issues around chronic disease management are in the realm of GP services and the care plans that are now being Medicare funded within that context. There are now community health centres where we are doing what we can to also manage it. We are providing clinics around chronic diseases like diabetes and obesity and other things as well, particularly around our

rural health centres where they do not have as much access to other services. So in relation specifically to community nurses, I will ask Pip to address that aspect of it. There is not necessarily a direct correlation or, in that sense, that we can be -

Ms FORREST - Are you saying they are being shifted?

Ms GIDDINGS - Not necessarily.

Ms LEEDHAM - We are looking at the role of community nurses so that we are targeting their activity at specific nursing services but there has been a significant expansion in other services that have traditionally been the role of the community nurse. In those particular areas there is the expansion of each program and the community aged care package programs provided by the Commonwealth whereas before they existed, those sorts of service tended to end up with community nurses.

The other area where there has been an expansion is the role of practice nurses associated with general practice so that a lot of the occasions of service that were done previously by community nurses are now being done by practice nurses. What we are not wanting to do is reduce the number of our community nurses but we want to start doing a whole lot of program work. I think we will probably start to see some changes in the occasions of service going forward but over the next 12 months while we work through these different models, that is why there is a slight reduction in the target. In the actual activity data there has been a reduction in SHIA because it is part of the industrial negotiations to do with the nurses' EBA. We have a three-month period where the nurses' action was to not count any of their occasions of service.

Ms FORREST - Can we have an update on the occupancy rates of the Royal hospitals?

Ms LEEDHAM - The occupancy on average overall is 60.9 per cent at the moment but it fluctuates between the various sites. This the nine-month period from 1 July 2007 to 31 March 2008. I am just talking about the inpatient beds at this stage. I will talk about the aged care beds in a minute. The Campbell Town multipurpose service, the occupancy rate was 80 per cent. For Deloraine hospital it is 77 per cent; for the two beds at Toosey it is 82 per cent; on Flinders Island it is 42 per cent; at George Town it is 70 per cent; at Scottsdale it is 71 per cent; at St Helens it is 59 per cent; at St Marys it is 34 per cent; King Island 35 per cent; Queenstown 44 per cent. Smithton is 49 per cent but at the moment because our system still counts the 16 beds we are actually reduced and down to 10 beds because of the redevelopment that is going on. The system does not adjust and reduce the bed numbers so whilst this is saying it is at 49 per cent, it is probably about 60 or 70 per cent of the beds that are available. For Rosebery for the period until the model changed it was 37 per cent; at Esperance it is 48 per cent; for the beds that we contract with Huon Eldercare it is 88 per cent; at New Norfolk District hospital it is 46 per cent; for the beds that are at Ouse it is 70 per cent; for the beds that are at the May Shaw which is contract with May Shaw Inc at Swansea it is 84 per cent; at Midlands which is Oatlands it was 84 per cent and for Tasman it was 40 per cent - averaging that out it cost the State at 60.9 per cent for that period.

If we then look at those facilities where we have aged care beds - for the high care beds at Scottsdale and there is 29 of those it was a 95 per cent occupancy; for Flinders Island there are five high care beds it is 100 per cent; for King Island with eight high care it is 79 per cent; Smithton until they transfer to Emerton Park and that occurred in March it was 97 per cent; Queenstown it was 94 per cent; Oatlands it is 97 per cent; for the low care beds we have four of those at Flinders - it is 100 per cent; King Island there are six low care 91 per cent; Queenstown

eight low care 99 per cent; Oatlands there are nine low care - it is 89 per cent; for the multipurpose services at Beaconsfield there are 18 flexible aged care beds it is 91 per cent. At Campbelltown where there are 20 flexible beds it is 85 per cent. Again, the occupancy in these facilities obviously depends on demand. Particularly when you are talking about the in-patient beds we do everything we can to keep people cared for in their own home; admission to the hospital is the last thing that we would want to do.

Ms FORREST - So, not having all those figures in my head, but some I have written down, St Marys having 34 per cent occupancy, was a hospital that was under consideration last year and the subject of some discussion about its long-term viability, particularly with the changes that were made to Ouse and Rosebery. Is St Marys likely to be targeted for change?

Ms LEEDHAM - What I would say is, in line with all of the rural health facilities, what we need to do is to ensure that they are sustainable from a staffing perspective, from a quality and safety perspective and if there are issues that arise in any of those sites then they will be considered according to the quality and safety providing services.

Ms GIDDINGS - Yes, which is in line. At the moment there are no plans to do anything at St Marys Hospital. We have completed the service changes that we planned to do. We are going through the process with Ouse. We have not completed Ouse. We have the independent review happening right now and I have said publicly that we will abide by the outcomes of that independent review. So I am waiting to hear what it tells me that we should be doing at Ouse, at Rosebery -

Ms FORREST - When do we expect that?

Ms GIDDINGS - I believe that the steering committee are hoping to get a report by the end of this month and that is a draft report. They get an opportunity to work with a consultant on anything that might be factually wrong in the report. So they will talk; all three members of the steering committee, which is the council of the Commonwealth and the State, will work with the consultant over that report and then it will be a couple of weeks down the track from that point that it would then be released publicly to everybody and we will then move forward with Ouse from that point.

Rosebery, the model has been developed now in conjunction with the community and I understand that the community are very comfortable with the model that we have progressed there with them through a lot of negotiation and time, especially time spent even by the secretary, are working with that community.

St Marys and any other centre, there are no plans to change models with any other rural centre. But those issues in the health plan are there for a reason, the sustainability issues, the quality and safety issues that Pip outlined.

I think what is really important is that communities do not just put their head in the sand and hope that all of this goes away, but through their medical advisory groups and the like, and St Marys has one, they work closely with us on the issues around retention and attraction of GPs, for instance, and retention and attraction of nurses, so that we are not depending on locum staff to provide the nursing or medical. They should work with us around what are the appropriate services for their community as well. It is about working with communities - this is what you have currently and this is what you are missing out on. If you work with us and get these

additional services you are also going to have to work with us on what you do not now need as a community. That is going to be a process of negotiation and discussions with communities wherever they may be, forward into the future, around sustainable health services.

Ms FORREST - Have the respite beds at Rosebery been used and how often and for how long have they been used?

Ms LEEDHAM - I do not think they have been accessed. There has not been a need because one of the benefits that has come out of the Rosebery model is the additional services that have gone into the community, particularly the additional community nursing services.

Ms FORREST - Under the Infrastructure Fund there is $500 000 for minor works for the implementation of a primary health plan. What are the minor works for the implementation of the plan referring to here?

Ms GIDDINGS - That is in the capital funds?

Ms FORREST - Yes.

Ms GIDDINGS - There is a lot of the work around the health centres that falls into that category.

Ms LEEDHAM - There is some work that needs to be done at Rosebery to prepare for stage 2. I cannot remember what that is and there is some other signage and some minor works that we need to do at some of the sites around access to some clinical services, access to visiting specialist services and even where we need to do some work around GP services in some of the centres.

[3.30 p.m.]

Ms FORREST - The patient transport services review, where is that at and when can we expect some direction in that?

Ms GIDDINGS - Catherine can talk to that one, but it is not far away, as I understand it.

Ms KATZ - We are expecting a draft of the patient transport review by the end of this month.

Ms GIDDINGS - So we are expecting a draft of the review by the end of this month. We have engaged a consultant to assist us through that process as well.

Ms FORREST - Will it be released at that time for public comment?

Ms GIDDINGS - No, it will not necessarily be released at that time. It has to come to Government as yet, and I have not at this point in time actually seen it.

Ms KATZ - It is the draft that will be made available at the end of the month to the minister.

Ms GIDDINGS - But it is progressing.

2.2 Oral health services -

Mr MARTIN - A lot of good news in oral health with this funding. I have a couple of queries. You mentioned early this morning about the difficulty in finding dentists. Can you update the committee on the current work force distribution throughout the State, on any current shortfalls in recruiting and what you are doing about it? I think you mentioned the Adelaide University. I would be interested in some figures.

Ms BLACKWOOD - In terms of the dentists that we have got, we have got a total statewide FTE of 19.3, which is nine dentists in the south, 7.7 in the north and 2.6 in the north-west.

Mr MARTIN - What was it compared to before the additional resources?

Ms BLACKWOOD - Under the additional resources, we recruited seven new dentists under the Better Dental Care package. They came to us through the public sector dental work force scheme. Of those we had two in the south, four in the north-west - two have just recently started in Burnie of that group - and the remaining three in Launceston. So the recruitment package was very successful in fact.

Mr MARTIN - Is there more to recruit? Do you still have vacancies to recruit?

Ms BLACKWOOD - No, there are no more.

Mr MARTIN - They are all filled?

Ms BLACKWOOD - No, I am sorry, that is not right. Under the Commonwealth dental health package we are expecting to be able to recruit more and we are starting the process of doing that.

Mr MARTIN - How many more?

Ms BLACKWOOD - Probably three more dentists. We have started initiating the sort of selection and interview process and everything to get people. Potentially one more for Devonport and two for the south - that is dentists. We also have dental therapists, dental attendants and the other staff that go with the prosthetists, people who make dentures and all of that.

Mr MARTIN - The performance indicators for children's occasions of service - I do not quite understand what is going on there. There have been just over 70 000 occasions of service in each of the last three years but the target has dropped to 60 800 for next year. Can you explain why?

Ms BLACKWOOD - Yes. The issue here is around the capacity to retain an ageing work force. The children's services are predominantly undertaken by the dental therapists - it is the old school dental service - and dental therapists, like much of the work force but unlike the dentists for different reasons, are an ageing work force. They are a work force which is subject to a certain amount of injury due to the nature of the work with the bending, stretching and all of that.

Ms FORREST - And chasing the kids around.

Ms BLACKWOOD - We do have occupational health and safety issues for dental therapists. We understand that. It is because the work force of ageing people are leaving and it is difficult to

replace them. We do not run a bachelor of oral health education in the State, and it is difficult to get graduates in an environment where the private sector can pay an awful lot more for oral hygienists than we can. But one of the major reasons is not being able to train people in the State, so the occasions of service have gone down because the number of dental therapists in the practice has gone down due to these reasons.

Mr MARTIN - So that means the kids are not getting their teeth checked?

Ms BLACKWOOD - Kids are not getting their teeth checked to the extent that they were in the last financial year. It has dropped.

Mr MARTIN - Are there any plans to try to improve that?

Ms BLACKWOOD - Yes, there certainly are.

Ms GIDDINGS - We are trying to recruit.

Ms BLACKWOOD - We are trying to recruit; we are offering scholarships to the bachelor of oral health; and we are doing a sort of major recruitment campaign for dental therapists. It is an Australia-wide problem. We could look at providing the occasions of service through dentists themselves, but there are already twice as many dental therapists as dentists. Although dentists are a better resource and we have recruited to that resource, they are still a pretty scarce resource too.

Mr MARTIN - So obviously from your projected target you are not confident of recruiting too quickly?

Ms BLACKWOOD - The projected target for recruiting dentists?

Mr MARTIN - No, the occasions of service. It is a fairly big drop to project from 70 000-odd down to 60 000.

Ms BLACKWOOD - I know, and it is a major area of concern for us. I could say that I was confident that we would recruit, but it is more probably optimistic - short of confident - because I think it is a difficult problem across all of Australia. We are going to be mounting recruitment campaigns within the universities trying to attract people. We have three people with a scholarship to the bachelor of oral health at the moment - two people are currently undertaking it and one deferred - and we are hopeful that they will come back and work for us in Tasmania.

Mr MARTIN - So hopefully next year we will see the target back up to 70 000 or so.

Ms BLACKWOOD - I do hope so, yes.

Mr MARTIN - Good news for the general waiting lists, a huge drop there, but a huge increase in the dentures waiting list. Can you just explain that?

Ms BLACKWOOD - The reason for this is that when you manage to provide general care occasions of service for people, one in every three courses of care results in the requirement for a denture. So as you move through your waiting list for general care and you get the dental work done, then that creates a sort of unbalanced demand for the dentures.

Mr MARTIN - So is this a time-lag problem?

Ms BLACKWOOD - Well, it is just that if you do more dental work you generate a disproportionate amount of need for more dentures. It is not a direct relationship, and particularly in Tasmania where you have 46 per cent of the population over 65 are in dentures and have no teeth.

Mr MARTIN - It's a huge problem.

Ms GIDDINGS - It is. But having said that, it gets down again to is the waiting list the best indicator or is the actual occasions of service a better indicator or the waiting times, and those sorts of things. What we can say is that there have been more dentures provided in the last few years. In 2005-06 we provided 3 365 occasions of service, and now this year to the end of March, it is 5 863. That is quite a significant jump, and in fact our activities increased by 98 per cent compared to the same period, July to March, of last financial year. So as Mary said, it is an example of the more general care work you are doing, the more people who end up requiring dentures. We are in fact providing more dentures than we have for many years, but it is not keeping up.

Mr MARTIN - It is a good problem to have.

Ms GIDDINGS - It is a good problem to have, as you say, but it is still a challenge.

Mr MARTIN - But they will be able to get their dentures eventually.

Ms GIDDINGS - Well, we would certainly hope so.

Mr MARTIN - I agree with you about the waiting list. Are there no performance benchmarks on the waiting times?

Ms GIDDINGS - On the waiting times for oral health? I am not sure -

Mr MARTIN - Whether they should be better indicated and put in the budget.

Ms GIDDINGS - Waiting lists are not a great indicator.

Mr MARTIN - No, but waiting times, as you say, is what should be in there.

Ms BLACKWOOD - Waiting time is a much better indicator. Across Australia there is a lot of discussion about how you would measure that. Is it the waiting time for an emergency appointment, which in our system is within the day you will be seen if you are emergency, within two days if you are a priority one and within six weeks if you are priority two? Otherwise you go on the general care waiting list. These are people for whom there is no great hurry for their treatment and that is the general care waiting list. Our length of waiting time is about two years. In other states it is two and a half years. In the Northern Territory it is four years. We are working on a national way of counting this sensibly and it will be much better.

Mr MARTIN - It is a long time to wait.

Ms GIDDINGS - Some of us avoid our dentists for that length of time for general care. Not that I should be saying that.

CHAIR - I will say, Minister, if you provided those minties to every person in Tasmania there would be a lot more dentures needed, I can tell you. They are as hard as a goat's head.

2.3 Population health services -

Ms FORREST - Just a couple of issues I would like to look at in this area. As the Chair raised earlier on today about the obesity issue and that being the major challenge, has there been any serious consideration given to banning junk food in Tasmania and restricting sales in school canteens - which is a crossover to education, I appreciate - of all the green traffic light foods.

Ms GIDDINGS - If you are talking about banning junk food holus-bolus, no that is not being discussed and junk food will unfortunately be part of the Australian community I am sure.

Ms FORREST - Not banning the food, banning advertising.

Ms GIDDINGS - Okay, I did not hear you say advertising.

Ms FORREST - I mean advertising - sorry.

Ms GIDDINGS - Banning junk food advertising has been and is continually debated at the national level because advertising is in fact something that would have to be done at the national level, similar to smoking, alcohol, anything else in advertising. We have not come to the point of actually banning ads but it has been a bit more of a self-regulatory system that has been in place nationally where TV advertisers have undertaken not to advertise in children's peak hour viewing times certain products, the junk food aspects. We are continuing to have that discussion and trying to tighten up that self-regulation and looking at potentially regulating if we do not see enough progress on that; I am sure that that debate will continue.

The other aspect. You asked about the green traffic light food in canteens. We are currently also debating that issue at the Health minister level and the food minister level. In fact the last meeting that I was at we had examples put to us of what the traffic lights would look like against what other information you could provide on the front of food products. Not surprisingly the blander version is the version that industry would like to see and the traffic lights version is certainly what a number of us Health ministers would like to move towards. It has been particularly pushed by John Hill from South Australia but my personal preference was the traffic lights, as well, because it is a much clearer, very quick indication to a consumer as to the benefit or the risk of eating a certain product. But because, again, it takes national agreement we have not quite got there yet to introduce a traffic light model.

[3.45 p.m.]

Dr TAYLOR - The additional point about traffic light labelling is that there is research coming out of Britain because they have been implementing the system for a while and then Government failed to evaluate the effectiveness. So nationally, if people are waiting on the results later this year, we hope to have some more information to take to the food regulation ministerial council.

Ms GIDDINGS - It is always evidence-based, so our gut reactions around the table did not actually carry much weight - so to speak. Most of us I think were much in favour of the traffic light model but we need to get the evidence to back it up before we are able to mount that case with industry to take on that additional cost it will be to them.

With the schools element, we have some programs that Roscoe can talk about it that we take into schools. We do raise the canteens with the education department periodically - concerns around junk food being sold in canteens; it gets down, as I understand it, to the individual schools as to the policies that they have but it is very much a self-management issue with schools nowadays and if they choose to have a policy of less junk food then that is how it is, but if they choose to have more that is the school community's choice.

Ms FORREST - It is mostly parent-driven.

Ms GIDDINGS - It is mostly in that sense, I believe, parent-driven but we -

Dr TAYLOR - There is a Cool Cap accreditation program that -

Ms GIDDINGS - Maybe if you were to talk about the program, Roscoe, and say what we are doing.

Dr TAYLOR - There is a Cool Cap or Cool Canteen accreditation program at school canteens. It has been running for some years in Tasmania. It has been a hard slog. We have probably accessed about half of the schools and a couple of them are on the gold standard of accreditation a few in the silver and more in the bronze of what they sell. A gold standard school is selling healthy foods only. It takes a lot of commitment from the school, parents and the community and in particular community to change a habit. It is a slow process. It does have the benefit of longevity if you get the collaboration in the beginning, so it is a voluntary thing but it is a harder row to hoe than it would be if a more mandatory approach brought in.

Ms FORREST - One of my absolute pet areas is smoking and drinking in pregnancy. What are we doing or what are we going to do to warn people. I would like to see an advertising campaign that says, 'If you drink during your pregnancy the baby can acquire a permanent irreversible brain injury'. There is a lot of intelligent people out there who do not know that and I think that is so important that we tell people that you get one chance to control a child's environment to some degree. It has huge implications on our health system, on our education system and ultimately our justice systems from these children and I would like to see some really major attention here. I would like to know what the Government is going to do.

Ms GIDDINGS - We have been able to put forward $2.7 million for smoking cessation programs in this year's Budget. We are working with pregnant women through the hospitals currently with Quit Tasmania and I expect that we are going to be doing more of that around the harms of smoking while pregnant. Certainly the issue of children ending up with foetal alcohol syndrome is of real concern to us as well in fact I think that has been raised at the national level for addressing. Again perhaps, Roscoe, you want to talk about what the smoking cessation funding will help to do.

Dr TAYLOR - Recently the Commonwealth Government's funded midwife employed by Quit to work with each of the public hospital antenatal clinics was rolled out to Burnie as a second step not so long ago. That has actually generated already a very high level of interest from the

midwives. They have already been requesting large numbers of Quit packs for their clients and that apparently has topped the other States' response. So that particular midwife working with those other midwives is doing very well right at this moment. So that is a plus.

In relation to alcohol there is a definite need not only on alcohol interventions to do things for the whole community but to target women in pregnancy. It is our hope through the new measures that are being brought in by performance driven responses inside the department, driven by our secretary. We will be able to put in place in every antenatal clinic encounter, especially the first one, the question - when was your last drink?

Ms FORREST - The problem is the damage is down in that first couple of weeks or months. We really have to get the advertising out there to say don't do it. Alcohol is responsible for a lot of pregnancies, I understand as well, so if it was not for alcohol some of them would not even be pregnant. It is a problem that is not going to go away easily. We need to not just target the antenatal clinics and places like that; it is not to late but you are missing the boat.

Ms GIDDINGS - That is certainly true and there is no doubt that there is more that we could be doing as well. There has been a general understanding across the broader community, and it tends to be a socioeconomic group issue largely. More broadly, understanding of the damage that alcohol can do across the community is understood. However, for some groups within the community it is not at all. That is where that hands-on approach that we are doing with smoking cessation and foetal alcohol syndrome is actually very important.

We can look at the issue as well within the development of the alcohol action plan and see how we might be able to address it within that. That is something that I just recently announced that we are going to be developing. That would also look at issues around labelling on bottles of alcohol to say, 'Be aware that drinking this product while pregnant could harm your baby' - similar to what is on cigarette packages. A blanket advertising campaign is one element of what you can do but we are certainly looking at what else you can do on the one-on-one, labelling and other elements.

Ms FORREST - I look forward to that. One other area was identified in the recent state of the public health and the health indicators report - the rise of chlamydia and the need for a more comprehensive approach to screening. Are the government planning to introduce any broadening of screening, particularly for the younger population?

Dr TAYLOR - Tasmania, at this point, does not have a plan to introduce a broad population prevalence study of chlamydia. We have been lobbying for some time for the National Government to take a national approach to the issue and introduce one really large prevalence study so then we know where our target groups are.

We know the age bracket but sometimes it is within that we need to work. We are particularly concerned about young men having the disease and not realising it. Women are more likely to get tested because they are turning up at the GP for contraceptive advice. We have been working on a process to explore self-testing from the purchase of kits from pharmacies as well as a more discreet approach for some people in that age bracket who might prefer it.

Ms FORREST - When they buy their packet of condoms they get their chlamydia screening test at the same time.

Dr TAYLOR - The danger would be if they tested negative and then threw away the condoms because they thought that they were clear of an STI.

Ms FORREST - Hopefully the condoms are there for contraception as prevention of STIs.

Dr TAYLOR - It is an area that needs a lot more work.

Ms FORREST - Can you provide the details of the people within the cancer network?

Ms GIDDINGS - The chair is Professor Ray Lowenthal but we will have to get back to you with the other names.

CHAIR - Now and again pesticide residues are detected in Tasmanian waterways. As I understand, most of the levels are below the national drinking water guidelines. Could we table or take on notice a list of those that have not been detected. Furthermore - maybe it is a question for Dr Taylor - does he have any concerns in this regard?

Dr TAYLOR - There is a quarterly monitoring program plus some of the monitoring stations have flood-triggered monitoring, which is a high-risk period, for the detection of pesticides. There have been sporadic detections in the Coal River, the George River, the Great Forester, the Jordan, Macquarie and Montague rivers. Of those river systems, the George and Macquarie are catchments that provide water for public drinking water supplies. In all of the cases the levels of pesticides were found to be well below health guideline values, but the approach that is being taken is that there are two sets of values in the Australian Drinking Water Guidelines. The second and lowest one is what is called a straight guideline value. The detection of that is set at around the limits of laboratory capacity to detect. A detection is not ignored; it is still looked into to see if there was a preventable or identifiable source upstream.

The two incidences where drinking water supplies in Tasmania have been effected most significantly have related to simazine detection: in 2004 to 2005 in the township of Orford from the Prosser River, and last year in the township of Ross from the Macquarie River. In both cases the simazine persisted for some months following a run-off from operations in the catchments. That is the summary of it. If you need more data we can -

CHAIR - If you could provide it, please. Just quickly on the simazine or the triazine group of chemicals, not only is it used extensively in forestry but it is used very extensively in agriculture. I think there has been a nine-year or 15-year study recently in Victoria which showed no links with cancer. Have you seen that study?

Dr TAYLOR - I do not think I have seen that particular study from Victoria looking at cancer outcomes. Simazine and atrazine are not really regarded as human carcinogens any more. There was a stage when they thought the evidence looked that way but subsequent review showed that not to be the case. Cancer as a health outcome from simazine and atrazine, especially at these low levels, is extremely unlikely from a public health perspective.

2.4 Mental health services -

Mr MARTIN - Would you be in a position to give an assurance to community service organisations that are currently involved in the profession of disability services, ones which meet the government standards of service provision, quality assurance and funding guidelines?

Ms GIDDINGS - Disabilities or mental health?

Mr MARTIN - Mental health so far as I know.

Ms GIDDINGS - You just mentioned disabilities, that is all.

Mr MARTIN - Mental health services, sorry.

Ms GIDDINGS - It is okay. I was just thinking we were in the wrong output group if we were talking about disabilities.

[4.00 p.m.]

Mr MARTIN - They want assurance that the contracts will not be terminated or not renewed under the new arrangement?

Ms GIDDINGS - I think that is Disability Services with the reforms. I am happy to answer that for you when we come to disability.

CHAIR - This is an issue I had wanted to raise and it relates to Ward 1E at the LGH. On 14 April 2005 the previous minister, Mr Llewellyn, said and he was referring to, I think, three nurses and I quote:

> 'I understand these nurses have claims against the department and I have instructed the department to settle those claims.'

That is what he said. My information is that three years later these whistle-blowers in inverted commas continue to have an outstanding claim -

Ms GIDDINGS - There is one that has been outstanding.

CHAIR - Yes, one has received a limited small settlement, apparently.

Ms GIDDINGS - One has settled with us and the other one has chosen not to settle with us. I understand there has been other legal action now being taken by both of those people. That is now in the hands of our lawyers again and the court system, so there is nothing more that I can provide that I have not provided to the committee in previous years on that issue of the whistle-blowers. Effectively, it is out of our control. We made offers that were appropriate according to the legal advice that we are provided with and if those offers are not accepted and, in that case, one did accept our offer and the other one chose not to, that is their right not to do that. But that is their right to then delay the process longer and their right to go through other legal avenues to have their concerns resolved. I do not think that is a reflection on the department. I do not think that is a reflection on the Government. I think it is just a reflection of individuals choosing to use the legal avenues available to them.

CHAIR - I accept your answer and I will make the point that I think there has been an enormous amount of stress within those particular families. It has been very difficult and I would urge that yourself and the department try to settle the matter as soon as you possibly can.

Ms GIDDINGS - We have always aimed to settle the fair outcome and I always think legal action should be the very last resort because I have seen people's lives destroyed by legal action because it drags on and on; very few people come through the legal process feeling victors. I have constituents of my own who have been through the legal process and have been really destroyed by and become very bitter by it. I was hopeful that we would have been able to settle both cases. But, as I said, it is the right of the individual to use any legal avenue available to them and that individual and at least one other have now decided to initiate other legal action in relation to those events. So we just have to work through that now.

Ms FORREST - Can you give me a time frame for the Mental Health Act review, when we can expect to see it before the Parliament?

Ms GIDDINGS - Yes. Legislation came through the Legislative Council to extend the time frame on the Mental Health Act and we now expect that it will be operational in January 2010. We are hoping to get it through Parliament in that latter half of 2009.

Ms FORREST - Has there been any progress on the north-west coast in advancing psychogeriatric services?

Mr CRAWSHAW - We already have, as you may well be aware, a community-based outpatient and older persons community health service, and have had visiting doctors providing a service to the north-west. That team seems to be functioning very effectively. I am aware of other pressures in the north-west, and we are still working through how to deal with them.

Ms FORREST - There is no suggestion at this stage of a Roy Fagan-type centre, on a smaller scale, obviously, for the north-west?

Ms GIDDINGS - The Roy Fagan Centre is a specialist centre, one for the whole State. I am able, however, to say that we have been successful in recruiting two psycho-geriatricians on the north-west coast. The secretary has also established a working group in the north-west, chaired by the CEO of the North West Regional Hospital, with membership from Mental Health Services and the Division of General Practice to undertake a needs analysis for older persons with dementia and behaviour management problems.

Ms FORREST - The new Umina Park facility will assist now for dementia.

Ms GIDDINGS - I expect that working group will look through those issues as well.

I should just clarify that because I did not read the whole dot point for you. Around the two psycho-geriatricians, both of those consultants are located in the south of the State, but provide regular support and services to the north-west. I need to clarify it.

Ms FORREST - So the truth comes out after all. I was going to go and find them on the north-west.

Mr WILKINSON - I note there has been an increase, and there is going to be an added increase up to 2011-12 in relation to this line item, and it talks about drug, alcohol and smoking reforms. Can you give us a brief overview, because I know time is not on our side, in relation to what reforms are expected to cover that increase in costs?

Ms GIDDINGS - I will give you just a general overview first, but then I think Dr Crawshaw can give you a much better understanding and detail around it. I am really pleased that we have been able to invest some $17 million into alcohol, tobacco and other drug services over the next four years in this Budget, and more than half of that will go to the non-government sector. About $9.45 million over the four years will go to the NGO sector.

From my perspective, a lot of the social problems that we have in child and families leading to some mental health illnesses, or other issues, are actually related to drug and alcohol problems. So to have this investment, to me underpins a lot of the reforms that we are driving, and other aspects of my department as well. The specific initiatives around that include a completion of the future directions plan for alcohol, tobacco and other drugs sector, in conjunction with the government and non-government services; improved access to treatment for clients: we expect 50 additional admissions to the specialist withdrawal management unit within this year; improvements to the quality of life and reduction of the risks for people with addiction issues by providing access for an additional 100 clients to the statewide opioid substitution program; specialist training and support for acute care staff, general practitioners and community-based pharmacists to improve the delivery of care and support to people with addiction issues; increased home-based programs that support and rehabilitate people to assist their return to a drug-free lifestyle; a specialist support program to prevent people with drug dependence returning to a harmful drug use lifestyle following treatment; investment in the long-term development of a specialist workforce through the establishment of a medical registrar; a graduate nurse program within the alcohol and drug service; and finally, improved access to specialist support for young people with drug abuse issues by recruiting additional staff with clinical expertise in working with this client group.

Mr WILKINSON - Okay. Drugs, without a doubt, in the last 30 years have escalated quite markedly in the court system, and the majority of people - 80 per cent, I think it is - are there as a result of a drug or alcohol addiction. What are the new reforms in relation to drug and alcohol treatment that hopefully will see a marked improvement in drugs and alcohol in the community?

Mr CRAWSHAW - The first part to be said is that while there is a lot of focus on drugs, alcohol is by far the more damaging and represents greater morbidity - and mortality for that - matter to the population. In terms of the additional funding that we have been granted, it is about initially building up our pharmacotherapy program and our specialist workforce. In particular we are hoping to be able to attract an additional addiction medicine specialist into the north-west, and if we cannot get them to the north-west, at least to the north so we can actually cover the north-west in a more appropriate fashion and develop the expertise with our general practitioner and acute medical colleagues.

We have to find a magnifier effect. We have to educate. We have already started to develop education programs within the University of Tasmania so that we can get to the doctors before they get out into the population. We have been in the process of revamping our pharmacotherapy policy and protocols so that we can decrease the risks associated with that in the population.

There are newer drugs which are becoming available in the tobacco area which will assist us. Especially in the pharmacotherapy area we are introducing a bupremorphine gateway model, which is a much safer mechanism to get people on to opioid pharmacotherapy. With respect to the issues around psychostimulants, there is yet a lack of good scientific data that would suggest there are any long-term pharmacotherapy effects for that and that counselling and other forms need to be used.

Part of the overall alcohol, tobacco and other drugs strategic focus is to develop more of an early intervention framework so that we are not just sitting as the ambulance at the bottom of the cliff, we are actually moving earlier up the chain. This is part of the reason why we are allocating more of the money towards to the NGO sectors, because they have a capacity to reach different target groups than just the high end state service provision.

Mr WILKINSON - Is there anything being done within schools that you are going to focus upon, because it seems you have got an audience there - an audience which is probably the biggest audience that we are ever going to get?

Mr CRAWSHAW - There are unfortunately two answers to that. There has been some debate internationally, not just within our State, as to what is the appropriate mechanism to get into schools. Some of the programs which have been tried in schools unfortunately have been shown to have a perverse effect and that they increase rather than decrease experimentation with drugs. We do fund some liaison person with education to assist them to trial programs in the schools. We also fund the Drug Education Network in the north of the State.

The problem really hinges around what is the best evidence-based practice to try to alleviate the introduction of children to drugs. Part of our strategy is to develop our youth component of our alcohol and drug treatment network across the State. That is why this year we brought an additional worker in the north and in the south as additional expertise within the State service, and we intend to expand the youth component of the total services, not just the State service. I have to caution from my reading that there is some debate as to just what should be done with the education within schools. Development of resilience and teaching other forms of more general public health or public mental health interventions is probably as effective as specifically targeted drug education.

Mr WILKINSON - If we wanted to go to any country in the world or State in Australia and say, 'This is the system we want to follow,' where would you go?

Mr CRAWSHAW - There are different countries -

Mr WILKINSON - As a resource -

[4.15 p.m.]

Mr CRAWSHAW - It is equally a question that this is a newly developing area and there are some very good systems that we would like to cherry-pick, as it were, from different States. We are fortunate in that we have a clinical director who has a very good linkage with a research base which is occurring within Australia and is well in touch with what is happening internationally. So rather than holus-bolus pick up one service component, our preference would be to learn from what is best. Part of what we will be moving forward with in July is doing a series of workshops with practitioners in the State to try to develop best models of practice for some of the service elements.

Mr WILKINSON - Final question, you have a magic wand and you are just about to wave it, what would you require for this system if you could wave that magic wand? And do not say more money because I suppose that is consistent with a lot of it.

Mr CRAWSHAW - I think the minister has granted me what my magic wand wanted. We have a sustainable funding base now to move forward. Our real issue will be to develop the service models and then to attract skilled staff to the State to be able to put it in place. I believe that we have now the basis to move forward.

I have to say that I would ask for some patience, because we will have to build up staffing both in the NGO sector as well as in the State sector. It took us six months last year to get a specialist on board from the UK and some nine months to get the youth specialist positions in place, and this is simply because we are competing for a very limited resource, Australasian and international.

Mr MARTIN - Back in 2003 the Glenorchy City Council - great mayor -

Ms GIDDINGS - You were the mayor then?

Mr MARTIN - I was the third mayor but still continue to be a good man. The council and the State produced a report entitled 'Services for young people from birth to 24 with mental health and/or drug and alcohol issues'. The report made a number of recommendations for increased services in the Glenorchy local government area but no action has taken place in relation to the recommendations. It is a report that came out of the partnership agreement, but nothing has happened. As a result of that, many of the young people in the target group are now in the cycle of homelessness because of the drug and alcohol issues and mental health issues. Is there any strategies that the Government could look at in relation to the recommendations of the report?

Mr CRAWSHAW - I am aware of the particular recommendations that you are mentioning. Unfortunately, for us to have done any implementation at that stage meant that I would have had to have diverted all of my youth support service into Glenorchy.

Mr MARTIN - Well, I am all for that.

Ms GIDDINGS - Your colleagues might not have liked it, the then mayor.

Mr CRAWSHAW - Part of the reason why we have given such high profile in the ATODS review to developing services for youth is to start to target these services in a more concerted fashion right across the State. We are well aware that youth with alcohol and drug problems feature quite heavily not only in homelessness but also in other areas of disadvantage in the State. They are a source of concern for Youth Justice and Child Protection. We have quite deliberately given this a very high profile within the ATODS review. That is why we started to bring on a resource last year to start address it and move it further forward.

The issue with youth is that they tend to prefer to go to things that are not labelled drug and alcohol but are labelled something else so that they are not seen as being stigmatised. We are trying to work with other agencies to try to increase that. While we have not forgotten the recommendations that were made within that report, our concern has been to develop a process which we could deliver equitably across the State, and that is what we have been focusing on doing.

Mr MARTIN - Okay. I cannot remember the specific recommendations in the report but is what you are doing based on those recommendations?

Mr CRAWSHAW - What we are trying to do is to develop youth targeted services. My recollection of that report was that it was wanting a particular youth worker to be supplied by the State working with alcohol and drugs in Glenorchy. As I say, that would have meant that I would have had to divert a scarce resource at that time into one council area when I knew that I had problems in other council areas as well. We had been trying to increase our specialist resource then support NGO who can provide additional services.

Ms GIDDINGS - The connection to homelessness is also something I think that we will talk about when we come to housing and the common ground model and why that intensive model has some attraction to supporting homeless people with addiction and other issues.

Mr CRAWSHAW - Part of the draft plan that we are working on and are going to discuss with the sector is how we provide improved service for youth and early intervention services and with the additional money that gives us the chance to work quite concertedly on that.

The committee suspended from 4.23 p.m. to 4.38 p.m.

Ms GIDDINGS - I will table the FTE head count on the resignations of staff. Medical practitioners is what the request was for. The information we provided you was for the permanent medical practitioners because I believe that is what Mr Wilkinson was wanting to know

I will give you this information but interestingly in acute health services at the LGH there has only been two and at the Royal there has been three. There is not very many. That is over 2007-08. So we will table that for your benefit but there are not many.

The other issue that I was asked to provide some information on was the Cancer Network. What we have is the advisory committee that has been established to get the Cancer Network operating. Effectively, anyone involved in cancer becomes part of the network should they want to participate in it. That is how networks operate but for this advisory group Professor Ray Lowenthal is the chair. Other members are Dr Rob Brodribb, Dr Stan Gauden, Carl Castellino, Marianne Hercus, Maureen Ramsden, Dr Lee Gruner, Dr John Menzies, Pauline Denton, Michael Beamish, Virginia Dauney, Catherine Austen, Gail Raw, Anne Correy, Dr Paul Dunne, Celia Taylor, John Oakley, Karen Forster, Kim Gabriel, David Gardiner, Nick Harkness, Ian Byard and Deidre Tuck.

Output group 3
Human Services

3.1 Children and Family Services -

Mr MARTIN - Minister, there is a $6 million injection into child protection; can you explain what it is going to be used for?

Ms JACOB - I assume the $6 million you are talking about is the $6 million for out of home care? That is where the $6 million is.

Mr MARTIN - It is all in -

Ms JACOB - There is a lot of money that is going into children and families, $6 million into out of home care and an extra $35.5 million into family support services. That is quite a big combined budget of new initiatives in children and family.

Mr MARTIN - Can you just give me a brief overview of how that is being spent?

Ms JACOB - Well, a big briefing would probably be more appropriate, but in five minutes. The $6 million for out of home care is going to extend the range of out of home care on types of service that we can provide, particularly increasing the number of kids who go into kinship care - who are placed with their family member. But also to provide more therapeutic foster care and therapeutic options for children in care who have various behavioural and psychological problems.

Mr MARTIN - So more staff?

Ms JACOB - More staff, more services, more support. For example, we are going to be providing an extra $10 a week for foster carers. That is one of the provisions. There are a whole range of services allowances, staffing provisions and some of that will be contracted to the non-government sector over a period of time. but it will be one of the reforms that we are going to bring in over the next three years.

Mr MARTIN - Has this been documented?

Ms JACOB - Absolutely, it is all on the web site and there are action plans; if you have a look at the web site there is a detailed action plan for children in care that details every action that we are going to do over the next three years and there are similar documents for family support.

Ms GIDDINGS - Have you seen the action plan?

Mr MARTIN - No, I have not.

Ms GIDDINGS - I am happy to table the action plan for you. And there is another one for family support services as well.

Mr MARTIN - Some of the other question I have might be answered by that so I will run through them. Do you have any plans to do an advertising campaign to encourage the community to be more involved in child protection so that we do not have a similar situation to what has occurred interstate in relation to the death of the two young children - a community awareness campaign?

Mr BYRNE - There are discussions on a national level. You might be aware of a national child protection framework that the Federal Government is trying to establish in partnership with state governments. They are looking for right type of advertising, because we do not want an advertising that is like the grim reaper-type adverts; it is more about how can we all contribute and work together to effect child protection. We are actually in discussion in the context of that. We are hoping also to publicise the kind of new directions and the reform that is going to build broad support across the sector for some of the changes that we are trying to do.

Mr MARTIN - So the time frame for action at the national level?

Mr BYRNE - The national child protection framework is going to be released by the Federal Government, I think around October-November this year. It is out for consultation at the moment.

Mr MARTIN - I understand that Foster Carers Tasmania are amongst the lowest paid Australians in regards to the reimbursements for looking after a child. I was incredulous about the $10 increase. Does that come up to reasonable standards?

Mr BYRNE - It is true that on the base funding, foster carers in Tasmania appear to receive the lowest rate in the nation but the average cost of the foster care package was $18 000 which is a direct reimbursement to the care giver. There is a funding methodology which means that you start from the base depending on the needs of the kids involved and then you build that up. The real figure is $18 000 rather than the often quoted figure of about $7 500 as being the foster carer payment. It is actually significantly higher than that.

Mr MARTIN - I have good friends who are foster carers and the recompense that they get is nowhere near adequate for the dedication and passion and the work that they do. I do not think you could adequately compensate them but it just seems so exceptionally low. With the $10 increase does that lift them up towards national standard?

Mr BYRNE - The actual real figure of what is given to them is already at the national standard. It is just on that base funding that they appear to be low but I can make available funding methodology if you like so that you can see the way it is built up. It is based on the demands of foster caring due to the needs of the children they are caring for.

Mr MARTIN - I would not mind that information.

Mr BYRNE - It is publicly available.

Ms GIDDINGS - That's fine. We are able to get that for you.

Ms JACOB - I was just going to say it is part of the reform with the new models of foster care which we are calling therapeutic foster care for children who have more challenging behaviour or disabilities or extra needs. Those carers would be paid at a higher rate than the carers of children who do not have those additional challenges. So that would be built into the model as well.

Mr BYRNE - The national child protection framework is also looking at how the Australian tax office can deal with these reimbursement as well at a higher level so there is a discussion going on around that as well. There is a point where allowances become an income and we don't want to disadvantage foster carers any further than they are.

Mr MARTIN - Do you know how long it has been since the funding methodology for foster carers' main reimbursement has changed to reflect the massive increase in things like running a vehicle, groceries et cetera?

Ms JACOB - I would have to confirm it but from memory it was within the last two years that we revised the formula - I cannot remember, it certainly was within two or three years. We will have to confirm it for you.

Mr MARTIN - One of the things that I find staggering is the allowance that a foster carer gets to cover transport costs including bus fares for a 14-year-old child in care is 36 cents a day which would not take the car out of the driveway basically.

Mr BYRNE - We are aware that the transport costs have grown, that is part of the rationale behind the $10 increase to contribute to some of those problems, particularly as petrol has risen it has been more acute.

Mr MARTIN - I would have thought they would be beyond the $10.

Mr BYRNE - I think - we are in dialogue with the Foster Care Association of Tasmania on a regular basis so it will be discussed through those processes.

Mr MARTIN - Okay. The KPMG report entitled Child Protection Strategic Framework.

Ms JACOB - KPMG have done a large amount of impressive work for us and one of the things they did was produce a framework for child protection services which led us to reorganise the way we structured our services and added new work practices and many other recommendations that have been gradually implemented over the last 12 months and will continue to be over the next year or so.

Mr MARTIN - One of the major recommendations was the emphasis on early intervention strategies. Are those recommendations being implemented?

Ms JACOB - That is really the genesis of the family support service that we have just put $35 million into this year. KPMG basically provided the Government with a series of recommendations about how to do family support in a way that would allow us to intervene early with families and stop them escalating to the need for them to come into the statutory child protection system. The full amount that they estimated that we needed to put that system in place has been provided in this Budget.

Mr MARTIN - $36 million is adequate to reflect that.

Ms GIDDINGS - The other aspect to that though is even prior to our having all the reports completed we did establish that pilot out in Bridgewater-Gagebrook, the early support program which has helped to verify how you can with early intervention bring down the demand on the acute end of the system in child protection. We have now spread that program across the State and it is in line with that sort of approach that our reforms are directed. This funding is a significant amount of funding that will help to implement that. In fact the funding will now enable up to 3400 families per year to access targeted family support services - 870 in the south-west, 750 in the south-east, 970 in the north and 800 in the north-west.

Mr MARTIN - I think there has been a shortage of caseworkers in the north of the State. So in order to reduce the unallocated list, is there -

Ms GIDDINGS - The north-west particularly, that is right. The north is okay but the north-west has had a shortage and we have been supplementing that with work being done by caseworkers here in Hobart. Where there has been a requirement for face-to-face interviews I understand those workers have travelled to the north-west to undertake that work. What is

effectively paperwork that can be done off the desk is being supplemented by staff in the south to help get their unallocated list back down again.

Mr MARTIN - Do you have figures on how many foster carers you sign up each year compared to how many are leaving the system?

Ms GIDDINGS - Yes, we do. It is pretty stable in terms of the numbers in the system. There would be, each year, some coming and going.

Ms JACOB - I can tell you how many children are in foster care. I am sure that we have something.

Ms GIDDINGS - We do have that information, I am positive. We will just find that for you, Terry, if you will give a couple of minutes - maybe ask another question while someone looks for it.

Mr MARTIN - Can you tell me is the average amount of time a foster carer stays within the system? Of course leading to my question about if there are any problems with retention?

Mr BYRNE - Tasmania is very fortunate. A lot of its foster care has intakes of a high number of foster carers which in a perverse way is leading to another problem that it has an ageing foster care group as well. We are currently doing a statewide campaign to boost the attraction of foster care and trying to appeal to some more. It is a problem. I think that we have to learn from mainland States that have experienced exactly the same problem. I think Alison alluded to the therapeutic foster care, actually increasing the support available for foster carers who want to come in and do this.

Ms GIDDINGS - We do have with us the number of foster care households. As at 31 March 2007 there were 178. The same time this year in 2008 there were 172. That is relatively stable and has been.

Mr MARTIN - Do you have figures on how many come and go?

Ms GIDDINGS - Not exiting and entering. I would like to have those figures. We will probably have to try to get those for you and take that on notice.

Mr MARTIN - Could we do that?

Ms GIDDINGS - The number of foster carers entering and exiting the system.

Mr MARTIN - Over the last few years.

Ms GIDDINGS - How many? Three? Three is about as far back as is comfortable to go back through our system so that is fine.

Mr MARTIN - Also at the same time, what was the average amount of time a foster carer stays within the system?

Mr BYRNE - Yes, we can do that.

Ms GIDDINGS - You can do that as well? Okay. That is fine.

Mr MARTIN - How many children would there be that the department would like to place in foster care but you cannot because there are not enough places?

Mr BYRNE - That is a really difficult question. The answer is that not every child can go into a foster place when they are not ready. Sometimes we could say that we are working and we develop packages of care for a number of kids that are in residential care to move them into foster care, but it takes a real amount of planning and will in actually finding the right carer. That is just as important. There are no children in rostered care, for example - in residential care - that could be accommodated in foster care at the moment. It is not a question of demand.

Mr MARTIN - None at all.

Mr BYRNE - Basically those children that can be accommodated in foster care we will find a foster carer for them. We are also looking at kinship care as well. It is only the children in residential care who are being cared in rostered care that cannot be placed in foster care.

Mr MARTIN - I did a short speech in the Chamber a couple of weeks ago about grandparents raising grandchildren. I could do a great spiel on this but I won't given the time. You would be aware of the organisation, obviously. I would think there is a need for them to receive more adequate recurrent funding.

Ms GIDDINGS - We actually recognised that last year and provided them with additional funding.

Mr MARTIN - Is that recurrent?

Ms GIDDINGS - The respite contingency fund for grandparents raising grandchildren was part of our $1.2 million package launched in February 2007. There is information there in relation to the camps and things that that enables. The allocation is spread over a four-year period starting with $150 000 in 2006-07 and increasing to $350 000 per year in the three subsequent financial years. We did consult with them to determine priorities for the available funding and, as a result of those consultations, a twice-yearly lump sum payment of $364 was added to the annual funding package of relative carers. This brings the total annual package for relative allowance recipients to $1696.

We have also done work to clarify the eligibility requirements for adolescents receiving the allowance with recognition of what Australian Government assistance a young person may be eligible for. Part of the critical aspect is that generally speaking where it is blood relatives, it is actually the Commonwealth Centrelink system that provides the funding for the child. So in many respects the purpose of our funding is to recognise the important role they are playing in assisting us by looking after children that otherwise could fall into our system, but it is not actually funding to fund them to look after blood children of their family in that sense. That is what the Commonwealth would do through family allowances and so on.

Ms JACOB - If the child is actually on an order and under the guardianship of the secretary, then the kinship carer is paid exactly same allowance as any other foster carer.

Mr MARTIN - There are a lot of cases where that is not the case.

Ms JACOB - If that is not the case, then that was precisely why this funding was provided for people who are informally caring for their child but it is not a child protection issue or anything in that sense. That is where we have been really trying to provide a greater amount of support and funding. One of the aims of that reform that we talked about a little earlier is to increase the number of children who are placed in a kinship care placement, because we believe that is better for the children. We are looking at ways in which we can additionally support kinship carers.

Ms GIDDINGS - That is the fundamental point that I was trying to get to in my discussion there. Fundamentally it is the role of the family to look after children in that sense. If a child is on a care and protection order, then that role has been abrogated to the State to take on that care. But where it is a child that is not part of our formal system, ultimately it is the family who is responsible for the children of that family, and again that is where Centrelink becomes the important place for them to get the payments they should be receiving for the care of that child.

Mr MARTIN - The grandparents have 'no direct responsibility', apart from their love.

[5.00 p.m.]

Ms GIDDINGS - No, but I do understand they are eligible for payments through the Centrelink system, so that is where they would get their compensation from - not from the State system unless it is a child in care. The other point that Alison made is really critical too: We want to see more kinship care occurring and less rostered care where we have very difficult children.

Ms JACOB - Minister, it is also probably worth mentioning that, with the additional budget going into family support services, we would expect that where grandparents need extra support for their family where they are dealing with one of these children, that would be another source of support for them over the next few years.

Mr MARTIN - They could access some of that? That will be available for the next few years?

Ms JACOB - We will be increasing the numbers of general support to families available locally. If you are a grandparent who is looking after your grandchild in an informal way, we are hopeful that those family support services will add another layer of support that will be available to those grandparents.

Mr MARTIN - Terrific, that is all I have.

Ms FORREST - I have a question in relation to Child Health and Parenting Service, now called CHAPS. It used to Family and Child Health Service when I was around. Whilst I accept that visiting CHAPS is voluntary, my first question is: Why are the number of enrolled children who visit for milestone checks at six weeks, six months, 12 months, 18 months, three years, for example, not recorded in more meaningful figures than just enrolments alone? Parents can enrol but then never visit. The reason I ask is that if there was some sort of recording of how many parents actually did attend those milestone checks, we could eventually avoid situations like those unfortunate twins and their recent deaths. Do we record that information? It is certainly not in the Budget papers, but is it available?

Mr BYRNE - Yes, it is actually recorded, but the problem is extracting the data from the system that we have at the moment which makes it hard to report. We are trying to get better data and recording systems. We are looking at the kids first outcomes framework to give us some guidance on that.

Ms FORREST - Are you able to get those figures?

Mr BYRNE - We can get the figures; the figures exist. But to get them out of the database that they are in is quite difficult.

Ms JACOB - I think it would be fair to say that the information management system that we have in CHAPS is one of the ones that we are really concerned about and want to do something about. It makes it really difficult for us to be able to get the data and to monitor it in the way that we want to be able to do.

Ms FORREST - So is this one of the areas of IT that is going to be upgraded in whatever million dollars it was?

Ms JACOB - We are certainly hoping it will be part of that mix, yes. With the new child protection information management system we think there is some capacity to be able to expand that to use it for some of those wider purposes. But we conscious of the fact that we do have a deficit of good data to monitor the work of our Child Health and Parenting Service people, and that is something that we really do want to address.

Ms FORREST - Hopefully we will get those figures next year.

Ms GIDDINGS - The IT aspect has been one of the first areas we have addressed out of the 2006 report that Alison and the then Commissioner for Children, David Fanning, were involved in. So for much of last year we were involved in trying to upgrade, as best we could with the funding we had, the IT systems in child and families, but of course with the additional funding now we will be able to do a lot more. We have successfully implemented stage one of the new child protection information system as the first stage in replacing the current antiquated information system. It supports the intake and assessment functions and offers many advantages, including a single centrally-managed database to store and manage child protection information and providing statewide access to child protection information for all authorised staff. There is a stage two that we hope -

Ms JACOB - It has been funded for this year.

Ms GIDDINGS - Stage two has been funded for this year already, which builds on that. If you want more information, I can provide it to you but, if not, I will leave it at that.

Ms FORREST - One other question on that area: The figure of 51 per cent of babies attending CHAPS being exclusively breastfed is quite a disturbing figure. From my experience, the women who visit CHAPS are more likely to be breastfeeding and wanting breastfeeding advice, so it reflects the majority of the women who are breastfeeding exclusively at six weeks. Do you accept that as a pretty low level of exclusive breast-feeding and if so do you believe that action needs to be taken and what will the Government do to increase the information surrounding the importance and benefits of breast-feeding?

Ms GIDDINGS - I could not agree more that you want to see more breast-feeding occurring in the community and again it tends to be a socioeconomic issue, that the lower the group in economic status the less breast-feeding million there is which seems silly considering it is a free product rather than buying, on tap -

Ms FORREST - On tap, right temperature.

Ms GIDDINGS - That is it, everything, and it is in fact the best source of nutrition for a baby. It has actually been an issue that has been of quite some interest to me personally since I have been a health minister.

We have, as you would know, over the last couple of years had to keep a very tight rein on the health spending so every sort of preventative health promotion program I would like to have engaged in and had happen we have had to be sensible and careful around the direction we have taken on that.

As I understand it in the public system, our midwives do encourage breast-feeding and there are follow-up supports that we provide. We have been encouraging breast-feeding as well and of course we have also got that See You at Home program which has been a very successful program for first time mothers aged between 15 and 19 and again we would be providing that same advice to them about the importance of breast-feeding as well. We always have to balance comments on this against those mothers who cannot breast-feed and we do not ever want to make them feel -

Ms FORREST - Which are a very small percentage.

Ms GIDDINGS - Yes but there are some and we do not want them to feel inadequate because they cannot, so it is a fine balance but I would like to see those numbers go up.

Ms FORREST - The target being 53 for 2007-08 and 2008-09 still to me reflects a very low number. I would like to see the target higher and doing something to try and achieve it.

CHAIR - We will move to 3.2.

Ms GIDDINGS - Before you do can I just put a couple of other things on the record as well. I wanted to get clearly on the record about the psycho-geriatrician issue that was raised with Ms Forrest earlier. We did mention there are two psycho-geriatricians who are currently providing services to the north-west. That is true, technically very true at this point, but I have just been advised that this morning we were advised that one of those people is going to have to withdraw their services from July, but I have been assured by Dr John Crawshaw that the services to the north-west will be continued; we will have to find another way of doing that. For the record, I was technically right but I did not want anyone to think from the long term that I had misled the committee here.

There is also clarification for Mr Harriss on e-health. I am told the state-wide rollout referred to, which is completed, was for the electronic notification from hospital to GP of admissions and discharges. The discharge summary project was piloted in the LGH in 2006 and is being rolled out across the State now. That is for much more comprehensive information and goes by fax or e-mail, so there have been two initiatives.

The ReferralNet is the name of the system of electronic communication between GPs and specialists and known as the SECI project for specialist electronic communication. It is well under way across the state. Both of these are funded by HealthConnect and DoHA and managed through contracts by the Department of Health and Human Services and in our services. The aim of both projects is to secure electronic clinical communication between professionals.

3.2 Youth justice services -

CHAIR - As you are probably aware there was a bit of anxiety building up since the report was tabled by the select committee but I must place on record my appreciation of the briefing we had a couple of weeks ago. I think all former members of the committee really took quite a lot of comfort out of the manner in which that briefing was done. So thank you.

Ms GIDDINGS - Thank you, and I am sure the officers involved will appreciate that feedback.

CHAIR - I just made a couple of notes there in respect of the recommendations that we had. There were 30 or so of them in recommendation 2 and the Government's response to that was that a proposal for bail and remand options is being considered as part of the 2008-09 process. Has that happened and is there any detail on that one please?

Ms GIDDINGS - In response to the review of juvenile remandees in Tasmania by David Fanning, the former Commissioner for Children, my department established, in late 2006, an interagency working group to progress the five recommendations. I am pleased to indicate that the work of the working group is now complete and a final report was considered by Cabinet in March this year. The final report indicated that mechanisms have been established to sustain the necessary system changes and expressed confidence in the momentum and ongoing commitment of all stakeholders involved. In particular, since receiving the report in March, workers commenced on the review of the Youth Justice Act 1997 in line with the former Commissioner's fourth recommendation.

Also, there has been significant work undertaken to the fifth recommendation regarding development of supported bail services. A range of models and options have been explored and costed and preliminary discussion planning between Housing Tasmania, the social inclusion unit and Youth Justice Services as well as with the support agencies across other agencies, has commenced. The objective is to develop appropriate supported housing models to expand available housing and bail options as alternatives for young offenders at risk of being remanded to Ashley. Exactly what configuration or model or how many places across the State will become available is the subject of these negotiations and naturally of funding being available as well.

Mr MARTIN - Is there funding available in the Budget?

Ms GIDDINGS - There has not been a specific line item on the bail options, as I understand that, within this reform agenda that we are pushing. But that does not always hold us back. We continue to progress reforms and changes that are required according to what we can do within our existing resources.

Ms JACOB - I think what we will be doing is certainly looking at some of the initiatives that Housing will be bringing forward to support homeless people because many of these young people are homeless and that will give us an avenue for looking at some supported

accommodation models for some people who would otherwise be remanded. We are also looking at how some of the family support budget that we talked about earlier would be able to provide some of the support services that these young people will need. So we are hoping that we can, through those various ways, provide at least a better level of support to young people who would otherwise be remanded to Ashley.

The other part of that is that because there is quite a high overlap between the Ashley clients and the children who are clients of Children and Family Services and therefore need out-of-home care accommodation, because we have some money for that we will also be able to include some of those young people in that initiative. What we will be doing is looking at ways in which we can use some of the budget that has been provided in various ways to support the bail option support program.

Mr MARTIN - Minister, I agree that the briefing was terrific. I think I said at the end that the response from Government, Alison, on a number of occasions said, 'Subject to funding.' I said, 'Subject to funding - if all the funding was there I would give it eight out of 10 and if the funding is not there, five out of 10.' It was the day before the Budget. I think we are interested in the funding, aren't we?

Ms GIDDINGS - You always have competing priorities with any budget and this Budget has given significant amounts of funding to significant reforms in the Budget and it is now up to the agency to determine, from its internal resources as well, as to what the other priorities might be. We will continue to work, as best we can, within the resources we have to deliver as much as we can across the agency and bail options are certainly one of those areas which, while there is not a specific funding allocation from Government in the Budget, we still see as an important issue that needs to be progressed within the agency.

[5.15 p.m.]

CHAIR - Just in regard to recommendations 7 and 8 that in addition to three additional youth workers recruited to support the community service order system program and allocate appropriate funding, the comment was made that 'opportunities are being considered to further resource this program'. The comment I make is that additional staff are also needed to increase the number of youth workers in the youth justice programs. What was the outcome and will further funding be made available?

Mr PLAISTER - Over the last 12 months we have recruited three additional youth workers.

CHAIR - Yes, I am aware of that.

Mr PLAISTER - We have also supplemented that with additional funding for diversionary workers within the south and the north-west. So we have an additional 0.5 in the south and an additional position which varies from 0.4 to 0.6 in the north-west to manage the backlog for those young people who are on orders to find places and to support them once we have found those places.

In addition to that, we have developed a community engagement strategy that we have launched and rolled out over the last 12 months. The main focus of that strategy is to work with local communities to build their capacity and also to identify places and qualified people, if you like, or volunteers within those organisations to supplement the workers that we have formally

recruited. As part of the recruitment process with the additional area managers that we have put on as well, a specific component of their role is to work much more closely with the community.

CHAIR - Minister, just in regard to recommendation 9 that talked about early intervention and that was one of our major recommendations. I note that several areas of the department are engaged in early intervention. It all looks good on paper. But my question is: When will we be able to consider measurable outcomes of that?

Ms GIDDINGS - Can I make the very important point on youth justice that some 97 per cent of young people who come in touch with the youth justice system do not end up in Ashley at all. They end up being cared for and catered for through the community aspect of youth justice. Of course, ideally we would not want them to come into contact with youth justice ever, that they would not need our services. Those early prevention programs relate to what we are trying to do with family support services and the child protection reforms as well. If you can intervene early in a family who is under stress, then hopefully you can deal with the issues that lead to young people engaging in some form of criminal behaviour down the track. I think the record of our investing in the reforms is very strong in this area around early intervention and prevention strategies. Then once they come in contact with youth justice, I think our record is also very strong in actually keeping young people out of the semi-prison end of the youth justice system which Ashley is as a secure environment.

CHAIR - Recommendation 13 was the implementation of all of the October 2006 Fanning report. The recommendation outstanding from the Fanning report relates to a bail options program and was considered as part of the 2008-09 budget process. I could not find anything in the budget papers.

Ms GIDDINGS - That is what I have just been talking about earlier when we were talking about bail options.

CHAIR - You have covered that one. Recommendation 31, independent advocate -

Ms GIDDINGS - Yes, there is an independent advocate now.

CHAIR - Obviously he or she has been appointed. Who is it?

Mr PLAISTER - A woman by the name of Bernadette - I am just trying to think of her last name - commenced in March. She visits on a Tuesday and meets with the young people there. She meets fortnightly with the manager as well to canvass the ideas. They will be tabling a report to the advisory committee on the systemic issues that they find.

Mr WILKINSON - One of the issues in relation to youth justice and also probation is that youth justice now has taken the majority of people who would otherwise have been probation officers, because they are paid approximately $10 000 more to be a youth justice worker as opposed to a probation officer. So there is that conflict between the two. Probation is saying, 'What about me, we should be getting the same amount of money,' and people are moving from one to the other.

Ms GIDDINGS - And when I become Attorney-General as well as the Minister for Justice -

Mr WILKINSON - But that is why is occurring. It is good because you starting at the front end rather than the back end, so it should get a tick because of that I think.

Ms GIDDINGS - There is a real issue around probation, I agree. Thankfully it is not my challenge though.

CHAIR - This is the last issue that I might just get you to comment on, Minister. I am looking at a letter written to the *Examiner* newspaper, it may have been in the *Mercury* too, by Ricky Maynard from the Tasmanian Aboriginal Centre, TAC. He gave you a bit of a bashing up actually.

Ms GIDDINGS - Did he?

CHAIR- Yes. He was saying that detention on Clarke Island was a much better option. He says, 'It is a far safer and culturally appropriate environment for our children, and the minister and the courts must seriously consider Clarke Island for both remand and sentencing options.' You might like to make a quick comment on that please.

Ms GIDDINGS - Absolutely. The proportion of admissions to Ashley Youth Detention Centre for young people identifying themselves as Aboriginal remains disproportionately high compared to the proportion of non-indigenous admissions. We remain committed to identifying and developing culturally appropriate community-based support options for young Aboriginals at risk of coming into custody.

In furthering that, we do fund the lungtalanana program on Clark Island which is administered by the Tasmanian Aboriginal Centre. In the period 1 July 2007 to 30 April 2008, four Tasmanian Aboriginal youths were accommodated for a time on Clarke Island. These youths would otherwise have been detained at the Ashley Youth Detention Centre. It does remain an important program for the diversion of young Aboriginal people in custody.

I have met with the Tasmanian Aboriginal Centre on a couple of occasions as well, discussing their concerns about the program not being used sufficiently. We are working through those issues with them. But we also need to ensure the safety of the participants in that program and also the community and other issues around it. It has been a difficult issue at times for us to try to work through with the Tasmanian Aboriginal Centre, but it is one that we will continue to work through. I do see that there is a need and a role for that program. But there is also a need to ensure they have the understanding that there is an issue around why those young people are at Ashley in the first place and there are considerations around their supervision and the care that is provided to those young people.

I think we should be using a culturally aware program as much as we possibly can. I am committed personally to continue working with the Tasmanian Aboriginal Centre to iron out any problems that there may well be in the expectations of us in delivering the service and in the expectations of the community in providing that service on our behalf.

CHAIR - Have the programs on Clarke Island delivered successful or measurable outcomes? And also at what cost have they been?

Ms GIDDINGS - One of the difficulties we have is being able to measure the success of the outcomes in that program. That is one of the things we are trying to work through to get that sort

of accountability and data into the system. These are very culturally sensitive issues as well, and sometimes these things are not easily measurable. I think the community can feel and at times they are concerned that these things are going to be taken away from them because they cannot articulate the benefit that has been provided to one of their young people. Again, I think we have tried to remain as culturally sensitive as we can through all of this and continue to work through them. But we do want to see the outcomes there as well. In terms of funding for the program, funding the year 2008-09 the financial year based funding is $137 022. There is indexation on that of $4 522. So the total base funding will be $141 544 and there is GST on top of that.

Mr PLAISTER - It is worth noting to that we do actually provide on site at Ashley a range of programs through the school and through our program.

CHAIR - I am aware of that one as well.

Mr MARTIN - To clear up something I heard in the media last week, it stated that 100 per cent of Ashley detainees finish up in Risdon, which I am pretty sure is not right.

Ms GIDDINGS - That is not true.

Mr MARTIN - It was not contradicted by anyone but do you have the figure?

Ms GIDDINGS - We did get a figure. It was Rob White from the university who maybe can claim to be misquoted in that newspaper article. But we did at the time, I thought, get some figures together.

Mr PLAISTER - We did and I have them here. I just need to find them.

Ms GIDDINGS - Can I also say that yesterday we were able to announce two extra teaching staff to be employed at Ashley school and that will enable a 48-week school year. That is an important aspect of the services that are provided at Ashley, ensuring that we try to keep some normality to their lives while they are within the centre.

Mr MARTIN - It is a proper school - 48 weeks a year?

Ms GIDDINGS - I would have to find out. Alison, you wouldn't know?

Ms JACOB - Forty.

Ms GIDDINGS - So in fact it is more, 48 weeks.

Mr MARTIN - But it is the right number of hours, the normal number of hours per week?

Ms JACOB - It will increase that. What it will allow us to do is to extend basically the school year for all but four weeks of the year.

Mr MARTIN - How many hours per week?

Ms JACOB - That is something Education would have to answer; I cannot give you that specifically but two extra teachers with an average of 35 young people at any time will obviously

the capacity increase the hours as well as the number of days. But I could not tell you exactly education would have to give us the information.

Mr MARTIN - Since we do not have Education coming up, is it possible for you to get the figures?

Ms GIDDINGS - It is not our information, so it is not possible for us to do that because it is another agency. But you could put a question on notice to the Premier. The other element that might be of interest to you, if we have the other figures is in relation to the closed circuit television which was also a recommendation of the former Commissioner for Children. We had a 12-month trial of that which was concluded in September 2007. It was confirmed that the benefits outweighed any concerns in relation to that and as a consequence we have now provided $300 000 to extend that.

Ms JACOB - What we can tell you is the recidivism rate for children coming back into Ashley as opposed to Risdon Prison was 47.1 per cent.

Mr MARTIN - 47.1 going back into Ashley

Mr PLAISTER - That is within a two-year time period. One of the issues we have is that most of the age group at Ashley is usually the older age groups between 15-16-17. Once they are released from us if they are close to 18 then and they offend again they end up in the adult system and we do not have an interface in terms of data between our system and the justice system. We are now talking with them to try and to that interface so that we have a common record number and we can access that and start to do some analysis about those who go on to offend and get some understanding of the outcomes in terms of our own juvenile justice system.

[5.30 p.m.]

Mr MARTIN - So you cannot access the figures to contradict what Rod White said?

Mr PLAISTER - We do not have them specifically - we have done a guesstimate and that was meant to be in the article I think.

Ms GIDDINGS - You did put something into it.

Mr PLAISTER - I put something in but I do not specifically have it here.

Ms GIDDINGS - We do not have the article with us.

Ms JACOB - We can take that on notice.

Ms GIDDINGS - We can find the information that we provided at that time to that newspaper article - that is not a problem. Interestingly, the -

Mr MARTIN - Because it is a damning indictment -

Ms GIDDINGS - Ah, yes.

Mr MARTIN - It is certainly not a hundred per cent.

Ms GIDDINGS - No.

Ms JACOB - And Rod White later corrected that and said that he had been misquoted.

Mr WILKINSON - It would be a significant amount though, would it not? It would be certainly half or 50 per cent, I would imagine, because -

Mr PLAISTER - No -

Mr WILKINSON - you disagree with that?

Mr PLAISTER - From the figures, I understand, it is somewhere in the forties but I just need to confirm that for you.

Ms GIDDINGS - This is apparently what Mike said at the time - I have spoken with Rod White - I think the important aspect here is that the trend has been down on recidivism for young people at Ashley which has been the important part; it does fluctuate from year to year but it has been trending down and you would hope that will also be reflected in those that then, some would argue, 'graduate' to Risdon prison. We still have the problem with the occasional young person who actually is almost begging to go to Risdon; they want to be there, that is where there bigger brothers are, that is where they gain their stripes, so to speak, so it is a rite of passage for some.

Mr WILKINSON - Instead Ashley is the last place, is it not, because there is a difference between junior sentencing in a youth court and sentencing in a senior court. That is why rehabilitation is of paramount interest - it is only the real hard nuts that go Ashley, I think that has to be remembered.

Ms GIDDINGS - Absolutely, and the other aspect to remember is you are talking relatively low numbers at any one time of people in Ashley. I think it is on average about thirty young people at any one time in Ashley itself.

Ms JACOB - The rate of young people in custodial youth justice in Tasmania is about the same as the national average, so we are not higher or lower - we are about average.

Ms GIDDINGS - Okay.

CHAIR - Thank you for that. It is encouraging to have those two extra teachers. I think, as Mr Martin has indicated, that we really want to know from the Education Department, how many hours a day that the actual residents are actually in the school itself because that was something we found in other States - it was mandated to attend the full school hours and that has not been happening here. Thank you.

3.3 Disability Services -

Mr MARTIN - The 2008-2009 total for clients who received supported accommodation is only four more than the total gross in 2008. I would have hoped for a bigger increase than.

Ms JACOB - It would be fair to say that the review of disability services and the recommendations went to the Government very late in the piece. It did get into the budget cycle,

but in terms of us looking at the calculation of targets for increased services, we did not get those figures in to the budget papers in time, so we wanted revise those figures. We have -

Mr MARTIN - So what is the target?

Ms JACOB - The target in terms of the review and what we intend to do in 2008-2009 is an additional 12 accommodation places, 75 individual support packages, 50 community access packages and 70 respite packages. We will obviously want to correct figures in the budget papers but it was a timing issue and we did not know whether we had any funding at the time when we were doing the targets. We have gone on record with the release of the disability review and the funding that accompanied it by putting a fairly ambitious target of an extra 1 000 client services over the four years.

Mr MARTIN - It could be the same as what is now expected an increase in the number of day option clients.

Ms JACOB - That is correct. Our revised figures are the ones I just read out.

Mr MARTIN - Can you table the new figures?

Ms JACOB - Absolutely and they are in the fact sheets which are on the web site accompanying the disability review. Those figures are on the public record but we would be happy to table them.

Mr MARTIN - Okay.

Ms GIDDINGS - Do we need to formally table them, Terry? I am just thinking of the work of having to do it. I can even give you the fact sheet right now.

Mr MARTIN - It is good to see in the State Budget that $1 million was allocated to upgrade the qualifications of child care workers. Are there any additional resources allocated to a similar project for non-government disability workers?

Ms GIDDINGS - We do have a work force development program and we are continuing to implement strategies to address recruitment and retention of qualified staff.

Ms JACOB - Can you clarify your question?

Mr MARTIN - Yes, it is about whether there are programs for the training of non-government disability workers.

Ms JACOB - That is part of the reform and $50.8 million over the next four years will be specifically targeted at a work force capacity-building project. The implementation plan is also on the web, and we would be happy to table, and it gives the work force development strategy for which part of the budget has been allocated, the implementation plan details and the things that we will be doing.

Mr MARTIN - That is on the web site?

Ms GIDDINGS - To let you know what we have done and the list of NGOs and our own government services which we are moving into the NGO sector anyway, from 1 July 2007 to 14 May 2008 we funded through Disability Services some key training activity for disability services sector staff. In that was medication training for 447 people, first aid for 380, manual handling for 175 and fire training for 112. There will be ongoing training primarily in the non-government sector if we progress further into our reform.

Ms JACOB - We employ four people at the moment in work force training and we would be looking at expanding that in terms of the reform.

Mr MARTIN - Is the department prepared for a wage increase for the non-government disability workers as detailed in the NDS budget priority submission to Treasury?

Ms GIDDINGS - What we have been doing around wages, because this has been a topic of great interest for those involved in delivering disability services, is talk about the reforms around the unit costing of the services in the future. What we are trying to do is move away from a system of competitor tendering which has seen NGOs have to compete against each other for work, to what we understand to be a unit cost for a service which encompasses a fair wage as well as what we consider being the cost to provide that service. We will become not a deliverer of services as we have traditionally been but we will become a purchaser of services in the non-government sector. A lot of work has been done by KPMG around how a unit cost model would operate and the preliminary work they have provided us is based on a Victorian model which, as I understand it, has a fairer wage component in it than what we currently would provide to the NGO sector. But this is very much a chicken and egg discussion that we are having with the sector. It is very difficult because the sector cannot negotiate with their employees if they do not have the money to negotiate with and we cannot just provide a bucket of funds and say, here is your money, now go away and negotiate. Treasury just will not allow that to happen. We have been in this problem area with the sector saying, 'How can we negotiate?' and us saying, 'We are not the employers, we cannot negotiate for you.' This unit cost model should help to get around that, where we do get what we see as a fair and reasonable unit cost established, recognising that there has to be some increase in the actual funding available for employees. What I think we anticipate doing is providing that to the sector and saying, we believe we can purchase *x* number of respite beds for this amount of money, and built into it will be the wage component. Then the sector will have to go away and negotiate with their employees an industrial agreement that works within the funding they receive.

Mr MARTIN - Is the projected cost of this, as calculated by TCCI, expected to be about $8 million?

Ms JACOB - That was work that the National Disability Services people contracted the TCCI to do. It was not something that was done within the agency, so we really cannot comment on that.

Ms GIDDINGS - We had our own work done through KPMG as part of the overall reforms in disabilities.

Mr ROBERTS - I think we do need to be conscious that providing service in the non-government sector is not just another means of the Government providing a work force. These are independent organisations and, as such, it is their role to find their work force and to train their work force and, they need to be paid in a way that enables them to do that. But if these

organisations get too close, that is I am responsible for setting their wage bill, then effectively they are just a public service again and that is not what we want to see. We need to be clear that we have a quality and a financial regime against which fair funding can be put into the marketplace for NGOs to both emerge and to survive and thrive to provide these services for us, but not that we are negotiating their wage bill.

Mr MARTIN - Going back to the question I started to ask on the mental health, are you in a position to give an assurance to the community service organisations that are currently involved, that is, service provider and disability services that meet government standards of service provision quality assurance and funding guidelines, that the contracts will not be terminated or not renewed in 12 months under the new arrangements?

Ms JACOB - We do not have a reform process that will deliberately get rid of organisations at all. But we are moving to a different method of funding through the unit cost model and we will be saying to the sector, we have this amount of funding available and we want to purchase this amount of service from the sector. We will have the agencies which can provide that for the unit cost price coming forward. If they cannot provide it for the unit cost price we expect there will be other agencies that will be able to. It will come down to whether or not the individual NGO can take on the work that we want to purchase. That is where this unit pricing model is critical in getting it right what is a reasonable and fair outcome that covers the costs of not just the wages element but the infrastructure, the brokerage and other operational costs as well. As I said, there has been a fair bit or work that has gone into that.

[5.45 p.m.]

Mr ROBERTS - I think it is also now understood and recognised that we have created the office of the community sector development. That has a deliberate purpose for us in terms of enabling us, the agency, to contract, commission, monitor and have performance regimes within the long Government sector, just as we do within the public service. We do not see any distinction between ensuring that we get the quality standards and performance from the non-Government sector as in the government sector. So over the next 12 months we will be reviewing and putting in place more robust performance agreements and contracts with all of our government and non-government sector providers to ensure that we get that standard of care and provision.

Ms GIDDINGS - What we are hoping to encourage here is for groups to work more closely together as well and fill the gaps that are in the system, and work in partnership a lot more. The fact that we are getting rid of our competitive tendering element should assist that.

In fact I have already had groups come to me saying, 'We're starting to talk to each other about how we can complement each others services'. Even before the reforms came out, this had stimulated this discussion within the sector and they were already looking at innovative ways of working more closely together, rather than being competitive and therefore, perhaps, potentially seeing groups go.

But also one of the reasons why I have been very keen to drive these reforms is that we have had over decades small groups pop up around the State, largely established around a family who have had a child with disabilities and it becomes a very specialised group for that immediate community around. We cannot sustain funding numerous lots of little groups. What we would hope will happen is that, in time, these groups will form partnerships, in time they even may amalgamate or they will work more closely together, share resources if that is appropriate - and

that might be building resources and those sorts of things - sharing electricity costs and so on so that we can have a strong, robust non-government sector, not ones that are just really surviving on the smell of an oily rag.

We are not deliberately getting rid of anybody. I think the system, itself, over years will sort itself out.

Mr MARTIN - Yes, obviously a little bit of nervousness though from the questions that have been asked.

Ms GIDDINGS - Yes, I can understand that people in times of change can be nervous but I think others are seeing this is as an opportunity to grow their business rather than see it as a threat.

Mr MARTIN - I have been asked to seek a few other assurances. Are you able to give an assurance that there will be good governance and probity in the new contract management structure to remove any potential real or financial conflict of interest between the regional lead contractors and the service providers directly providing disability services?

Ms GIDDINGS - I would be confident to say that we are going to be doing all that we can to ensure we have the most robust systems in place to cover all of those elements and, in fact, we even now have Mr Des Graham heading up a specific part of our agency, looking at how we work with the non-government sector and how we have our contracts drawn up. All of those sorts of things he is looking at to ensure we do have those checks and balances in there, that we have performance elements in there, that we have the quality assurance, the oversight of those contracts, all of those things to ensure that it is a robust system.

Mr MARTIN - Are you able to give an assurance to people in group home residential care that they will not have their quality of life disrupted against their wishes or the wishes of the family by forcing them to change disability service providers simply on the basis of rationalising the number of providers in the disability sector?

Ms GIDDINGS - We are not looking to rationalise the number of providers in the disability sector. It is not an issue that has been brought to me before so I do not believe that it is one of concern.

Ms JACOB - There will certainly be no change like that without any consultation with individuals concerned and there is nothing that we have planned. All of the accommodation services have now been devolved to the non-government sector and that has been a planned process and those organisations have those contracts and would expect those to continue.

The only change that will occur in the course of the reform will be devolution of some of the other services - day support services, respite services and so on - but that will occur again in a planned way, and none of that would occur without each individual having a plan that is put in place through consultation with them and their families.

Mr MARTIN - So none of these reforms should lead to the clients having to move?

Ms JACOB - Not specifically, no.

Mr MARTIN - No, okay. Finally, can you give an assurance that capital funding, maintenance, accrued home residential care will continue to be provided separate to the disability services contract as presently the case?

Ms JACOB - We would imagine, yes, it would continue to be a separate sort of program where we maintain and we have certainly been looking at how we run the accommodation options and how we upgrade the facilities as they are required. So that would certainly continue as a separate program.

Ms GIDDINGS - Perhaps I could just make the point that change is difficult, reforms are difficult and I can understand some nervousness there. I would also make the point that I acknowledge too that it is equally so for our government employees who are going to probably experience some of the biggest change rather than the non-government sector. We are conscious of that and we will be working closely with our own employees through that change process as well but that is probably where more concern really lies rather than any real dramatic impact on the disability sector.

Ms JACOB - Minister, it might also be worth saying that on 21 and 22 July we have a two-day workshop to which we will be inviting the CEO and the chair of each of the non-government organisations to come together with us to work through what is going to happen and give a full explanation because we are talking about major reform, reform that we know is going to take three years and that we have been very explicit about. We do understand people being a bit concerned and that is why we will be bringing those people together for the two days and hopefully after that people will be much clearer about what is intended to happen.

3.4 Housing services -

Mr MARTIN - Minister, regarding the $60 million announcement by the former premier and the Treasurer on 14 February, the former premier did at the time say that funds would be immediately available. There was a lot of shock I suppose when, unlike the glossy brochures which talked of $91 million, the budget papers actually indicated $10 million this year and a four-year spend of $10 million, $10 million, $20 million and $20 million over the next four years, which was the first time the community sector realised it was to be spread over four years. There were numerous exchanges in this Chamber with the honourable Treasurer. The bottom line is that he is now saying that the money is totally available this year.

Ms GIDDINGS - It always has been.

Mr MARTIN - But the question mark, the reason it has been spread like this is because of advice that it is impossible to build more than $10 million this year.

Ms GIDDINGS - We were asked to provide advice to Treasury around what we thought was how we could spend that funding. We believed that we could spend around $10 million this year, $10 million the following year and $20 million for each year after that but, having said that, I sought assurances straightaway at the time from the Treasurer that should we be able to spend more than that, that that funding would be available and, in theory, if we could spend the full $60 million it would be available.

I got his assurances at that time that yes, if that was indeed the case. You will be pleased to know that yesterday this same issue was raised with Mr Aird and Mr Challen and I will read you the quote of Mr Challen since he is the most powerful man in government.

Laughter.

Mr MARTIN - Do not tell the Treasurer that. Mr Harriss and I are going to quote that so many times.

Mr HARRISS - No you are right, Minister.

Ms GIDDINGS - The Treasurer was very clear about this. The bit that I particularly wanted to pay attention to was Mr Challen who said, 'There is no question that these funds are immediately available. The parliamentary process to put them into an account in this initial deposits and trust fund has been completed'. There is an account that has $60 million in it. All that is required to spend that $60 million is for the Treasurer to approve that particular set of cash flows. The funds are there, they are sitting there. It is just a matter of a program to spend them.

So that is exactly what Mr Aird, the Treasurer, reassured me would be the case as the time that we were first asked to provide a funding program should we not be able to spend the whole $60 million in the first year. So I am very comfortable to say to the sector that there is absolutely no doubt that, should we be able to get sufficient programs up and running, should we be able to get the building industry to build all the homes that we want to see, that we will be spending that $60 million.

Mr MARTIN - I have in writing from the HIA that the capacity is within the State providing they note that they need to ramp up.

Ms GIDDINGS - Yes.

Mr MARTIN - It is possible to spend the $60 million this year.

Ms GIDDINGS - I do not know if you are aware of the public debate that went on just two days ago because the Master Builders Association said the opposite in that sense. So while the HIA said that they could do it, the master builders said that it might be difficult to achieve that. The reality is that we will do all we can to get our housing program built. That is true not just of the $60 million but what we are also doing through Tasmanian Affordable Housing Limited right now. We have a number - I think up to 500 houses now through the tender process for TAHL which we would hope to see built as soon as possible as well. So that is happening right now. The $60 million is additional to all of that. I do not know about you but people I know who try to get builders find it very difficult; the building industry is still booming in this State.

Mr MARTIN - I do not think it is as hard to get builders now as it was, say, two or three years ago from my personal experience and certainly from what HIA and MBA have both said to me. I would be amazed if you cannot spend more than $2 million - whether it is $60 million, I do not know. Assume for a minute that the HIA is right: who in the Government - I am a bit confused as to who - Housing Innovation Unit, Housing Tasmania, TAHL - is coordinating trying to spend the $60 million and getting people in with roofs over their heads.

Ms GIDDINGS - David Roberts is. As the secretary of the department, he is responsible for all the elements that are under our control in that respect. We do have the Housing Innovations Unit which is driving a lot of the innovation programs that are forming out of the $60 million. Equally, we have the great expertise of Mercia Bresnehan and the others of Housing Tasmania who are working closely with Scott Marston, the Housing Innovations unit director. It is a group effort in that respect as well as TAHL, which is independent of us but works closely with us too as its funder to get houses up and going.

Mr MARTIN - I have been pleased with the statements over the last week both from the Chamber and yesterday and so on. What worries me is the fact that there is only $10 million in the budget and I want to be -

Ms GIDDINGS - There is not, though, Terry. I can assure you there is $60 million in the budget.

Mr MARTIN - What I want is an assurance that everything is to spend in this year.

Ms GIDDINGS - We will do everything we can to spend it. Absolutely. The faster I can get houses up, the better. The 50 quick-builds are a prime example of where we are trying to do things differently. We are recognising that technology and innovation has moved on from when quick-builds were first established and when Housing Tasmania had some serious concerns about the quality of those structures and therefore did not use it as a simple, quick solution at the time, for instance, around the Affordable Housing Strategy. But time has moved on. We have reassessed that and decided that nowadays the quick-builds could well be appropriate housing. We want to pilot it and that is why we have funded 50 in this year's Budget to see whether or not they are worthwhile houses.

[6.00 p.m.]

Mr MARTIN - When will you release the details of that and -

Ms GIDDINGS - We hope to get the tender up in July, I believe.

Mr MARTIN - Is the tender let or called for?

Ms GIDDINGS - My advice is that we would hope to get 30 up in July and then in August get the other 20 up through the tender process.

Ms BRESNEHAN - I think what tends to happen when you read the budget papers is that you get bits of information. If you put the whole lot of activity that we are doing in the housing space together it tells a very positive story. There is activity happening in public housing around our capital program, around tied and special programs and then around the Innovations Unit. There is activity happening in all three spaces.

Mr MARTIN - Can you outline them now because you cannot get that out of the budget papers?

Ms BRESNEHAN - In Housing Tasmania the budget papers indicate the $21.6 million capital program and there are specific projects that are identified in that.

Mr MARTIN - With your performance indicators, I used them to be quite critical last week in the Chamber. From what I can work out it shows that you will finish up with fewer dwellings at the end of the year than you will have at the start because the ones you are selling outnumber your capacity to build new ones.

Ms BRESNEHAN - That is true in terms of public housing, but if you think about the whole affordable housing system, we aim to have growth. I will go through the numbers in each of those. In the public housing area there is $21.6 million which is across a range of programs including new constructions, upgrades, purchases and some other projects around compliance audits and some land acquisition, so there is a range of activity there. In the tied programs there is community housing activity, crisis accommodation and supported residential facilities. In the Innovations Unit - which Scott can talk about in more detail - there is the quick-builds program, work that is happening in TAHL, Community Housing Limited and also a new Commonwealth program called NRAS - the National Rental Affordability Scheme. Out of that we are hoping to get about 500 properties on the ground through those new innovative programs next year.

Mr MARTIN - Are you able to table the exact numbers?

Ms BRESNEHAN - That is the plan that we hope to do. Something like the National Rental Affordability Scheme is the target we have; that will be dependent on other investors and players coming in. There are up to 1 250 properties that we can access through that program and we are hoping to get a couple of hundred of those next year, all being well. That is the target for that affordable housing space.

Ms GIDDINGS - We have a number of things happening. I will go through some of the figures for you. Tasmanian Affordable Housing Limited has 53 homes available right now for rent in the market and they expect a further 153 to be completed in this next financial year. In addition, they have 306 new units that have been approved from a tender process it conducted earlier this year. We expect those to be completed in the 2009-10 year. We also have Community Housing Limited and it is expected to complete around 50 homes in this next financial year that will be made available to low-income earners to rent. We also have the 50 quick-build tenders, and I have already gone through that process. If that is successful, a further 100 homes will be developed under the program over the following two financial years or earlier, depending on whether we can get that money spent and out the door; the money is there to spend. We also have the National Rental Affordability Scheme, which is a Commonwealth scheme. We believe that Tasmania is in the best position to gain the most outcomes from that scheme because of the lower cost of housing in Tasmania. We have set a target of 1 250 new homes under that scheme over the next four years. We expect 100 new homes to come on line during 2008-09 and a further 250 in 2009-10 from that particular scheme. We are also having a number of other discussions with developers and 63 places coming on board with Star Street residential accommodation and Bilton Lodge. With all of those, I think, at one point Mercia had an aggregate number of all the different houses and elements coming together.

Ms BRESNEHAN - The only thing I would add to your list, Minister, is the opportunities for home ownership through shared equity at 180. Overall, we have about 780 new housing opportunities coming on line next year.

Mr MARTIN - How many of those would be public housing that is going to house the most in need, your categories 1 and 2.

Ms BRESNEHAN - Twenty and TAHL will also reduce our waiting list by 153.

Mr MARTIN - The select committee received evidence that they were probably not likely to take categories 1 and 2, otherwise they will have a sustainability problem.

Ms BRESNEHAN - They can take across the waiting list, that is true, so I do not know how many.

Mr MARTIN - We concluded that they are unlikely to take categories 1 and 2. There could only be 20 of those 700-odd properties for categories 1 and 2.

Ms GIDDINGS - Some of the quick builds will also potentially go into Housing Tasmania stock. They are not all for the non- government sector.

Mr MARTIN - We need some detail on that.

Ms BRESNEHAN - I would say that about 200 people from the waiting list will be housed into about 200 properties across Quick Build, TAHL and the new construction out program.

Ms GIDDINGS - I think what is really important is to understand this is about affordable housing for people and part of the reason our very low income Tasmanians are under stress is because there is not a sufficient supply of housing in the market so rents are going up in the private sector and so on. All of those programs that we have talked about are aimed at the affordable end of the market and particularly at low income Tasmanians.

Mr MARTIN - I applaud all of them.

Ms GIDDINGS - I think that is important because it is about increasing the supply of housing so that you increase the options available to people, whether or not its TAHL or its public housing, which should ease the pressure on the public housing waiting lists.

Mr MARTIN - True to an extent. That is a true statement but the one benchmark in the Government's Agenda 2008 speech was to halve homelessness but there is a bit of uncertainty about what the Premier meant when he said homelessness.

Ms GIDDINGS - The level of rough sleepers.

Mr MARTIN - I think he said that later on, but homelessness to me is categories 1 and 2 waiting lists because those people have been defined by your own staff as being either homeless or living in a potentially dangerous situations.

Ms GIDDINGS - Well, they are not homeless

Mr MARTIN - That is the category they have been defined as.

Ms GIDDINGS - No, it is not.

Ms BRESNEHAN - I will go through it with you. That is a bit of misnomer. Certainly if you are homeless that is a part of the consideration of your assessment but that is not the total assessment. When people are, as you are aware, assessed for public housing they are assessed

under three categories: the adequacy of their current accommodation; the affordability, how much money they are paying in relation to their income; and also the appropriateness of their current situation, so whether they are escaping domestic violence, whether they have a disability, et cetera. The homelessness component is one dimension of the adequacy. Obviously if someone is homeless then they would point high in that first factor. But it is not an accurate statement to say that all those people in categories 1 and 2 are homeless.

Mr MARTIN - So someone sleeping on a sofa in a friend's house.

Ms BRESNEHAN - They are likely to be category 2.

Mr MARTIN - In evidence to the select committee was that you would define them as being homeless.

Ms GIDDINGS - There is a broad definition of homelessness.

Mr MARTIN - So the benchmark set in the 2008 speech was about the so-called sleeping rough.

Ms GIDDINGS - The Premier of the day was very clear about that as well. Before he made the statement he had information that, unfortunately, was based 2001 census data, but that was the information he had available to him at that time. I think the number of people we believed to be sleeping rough from the Census in 2001 was 237.

Since then we have had our own working group trying to figure out a more accurate number so that we could get an understanding of what that commitment was in saying we would halve the number of those sleeping rough. That work has not been finalised but it is indicating that about 450 people are sleeping rough around Tasmania. So that is the figure we will be working with.

Mr MARTIN - I suppose the select committee's definition is a broader one. Our benchmark was that you should abolish it and, if you read the rhetoric in the 2008 speech, you cannot on one hand say that it is totally unacceptable for any Tasmanian to be homeless and then talk about a benchmark of halving it. It is an oxymoron.

Ms GIDDINGS - You are quite right in that sense. The aim would be to try to get rid of all homelessness. But you also do not want give a Bob Hawke speech where you promise to take every child out of poverty because that ends up creating more harm than good in terms of being able to achieve that goal and the cynicism that comes with that. We would certainly try to ensure that homelessness was not a problem here in Tasmania.

Mr MARTIN - It should not be; we are a rich society.

Ms GIDDINGS - I am not about to say that we are going to commit to 100 per cent, at all. I think the commitment made is a good goal, but I do not think it should ever be seen as an end goal. It is not an end in itself but if we can reach that target I would then be pointing to all do us to say the work is on now to get to the next point, which may be halving it again. Hopefully in time we would get to a point where we were rid of homelessness.

Mr MARTIN - The next mark should probably be the select committee's recommendation of using the broader definition of homelessness and to get rid of the category 1 and 2 waiting lists which requires spending $200 million.

Ms GIDDINGS - My first aim would be to get rid of rough sleepers. That would be my personal ambition.

Mr MARTIN - There are a lot of other people who would not fall in that definition who are doing it very hard and the impact on kids is terrible.

Ms GIDDINGS - Terry, what you are doing with your initiatives is actually driving supply of housing so that you increase the options of housing for those who are in categories 1, 2 and 3 on our waiting list because part of the problem, and why they are on our waiting list, is that they do not have other options. They cannot get private rental, they cannot get the assistance that we have for them because the houses do not exist.

It is not a question of just building more public houses, it is about understanding the whole breadth of levers that are available on the housing issue to try to resolve the problems that we have in Tasmania around a shortage of housing.

I think there is a lot of work that has been done nationally, and by Housing Tasmania to try to look at the levers and how to deal with this. Part of the problem with public housing issues across Australia has been that we have been starved of Commonwealth dollars for many years to direct into public housing because the Commonwealth have chosen to put their funding into Commonwealth Rental Assistance.

The CRA is only available to private rental people. It is not available to Government renters. Part of the sustainability issues with Housing Tasmania has been around the emphasis away from public housing which has put pressure on State Governments to look at how else you deal with affordable housing and housing issues in our States that do not rely on pure public housing. I commend the work that has been done by this Government since we came into power with the Affordable Housing Strategy and TAHL. Alhough it was a very difficult birthing process for TAHL, it is now born and is now delivering but it was the first time really we have set up that sort of structure and there were teething issues.

[6.15 p.m.]

Mr MARTIN - I applaud TAHL but I did predict that.

Ms FORREST - It was being breastfed.

Ms GIDDINGS - We are getting there. Maybe that was the problem. Maybe it was the formula it was on.

Laughter.

Mr MARTIN - We are getting very conscious of the time.

Ms GIDDINGS - However we are delivering.

Mr MARTIN - Honestly, we could talk about this for many hours but I think there comes a time.

The maintenance backlog is a dire circumstance for Housing Tasmania; $80 million and I did not see any extra funding. How are we going to address that?

Ms BRESNEHAN - We have $32 million aside for an ongoing maintenance program and $2.5 million for an upgrade program, so there is a part of maintenance for which the maintenance recurrent budget goes towards the backlog and $2.5 million has been dedicated to fixing critical problems.

Mr MARTIN - How much is going to the backlog?

Ms BRESNEHAN - It is $2.5 million.

Mr MARTIN - That is a lot of years to get to $80 million if you are going to get there.

Ms GIDDINGS - That is exactly why we are wanting to look at how we can make our housing assets more sustainable and why we have the whole discussion and the consultation about to happen in terms of what are other models that could be used that could make our asset base a lot more sustainable than the traditional model. The environment has changed with housing over the past decade with the likes of levers like CRA being involved, with the latest lever being this national affordable rental program that the Commonwealth are pushing which again is not funding public housing, it is funding private housing. All of these things mean that we have to be open to looking at how else we can deliver public housing in a more sustainable way, which is why we are taking on that discussion within the community to say how else can it be done because just maintaining the status quo we can see is failing the system; it is not working.

Mr MARTIN - In terms of maintenance it is not even treading water at the moment.

Ms GIDDINGS - No, and I have really had a philosophy in my time as Health minister that you do not just throw money at a system that is broken. It is not just broken in the sense that it is easy to say that the State Government just needs to put more money in. It is much broader than that. The system is not just a State Government system, it is a Commonwealth system, it is a system that has shifted so far in the last decade that we do need to say, all right, if we are to reform this, if we are to deal with this issue, we have to actually look at what is going on and one of those issues is how best do you deliver those services into the future. That is the discussion that we want to have in consultation with the sector around not just a State-owned company but, for instance, it could be that community associations are a better model for delivering these housing options into the future. I have been interested, the sector have been quite keen to talk to me about community housing options around stock transfers of up to 1 500 houses from Housing Tasmania into that form.

Mr MARTIN - Some parts of the sector.

Ms GIDDINGS - Some parts of the sector. But they are very vocal parts of the sector who have mentioned that to me. Dave Roberts from his experience in the UK where they run housing associations very differently from here has also said that it would be wise of us to look at the models that they use in the UK, too, around this issue of sustainability. I am very keen to have a

good discussion around this as we have had in disabilities, as we have had in children and families and say that we need some open-mind thinking around the issues of housing.

Mr MARTIN - Do you have a vision on what you are trying to achieve there and -

Ms GIDDINGS - I am trying to achieve sustainability for public housing in this State and not privatise it, and not get a profit out of it. I want to be very clear about that. We want to make sure that we have public housing in this State. This is a debate that is happening nationally as well.

Mr MARTIN - There was something else I was going to ask. The Treasurer the other day said there was no intention of privatising it. Would you agree with that?

Ms GIDDINGS - Absolutely. We will not be privatising public housing.

Mr MARTIN - Not by stealth either, by transferring all of the stock?

Ms GIDDINGS - You could set up a model like the State-owned company model, you could set up that, that is not privatising, you could potentially move all of your housing stock into a State-owned company -

Mr MARTIN - Yes, but that is not privatising.

Ms GIDDINGS - That is not privatising, so that is not it, but around some of the other issues that I think we should talk about in this consultation phase are the examples like what happens in the UK where their stock is totally operated by community associations. That is a different model again in that sense but what I would be wanting to do in any discussions is protect public housing in this State, ensure that it is not privatised public housing, ensure that there is nobody trying to make a profit off the back of low-income Tasmanians. I also want to try to ensure that we are delivering appropriate housing options to low-income Tasmanians that protect them the best way. We can, and there are a number of ways that you can do that.

Mr MARTIN - Okay. The Affordable Housing Strategy - I think 17 weeks since Rosanne -

Ms GIDDINGS - Rosanne Haggerty. Yes.

Mr MARTIN - Rosanne Haggerty's draft of the policy -

Ms GIDDINGS - It will not be long and I think I will be releasing Rosanne Haggerty's work. She certainly has been working with us on looking at the common ground model here in Tasmania and you would know that we have been doing the pre-feasibility study into Highfield House around establishing that model. We have got the pre-feasibility study and I am happy to table it for you if you would like.

Mr MARTIN - Is it a goer?

Ms GIDDINGS - Yes, they are recommending that we go ahead and do the full feasibility study.

Mr MARTIN - Just in relation to the consultation with the sector vs State-owned company proposal - the details of what consultation are doing?

Ms GIDDINGS - With the State-owned company?

Mr MARTIN - Yes.

Ms GIDDINGS - The details of the consultation? The consultation will be going from July to September and we will be actually getting an independent body to come in and undertake that consultation process so that we can have, as I have done with the other reviews, that independent view of what is going on so that we do not run it internally.

Mr MARTIN - And the select committee's recommendation, that had some perameters attached to it in relation to that recommendation - State-owned company - and also was premised on the fact that there should be a cost benefit analysis done which was far beyond their capacity. So will that be done?

Ms GIDDINGS - Well I would expect that in the exploration of what is the most sustainable way that we can provide services that we would want to have the expert advice on that - we will not be making a decision without having appropriate understanding of what would be the benefits or not of having a different model. I do not think that there is anything else to add at this point on that.

Mr MARTIN - Thank you.

Mr ROBERTS - The only thing I would say is that we are fully committed to a period of dialogue which I think is absolutely essential but we are not wanting that three-month period to stop us or delay us from progressing all of the issues that have been spoken about so we will carry on implementing these issues.

Mr MARTIN - What the sector is hoping is that it is meaningful consultation and not just a one-day seminar or -

Ms GIDDINGS - I am happy to give them that assurance that it will be meaningful consultation through that three-month period and properly done through, as I said, engaging a professional consultant to help assist us through that process. I think that that independence is very important for the sector to have some confidence in the process as well, that this is not a predetermined outcome of government, this is not predetermined within the bureaucracy or directions been given in the sense that we want an independent body to come in and actually conduct that consultation.

Ms FORREST - Just one question I have - it is related to the shared equity scheme.

Ms GIDDINGS - Certainly.

Ms FORREST - Will this scheme be open to all low-income tenants or will it be restricted to specific areas? If it is for all low-income tenants, who is classified as a low-income earner?

Mr MARSTON - The eligibility for the shared equity scheme is the same eligibility as our streets ahead scheme that has operated since 2000. The eligibility criteria work on a combination of income and assets. The income eligibility for a single person starts at approximately $850 per week. It is linked to the median household income. For families we have an equalisation factor.

So couples with four children can theoretically earn approximately $1 500 a week, if you have four children in your household. In addition to that, we have asset eligibility which relates to financial assets; that is, shares, cash and those sorts of assets as well as potential equity in land for a new construction home where the maximum is linked to the median price of the home across Tasmania - 20 per cent. I think that has just been reviewed and it is approximately $55 000. But we can certainly make those eligibility criteria available in full detail, if required.

Ms FORREST - That would be good if you could do that. You explained the eligibility criteria well, but is the scheme open to all low income earners that meet that criteria?

Mr MARSTON - Yes.

Ms GIDDINGS - But the shared equity is for new constructs. We want people who are building to increase supply as well. So it is not to buy private houses, although the shared equity scheme will still abide by public houses. So if you were a tenant and you want to buy your own public house, then we will have the shared equity scheme cover that. But if you are wanting to buy in the private sector, you will have to build a new house and we will then allow you to be part of the scheme.

Ms FORREST - So any tenant who meets the criteria and who wants to buy their Housing Tasmania property, regardless of where it is, will they be able to do that?

Ms GIDDINGS - No.

Ms FORREST - Where is the restriction around that?

Ms GIDDINGS - We want to ensure that we keep appropriate properties in appropriate areas, and naturally the ones that people want to buy are often the ones in the best suburbs. That makes it very difficult for us to ever have that property freed up for other tenants to be able to move into suburbs that are more popular than other suburbs. So our houses that are up for sale are those within the broadacre areas primarily in order to ensure that we get a mixed community within those broadacre areas, with a mix of public and private, and hopefully to be able to solve some of these social problems that come from having a high density of similar socioeconomic groups.

Ms FORREST - It could be claimed that it is discriminatory in some regards if you happen to be allocated a place in one of the nicer suburbs.

Ms GIDDINGS - That is right.

Ms FORREST - And you accept that?

Ms GIDDINGS - Absolutely, and I would not have it any other way, because it is very difficult for us to be able to buy back into those nicer suburbs to ensure that we have stock that any public housing tenants may have the ability to go into. It is a different form of discrimination when you end up not having those housing options for low income Tasmanians because you no longer have the stock.

Ms BRESNEHAN - I would support all that, Minister. The other thing is that the three bedroom predominance on our waiting list is predominantly singles with children, so we are

needing more one- and two-bedroom stock. The minister is quite right that we try to sell in broad acres and the three bedrooms to realign our portfolio and to get the mix of community outcomes in those areas.

Mr MARTIN - Are we going to receive a response to that select committee report?

Ms GIDDINGS - Yes you will receive a whole-of-government response.

Mr MARTIN - When could we expect that?

Ms GIDDINGS - Hopefully in the not too distant future. We have been pulling it together from all the various departments and I have yet to take that report to Cabinet. But I hope that will not be too far away - similar to what we did for Ashley.

Mr MARTIN - Yes, that would be good.

[6.30 p.m.]

Mr MARTIN - Just one other minor point, my only problem with that would be if it was all created out of broadacre.

Ms GIDDINGS - We do have an issue around where crown land is available and while we have pockets of crown land available spread across the community, the vast majority of crown land that is available still happens to be in our broadacre areas so we are trying to do a balance there of developing where we can in blocks - and we are, in fact, buying blocks when different blocks become available - and Brisbane Street is an example of that where a block became available in about March/April of this year and we bought that in city block to give us options in the future.

But, again, when you are talking large amounts of land it still tends to be in those broadacre areas so some of our housing developments will be out there in those broadacre areas but others we are trying to get as in-fill building around our inner city areas.

Mr MARTIN - My absolute final question is the Chigwell Primary School site, when would construction be expected to commence on that?

Dr WHITE - The site is currently with council for final approval so we would expect in this financial year to start to see blocks released on that site. We will determine the way we go ahead and manage that subdivision, and the way we will do it in partnership, dare I say, with HIA or private developers et cetera in order to release outcomes. We are looking for a mix of affordable housing on the site together with sales in the general marketplace and using shared equity schemes et cetera for support. But we would certainly anticipate land coming on line next financial year from that site.

Mr MARTIN - Thank you.

CHAIR - I think finally, Minister, we are done and dusted. Might I say, thank you very much to yourself, your advisers and staff for providing us with a raft of information. I think you have had a good hearing. I wish you all the best tomorrow when you have those other more uncouth people downstairs to deal with.

Ms GIDDINGS - I do not think it will be as pleasant as today has been.

The committee adjourned at 6.33 p.m.