Monday 3 June 2013 - Estimates Committee A (Michelle O'Byrne) - Part 2

Ms O'BYRNE - Still at the table. It is my chief of staff, Bernadette Jago, secretary Matthew Daly and deputy secretary David Nicholson and if I can, Chair, through you, this is the overview of the connected care strategy for ICT which has managed public health and human services that we indicated that we would table. There is still one question on staff and children ratio at Ashley detention centre; the ratio of staff to young people at AYDC is one to three - one to four, I apologise – one operational custodial staff who supervises young people in custody to three youth. This ratio is maintained at all times; the number of young people in custody at Ashley on 25 December 2012 was 13 and the staff who met the required one to three ratio.

CHAIR - We will go back to the theme that Ruth was developing with regard to THOs. We are still on the broader rather than the specific.

Ms O'BYRNE - I can probably give some examples if that would make life easier. It is intended, as we said, to create that commercially focused corporate service entity for DHHS and THOs. A shared service general manager was appointed in early April for the lead in the development of the new model and managing the transition to it. When the model is proven effective and efficient, the intention is that the shared service will act more independently with the agency and it is designed to reduce the potential for duplication and, as I said, the contributions to THOs will be identified in their service agreements. The intent of the question seems to go to whether or not one or three THOs was going to create further levels of duplication and whether there are three THOs or one THO, and I point out that the legislation passed by both Houses does not give a number - there could be three, there could be one, there could be 20 - not that we would have 20.

The THO: the arrangement would remain the same regardless of the number of THOs; they are required to use the services under section 38 of the THO act and they are provided on a statewide, coordinated and consistent manner across all four client areas, the DHHS and THOs south, north and north-west. An example that probably spells it better is that we have a statewide payroll service coordinated by shared services with staff operating in each of our four major sites to coordinate activities in support of that service. The north-west THO has a payroll office working as part of shared services, providing local control over payroll issues in the north−west and that would apply regardless of whether there is one or three THOs because there will always be a need to have payroll resources where major employment occurs in the system they are supporting. The same number of doctors, nurses, attendants, allied health professionals, et cetera, would still need to be supported by the same number of payroll staff.

Efficiencies will be found in streamlining the systems and the processes that we use to deliver those shared services, in looking for opportunities to remove things such as we have at the moment - whilst we have a statewide payroll system, we still have things like manual handling for timesheets - collecting data direct from systems and moving to a greater level of automated systems to make them less dependent on that kind of manual operation.

It means setting a new framework for procurement; we spend currently around $700 million on goods and services per annum and we can make better savings by coordinating and strategically aligning that procurement and, as I think Mr Nicholson mentioned before, we brought KPMG in to assist shared services to create a new model for procurement. Part of that was one of the attempts we made about how we might procure better with other jurisdictions; Victoria and New South Wales are keen to do joined-up models of procurement. Probably you should align a whole lot of things and get consistency with your procurement practices before that can occur. That is part of the work KPMG was doing and those gains will be made regardless of whether you have one or three THOs; it is really about that broader system. Services and shared services will include payroll, financial operations, business systems, procurement and asset management and there are further services under consideration being reviewed over the next 12 months. They will be provided on a statewide basis to

achieve economies of scale and deliver greater efficiencies over time.

Some of the work they are doing at the moment is a functional review of services provided by the group to inform the development of service delivery improvement and KPIs, developing a negotiating service level agreement between shared services and customers and developing an operating plan to better inform the group of its customs, the functions and the objectives of shared services and establishing clear and effective communication channels between shared services and their customers. Their focus so far has been pretty much on the procurement and payroll improvement services. Does that help at all?

Ms FORREST - Yes, that's good. There was a comment made either by you, minister, or by Mr Nicholson about there going to be a committee to oversee the shared services. How will that work? Is that people employed by the department or is this a separate committee that is going to be paid to sit?

Ms O'BYRNE - The shared service model is basically set up as another board operation with the three CEOs sitting on top of that so they can direct and monitor those channels. The committee is the transition to that model.

Ms FORREST - The committee is only to drive the transition, not as a long term -

Ms O'BYRNE - Yes, and then there will still be the CEOs who will need to sit on the board and they will need to have a normal governance structure around it because they will also be selling their product to other parts of the agency.

Ms FORREST - You mentioned increasing efficiencies and suggest ways to try to reduce duplication. In the Auditor-General's Report No. 11 Volume 5 released the other day, it makes recommendations that the DHHS increase the number of efficiency indicators reported, such as the value reported equals or closely equals total expenditure incurred in the acute health services and on its other output groups. Each of the three Tasmanian Health Organisations similarly report efficiency indicators such as that the amount of reported output groups equal or closely equal total expenditure incurred on each output group. What was the response to that recommendation initially? How are we going to see efficiency indicators better reported? The Auditor-General has made mention of this in the past as well.

Ms O'BYRNE - That is the work being undertaken by the commission. The Auditor-General's report ended June 2012, so a lot of work has been undertaken and the transition has been made since then. Also, that is the role of the commission of health services - Alan Bansemer, Alasdair MacDonald and Heather Wellington. It is about trying to make sure that we are reporting against the same things because one of the problems has been so many levels of reporting. It has also been one of the challenges of national health reform with the Australian Government requiring more reporting. The battle we have is that we want to be transparent, so there is no point in collecting different data sets for the sake of different data sets. We want them to be consistent. That work has been undertaken.

Mr DALY - I guess in the evolving process of the service agreements, the KPIs have been more refined, the sophistication of them tied to either national benchmarks or ministerial objectives, particularly as we improve those KPIs around clinical governance and patient safety. This is the second year now that we have had these service agreements. The first year was very straightforward in terms of activity. This year we have started to introduce additional qualitative indicators and we undertake quarterly reviews formally with the THOs, so that gives the opportunity, if there is a new ministerial or new national objective that isn't formally locked into the service agreement, for us to introduce it at that point. It is a fairly flexible tool to introduce it, which is their obligation to deliver and that becomes the peak group of KPIs that we monitor. It is not the only group, but it is the peak group of KPIs that we monitor with the THOs.

Ms FORREST - The issue is here efficiency indicators as well as outcomes, as opposed to outputs. I know that you have reporting to the commonwealth, but is that where we are trying to head and see what the impact are? The whole purpose in some respects of reporting these sorts of indicators is so that we can see how the dollar is spent that could have some benefit for the people of Tasmania. Is that where we are heading with this and when will see these indicators? When do you expect the report of the commission?

Ms O'BYRNE - The commission is doing a report to the commonwealth and I understand that is being sent to me formally - I am hoping to get it in the next week or so. Because they have sent it through to the commonwealth and the commonwealth will share it with us when finally they have it. That is going to indicate them as well as the commonwealth savings. I think you are right, one of the issues with National Health Reform is that everything has been funded against outputs, but the broader conversation we need to have is how you measure health outcomes and the Auditor-General touches on that. That is why, when I talked before about the different ways that we could purchase under the system, you could actually purchase health outcome as opposed to a health output. A health output is the fact that you saved somebody who came in with a heart attack; a health outcome is that you are presenting at ED and that is -

Ms FORREST - And some of their family, too, potentially further down the track.

Ms O'BYRNE - That is a lot of the partnership work that we are doing with Medicare Local as well. Medicare Local is another commonwealth instrumentality; it is different in the original section and it is still quite new so it is developing its role in that primary health purchasing. There is nothing to stop us really purchasing from Medicare Local and Primary Health those sorts of outcomes rather than outputs. We have indicated that we will be taking on board everything that the Auditor-General has said and with some of the work we are in advance and some of it we need to do some more work on.

Ms FORREST - I am interested in some of the strategies that you intend to use either at a department level, or maybe it is the THOs, into reducing waiting times and lists, and also how the integration with preventive health in the primary health sector is going to be used to facilitate a reduced demand on the acute services.

Ms O'BYRNE - That is some of the work that is being funded but I cannot remember the project with Medicare Local at the moment, but it is about the primary care pathway. Is that what is called, 'primary care pathways'?

Mr DALY - Yes, that is the working title that I will be using as well.

Ms O'BYRNE - Which is exactly that they invested in that process; it is looking at people and managing conditions other than surgery. We have seen, and you would have seen, patrol in the north-west with the Kneehab program. People want to get their knee surgery because they have pain or mobility issues. If you can manage pain and mobility through exercise, diet, physio or better pain management then not having surgery is a good outcome. That is some of the work that is happening through the patient pathway process.

Mr DALY - We could get Michael to come and talk about the efficiency that we are building into the commission -

Ms O'BYRNE - I would like to invite Mike Pervan to the table. He will move slowly because he has had his own surgical incident recently. Could somebody get him a different chair? Mike is the commissioner so the purchasing work that we are doing from the THOs comes through the commission unit against the Tasmanian Health Plan but also allows that connectiveness with primary health issues. Anyone who has had an injury to their health knows the disconnection between

primary and tertiary health has been absolutely huge and Mike may be able to add to that.

Mr PERVAN - At the moment we are looking also at work that has come out of the discussions with the commonwealth commission, which is the Canterbury pathways project. It came out of New Zealand and is now being very successfully demonstrated in Barwon Health and in Hunter New England Health, where both the CEO of Medicare Local in Hunter New England and the CEO of the Acute Service cannot speak highly enough of not only the increased efficiency but the improved patient experience they get from it. The lines of communication between primary care and the acute hospitals are always pretty patchy. Once you have an articulated pathway leading from the first visit to a GP into the acute and back again, what you are able to do is identify unnecessary waiting and duplication, and things like diagnostics can be better done in the community and done faster than on an admitted basis.

Once mapped out, the patient's time from first diagnosis through to treatment and ultimately, we hope, cure is greatly reduced. With that better outcome also comes increased efficiency because, as the minister was saying earlier, you are not duplicating tests, you are not having people wait so long between having a diagnostic test and being admitted that they have to have the diagnostic test repeated and issues like that. That is work that everyone is very enthusiastic about in the system and we are very interested in doing our part to support in terms of improving elective surgery throughput or reducing the median waiting time, because it is not so much how many people you have waiting but how long they wait. That is a matter of using the service agreement to target the patients who have been waiting the longest and where there might be more complex patients, to see what we can do, working with the THOs, to identify the cohorts of patients that need special attention and directing the funds towards them. That is the whole essence of our elective efficiency. It is something that we are all going to have to learn to do because it is not something that the system is currently geared up to do. But everyone wants it to happen so it will happen faster than it otherwise would.

Ms O'BYRNE - Do you want to comment on the statewide waiting list management?

Mr PERVAN - One of the things that have been raised with us with the commission, and one of the things that we have been looking at over many years, is the concept of having a statewide waiting list. Not to have a group of bureaucrats in Hobart who are dictating who gets surgery and where and when, but to keep oversight of the lists that all the THOs have and where a list with a particular procedure or craft group is moving faster in one THO than another, to offer the patient the choice.

Ms O'BYRNE - The endoscopy work that was happening at the Mersey was going through at an incredibly rapid rate due to the highly trained nurses and the skill mix we had there. It has grown in other areas now but they are the sorts of opportunities that you might want to look at.

Ms FORREST - Are you doing that across more areas - endoscopy and some of the other areas being looked at?

Mr PERVAN - The difficulty is, that like most jurisdictions, there are a couple of exceptions. We do not have a discrete elective surgery facility like Lakeside or one of those, and as a consequence there is always that tension between the emergency patients coming through the door in winter and the seasonal impact, and how much throughput we can plan significantly into the future. We are looking at increasingly using the capacity of the whole state, as we have with Mersey, to undertake specific procedures where there is some room to move in that direction.

Ms O'BYRNE - There are some challenges with some stand-alone elective procedure hospitals where they have occurred in the transition of the patients, should the surgery not progress in the right way. St John of God in Western Australia has had some significant issues with transferring people back into the acute sector of the -

Ms FORREST - It was co-located.

Ms O'BYRNE - That was another issue.

Ms FORREST - I know it is another issue but you do not have the emergency season that everyone whinges about.

Ms O'BYRNE - The high rates over there?

Ms FORREST - Yes.

Ms O'BYRNE - True.

Mr DALY - Should we share with you that with the commonwealth moneys, we took long-wait patients from the north and funded them to be treated in their home region which was the north-west and for the first time we are now starting to move patients around the state with their choice and support.

Ms O'BYRNE - Surprisingly, people are quite happy to get further up the list if they can get access to a procedure.

Ms FORREST - It is not far to go in the bigger scheme of things.

Mr DALY - No, it is not at all. We were hesitant in doing it, thinking we would not get a positive response but it has been a very positive response and facilitated us truly addressing the longest of long-wait patients in the state.

Ms FORREST - With regard to the reward payments for meeting certain commonwealth requirements for additional funding, are we getting those reward payments, are we missing them?

Ms O'BYRNE - We have ticked off the bulk of them. The one that we were always going to struggle to meet and we talked about it when it was first announced, that some of the reward payments are such a small amount of money, that if you strove to meet them rather than doing the system reform that we need to do you would do yourself a disservice to the service overall. The work that we are doing around system changing in the hospitals, the work that the commission is doing, and what the hospitals are doing, is more important than meeting an arbitrary timeline. They have always known and we have been very upfront that we would rather get our system reform sorted so that we can meet the needs into the future rather than funds. There was one we have always identified as a struggle to meet but most of the others have been okay.

Mr PERVAN - Yes.

Ms O'BYRNE - The health MPA was the one that we were going to struggle to meet but the access target

Mr NICHOLSON - The emergency access target.

Ms O'BYRNE - We're already on the record as having spoken to the commonwealth and said we've got an opportunity to do our system reform or we can meet the target. In fact, we'll try and get system reform done because our costs are still so amazingly high.

Ms FORREST - With regard to the system reform, is this progressing the Tasmanian health plan effectively?

Ms O'BYRNE - It's the health plan for the work of the national health commission so the health plan with the lead commission is the national health commission but also the work that each of the

THOs are doing themselves in unpicking their costs. They don't want to go on the record, and I can understand why; there's a couple of very expensive contracts that Health has. Given where they are, I'd rather not go into public conversation about them but I'm happy to do it *in camera* at another point. They are the sorts of things that will make a significant change to the cost structures in some of those areas.

Ms FORREST - An AG issue.

Ms O'BYRNE - Yes. Given where we are in the discussions, I'd rather we didn't go into that too much because there are commercial implications of that. I am happy to privately or off the record - I don't think Estimates can go *in camera*. I'm not sure what the ruling of the upper House is for that.

Mrs HISCUTT - I will ask your guidance. I would like to ask questions about the FTEs and each individual THO and the breakdown there. Would you like that question now or when we have the three -

CHAIR - Let's do it when we go to individual THOs please.

Mrs HISCUTT - Okay.

Ms O'BYRNE - We'll make sure we have that ready.

Mr VALENTINE - If all the THOs get through to the end of the year or towards the end of the year and they find they have run out of money, what happens?

Ms O'BYRNE - Well, they haven't, which is fortunate. The purchasing is based around the dollar that we have. The hospitals have been carrying over significant debt and the ability to match that debt has been a challenge at this stage and I'm sure the THOs will talk about it when they're here. The LGH is going to be on budget so THO north will be on budget; THO north-west has some significant issues around contracts which impacts on its capacity but they have a plan on track to deal with that; the Royal Hobart Hospital has gone from a $30 million deficit to projecting around $6 million to $7 million. Whilst it is still a $6 million to $7 million deficit, they have managed to meet their throughput target and significantly dealt with their debt management. That's effectively the work that they've done; finding efficiencies within their system. This new model is driving us to live within our means and we're getting a lot closer to doing so. We don't need to go to Treasury to find that money; that money is being managed, cashflowed through the Royal Hobart Hospital's budget itself so they're also managing the deficit themselves for the first time.

Mr VALENTINE - Good.

Ms O'BYRNE - It's a good story. It's a significant shift from a culture where you just did what you did and somebody would pick up the tab later on. Given the challenges we've had in Health over every state and territory, I don't think anyone thinks that's the way that Health can continue going. It means that when we negotiate costs with them, they have got their costs down, so we are getting a better bang for the taxpayer dollar as well.

Ms FORREST - Minister, does the Mersey Hospital funding sit within the THO?

Ms O'BYRNE - It's a contract with the commonwealth but we fit it within the THO north−west because that's the only way the health plan can work for THO north-west.

Mrs ARMITAGE - Going back to waiting lists, you explained quite well the fact that you are trying to move them around and cover them. I think we all know there are a certain number of people on the waiting list that will never be treated, depending on their category. Do we advise them of that so that they can make alternative arrangements or do we leave them sitting on the waiting list thinking

they're going to be treated when the doctors and we know full well that their category will never get to -

Ms O'BYRNE - They need to have that discussion with their own doctor. The department can't do that. It depends on their clinical need and also the throughput of that particular area. I have to be a little careful because I might identify a person and I don't want to. There is one case that is always on the over-boundary 10-year-plus case, and it's a cosmetic issue. Without going into it, the reality of getting to this particular one isn't easy because it's always back there, but I believe that the medical practitioner involved has been up front with the person and she chooses to be on that list. I don't want to identify it any further because, given the nature of this it would be very easy to identify that individual.

Mrs ARMITAGE - When we get to the THOs you will give us breakdowns of the waiting lists, so I will not ask it now.

Ms O'BYRNE - I can do that now, if you would like.

Mrs ARMITAGE - Yes, that would be good for the three THOs.

Ms O'BYRNE - Do you want separations, waiting separations and back waiting lists or just the waiting lists?

Mrs ARMITAGE - Separations would be good.

Ms O'BYRNE - For raw separations, and bearing in mind that they are not adjusted for the complexity of the episode or the individual care that is required: at the end of 2011-12, the Royal Hobart Hospital had 33 452 raw separations and to March this year had 33 854 so it is on track to meet its service agreement and has increased raw separations. The Launceston General Hospital in 2011-12 had 25 199 raw separations and in 2012-13 to 26 March, 340. The North West Regional Hospital had 5 941 and in 2012-13, 6 492 and the Mersey Hospital was 6 606 and 7 442 to March. And if I can take you back to the 2009-10 figures because that is before there were budgetary changes - and I know that is what the next questions would be - the Royal Hobart Hospital is 33 568; the LGH, 25 877 - this is the 2009-10 year - the North West Regional Hospital, 6 610 and the Mersey Community Hospital, 6 456.

When you are looking at weighted separations, which deal with the complexity of the case, and combine with the number of times people come into hospital and how ill they are when they come into hospital, the figures are a little different. I will give you 2009-10, 2010-11 and then to March this year so they will be the three figures: the Royal Hobart Hospital in 2009-10 was 39 131 and in 2011-12 was 40 797 and to 31 March this year, 39 804, so on track to be pretty well where it was last year. The LGH, 2009−10, 24 134, and in 2011-12, 24 676, and to 31 March, 23 394. They will be close to getting their last year's figures but they might be a little bit under but we are just finalising it. We will not really know those figures but they are comparable there.

The North West Regional Hospital in 2009-10, 8 532 and in 2011-12, 8 359 and in 2012-13, 8 303 to 31 March again. The Mersey Community Hospital in 2009-10, 5 561 and in 2011-12, 5 253 and in 2012-13, 6 978 to 31 March, and there is the three months and the one month that we are still going to before they get the end of year figures. Did you want ED presentations?

Mrs ARMITAGE - ED would be good because I think we all know -

Ms O'BYRNE - That is the input.

Mrs ARMITAGE - It is. A lot of these people on the waiting lists present as EDs because they do not get treated in a timely way.

Ms O'BYRNE - No, I do not think that the evidence necessarily backs up that they presented to emergency but I will get -

Mr DALY - I spent a lot of time at the inquiry that you headed, Ms Forrest, and we could not identify any evidence of an increase in emergency surgical admissions. We can resurrect those figures again for this purpose but that was not a recollection of the upper House inquiry.

Ms O'BYRNE - I am happy to give that on notice, Mr Chairman.

Mrs ARMITAGE - I think identifying them and speaking to people in ED, that they see these people come in and it is a bit of a balance, but anyway.

Ms O'BYRNE - Sometimes there are co-morbidities so somebody might be on a list or something but the level of significant co-morbidities that we have across our chronic disease population in particular -

Mrs ARMITAGE - But the 2011-12 when we looked at it we had 9.4 per cent of patients waiting longer than a year in Tasmania for operations compared to the national average of 2.7 per cent.

Ms O'BYRNE - Do you want the ED figures now?

Mrs ARMITAGE - Yes.

Ms O'BYRNE - The figures for 2009-10, 2011-12 and 2012-13 to 31 March are the three figures again. For the Royal Hobart Hospital - 35 773; 36 437; and year to 31 March, 38 423.

LG - 2009-10, 32 388; 2011-12, 32 319; and 2012-13, 33 530.

North West Regional - 2009-10, 19 811; 2011-12, 18 627; and 2012-13, 18 303.

Mersey - 2009-10, 19 597; 2011-12, 19 325; and 2012-13, 21 005.

I went from 2009-10 to 2012-13 because it gives historical data prior to the budget challenges.

Mr VALENTINE - So 2010-11 is out?

Ms O'BYRNE - I can give 2010-11 if you would like it but it will make it even more complex.

Ms FORREST - No, no.

Ms O'BYRNE - It was to give that comparison to last year but also a comparison to prior to the cuts, so that we were comparing more appropriately. I have the ED patients seen within recommended timeframes. I will give you this year's figures and the other year's figures are on the record.

Royal Hobart Hospital - Cat 1 is 100 per cent; Cat 2, 89.1 per cent; Cat 3, 55.3 per cent; Cat 4, 62.1 per cent; and Cat 5, 86.2 per cent.

Launceston General Hospital - Cat 1, 100 per cent; Cat 2, 68.7 per cent; Cat 3, 55.8 per cent; Cat 4, 62.1 per cent; and Cat 5, 86.2 per cent.

North West Regional - Cat 1, 100 per cent; Cat 2, 88 per cent; Cat 3, 88.9 per cent; Cat 4, 87.1 per cent; and Cat 5, 96.1 per cent.

Mersey - Cat 1, 100 per cent; Cat 2, 78.6 per cent; Cat 3, 69.9 per cent; Cat 4, 73.6 per cent; and Cat 5, 94.6 per cent.

Elective surgery waiting list - I might give you the percentage changes first, compared to the same time the previous year. March 2012 to March 2013.

The elective surgery list decreased by 15.9 per cent at the Royal Hobart Hospital; increased by 11.9 per cent at the LGH; increased by 1.5 per cent at North West Regional; and increased by 1.3 per cent at Mersey.

The median waiting time for patients from the waiting list, to the same time points, March to March:

Increased from 39 to 40 days at the Royal Hobart Hospital; decreased from 37 to 34 days at Launceston General Hospital; decreased from 40 to 32 days at the North West Regional; and decreased from 32 to 28 days at the Mersey.

In terms of elective surgery, patients that were seen within the recommended timeframes - we saw improvements in categories 2 and 3 at the Royal Hobart Hospital. We declined in categories 1 and 2 but improved for category 3 at the LGH. Improved categories 1 and 3 at North West Regional Hospital; and improved categories 1 and 2 but deteriorated for 3 at Mersey.

Ms FORREST - It is interesting at the Mersey when you think that without quite the acuity of patients generally, that category 3 would have deteriorated. Is there a reason for that?

Ms O'BYRNE - It might be more appropriate to get Gabby. I would not want to speculate at this point.

I can give some overall staffing numbers. THO South, 7 July, first pay period in July last year to 30 March, 3 345.31 FTE; to 30 March was 3 428.86, an increase of 83.55 FTEs; for the North, 7 July 2012 was 2 123.52, increased by 30 March to 2 152.86, which is an increase of 29.34.

Mr VALENTINE - Sorry, what was that last bit?

Ms O'BYRNE - 29.34 increase of FTE.

Ms O'BYRNE - And for the North-West for 7 July 2012 was 1 238.12 and at the end of March it was 1 282.23, an increase of 44.11 FTE.

Ms FORREST - Would you break this down into the number of direct clinical care staff?

Ms O'BYRNE - That is the overall staff but for instance, nursing in the South increased by 23.57 FTE, in the North by 18.59 FTE and in the North-West by 13.06. I would need to add up all my salaried medical practitioners to give you the figure but it looks like - and I would have to confirm - I have around 18 FTE, 17-18 additional medical practitioners in the South, so possibly about 17. I have an additional 10 FTE in the Launceston General Hospital and in the North-West an additional roughly 13, possibly 14 FTE's; I would say 13 to be safe, so I would round it up in medical staff, - sorry, in actual medical practitioners. That does not include, obviously, radiation therapists.

Before anyone says, 'I do not think that says that we are taking the foot off the pressure on them,' I think what it says is that they are gaining efficiencies in their structures, savings that there may arise to be translated into the staff decisions that they have made because they are living within their service agreement budgets.

Mr VALENTINE - With respect to consultants over that period of time, have you any figures on that?

Ms O'BYRNE - Over the broader department?

Mr VALENTINE - The broader department was the first instance.

Ms O'BYRNE - I will give you a little bit more than you are asking for if that is okay, because otherwise if I try to unpick it I might make an error. As of 1 May the DHHS and THOs entered into 76 contracts for the value of $50 000 or more and the total value of all of those contracts was $123 million. Of those contracts, 11 went out to consultancies and have a total value of $22.3 million. Five of these relate to consultancy services for building projects, predominantly the Royal Hobart Hospital redevelopment.

Mr VALENTINE - Is it granted in total or not?

Ms O'BYRNE - We will table that.

CHAIR - We should move to THOs, we have done the overview and given it a fair run, Rosemary. Can we commence with THO north, please?

Output group 2
Tasmanian Health Organisations

2.2 Tasmanian Health Organisation - North -

Mrs ARMITAGE - Minister, I understand that the northern THO, for a start, ran its own capital works program as opposed to others. Was it efficient and effective and how did it work?

Ms O'BYRNE - Yes. That doesn't mean it didn't engage contractors; they certainly did. There were a number of local contractors on site during the time.

There were a number of significant projects being done. There was the $5 million for the car park. I know, to other people, it sounds like it doesn't matter but we would not have got council approval to extend the other facilities in the hospital, being the cancer service, had we not invested in the car park.

Mrs ARMITAGE - The car park is a huge issue around the hospital.

Ms O'BYRNE - It made a significant change. There's the upgrade and expansion of the Holman Clinic's Medical Oncology area with the additional 17 chairs up from 12, consultation rooms and social work rooms. That's working really well. We are very close to opening the redevelopment of the former John L Grove facility, which is a 20-bed sub-acute rehabilitation unit, with 14 single and three double rooms. The intensive care unit operating suite on levels 4 and 5 have been expanded to 2 400 square metres and we've got the fit-outs, hopefully. The middle of next year is the cut-off for everything to be finalised.

Most of the projects were managed internally but along with building contractors. Contractors now actually come with the management of the building project under normal circumstances.

Mrs ARMITAGE - You mentioned that the budget for the THO North is likely to come in on budget.

Ms O'BYRNE - Yes.

Mrs ARMITAGE - If it is shaped up on budget, are there likely to be any further reductions in staff? Basically, are there any penalties for actually coming in on budget?

Ms O'BYRNE - No, the others aren't getting rewarded for going over budget. This is the way the south and the north-west are dealing with it - they have to deal with their own overruns within their own cashflow management, which they are both able to do. If either of them have a crisis issue with that, then we'll work with them around what we're asking of them but there isn't any additional money to reward a hospital or a THO that doesn't meet its requirements. I don't think it would be a very good message to send to those that we're asking to come in on budget if we then reward someone for not coming in on budget. I think that's historically what has happened in the past.

Mrs ARMITAGE - Sometimes if you come in on budget, it's almost like 'Well, you must have had too much money; you've managed and we'll cut you back next year'.

Ms O'BYRNE - The thing is that we don't give them the money and say if they haven't spent the money give it back. We are now purchasing services at an agreed price. If they have some money left over after delivering those services, they can keep that money. It's entirely theirs; they can spend it however they want internally; they can do more procedures, they can invest in equipment or they can do what they want. The only time we are concerned is if they don't meet their requirement or if they don't meet their requirement and still have cash. That would be something that we would be extremely concerned about. If you haven't met what we've purchased and you've got money in the kitty, we would think possibly you should have spent some meeting your service agreement and they would be in breach of the service agreement and we would deal with it through that process.

Mrs ARMITAGE - Have each of the three THOs signed their service agreement?

Ms O'BYRNE - Just. I signed off yesterday on those that came to me. They will be tabled in parliament at the next sitting.

Mrs ARMITAGE - Are there any budgetary impacts of the THOs, particularly from the north-west, where the north have to cater for large numbers? I know in the past there have been. I accept you were saying that there has been an offer now for people who are on the waiting lists to perhaps move out of region but I know that the north has always had a large number that have come up from the north-west, either having been transferred from the north-west hospital for particular procedures or they've had a preference to have their procedures done at the LGH. Is there a balance? Are they compensated for taking patients out of area, basically, in a budget?

Ms O'BYRNE - It would be an issue if we just gave them a bucket of money and said do what turns up. We're actually purchasing procedures now so that's the way that's managed. We purchase the procedures on a statewide basis within the three THOs so there is no penalty, otherwise with the Royal Hobart Hospital having the tertiary area, we'd have the same argument. One of the challenges has been that people often get transferred to a hospital with capacity for a higher acuity management and then when the treatment is done and that hospital tries to send them home again, the other referring hospital goes no, no, we're full, go away. I think that's been an historic issue. There's probably been more of a challenge.

Ms FORREST - Home to the referring hospital, not home to home.

Ms O'BYRNE - No, home to the referring hospital. I think that's probably more a challenge but because we're purchasing procedures now, the shift is different. In a statewide system we're always going to have, in a statewide system, people travelling around the state to access services but we purchase those services and the model should shift.

Mrs ARMITAGE - Now that the CEO of the LGH for the THO North, what efficiencies have they been able to come up with and what areas are they working on particularly to try to bring down

things like the waiting lists and other areas?

Ms O'BYRNE - I thank Mike Pervan, and bring to the table the chair of the governing councils, Graeme Houghton. Graeme Houghton is the Chair of the Tasmanian Health Organisations pre-government practice. Each THO has been looking at its efficiencies and the way in which it performs procedures. The LGH surgical area with Berni Einoder has a particular fascination with insuring that - Berni has always gone through every surgeon's list to make sure that they are doing as much work as humanly possible; a that is an historic reality for the LGH which will continue under whoever takes the director of surgery position in the future. I will take this opportunity to put on the record that there are not many directors of surgery who have stayed in the system as long as Berni Einoder given he has just announced his intention to step down from that role but will still be practising for us.

Each hospital has done slightly different things. I might hand to the chair as the question is around the sorts of efficiencies that each of the THOs have been able to -

Mrs ARMITAGE - For the north, particularly seeing I am working with the north.

Mr HOUGHTON - It would be best, minister, to ask John to give us some detail on that.

Ms O'BYRNE - John Kirwan is the CEO of the THO North. There are also, if necessary, members from the audit committee from the THO North here as well.

Mr KIRWAN - There are probably two parts to the question, from my perspective. We had a range of saving strategies that were endorsed for the 2011-12 period - some 61, most of which were successful, some less and some more; there was an averaging-out which allowed us to develop and come in on a balanced budget in 2011-12 and 2012-13.

In respect to those savings strategies, some were recurrent and some were one-off and some have been somewhat contentious, such as closing the Hospital in the Home program, which I should put on record was actually not a withdrawal of the service but a reconfiguration of the service so that is now provided through the acute medical unit in what we would argue is probably a more clinical efficacious manner. Other areas were closed, such as Ward 4D, and other areas like that. We have since -

Ms O'BYRNE - Ward 4D for some time, though, was a decanting facility for the Holman Clinic as well.

Mr KIRWAN - Those areas have been used. We now have reopened, in coming specifically to elective surgery. Our activity levels are pretty well limited by our physical capacity. We are now entering the last phase of our major capital works redevelopment as of a week ago, and we now have a 66-week building program. That will require us to operate on four theatres only and so we are at a physically limited capacity for the next financial year - the one we are not in yet. However, at the end of that process the redevelopment of level 5 will give us the capacity to operate nine theatres rather than four theatres. It will give us a day surgery capacity through our ambulatory surgical unit which will allow us to separate the day workers quite clearly from our major cases, particularly our emergency surgical work, which as a percentage remained relatively constant but as our emergency presentations continue to rise we still require one or two more surgical places a day and to be able to run a dedicated emergency surgical session is very important.

We have been able to achieve and are on target to achieve all of our KPIs in respect to elective surgery this year, however, understanding that we have actually been doing quite high levels for the last three or four years because of the one-off recurrent and reward funding from the state and the commonwealth, we will get through this year we are coming into and then next year we believe we will be well-placed.

Quite significantly, we have also been looking at our costs per procedure, particularly our prosthetic and other costs, and we have been quite aggressive in driving those down so that we are at, or will be at or below, in our view, the national efficient prices when we move into the funding model particularly with the commonwealth and state sharing the funding.

Ms O'BYRNE - Can I ask you to spend a moment picturing Berni Einoder's face when he discovered that a particular company was selling prosthetics to the private sector cheaper than they were to him? Imagine how we could have sold tickets to that meeting.

Members laughing.

Ms FORREST - And paid for many more prosthetic procedures.

Ms O'BYRNE - They would have brought in a fortune. I would have bought tickets for that meeting.

Mrs ARMITAGE - Four theatres will be operating. I do not know if you can tell me how many people since this has started, 1 July, we have sent home because of a lack of beds? Not a lack of a theatre but a lack of a bed whether it be a recovery or not.

Mr KIRWAN - I can pull out figures. We report internally and review it on procedures that are postponed through our activity, and procedures that are postponed from patients - sometimes a sick sibling, or the flu, or whatever. Those that we have cancelled through the lack of a bed I can pull those figures out and get them to you. They are reported and recorded. My memory of the last time that I looked at those figures they were lower than they have traditionally been.

Mrs ARMITAGE - It is improving?

Mr KIRWAN - Yes. In part, because we are not doing as much theatre. We used to have seven theatres, we are down to four, so we need to be careful. The numbers that we have cancelled, we had a peak the winter before last because of ICU block, but because the state government allowed us to increase our ICU beds, the ICU block particularly in July/August where basically any major theatre that had been sheeted for Monday was unlikely to go ahead, that has been significantly reduced, if not eliminated. ICU block for major operations has been stopped. Beds have been delayed and I can pull those figures out for those cases where we have cancelled them because of the absence of a bed. My memory of the figures are that it is more often because of an overriding emergency. Emergency surgery has caused the theatre time to be expired and then they have filled up the beds or the surgeons have run out of time because they have been operating all day so that in those surgical subspecialties we do not have a surgeon who can do that work. Again, the numbers are not of any great concern the last time I looked at them.

Ms O'BYRNE - They also restructured the nursing hours around surgery which has given greater throughput.

Mr KIRWAN - Yes, we have used the opportunity to change the shifts within theatre for the nursing staff and it is now far more efficient and theatre utilisation is 100 per cent.

Mrs ARMITAGE - I was going to ask that - how many patients that might be on a list do not get done and get sent home because at the end of it, the nurses have finished their shift and the patient has not been treated.

Ms O'BYRNE - Less than historically.

Mr KIRWAN - Not that many, other than those that have been by overriding emergency. The surgeons are good, they will normally finish the list if that is possible but they will not start a big case

if it is late and there is some confusion and some of the complaints we get from your electoral offices, through the ministers office, are that we will say to people there is a chance, we will basically stand-by you. Some people complain that they do not get that, that is not a booked admission, that is a case of we believe that there is a possibility and we will do a number of those procedures. It is a case of us queuing to make sure that the theatres are always busy but the down side is that some people believe, and we get complaints from people saying, that they have been cancelled two or three times.

Ms O'BYRNE - Historically, it is more their families that complain. The individual patient is reasonably okay with it because they know what they have agreed to on a stand-by list but for families it can be quite distressing.

Mrs ARMITAGE - How many beds would we have closed at any one time? Has it changed? At one stage last year there were quite a few beds closed, have they been reopened or are the beds still in storage?

Ms O'BYRNE - All hospitals flex up and down, based on demand.

Mrs ARMITAGE - I appreciate that but there was an issue.

Mr KIRWAN - Using elective surgery as specifically the case, we had two 32-bed surgical wards and at no stage were the full 32 beds open. In one area there is an issue in respect to Occupational Health and Safety in size. Remembering these wards are 30-year-old wards and are quite cluttered, lack storage, and a whole range of other issues. We now have all of those 32-bed surgical wards, both now have 28 beds open, and have authority to staff permanently, not flex up in those areas to that. That is only relatively recent. We had some difficulty recruiting the staff to allow that.

In the two surgical wards, as much as there is nominally eight beds closed, they physically could not be opened without some capital works and addressing some work, health and safety issues which we would like to do in ward upgrades in the future, which is before a separate process.

Ms O'BYRNE - The figures up at John L. Grove - we have 340 beds, including 274 overnighters and 66 same-day. That is an increase of 14 more overnight beds and two more than we recorded in 2011-12. Does that include the John L. Grove we are about to open?

Mr KIRWAN - No, John L. Grove comes on stream in August. So there are 20 sub-acute beds which will take 20 sub-acute patients out of the LGH into John L. Grove. That is commonwealth funded in respect to the capital and also recurrent for the first couple of years, which is very pleasant and very unusual.

Mrs ARMITAGE - What exactly do you class as sub-acute?

Mr KIRWAN - Slow stream step-down rehabilitation. It is an area where the nursing mix will not be as rich; use of PCAs, enrolled nurses, allied health, rehabilitation physicians. It is those slow streams - understanding that in the north of the island the only place that is available for rehabilitation is currently at the LGH rehab ward. This allows the rehab ward to be dealing with the more acute, particularly post-surgery, patients but the slow stream areas - this allows that there is that sub-acute gap which hasn't been in existence since we got these 20 purposeful beds. It was a health facility a fair while ago, but it has had to be rebuilt on the national standards to the extent that we haven't seen before, including making of dementia appropriate. We have had experts come and make sure it is totally up to the most contemporary standards.

Mrs ARMITAGE - How many aged patients would we have currently in the LGH, awaiting nursing home beds? Is that still an issue as it was in the past?

Ms O'BYRNE - Not on the same level. Probably the north-west has had a greater challenge but they are still within the national standards. I think we have a far better transition rate, remembering that the delay in transition for a modern family just wanting to get the right placement can be quite challenging.

Mrs ARMITAGE - And a particular nursing home as opposed to taking any nursing home.

Mr KIRWAN - Adding to that, minister, three or four years ago we would have had 60 to 70 aged care patients waiting for beds in a hospital and that was causing us some major problems. If it is up to more than 10 or 12 it is rare - normally the high-dependency dementia. In other areas there is still a deficiency in the north having enough for those dementia and aged care secure facilities around, plus the aged care facilities have had the ageing in place occurring to them as well, so the mixture of high and low dependency means that predominantly they are high dependency so they need to get their skills mix, including for their funding, resourcing and staffing.

We significantly do not have a problem with aged care waiting placements; in fact, substantially due to the fact that the aged care centre has really got its act together but also our transitional care beds that we use - we have 12 beds at The Manor - have really changed the dynamics of the system to where we were pushing patients out and getting some resistance, including, as the minister says, 'You can't push an aged care patient into an aged care facility that they don't agree with'. They have the right of choice, so inevitably a lot of them will choose the best, brightest, newest one, which is a bit of an issue, given our aged care stock. But now what happens is that we will have them at the transitional care beds, they will still be managed by us so we can move them out of the hospital into those beds and then in that process they get used to what an aged care facility is like and The Manor does a good job with us on that. Then what happens is that we find the other aged care facilities coming to there, to some extent marketing and selling themselves when they have patients - they are already worked up, already ready, and the turnover is great. It is a really good model; it has worked very well.

Ms FORREST - Worked up and then ready for surgery - worked up emotionally.

Mr KIRWAN - No, worked up ready for placement in aged care.

Ms FORREST - Someone reading *Hansard* may not get that.

Ms O'BYRNE - One of the big issues, and I think it is the reason we are doing a lot of the care directives, is that if you make a decision on aged case placement at a point of crisis in the family - so when mum has had a fall and broken a knee or where there has been an incident, it is a much more stressful circumstance than if you have that conversation while mum is still well and living at home and saying, 'This is the path I want to go'. So it does show that real need to invest in the work between them - the north-west has done quite a lot of good work in this space with the commonwealth around making decisions about what health care they need when they are older. It is hard to make a decision at the point of a crisis.

Mrs ARMITAGE - John mentioned transition beds. I am wondering about palliative care beds and how the hospital is facing that.

Ms O'BYRNE - We fund four beds and the private sector has some beds. Predominantly, aged palliative care is moving into the hospice without walls model and funding care programs around people remaining at home. I had this discussion recently with the Philip Oakden group about the need for palliative care beds and their desire -

Mrs ARMITAGE - They are obviously hoping for a facility to be built near the LGH in Howick Street.

[3.00 p.m.]

Ms O'BYRNE - I have suggested they speak to the governing council about the governing council's site plan for the LGH. We think the facility would be great, but setting up that kind of facility you would effectively be setting up another small rural hospital, which is a significant cost, and the palliative care clinicians are advising that they do not see the demand at the moment. If they came back and said that demand had suddenly escalated and they needed the government to fund *x* amount of beds, then that is what we would do, commissioning a unit, because that would be the request.

We have Michael Ashby, the senior palliative care clinician on the lead clinicians group leading a conversation with doctors in the community palliative care space about what it is we need for statewide planning around palliative care. There are also some additional commonwealth dollars as part of the commonwealth package for palliative care primarily focused on the primary care sector. It is an emotional issue for a lot of people because there is a great attachment to what used to be funded within and supported by what was The Manor. They decided to pull funding from the stand-alone facility and since then we have funded beds we are purchasing from the Little Company of Mary at Calvary. At this stage there is not a demand from the clinicians for additional beds.

Mrs ARMITAGE - How many of the four palliative care beds at the LGH -

Ms O'BYRNE - No, they are at Calvary.

Mrs ARMITAGE - So you do not have any at the LGH.

Ms O'BYRNE - No, we purchased them because they are then aligned with the other which allows Calvary to have the capacity to do a ward as opposed to independent beds, but we have palliative care beds in each of our regional facilities as well.

Mrs ARMITAGE - What I am trying to ask is are the four beds full, do we have a waiting list for them, do we have patients who are currently in the LGH needing to go to the public care beds?

Mr KIRWAN - No, we do not have a problem with access. The Calvary contract is a good contract from our perspective because they run both the private and the public beds, although they are our physicians and we provide some other support staff. They have the ability to flex up if there are five or even six public patients. If the contract averages on four that works out pretty well; that is the critical mass that is available for having a hospice palliative care service within an existing facility.

The LGH has a number of patients in palliation but for those for whom it would be uncomfortable or inappropriate at their stage of life to go through the trauma of an additional move we would seek in our ward upgrades - which is probably our next cohort of capital works should we ever be successful in getting some - to provide some slightly different room configurations to allow that. The patients who are with us are probably in ICU high acuity end-of-life where the palliative care hospice model is those that are probably on a more gentle trajectory. I would totally agree with everything the minister has said - that is, that the model works well. We are in constant contact to meet monthly or six-weekly with the relative group. We have indicated in our site master planning which is starting to occur this year, particularly if a co-location with Calvary is explored, that there would be options to deal with that, but a stand-alone palliative care hospice is unlikely to be supported by anyone. The capital is one thing but the recurrent cost of anything less than probably 30 or 40 beds now is just very, very expensive.

As the minister said, once the Flinders redevelopment is complete, every one of our primary health sites will have a palliative care facility in those areas. The focus is very much on dying with dignity at home if possible, so the actual demand is being met at the moment and I don't think on the figures it is likely to change much.

Mrs ARMITAGE - While we are talking about beds and private beds in private hospitals, I am sure we have all noticed in the media of late that there was talk of some of the private health funds not funding private beds in public hospitals. How is that likely to affect hospitals such as the LGH?

Ms O'BYRNE - Before I flick to John to talk about how they will manage that, can I remind everybody that in the late 1990s the Australian populace was almost forced into having private health insurance because if we did not then there would be entry fees and the rates would get higher as you got older. It is entirely appropriate that people who have been encouraged very strongly to have private insurance should also use their private health insurance. Some 45 per cent of Tasmanians have private health insurance, the rate of usage of private health is way below that but I will let John talk about this circumstance.

Mr KIRWAN - Thank you, minister. Just so that it is clear again, the services are somewhat different across the island; this is not unique to Launceston but we are a little different. Calvary does not provide intensive care, it does not provide major theatre work, it does not do deliveries. That is the major difference. As such, if you need any of those services there is only one hospital to go to. We encourage the use of the private sector and believe that Calvary and the two campuses are absolutely critical and complementary to us and we quite intentionally do not compete with them by any stretch of imagination at all.

Ms O'BYRNE - In fact, they have spent some time working with us after we encouraged them to go and work; some of our physicians have not been keen on working with the private sector as well as the public sector.

Mrs ARMITAGE - I am aware of that.

Ms O'BYRNE - Certainly it was quite a bit of work trying to encourage them to go there because we want to see the survival of the private facilities.

Mr KIRWAN - It is a complementary system. Our private insurers, of which there is a number of different ones, have taken a slightly different view in that starting from late last year or early this year, they have written to us and indicated that in their view in Tasmania, it is not unique to us because what we charge for private patient bed-day fees is governed by our legislation. There is a regulation that says and we get an advice from the department every year to say this is what the fee is; this financial year it went up I think $9. Interestingly, the private insurers - most of them, not all of them - have written to us and said they believe that they are paying too much in Tasmania and that they are going to choose not to pay the scheduled fee as per our regulations, and they have now set a rate they will pay somewhat slightly different and lower on that. The process is very clear: when someone comes to our hospital for admission, they are asked if they are privately insured. We encourage them if they are privately insured to use that because we like the revenue but it is the choice of the individual and so if they want a doctor of choice, which is the determining factor, that then means a range of other things. They cannot, for example, have a doctor of choice and then not pay the bed fees; one goes with the other and the system is designed that way.

What has occurred recently is that in a couple of the insurance companies' instances they have now said to their members, to our patients, that because of the LGH there is now a gap. For privately insured patients in other areas, we generally make sure there is no gap so we take the revenue directly from the insurance fund and take that accepting that between 40 per cent to 60 per cent of our costs are still covered by the state. We do not make money out of private patients; it is just a revenue source for us. That is what was in the media; we do not get a choice, that is our private patient bed-days are covered by our legislation, it is either that or they write off the gap that the insurance company now chooses not to pay, and that is not something that we are prepared to do.

There is a cohort of patients that I have some sympathy with. These are patients who have been

to their GP when they were pregnant, have elected to be private, so that they then go to see their private O&G and then they front up and they get their pre−admission with us after 20 weeks. At that stage they are a private patient and they cannot change, and that means the private fees for the bed-days apply. A number of other fees do not apply because by our regulations we are not allowed to. From the insurance companies' perspective, we are still a cheaper option than going to full private hospitals or private not−for−profit hospitals and that is where the gap fee has come to us.

Mrs ARMITAGE - And they will have a gap.

Mr KIRWAN - For those insurance companies that have chosen to reduce their payments to us - because we still have to charge the fee because it is in our act, our regulations - that is where the gap is and the gap, depending on the insurance company, is around $100 plus or minus.

Mrs ARMITAGE - For a public hospital.

Mr KIRWAN - No, for a private patient in a public hospital.

Mrs ARMITAGE - That is what I mean, but you are a public hospital.

Mr KIRWAN - Yes, we are a public hospital but these are private patients with a doctor of choice.

Mrs ARMITAGE - I appreciate that but that is why I wondered about the difference that there will be because, as you have said, you have intensive care and you are the only hospital with an emergency department. Some people were encouraging them to have private health insurance but on the other hand, they may need to come to the LGH but they are still going to have a gap. Other patients - apart from the anomaly of the pregnant woman, where one would have thought being a public hospital there should not be a gap either, even though they are coming in as private patients - do not have choice but to admit they are a private patient. I can go to your hospital, I have private insurance, I can be asked, 'Are you a private patient?' and I can just say -

Ms O'BYRNE - You can choose not to - you can say, 'Yes I am, and I don't want to use -

Mrs ARMITAGE - Exactly, I can choose not to use my private health. However, if I do use my private health insurance, I don't have a gap.

Mr KIRWAN - You may have a gap now, on the bed-day care.

Mrs ARMITAGE - So I still may have a gap.

Ms O'BYRNE - Depending on your private insurance.

Mr KIRWAN - We will tell you that up front. You have a choice of election.

Ms O'BYRNE - It depends on the policy that you have when you enter.

Mr KIRWAN - Yes. It depends on who your insurer is, and depends on the size of their gap. That will be explained to you to say, 'Your choice.' If you still want doctor of choice, you could have these additional payments. At that stage, the patient has a choice of being private or public.

Mrs ARMITAGE - Some may have no choice because I think we all know that some of the private hospitals often don't have any beds either; they're often quite full.

Mr KIRWAN - I don't want to sound argumentative, but you've always got a choice about whether you are public or private other than this small cohort of O&G patients because -

Ms O'BYRNE - Who've identified -

Ms FORREST - You usually know that it's happening.

Mr KIRWAN - They will know at 20 weeks what the cost is.

Ms O'BYRNE - They've already made their decision on the private.

Mr KIRWAN - Most of or a lot of those O&G private patients will only have their delivery with us and then they'll be moved to Calvary so you're talking about one or two days with us.

Mrs ARMITAGE - Okay, we'll leave that part. Another area: outpatients. I wonder how you are going towards outpatients. You have the waiting lists, obviously; you have quite a long waiting list for surgery. How are outpatients faring with the different disciplines that you've got?

Ms O'BYRNE - There seems to be a belief in the community that everybody who gets referred for an outpatient appointment then requires a surgical procedure.

Mrs ARMITAGE - I'm not thinking of that. I'm wanting the comparison between the different areas.

Ms O'BYRNE - Sure. John might talk broadly, while I find the numbers.

Mr KIRWAN - The outpatient areas have seen some significant growth, partly because what we are seeing, as the member for Launceston would know, the private physician market is in steady decline simply from a mixture of the ageing population, the level of co-morbidities in the population and the decline in the physician representation in the workforce. General physicians: once Dr Dunstan retires, I don't think we'll have any paediatricians in the private sector as such, other than the LGH-based ones doing private practice. What we have seen is -

Ms O'BYRNE - It's just in the nature of the workforce.

Mr KIRWAN - significant and the nature of the physicians themselves being, as the minister already referred to, less keen. Our outpatients demand continues to grow fairly significantly. It is an area we are looking at. It is an area that is under pressure on occasions. It is across the board, not only for specialist clinics, for the surgical areas, particularly the orthopaedic clinic but also in allied health. In some areas, like allied health, we've seen some significant improvements. For example, when I first came to LGH, in areas like speech pathology; it was a couple of years and now it is back within standard. The difficulty here - sorry to sound evasive - is that this is not an area that has some of the best information systems. Some of these are captured by paper so you see some significant variety on how we've been reporting them, but it is an area generally under pressure for the reasons I've already outlined.

Mrs ARMITAGE - I certainly don't want to put you under any pressure or extra work in getting figures that take you away from running the hospital.

I have a couple of other questions. After hours dental service has always been an issue, I believe, with an emergency after hours dental service at the LGH. Has that improved? Do we now have an after hours dental service for people coming in?

Ms O'BYRNE - Can I just finish the answer in relation to your question because I have the detail for you.

Mrs ARMITAGE - Sorry.

Ms O'BYRNE - We looked at the 2011-12 figures.

Ms O'BYRNE - 2011 figures on outpatients. There are about 150 000 episodes of referrals. Of that, only about 13 per cent required surgical intervention at the end of that.

Mrs ARMITAGE - 13 or 30?

Ms O'BYRNE - 13.5 per cent. As to what the picture of outpatients often is, it's not necessarily a direct pathway to a surgical intervention.

Mrs ARMITAGE - Regarding emergency dental service: it really has been non-existent at the LGH apart from the director, I believe, being called in on occasion.

Ms O'BYRNE - David Butler has to come.

Mrs ARMITAGE - Yes and he can't obviously, on his own, cover 24 hours, 7 days.

Ms O'BYRNE - He's also retired.

Mrs ARMITAGE - What is the current situation we have now with dental emergencies such as abscesses?

Mr KIRWAN - There are two parts to this. One is what would we provide to assist emergency dental services but the oral health services, provisions of the dentists that do the work, is with Oral Health Services which is run out of the south. For emergency dental services, and there are a range of different dental services that we assist with, it has not changed for us. For example, someone fronting in an emergency department with maxio-facial issues from a car crash, the dentist will be called in and they will undergo a general anaesthetic or work with our other surgeons, our plastic surgeons.

Mrs ARMITAGE - You say the dentist will be called in, who do you call in if you do not have an after hours dentist?

Mr KIRWAN - There is one. I am unaware that there is not.

Mrs ARMITAGE - That is not what I am led to believe.

Mr KIRWAN - The provision of the dentist sits with Oral Health Services. My understanding is the dentist services are better serviced and well serviced than they have been for quite some time.

Ms O'BYRNE - In the past one of the issues for surgery, and there were some firm views around surgery, was that they needed to have a dental surgeon on staff in ED at all times. But I think that is more of a philosophical difference but the service is being provided out of hours.

Mrs ARMITAGE - Now that David Butler is no longer available, there is someone that we are calling out?

Ms O'BYRNE - I do not know the individual names.

Mrs ARMITAGE - That is all right.

Mr KIRWAN - I think that we would have to check with THO south. It is not a service that we run. The dentist is not part of the service. We provide the theatres and the anaesthetist. I am unaware that there is a problem.

Mrs ARMITAGE - I was not thinking of maxio-facial. I was thinking more of someone who comes in with a broken tooth, an abscess, they go to ED, they need a dentist and we do not have a nurse with a husband that is a dentist that can come in, then we might be in a bit of strife.

Mr KIRWAN - No.

Mrs ARMITAGE - Okay. I will park that one.

Ms O'BYRNE - People would be referred to the Oral Health Service the next day for an abscess. We would give pain management in the ED. But remembering that emergency departments are for an emergency, they would be predominantly a category five so we would stabilise the condition and then refer them onto appropriate healthcare. The point of that would be dental services the next day.

Mrs ARMITAGE - Unless it is a weekend, of course.

Ms O'BYRNE - If it is a true emergency that would be a matter that Oral Health Services would deal with for an emergency on the same day as triage, depending on whatever their clinical urgency might be.

Mrs ARMITAGE - Another issue I want to ask you about is mental health. Does Ward 1E come under the LGH now with the THO?

Ms O'BYRNE - From 1 July it does. I do not know whether or not for the purposes of today's questions, Chair, you would like those to be answered by the director of Mental Health Services when we get to that point given that we are not on 1 July yet. I can invite Mr Goddard to the table now but I will seek your advice on how you would like to do that.

Mrs ARMITAGE - I am happy to leave it until later.

Ms O'BYRNE - If it is a small question it might mean that we knock it off now, Chair, it is a matter for you.

I will invite Nick Goddard, Acting CEO, Statewide and Mental Health Services, to the table and we will see whether or not the question is for Mr Kirwan or Mr Goddard.

Mrs ARMITAGE - Mental Health in the north has always been an issue, mainly because ward 1E has been a separate entity and has not come under the umbrella of health or under the LGH. I was wondering how it is going to be implemented particularly with after hours. Does the Medicare Local track in, in mental health?

Ms O'BYRNE - Mental health is primary care. There are two levels of mental health where we have a responsibility in the acute spectrum but we also do work in community mental health care. The commonwealth government have just funded an increase in mental health care medical packages.

Mrs ARMITAGE - I have heard from many GPs and police, there is often an issue that mental health patients are taken to the LGH.

Ms O'BYRNE - We do have psychiatric nurses in every emergency department now.

Mrs ARMITAGE - But often if they have to wait for a certain amount of time they leave and the police bring them back.

Ms O'BYRNE - There are a couple of issues around that. Sometimes the police might genuinely bring a client to an emergency whom they believe to be within the confines of some sort of episode.

Sometimes when that individual patient record is identified their care plan will say that they should not be treated in an acute setting. Partly that is because of behaviour management and rewarding particular behaviours. Quite often the police or the broader community cannot be advised of that, so it is a challenge sometimes that some people's care plan indicates that we should not be encouraging the behaviour of coming to ED or going to the police.

Mrs ARMITAGE - Bit of a worry when they leave and the police then have to bring them back.

Ms O'BYRNE - That is one of the challenges around the privacy issue. The other area, and it is a very difficult one, is people who demonstrate indications of being suicidal. Being suicidal does not make you a mental health patient, which is something that has always struck me as very hard to explain.

Mr GODDARD - The interface between the emergency department and Northside is a critical one, as it is in each region. A lot of work is done to make sure that presentations at emergency departments are appropriately managed and these are put in place with Northside. The basis of mental health care is basically community care; our inpatient facilities rely on a good, supportive, community-based system to keep people well in the community, recognising the fact that when they have acute episodes, presentations at ED and admission to Northside is appropriate. Generally, though, the mental health direction these days is to provide strong community support.

Ms O'BYRNE - Before you ask your next question, for the purpose of *Hansard*, Nick Goddard is the Acting CEO of Statewide and Mental Health Services.

Mrs ARMITAGE - How many psychiatrists could we have working out of your mental health service?

Mr GODDARD - I do not have the figure on me at the moment but I could give it to you. We have a multiple-disciplinary team approach so there is a team of psychiatrists in the north if we are talking about the north. We have a team of nurses, allied health professionals and medical staff who provide integrated care across the region.

Mrs ARMITAGE - Do we have a forensic psychiatrist in the north now?

Mr GODDARD - No, not in the north but the forensic service is a statewide service and so anybody across the state can access forensic services when they need to.

Mrs ARMITAGE - Minister, is there an independent process for each board and how are the three boards working together?

Ms O'BYRNE - Under the legislation, which both Houses passed, there is a governing council for each of the three THOs. We agreed at that stage that we would have a joint chair position to allow dealing particularly with that issue around duplication and competition and so we have a better integration. The governing councils do tend to meet on a statewide basis to share their knowledge and data and I think that has been a very positive thing.

Mr HOUGHTON - The governing councils took up their responsibilities on 1 July last year. We have had 11 meetings and they've established subcommittees along the way - in particular, the audit and risk committees that they are required to have under the legislation, and the chairs of the audit and risk committees are here today.

They have had a very busy time learning about their work, learning about the health services that they are responsible for and setting up their own machinery to get their work done. They have been very much focused on financial management in the last 12 months but trying to deal and get abreast of a very complex set of issues within the hospitals, the rural and primary care health services and so

on, so we have been very, very busy.

In addition to the 11 meetings that each governing council has had for each of THOs, we so far have had two so-called joint meetings although they are not truly joint meetings of the governing council in that they are not formally constituted decision-making committees. They have been very much more about sharing information, identifying issues that we might need to work with on a statewide basis or where we can work more efficiently if the three THOs combine their resources. We have had two of those and we will have another one in July and then probably another one towards the end of the year so we can expect that if current intentions prove to be sensible in practice we will probably have three or four joint meetings every year.

Mrs ARMITAGE - Is it working quite well with the decision-making at the coalface? Do you feel it is the way to go, that each area is concentrating well on problems that are in their own areas?

Mr HOUGHTON - I do. First of all the governing councils are focusing very much on their governance role. It occurred to me, as I heard John answer your questions, that we ask the same kinds of questions. We go into a whole lot of detail on an issue at a time but our general role is governance and we try to stay at that level as much as we can. I might have missed a part of your question there.

Ms O'BYRNE - Whether it's working; are you finding it is working?

Mr HOUGHTON - I think it is working well but I would say that, with only two joint meetings so far, again, we have been getting to know each other, we have been getting to grips with the issues and it is early days and there is a lot more work to do there but it is going to be very important work. The other point I should make though is that, as the chair getting to know each of the governing councils and each of the THOs, there is great enthusiasm for getting together and doing whatever we need to do and whatever we can productively and collectively.

Mrs ARMITAGE - There has been some criticism of the three THOs over one THO so it is good to hear that it is actually going in the right direction.

Ms O'BYRNE - We are committed to reviewing the legislation after 12 months so we have just commissioned the beginning of that review. I had my interview last week and I am sure there will be a number of interviews around the traps from the review committee who are looking at whether there are changes that need to be made in activity and how the government's model works.

Mrs ARMITAGE - One last question because I am conscious of time. The three THOs that we have; when it comes to things like, for example, a hip operation, do the three get together to work out their price for the hip operation or do you have individual prices? I know that was a bit of an issue to start with, with some of the surgeons saying, okay, the mainland price indicator or whatever it is called -

Ms O'BYRNE - The national efficient price.

Mrs ARMITAGE - How do we work that out so we know what, for example, I know Mr Einoder might be thinking is a good price in the north; do we had a similar thing in the south and the north-west?

Ms O'BYRNE - We went through a very interesting experience with the Australian Government funding because we were purchasing a pure ABF model in addition to the funding for our THOs and what it indicated, along with the other two, was the extremely different costs that each hospital was offering for price of procedures, but it is not because some of them were more expensive or less expensive than others. It was actually to do with what was costed in that. That is the biggest shift in activity-based funding that we need to deal with - making sure that we are all costing exactly the same thing at exactly the same time. The other work that will happen through the lead clinicians group -

and we talked about the four years that you can have one type of procedure but have seven or eight different ways of doing it being done in different areas around the state so actually sort of locking in behind on a statewide basis one way and therefore one set of continuables, in a way.

Orthopaedics is always very difficult because orthopaedic surgeons like their own particular products. There is a concern, after the very large legal cases recently around a particular prosthetic that broke down in people's bodies and created significant challenges. Where does this lie that compels only one type of prosthetic to be used and then you have an issue with that. That is a discussion that will happen in the lead clinicians group through those areas. They need to be clinically determined.

There are two aspects; one is that we need to make sure we have the best clinical model being used. The other is that we need to be sure we are counting the same things because the numbers can look glaringly different but they might not be if you are actually measuring like with like.

Mrs ARMITAGE - This is probably a question for Mr Houghton, currently where you have your three THOs, whether your surgeons are actually purchasing - is it a joint purchasing for the whole state, say, of hip prostheses?

Ms O'BYRNE - That is the procurement work that we were talking about with the shared−service model to allow us to do that. It requires clinical engagement.

Mrs ARMITAGE - That is what I am saying; you did mention that different surgeons have different requirements.

Ms O'BYRNE - They have historically liked to use their own products.

Mrs ARMITAGE - Will they all need to have one particular type of prosthesis?

Ms O'BYRNE - What we have said is that locums coming in cannot pick their own structures; that they will have to fit in with the existing ones and that has already saved us money. I think we have drilled down on the price of prosthetics across the state. Looking at Gavin from the north-west as well, everyone is having much better outcomes in prices in this anyway. That is part of the work of the commission - to look at why the costs are different. Sometimes they will be different and that is not because anyone is doing anything wrong; it is just because the size of the hospital, the scope of the capacity of the hospital, the skill base that you have are going to mean things are done differently. Understanding that is more important than just saying we cannot have it.

CHAIR - There are a couple of other questions. We will take a five-minute break right now. Ruth, you have some questions on north and so did Leonie. Then after that we will move to north-west.

Ms O'BYRNE - I am happy to finish off if you want to have it done.

Ms FORREST - Mine aren't very big, if you want to keep going.

CHAIR - Okay, let's finish with Ruth.

2.3 Tasmanian Health Organisation - North-West

Ms FORREST - A couple of things and you can probably just table it if it is easier, minister. The occupancy rates of all the rural hospitals in the north.

Ms O'BYRNE - We can probably table that; it is easier. Do you also want those on statewide THOs?

Mrs HISCUTT - I was looking at the breakdown of FTEs in each THO.

Ms O'BYRNE - Yes. We can do an FTE breakdown for each of the THOs and we can do an occupancy level. We can hopefully table that by the end of the day. If not, we will submit it to the committee in the appropriate time frame.

Ms FORREST - Okay. A little while ago you were talking about the private patients using public facilities. Whilst some of them have in the past been told when this happened before -agreed to be a private patient - the cost recovery of those has not been brilliant. Is that improving? When people have identified as a private patient, are you getting the moneys?

Ms O'BYRNE - We do not get the entire cost recovered under many procedures. I would need the north and other THOs but under the regulations we do not get the entire cost recovered anyway.

Ms FORREST - What you are entitled to, there was revenue -

Ms O'BYRNE - There have been challenges in the past and we are able to access that as well. That is further compounded by particular private health funds saying that they will cover less.

Ms FORREST - It is only some private health funds, not all of them, that are saying that, is that right?

Ms O'BYRNE - At this stage, I believe so.

Mr KIRWAN - At this stage.

Ms FORREST - They are all likely to follow suit, aren't they?

Ms O'BYRNE - It comes to a broader national debate around private health insurance. I must confess that we as a nation have been compelled down the private health insurance pathway and there is co-dependency with our private hospitals here. We want to see them sustainable but if you are paying private health insurance I do not think that there is a problem to claim it.

Ms FORREST - When you pay your private health insurance you go in as a private patient, depending on the procedure and a whole range of other things, including your policy; you can pay a gap but you are told up front, as John said; when you go into the LGH, you are told up front.

Ms O'BYRNE - You are told there is going to be a fee. That would be the case at each of the THOs - you would be advised of what the out-of-pocket expense might be. A lot of people still choose to use it. Deloraine Hospital, for instance, has a high take-up of people using private health insurance because they see it as helping the hospital from a community perspective.

Ms FORREST - Do they get a choice of doctor there?

Ms O'BYRNE - I guess they do - I do not know. I am surprised at the high rate if they are allowed to practise at your hospital.

Mr KIRWAN - Yes. We now have other surgeons working private/public, so if you elect to be private, it is doctor of choice - that is the key. From that generates a whole range of other things.

Ms O'BYRNE - There is a more philosophical debate around the role of private health insurances.

Ms FORREST - Not for this table, though.

Mrs HISCUTT - One last question. How many double shifts would have been worked in the north hospital in the financial year to date?

Ms O'BYRNE - We can give you overtime if that is of use to you.

Mrs HISCUTT - Do you have a breakdown of intensive nurses critical?

Mr KIRWAN - What do you mean by intensive nurses critical?

Mrs HISCUTT - How many double shifts are worked in intensive care and how many double shifts were worked in critical care? You might not have that.

Ms O'BYRNE - Acute care.

Mrs HISCUTT - Intensive care or critical care units.

Mr KIRWAN - The figures that I have are just double shifts.

Mrs HISCUTT - That is all right. How many double shifts would you have worked?

Ms O'BYRNE - I will say, while John finds those figures, that double shifts is one of the most expensive ways of covering a shift. Where possible, we always seek to use casual staff or roster accordingly. Working a double shift is a voluntary decision. There used to be, and I believe this has changed, a historical component of working a couple of double shifts and taking a few days off afterwards. I do not think that happens to the same extent that it once did and that has been worked on. I have double shifts in acute services and hopefully the THOs will let me know if I have these wrong. This is sourced from the electronic internet management system across acute services for the financial year to date, that would be 31 March.

Royal Hobart Hospital, 1 250 double shifts; we will confirm that when we come back to THO south. The LGH, 401. North West Regional Hospital, 806 and Mersey, 149. We would prefer that there were not double shifts and that does mean keeping a good casual pool structure and a lot of work has happened to strengthen casual pools. It has been a changing nature as we have shifted through the staffing changes that we have made but if I can give you how it equates per FTE for a percentage of overtime. If your overtime that was used was equated to individuals, it is for additional people that you might have on, and with THO staff there is a 1.43 per cent overtime FTE to paid FTE, 1.79 in the north, 1.24 in the north-west and 1.43 in the south.

Ms FORREST - This is in some of the speciality areas?

Ms O'BYRNE - I am seeing whether we can get a breakdown on some of the speciality areas that were done.

Ms FORREST - It is harder to cover an ICU shift than it is for general surgery.

Ms O'BYRNE - Yes, and ICU is much harder to manage but we will see whether we can get that breakdown.

Mr KIRWAN - The LGH figures are now significantly less than they used to be and mainly it is because we have filled a number of vacancies where there is difficulty and ICU is one of those. Predominantly for us it is only short shifts where staff are called in late out of our pool. For example, the core may not have ICU trained staff or theatre trained staff so that they will do double shifts and it is always predominantly so that we can keep the services going rather than closing them. Ours are pretty well only because of absences for sick leave that are unplanned, otherwise we will use our pool

and we will use, if we can, staff being redeployed from other areas. We use staff that are on call who are prepared to come in and give them predominantly part-time work or who are prepared to work additional shifts at short notice.

Ms O'BYRNE - One of the challenges that comes back to that co-dependency between the public and private system, is that a lot of our staff who might be part time, also work part-time in the private system so whilst we may have an understanding that they might be available for call-in, ICU nurses and theatre nurses are in high demand everywhere.

CHAIR - Doctor losses at the LGH in the past year and reasons for doctors moving out?

Mr KIRWAN - We remain very stable. All positions are filled and even our positions previously using locums are now being replaced by permanent staff. I would have to check to see if we have any vacancies we are currently recruiting to, but with the acute medical unit, with the John L Grove and other areas, there is an increase of around seven or eight FTEs in the medical workforce.

Ms O'BYRNE - I read into the *Hansard* a 37 increase in nursing and medical staff. I have it here. THO North for salaried and medical practitioners, practitioners and rural medical practitioners, adds up to a 9.81 FTE increase and that does not include the EMOs which are direct.

Ms FORREST - On that point, are there any unfilled positions that you are seeking to recruit to at the moment?

Mr KIRWAN - Not that I am aware of but that is not to say that it is something that I am not aware of.

Ms O'BYRNE - From a statewide perspective, there are always clinical shortages that we are looking for. I am not sure in what areas but we were desperately looking for ENTs that could work with children at this point last year but I do not think that is the challenge any more. There will be different specialities at a given point that we are attempting to recruit to.

CHAIR - I think we will take a five minute break or thereabouts.

Mr KIRWAN - There was one before we could get back to a question from the member for Launceston. The discharge, the reason for cancellation for surgery - unfortunately the staff member who looks after that is not at work today but I will take it on notice.

Ms O'BYRNE - We will take it on notice and provide it to the committee.

CHAIR - We will make it 10 minutes.

The committee suspended from 3.39 p.m. to 3.54 p.m.

Ms O'BYRNE - There is one comment that the chair of the three THOs wanted to finalise in terms of a response he was making.

Mr HOUGHTON - It was just a simple point I wanted to make, but an important one. It feels to me, and I think the governing councils and the CEOs would probably agree, that in each of the THOs we have been very pre-occupied with finance, and you would understand that, but we have been also very much focused on local issues. Palliative care and nursing homes are the kinds of issues we are dealing with in each of the THOs. We are very focused on finance, yes, but also there are those service delivery issues, which are different of course within each of the three.

CHAIR - Let us move into THO north-west. Ruth first, please.

Ms FORREST - The indication was that you are going to be a little over budget.

Ms O'BYRNE - Me?

Laughter.

Ms FORREST - The THO north-west and it was going to be dealt with within your operating cashflow. How are you going to do that?

Ms O'BYRNE - Within each of the THOs, they have a number of flexibilities around when they cashflow projects. The key has been to the governing council's understanding that running over budget does not mean we can help you out any more because there is no more money from what we have. So, it is a fundamental shift. In fairness to THO north-west, and we want to work with them, they have accomplished specific challenges that are historic challenges, that they are on track to deal with. Once they have resolved those historic challenges, we estimate they will be much closer to budget. It is expensive to provide services on the north-west in two locations and we all know what happened around those decisions but, by including the Mersey in the north-west regional, they have been able to structure efficiency in terms of the broader projects. Should I hand over to you, Graeme, or -

Mr HOUGHTON - Probably better to go to Gavin who can talk about what is being done and how well it is working.

Ms FORREST - And also the time frame for resolution of the contractual issues that are -

Ms O'BYRNE - I am inclined to ask that we do not talk about that too much - there are some commercial issues. I am not sure if there is an *in camera* opportunity within these committees but it might be a conversation that is best held *in camera*. I do not know the rules in the upper House.

Ms FORREST - Do the other stuff first.

Ms O'BYRNE - Perhaps you could decide that is something you want to do or if you would like to do it at a different point, would be appropriate as well. I am conscious that there are commercial conversations being undertaken that I would not want to jeopardise.

Mr AUSTIN - There are several.

Ms O'BYRNE - If we are a little hesitant, please understand the nature of the hesitancy.

Mr AUSTIN - The services of the north-west that are outsourced include maternity, radiology and pathology which are quite different to the other THOs and those are the subjects that the minister is referring to, where ongoing discussions are occurring.

Ms FORREST - I will phrase it slightly differently then. What is going to be pushed out as far as funding goes, to enable you to meet the budgetary challenge for this year?

Mr AUSTIN - Sorry, I do not understand the question.

Ms FORREST - You are running over budget so something has to be pushed out, probably capital expenditure I would imagine.

Mr AUSTIN - Primarily, yes - deferring capital expenditure until next year.

Ms FORREST - What will you be deferring; that is the question.

Ms O'BYRNE - Only to next year.

Mr AUSTIN - Yes. In terms of our cash flow, we are not consciously deferring anything; just the normal program processes that we go through for a capital build tend to take longer than we would like; that is a normal healthy thing in health where we do a lot more consultation and get clinicians to come back and say we do not think your plan is going to work as we would like it to.

Ms O'BYRNE - Clinicians are usually quite strong-minded on our plans.

Mr AUSTIN - They did not turn up to the first meeting that you invited them to so that becomes a challenge in terms of planning. Nevertheless, you do have to take it on board. That has delayed the capital projects that we have going.

Ms FORREST - Aside from the issues that you mentioned about the contract you have developed, making it more expensive on the north-west to provide services, are there other unique challenges aside of those that push the price up?

Ms O'BYRNE - I think the Mersey is always a unique challenge for the north-west.

Mr AUSTIN - Yes, and the west coast.

Ms O'BYRNE - Yes. Also, having said that, the LGH has similar issues with St Helens.

Mr AUSTIN - And the east coast.

Ms O'BYRNE - Everyone has those sorts of challenges but the Mersey is a complete anomaly in health funding. It is not the pathway that we had intended to go down. Having said that, the clinical work that is being done across the two is managing quite well. There were some clinical changes delivered in the last 12 months that, from a political perspective, I could never have delivered but the governing council in consultation with clinicians changed the way they did business and it has been accepted quite well by communities. There will always be ongoing challenges for the north-west in terms of the distribution of the client base which use the facilities of the two sites and high levels of chronic disease, I think, otherwise there are going to be the challenges.

Ms FORREST - The cost of running the west coast facilities - we have the West Coast District Hospital and the Rosebery -

Mr AUSTIN - We have a community centre at Zeehan and we have a little centre at Strahan. That's four centres.

Ms FORREST - And Smithton as well - do these add to the challenge and are there ways of greater utilising those facilities?

Mr AUSTIN - They add to the challenge. Equally, the north has the east coast, but they definitely do add to the challenge.

Ms O'BYRNE - We are using our community hospitals to a greater level of occupancy and transferring people with a greater acuity than historically we would have done. I think there has been a much greater use of hospice data in our community hospitals.

Ms FORREST - That is happening.

Ms O'BYRNE - We have been asked to table hospital occupancy rates so we will get those for

you.

Ms FORREST - You haven't got that yet?

Ms O'BYRNE - They are coming; they are on their way.

Ms FORREST - With regard to the national partnership - and this does go across all of the other areas as well - there are a couple of different aspects of funding for elective surgery and one is improving health service, which is $1.4 million for the north-west, and improving public hospital services and elective surgery is $400 000. How are those two different amounts targeted to what specific areas for elective surgery?

Mr AUSTIN - The $1.4 million is a tentative figure and probably not the finalised figure but it will be specifically targeted towards orthopaedic surgery in hips and knees. The actual figure will not be that, that was a tentative figure prepared at the time when the budget Estimates were made. The $400 000 relates primarily to ophthalmology and cataracts.

Ms FORREST - To try to ramp up the number that are being done again?

Mr AUSTIN - Yes. We have a huge number of cataracts added to the list. As fast as we can do them we have more added to the list. We have done a lot of work this year on reducing the list in the last couple of months but as fast as those extra sessions end the list will build back up again.

Ms O'BYRNE - There is a focus on dealing with the longest wait.

Ms FORREST - In terms of the orthopaedic surgery then, which was one of the areas particularly with the knee replacements that took the biggest hit during the budget cuts, what are we doing now?

Ms O'BYRNE - The reason, though, that they took the biggest hit was the north-west was significantly more advanced in its way through this list than anyone else so we did not have those long over-waits because they had been so efficient in the system.

Ms FORREST - It is a shame that it went backwards, but there you go.

Ms O'BYRNE - So the question is where we are with orthopaedics?

Ms FORREST - Yes, how many are we doing now?

Mr AUSTIN - This year, 164, and next year, 157.

Ms FORREST - Why the reduction next year?

Mr AUSTIN - The funding will be less from the commonwealth next year than it was this year. There is a slight reduction.

Ms FORREST - What is the waiting list on the north-west in this area looking like now?

Mr AUSTIN - It is growing. It has been steadily growing since the budget cuts.

Ms FORREST - How many are over boundary now?

Mr AUSTIN - I would have to get the exact number.

Ms O'BYRNE - We can get that figure.

Ms FORREST - Can I have the over-boundary patients in all areas? Across all THOs would probably be beneficial and not just the north-west.

Ms O'BYRNE - I do not have it by speciality but I can give you the over-boundary procedures on the statewide waiting list for 2012-13. What might be easier is the July 2012 figure and the April 2013 figure. Would that be useful or just the April 2013?

Ms FORREST - Both will do.

Ms O'BYRNE - For the Royal Hobart Hospital, over-boundary waiting lists at 12 July, 1 880. At 13 April was 1 619. The LGH, 12 July, 1 871. April, 1 945. The Mersey, 48 to 27. North-west regional hospital, 161 to 195.

Ms FORREST - In view of the fact that last year as minister you made the decision not to impose savings requirements that were initially proposed the previous year and this year again, we are not seeing any cuts in health, we are still seeing increases.

Ms O'BYRNE - Yes. But what you are also seeing is an increase in demand with an aging population. Also some levels of chronic disease that impact on joint health.

The hospitals have dealt incredibly well with the challenges but demand is continuing to grow. That is something that we need to deal with and part of the work in the primary pathway that we have been doing is about how you put people on a trajectory, particularly for joints, other than surgery. If you manage pain and mobility you can start reviewing the amount of people who are on your joints list. That work has to be done in conjunction with primary care and Medicare Local has done some significant work in that space. We are dealing with an older population with, in many cases, greater obesity issues, which put significant pressure on joints.

We are going to see an increase in demand for that sort of support. You can see that in demand around laparoscopic surgery. But in fairness, even when we have invested in infrastructure in hospitals, we are investing in stronger floors, in larger chairs, in beds that can take greater weights, in ambulances that can take larger weights. We are dealing with a population that is having significant issues with obesity which impact on overall health. There are two ways with dealing with that, one at the acute side - we have to meet the demand - but also we have to deal in the primary care space around wellbeing because if we do not and this continues there is no way the health system can cope.

When Dominic is here we can ask him about the cost of the bariatric ambulance that we have had to invest in across the state. At the Wellington Centre the chairs have had to be bigger for people. The demand on health services is changing in part because of chronic disease which we have to invest in. Part of the work with the commonwealth money is, and I know that there has been a call for us to spend it all in the elective surgery space, but we have to spend in the primary health space if we are going to change the dynamic of patient flows and patient demands.

Ms FORREST - On that point, you mentioned earlier the role of the Tasmania Medicare Local and I know that it is still fairly new but what are you doing in the north-west to engage with the TML in that primary health area?

Ms O'BYRNE - TML has been fantastic across the state. Medicare Locals look different in every jurisdiction so I cannot comment on how effective they have been in other jurisdictions but TML here has been working very closely with THOs, very closely with the state, and has an excellent relationship with GPs and Allied Health. The primary healthcare pathway work that they are doing is about shifting the engagements that we have earlier in someone's health journey rather than what we have historically done which is deal with it when it gets to crisis point in the hospital system. There is an MOU that has been signed for TML also. We will be continuing to make sure that there are staff

agreements with every aspect of DHS that we deal with. The other strength of TML is that they have been given significant commonwealth dollars, a large amount of money, they want to spend it strategically and we want a partner that can do that.

Ms FORREST - One of the areas, the changes to after hours access to GPs, there has been a concern that we will see a greater demand on our DEMs.

Ms O'BYRNE - There was if we have had a reduced service, but as I understand and I will get the documentation on it. Matthew, that would be you. The contract is an Australian government contract and it is through TML but it has been contracted to another Tasmanian-based company. The company who historically did it, their national body chose not to support a tender application which was disappointing.

Ms FORREST - An international body, I think it was.

Ms O'BYRNE - Yes, it was their international body, sorry, and they decided not to support that but, as I understand the new model - and I thought somebody might have seen the new contract - the after hours GP contract that has been signed.

Mr DALY - That was let by the commonwealth?

Ms O'BYRNE - Yes.

Mr DALY - With a private practice provider in Hobart.

Ms O'BYRNE - It is another Tasmanian-based one and the biggest concern was that we would see it go off to an interstate company, but it is a local provider.

Ms FORREST - It is a local triage? They are basically local triage.

Mr DALY - Yes.

Ms O'BYRNE - It is a TML contract but we will get that information for you.

Ms FORREST - Because it is a major issue for our rural areas.

Ms O'BYRNE - Absolutely and it has been one of the reasons that doctors have felt comfortable remaining in rural practice as they have had that activity. The other thing that I think will strengthen rural practice is the ability for in-surgery consultations with specialists and we have seen the roll-lout of some of those programs now where even Mr Harriss can go and sit with his Dr Valentine and they can talk to a specialist Forrest anywhere in Australia about a care plan and it is much easier to do that than for that individual to have to transfer, to go and see the specialist in Sydney, for instance, or wait until the specialist comes and the skills that are provided for GPs, so that they are getting that continual ongoing learning as well, does make them feel as if they have more peer support in rural communities. I am hoping that that is going to see a shift in the desire for GPs to stay in rural communities because it is a particularly challenging work load. I will get you the details of that.

Mrs HISCUTT - With regard to locums, can you tell me the cost of locums per THO according to individual business units?

Ms O'BYRNE - One of the commitments that we made to try to deal with some of our budget challenges was to reduce expenditure on third party locum staff particularly. To 31 March, $12.3 million has been spent on third party workers across the health portfolio, which is $4.4 million or 26.3 per cent less than expenditure to 31 March 2012, so we are seeing a trending down. The largest reduction was in THO north-west, which has reduced from $11.2 million in the nine months to

31 March 2012 to $6.4 million in the nine months to 31 March 2013. For THO north, if I give you the two figures that end at 31 March, so that you have the comparative data, as of 31 March 2012 the north was $3 235 866. The comparative figure to 31 March 2013 is $3 169 283. For THO south it was $958 906 at 31 March 2012 and at 31 March 2013, $910 642, and for THO north-west it was at 31 March 2012, $11 229 431 down to - and we will have applause, please, for this one - $6 426 372. They are broad local costs and they might just not be doctors, they might also be local nurses or some other specialist that might come in within that practice.

We are trending down. It is difficult, particularly in medical practice, for the north-west who have a broader challenge. Part of the reason comes back to that issue around doctors working in isolation; doctors tend to want to work together. Also, locum careers are profitable careers now for doctors. There are some doctors who just do locum work all the time and it works quite well for them.

Mrs HISCUTT - Do you have figures for reportable infection rates per THO?

Ms O'BYRNE - Yes, we do and infection rates are down. There were five reported cases of MRSA - methicillin-resistant *Staphylococcus aureus* - in Tasmania. We are the same as the national rate for methicillin-sensitive *Staphylococcus aureus*, which was 22 reported cases. The overall rate was below the national rate for *Staphylococcus aureus* bacteraemia, which was below at 0.08 per 10 000, and the national rate is 0.09 per 10 000. The national healthcare agreement benchmark is 2 per 10 000.

We were concerned that there had been a bit of a growth in *Staphylococcus aureus* bacteraemia and when we looked nationally there was a growth everywhere and it appears that quite a bit of it is coming into hospitals from the community, which is a more difficult thing to manage.

Did you want it by hospital as well?

Mrs HISCUTT - Was it spread evenly across the three areas?

Ms O'BYRNE - I think they all performed pretty well, actually. It's one of the areas that we've been commended for. We also led the reporting of them; we have been reporting on our figures publicly longer than other jurisdictions.

On the myhospitals website, which is where you will find this data for the *Staphylococcus aureus* bacteraemia, the Tasmanian rate of healthcare-associated infection is 1.06 per 10 000, which is comparable to other jurisdictions. The Royal Hobart was 0.66 for 2011-12. The Launceston General Hospital was 0.92. The Mersey was 1.31 and the North West was 1.18. It was that which made me question the figures nationally where there were a number of jumps. It appears that a lot of that is coming into hospitals from the community.

Ms FORREST - On the infections question, can I ask a question about *Clostridium difficile* and others?

Ms O'BYRNE - Yes.

Ms FORREST - Do you have that as well?

Ms O'BYRNE - I have; I was about to go straight onto that. The rate of *Clostridium Colostrum difficile* infection in Tasmania is 5.01 per 10 000 patient-care days, which is slightly higher than the published rate in other parts of Australia but lower than those published in Australia internationally, so Australia has fewer incidents already.

Hand hygiene compliance has increased from 35.5 per cent in March 2009 to 72.3 per cent in

October 2012. All hospitals are above the 70 per cent indicator. Healthcare-associated infections have a significant cost for all services everywhere and we fund our organisation that deals with both education and identification. They have done some fantastic work in Tassie.

Mrs HISCUTT - With regard to workers compensation, what was the total number of workers compensation claims to date for the last financial year? Do you have a cost on the numbers?

Ms O'BYRNE - The total workers compensation claims are down. In 2011-12 we had 501 at a cost across the department of $9 881 000 and is down to 376 year-to-date so $8 317 000 and they are down in each of the regions, north-west down from 75 to 65; north 108 to 61 and south 186 to 144.

Mrs HISCUTT - Would you say that was associated with obesity rates or something like that?

Ms O'BYRNE - The workers compensation payments have been down, I think we have had a more proactive engagement in management. It has been getting better at that every year. The other issue is that the compensation rates, the claims are highly individual so it is always hard to compare dollar to dollar.

The issue on GP Assist, Tasmania Medicare Local announced the successful tender of being Medical Practice Management Solutions. The director is Dr John Davis who co-founded the original GP Assist Tasmania service so from 1 July it will be largely similar to what is currently provided by GP Assist with after-hour services available through Health Direct Australia, and will have access to a registered nurse and where patients will be connected from the nurse triage service to an on-call GP. Support will be available to health professionals with direct access to health professionals. I would have to check.

Ms FORREST - Which is the major problem, the Derwent Health Direct, in the past, people have been sent all over the state because there is a lack of local knowledge and someone was sent via the east coast to Bruny Island during the night.

Ms O'BYRNE - Did they go?

Ms FORREST - Well, how could they?

Ms O'BYRNE - I was a bit worried. This is not a contract that we do, it is an Australian government contract but I think there have been concerns both ways. I have spoken to someone who rang the national level and instead of being diagnosed with scarlet fever was diagnosed with toxic shock syndrome. The other person rang a local line and was told that they should go to the hospital and reckoned they had a bad cold. I think you are always going to get those vagaries. It is an Australian government service.

Ms FORREST - I want to talk about the geographic knowledge. That was just one, there are many other places.

Ms O'BYRNE - I am aware of that but it is a matter that you would probably need to raise with those who fund it and we do not fund it.

Ms O'BYRNE - I think the key will be monitoring that but remember the rural GPs are also a commonwealth responsibility and whilst we partner and support them as much as we can, GPs are not the state government funding thing. If we had one single funder, it might be a different scenario but we have not been able to win that battle yet.

Ms FORREST - Potentially, it has a negative impact on our current reserves and services.

Ms O'BYRNE - We will be monitoring it. And we would go and get feedback if we believe

there has been any impact on our own health services.

Ms FORREST - In the north-west, are there any unfilled medical positions at the moment?

Mr AUSTIN - Always.

Ms O'BYRNE - That is why we have locums.

Ms FORREST - Do you cut your locums right back though?

Mr AUSTIN - We have and we have a full contingent of anaesthetists, both at North West Regional and at Mersey, but we lost a couple of ONGs so we are out there recruiting at the moment for replacement ONGs. We have fantastic success with the emergency department and Mersey in terms of permanent staff but always a challenge to get paediatricians but we have one due to start later this year so we have recruited and he is coming. Every time we seem to win one we seem to loose the other one so it is a constant battle.

Ms FORREST - They are not in the same area though?

Mr AUSTIN - No, in totally different areas.

Ms FORREST - Is it surgery?

Mr AUSTIN - General surgeons are excellent, orthopaedics good, fully covered.

Ms FORREST - But ONG mainly?

Ms O'BYRNE - Although, then you fill those and it will happen somewhere else.

Ms FORREST - I am not sure whether it was asked with the overtime - we will only be able to have time to cross all three THO's, will we?

Ms O'BYRNE - I think we gave the percentages for overtime for FTE medical. But we can double check if they are not there, then we will sort that.

Ms FORREST - Okay, thank you.

Ms O'BYRNE - I welcome to the table the CEO of THO, South, Jane Holden.

CHAIR - The President has already been asked for a ruling today on in-camera evidence for the other committee. I have a reading of our standing orders and, given that the President has already provided a ruling, we have asked for that to be communicated to us. The standing order says simply that all sittings of the committee are open to the public unless otherwise ordered. One interpretation of that could be ordered by the Council and not just by the vote of this committee.

Ms O'BYRNE - We are happy to have a conversation in another format. It is not a desire to not give the information; it is just the commercial sensitivity of it. If it is not appropriate to do so, we can do it another way.

CHAIR - We will move into the THO South, minister.

2.1 Tasmanian Health Organisation - South

Mr VALENTINE - A lot of the information has been provided in answer to the other questions, which is good. Waiting lists are obviously a significant thing in any hospital. Can you give us a

précis on what it is looking like in the south? Are there any specific types of surgery that stand out?

Ms O'BYRNE - Overall, elective surgery waiting lists at the Royal Hobart Hospital decreased by 15.9 per cent.

Ms HOLDEN - A reduction by 300 procedures. The high demand areas are orthopaedics, particularly. We have done a lot of good work on general surgery this year with some additional state and commonwealth funds. We have done some complex neurosurgical work and an additional 20 lap bands. Endoscopies have been a major focus as well.

Ms O'BYRNE - Endoscopies would not appear on the elective surgery waiting list because they are a medical procedure. In addition to the elective surgery work, there are a number of other procedures that do not get counted.

Mr VALENTINE - Are we winning the battle? That is the question.

Ms HOLDEN - We have certainly reduced the waiting list this year. We would like to reduce it more but we are focussed on getting people off the waiting list.

Ms O'BYRNE - One of the issues is that the more you work on the waiting list, the more people come on it. It is the nature of every health system.

Mr VALENTINE - I am not going to go into the technical aspects of the redevelopment and how it might be interrupting the whole operation of the hospital, but are you managing that okay?

Ms HOLDEN - Yes, we are, because a lot of the work at the moment has been done in the intensive care unit which was phased pretty well. While the new part was being built, we could use the old part; then we moved into the new part. We have tried to work around all of that to make sure that what we are doing is able to continue until we need to move into it. So that has not been a major barrier for us yet.

Mr VALENTINE - What is the impact on staff like as a result of that, though? There is obviously a fair bit of work gone in and their productivity having to move.

Ms HOLDEN - The productivity gains at South are very good. I think staff really feel very positive about moving from an environment that they had found challenging to one that is purpose-designed. The intensive care unit, the cancer centre and the Wellington centre are all really good examples of staff moving and morale increasing because -

Mr VALENTINE - The clinics are over in the Wellington centre?

Ms HOLDEN - Yes, and they are now working in purpose-designed facilities.

Ms O'BYRNE - Previously, in order to go from one instance of care to another you quite often needed a Sherpa guide and a packed lunch to get to the other side of the hospital. So actually putting facilities in a co-located sense is making a huge difference to the staff. But it is difficult and every one of our hospitals has been made a building site and it is a pressure working on a building site. It is great when they see returns for putting up with the noise and the difficulties but in the long run the outcome is there but it is always challenging on a building site for staff.

Mr VALENTINE - Can you give us a bit of an understanding - we were talking earlier about private patients being dealt with in public hospital, day surgery in particular. Are private surgeons able to use the Royal's facilities to conduct their day surgery or is that something that you do not encourage?

Ms HOLDEN - We use our day surgery facilities for public patients and our surgeons are working in their public time when they are delivering that work. We use those to the full capacity, which is one way of reducing our waiting time.

Mr VALENTINE - Their activity is not impacting on your ability to meet your -

Ms HOLDEN - It is public activity.

Mr VALENTINE - Specialists. I am talking about staffing. Are there any specific areas that are critical at the moment where you have vacancies?

Ms HOLDEN - We generally have stable staffing levels. We have had a net increase of around 15 full time equivalents of medical staff this year. The area that we are recruiting to right now is orthopaedics and we are recruiting with the agreement of a part-time orthopaedic team and full-time surgeons which is because of the public waiting list.

Mr VALENTINE - Okay. I notice in the budget sheet that the reallocation of overheads is given as a reason for variations in the budget for 1.1, 1.2 and 1.4 - all of those, the first four in particular: admitted patients, non-admitted patients, emergency department and community and aged care services; yet the percentages, to my mind, do not seem to stack up very well. For instance, with admitted patients there has been a 9 per cent change in the budget situation. At 23.1, it seems to have gone down and then the non-admitted services have gone up 36.6 per cent, the emergency department services have gone up 36.4 and community and aged services up to 24.5. I am assuming that there are other factors that come into play regarding the changes in those budgets.

Ms O'BYRNE - The decrease is linked to non-admitted services; emergency department service and community aged care is because of an allocation of overheads to the outputs more appropriately, as I understand.

Mr VALENTINE - They are increases.

Ms O'BYRNE - But a decrease in admitted patients.

Mr VALENTINE - Yes, sorry. What is in the overheads that is being pushed down? If you look at note 2 on the budget paper, talking about a more accurate allocation of overheads for those outputs, it just does not seem to be even. I am interested in what is included in those overheads that you are talking about.

Ms O'BYRNE - Jane, are you able to talk about that?

Ms HOLDEN - No. This is a DHHS comment, I think.

Ms O'BYRNE - The overheads are intern numbers. We are just trying to work out by the time I replay it to you I may as well ask Mr Mike Reynolds, Chief Financial Officer of the DHHS to explain the changes in allocations. There have been a number; with the payroll, we have been able to freeze those and we are attempting to work out more accurately where overheads sit because historically we have just had a bucket of money that is gone and that is where this work has been undertaken.

Mr VALENTINE - I am asking the question because it just seems to me that Community and Aged Care Services, with a budget of $74 479 has gone to $92 709, which is a 24.5 per cent increase and yet the emergency department's $24 532 is gone to $33 000, which is 36.4 per cent increase. I am just trying to understand that.

Mr REYNOLDS - It is not all overhead-related, that is a good point. Overheads are probably

the major component of it but there will be other movements that were going on within that output more generally as well. The overhead allocation is always a bit of a black art as to where it falls but it is no -

Mr VALENTINE - That is why I am asking.

Mr REYNOLDS - It is not the full answer in this situation. There would be other underlined movements going on between the output groups, particularly after the first year of full operation of the THOs. The budgets put together last year for the THOs were done in a very quick time frame.

Ms O'BYRNE - They pretty much reflected the year before so that there would be no challenges.

Mr REYNOLDS - Indeed and in fact one of our tasks will be, on an ongoing basis, to continue to review overhead allocations and allocations more generally than the outputs to ensure they are as accurate as we can get them for the purposes of costing that particular output area.

Ms O'BYRNE - Which comes back to that issue that we had before of why each hospital has such different charges for similar procedures. It is because they count different things in different buckets and it is trying to get to that consistency. It will take time; when Victoria moved to ABF in -

Mr HOUGHTON - In 1993.

Ms O'BYRNE - It took years to get to agreements on where things should be costed. There will still be the odd outbreak of disagreement on what a costing might look like.

Mr VALENTINE - We can expect to see adjustments again next year.

Mr REYNOLDS - There probably wouldn't be a budget without them.

Ms O'BYRNE - I would imagine so.

Mr VALENTINE - With regard to the emergency department, you hear quite often about people turning up to emergency departments who really shouldn't be there.

Ms O'BYRNE - Category 5s.

Mr VALENTINE - Category 5s - is that what you call them? That is pretty tough on the staff obviously when they are having to deal with these people who really shouldn't be there. They have lots of people waiting in queues.

Ms O'BYRNE - Part of that is that primary care work as well with access to GPs. Also there is a view in the community that you can pay to go to your GP or go to the hospital, where it is free. We have probably not won the debate in the community about understanding the cost of emergency care. If you go to your doctor, it is $60-$70 overall; if you go to the hospital it is $600 just to triage. That is what the costing nature is around it. It is one of the reasons that we now have the fast-track clinics and they are called something different in each of the regions but they are actually able to say to someone that clearly you are not an ED patient - off you go and a nurse can see you and give you a bandaid or your aspirin or whatever it is that you might need. But also it is some of the reasons that we partner with the commonwealth on the walk-in centres.

Mr VALENTINE - You have mechanisms in place to triage?

Ms O'BYRNE - Every hospital has that, and Jane might want to talk about that.

Ms HOLDEN - It is true to say that our category 5s are actually dropping.

Ms O'BYRNE - There are more GPs now.

Ms HOLDEN - They are not increasing in attendance, both for the ward hours in categories 3 and 2 - they need to come to hospital physicians. We do get fast track where it can be from just reassurance perhaps for someone with an unwell child or someone who just needs reassurance that they are going to be all right, through to stitching someone up or something which we will do through fast track or we screen our emergency department as well so there are different streams of people that go through the emergency department.

Ms O'BYRNE - We have run campaigns with ambulance and you would have seen the campaigns late last year and earlier this year to call an ambulance when it is an ambulance issue. We have had people call for ingrown toenails or because their prescriptions are about to run out - for a whole host of things. In the same way we had people presenting in emergency historically. There has been quite a bit of education around the sort of times you should present, but whenever we say that we do remind that if you have a young child and you are worried, children's conditions can change very rapidly, so whilst we say please do not come to emergency when you should see a doctor, but if you are worried about children you should always call in and seek advice and come in if that is necessary. I would like to put that on the record.

Mr VALENTINE - It is not easy always. Somebody could have some significant issue that presents as something minor.

Ms O'BYRNE - Dominic Morgan, the Head of Ambulance Tasmania, tells the story of the person who rang up and they are talking about the cut on their head that they had where they banged their head. It took some time for the triage person to elicit from that person the reason they had fallen was the heart attack that they had not mentioned, but they were mentioning the fact they were bleeding.

Ms FORREST - If they were still conscious that was a good thing.

Ms O'BYRNE - It is a difficult thing and the other thing that is probably a bit of a scourge is the internet. If you go to the internet and self-diagnose you would probably spend a fair bit of time turning up at hospital because that is not always the healthiest way to approach issues. The Australian Government has been investing through their - sorry, I cannot remember the name of their workforce group that does GPs in Tasmania at the moment, Peter Barnes' organisation - with placing GPs. We are getting a growth in the rate of GPs, which we think is helping and that has made a significant difference and the walk-in centres that the commonwealth announced, whatever that model might be, we hope will also happen.

Mr VALENTINE - Next question is on benchmarking, a very important activity within any hospital and there are national benchmarks that you try to meet. Do you have any benchmarking partners where you work specifically with another hospital to try to increase the performance?

Ms HOLDEN - Yes, we do. We are benchmarked nationally. There is a collaboration between Australia and New Zealand on the health round table and hospitals that are like you, are the cohorts you are benchmarked with. For instance, the Royal is benchmarked with a range of hospitals, including Canberra, Townsville, Geelong, Royal North Shore and that is all I can think of right now, but there are a number.

Mr VALENTINE - Is that arranged nationally?

Ms HOLDEN - Yes, it is, and in New Zealand we are benchmarked with Wellington and Waiata. The Royal is doing very well against those benchmarks, particularly in the areas of average length of stay and is in the top 75 per cent of complexity.

Mr VALENTINE - I will ask you to be brutally honest, what are the three top areas you have to concentrate on?

Ms HOLDEN - We have been concentrating on average length of stay and in the last six months we now lead the pack, so it has now been focused on a lot over the past 18 months to two years. We are still comparing ourselves around some of the ED benchmarks. All of our benchmarks are improving, but we are not where we need to be and we are clearly not leading the pack in our waiting list management yet, and outpatients, so they are the three areas we have a pretty big focus on for the next 12 months.

Ms FORREST - Just on that -

CHAIR - Just before you do, Leonie is in the same area.

Mrs HISCUTT - It is on recruiting so it goes back a bit. I understand in the north-west you have had one come in and one go out and that would be a steady reason for professional improvement perhaps. Is your hospital in the south similar? What are the reasons that people move in and out? Would you like to pick, say, on orthopaedics? You are recruiting orthopaedic surgeons at the moment?

Ms O'BYRNE - There is an orthopaedic plan going on at the moment. We have had predominantly part-time orthopaedic surgeons at the hospital and this is moving towards - with the approval of the part-timers - they are engaged in this into moving to permanent positions.

Mrs HISCUTT - How many are you hoping to recruit?

Ms HOLDEN - Two full time equivalents. We have one and we are going to the market for the second.

Mrs HISCUTT - Were they the part-timers that have the job or they have moved on?

Ms HOLDEN - No.

Mrs HISCUTT - Why would they move on?

Ms O'BYRNE - We have guys on sabbatical.

Ms HOLDEN - We had a death this year and we have had a resignation. We are working with them to get a model that allows us to give them traction on the orthopaedic waiting list. There has been a long history of just part-time orthopaedic surgeons at the Royal. There is an agreement with the Royal and with that team that actually we need a bit more firepower. So we have the hospital and full-time leadership there but we want a combination so that we are not losing anyone. With that reduction, we are going to add some resources to bring in a balance of some part-time and some full-time staff.

Mrs HISCUTT - Would a resignation be for professional development somewhere else in the rest of the world?

Ms HOLDEN - We have a pretty stable work force, by and large. Largely the resignations are from our junior medical staff who are on one-year rotations, although we get a significant number agreeing to come back for a second and third year. When they go, they are generally looking for overseas experience and their consultants are generally backing them to do just that. Then, ideally, they come back to us when they are as sharp as they can be and we will try to recruit them. We do not have a lot of movement with medical staff.

Ms FORREST - On the weighted average length of stay, the Auditor-General recently reported that Tasmania tends to have significantly different length of stay. Is there an explanation for that? What are we doing about it because there is a risk of infection as well the cost associated with it?

Ms O'BYRNE - There has been quite a lot of work done since the Auditor-General's inquiry has finished. Part of it is managing our transition into community hospitals, which deals with the occupancy rates into the community rather than putting them in acute beds. The commission is looking at whether or not there is a level of inefficiency around that or whether there is a key thing that we can change across all hospitals, as hospitals do it differently.

Ms FORREST - Do you have the breakdown figures through THOs in this area? Or is it more of a challenge in the south or the north-west?

Ms HOLDEN - We have certainly got south's data but there is a different cohort of patients in each of the hospitals. They are different and they have different -

Ms O'BYRNE - Yes, and the north-west challenge has historically been more in the aged care space. That is getting a lot better now and that has been why we wait to get people appropriately placed in the north-west. I think that is probably a greater challenge. What I have heard from CEOs about long-stay patients is that they are trending down in most cases.

Ms HOLDEN - I think it was largely a timing issue in terms of that report. There has been a huge amount of work done on the stay for everybody because we can move patients through faster if they stay for shorter periods.

Ms O'BYRNE - If you transfer someone to a more acute hospital and then transfer them back to their hospital of origin, that has historically been a challenge but it seems to be clearing up a bit now.

Ms HOLDEN - The regional hospitals' bed availability, if any, is made available to every ward round every day at the Royal to try to move patients to a hospital closer to their domicile

Ms FORREST - One of the comments that the Auditor-General made - and this may have changed - was that at the Mersey they are still using a paper-based bed management system. Is that still the case or have they moved into the 21st century?

Ms O'BYRNE - It is electronic.

Ms FORREST - They must have moved. It was in 2011 the figure.

Mr VALENTINE - What did you say your over-budget situation was?

Ms O'BYRNE - Jane did not say it because she was not here at the time. What I said was that they had gone from a projected $30 million challenge in recent years through to $65 million.

Mr VALENTINE - What are the areas that you are looking at targeting to try to improve that situation? Or is it just across the board?

Ms HOLDEN - It is specifically trying to reduce the number of presentations to the Royal, trying to work with TNL to look for alternatives for presentation to the Royal.

Ms O'BYRNE - That is that pathway work we have talked about -.

Mr VALENTINE - Trying to take the pressure off.

Ms O'BYRNE - Also the funding from the Australian government on walk in clinics so that you have fewer presentations arriving. As I said, if you turn up with a headache from your hangover as an emergency it is $600 for triage - you know, go home and have some Panadol and go to bed or do not drink so much.

Ms HOLDEN - I think, as the minister said, we do see people when they turn up and our do not wait numbers have dropped dramatically so we basically see everyone but we do counsel them not to come back.

Laughter.

Ms O'BYRNE - Or not to drink so much the next time.

Ms HOLDEN - That as well, but if we think that they would be better cared for by their general practitioner we give them that advice.

Ms FORREST - Or by their mother.

Mr VALENTINE - With regard to the budget, obviously we have talked about broader state budgets but the incentives for the various sections within the hospital to meet their budget and not go over - what are you doing to encourage them to know that there is just simply not a pot of money that they can delve into?

Ms O'BYRNE - They are purchased on activity-based funding, so that is the primary framework around understanding the cost for procedures. It is a cultural shift but I would suggest most people embraced it quite well.

Ms HOLDEN - It really is education and I think we have made the information much more transparent right down to the ward or departments so that people understand what money they have. We have introduced more information, for instance, between choosing one type of blood test versus another. One is green, which means it is probably the right test for what you are after and it is relatively cheap; the red one is really 'Think twice whether you need this because it is an expensive test and you may not need that'.

Ms O'BYRNE - We have the challenge for teaching hospitals as well. At the lower level of training, the earlier interaction in the workforce is you are inclined to ask for every single test.

Ms FORREST - The *Gray's Anatomy* approach.

Ms O'BYRNE - The *Gray's Anatomy* approach is another way of saying it - that you order every single test under the sun and it is important to recognise that some of those might sound fantastic. But if they are not necessarily going to improve your treatment of the patient then there is a decision about whether you should do it. So these tests are invasive, they are not necessarily good for our patient to undertake just for the sake. I have not heard the *Gray's Anatomy*.

Ms HOLDEN - We do similar things with radiology, which of course is another area that can be incredibly important diagnostics but also incredibly expensive if not needed. Right down to the department levels, we are getting feedback on how well they are doing compared perhaps to last year or how many more patients they have been able to treat and so, by and large, everybody wants to get as many patients access to the health service that they can. That is one of the real benefits of working in the sector - everybody is pretty much wanting to get patients through the door, so that is a pretty major incentive and the better we do the more patients we can get through the door. I think there is a really clear understanding that there is not an endless bucket of money for health. I think that is not something you would find too many people ambiguous about.

Mr VALENTINE - With respect to ICT, there are a lot of information systems in a hospital the size of the Royal and there is also a lot of exposure in terms of risk. A lot of these systems that may have been put in place are small systems - surgeon Such-and-such did this on his laptop at home and has brought it in, and it is now part of the systems that they rely in order to undertake their work. That surgeon leaves and no-one is there to be able to understand how the system works - there is a lot of exposure there. Is there any work being done to try to reduce that exposure at all?

Ms HOLDEN – Yes, there is. Actually, it is not as big a risk. We have had quite high thresholds to import stand-alone systems by and large and we have really been trying to work as a whole of hospital around how we are managing things like audits, which is where those home-made systems start. I just wonder how many of these are done, so we are trying to put those on the database because all THOs, and prior to them the area health services, had agreed that we should have statewide solutions for our IT systems.

That has been pretty frenetic for the last three or more years and it is being driven and working in partnership with the department. IT solutions are something that we are doing. We are sensitive to statewide solutions and we are sensitive to making sure we do not have orphan systems but systems able to embrace not just ENT but all surgery; not just a medical department but all medicines. We are working closely with all our areas just to make sure that we have systems onboard. Our IT people working with the north and north-west IT people and we are all working with the department trying to build these systems to do that.

Mr VALENTINE - Do you have in place mechanisms in a control form? If a particular area decides to put in for some commonwealth funding, which is outside of the normal funding, where they put in to have a certain system developed and it is okay to get the system built but there may not be funds to actually support the maintenance and ongoing.

Ms O'BYRNE - It has historically been a challenge when those sorts of things have occurred. The new funding model channels commonwealth and state funding through one mechanism. The IT conversations that we are having with the commonwealth are as a whole system makeover.

Mr VALENTINE - Any systems that are put in place have to go through a gateway?

Ms HOLDEN – Certainly inside THO south and I know in other THOs all of our wish lists must go through a system and they end up at the executive. They are either part of something else that is going on or they are in a queue. Our lists go up to a joint meeting of the state and we either get them up, they are in a queue, or they are being dealt with in a way that meets our needs but not necessarily as originally designed by us.

Mr VALENTINE - Sounds more positive than it has been in the past, which is good.

Ms O'BYRNE - There is some really good technology advances in emergency departments elsewhere where they have got game technology that draws data from existing systems and it is quite exciting.

Mr VALENTINE - That sounds good. It can increase productivity but the other side is in terms of reducing staff and staff morale in continually trying to cut staff as opposed to not offering a particular service. How are you tackling the reduction in staffing numbers? Quite often these systems replace staff.

Ms O'BYRNE - Staffing numbers in each of the THOs has increased.

Mr VALENTINE - I am not talking about the IT staff, I am talking about the people used to working on a paper-based system and then all of a sudden, because a new information system has come into play, it is cut by half.

Ms O'BYRNE - That is challenging but the bulk of the IT employment we had around that space was within the department itself as opposed to within hospitals and they were fixed term contracts predominantly. I am looking for the nod from Matthew at this point rather than a THO level.

A change in work force is always difficult and changes in health are incredibly fast. It moves very quickly all the time.

Mr VALENTINE - Another area where you are always trying to cut your cloth to suit your budget, you get to a point where staff morale starts to drop off because another person had to leave and they are simply being lumped with another set of tasks. What is the level of sick leave across the hospital? Is that an issue, stress and the like?

[5.00 p.m.]

Ms O'BYRNE - The sick leave levels have not increased. Sick leave 2011-12 - I am just double-checking because this is a percentage of FTEs.

Mr VALENTINE - Do you have 2010-11 as well?

Ms O'BYRNE - Yes, I have 2010-11. The total across the department is 4.29 to 4.37. So it is not as significant. That can be within any normal variable year.

Mr VALENTINE - Sorry. What does that figure refer to?

Ms O'BYRNE - It is what the FTE percentage would be. I think that is how that works. I am trying to get someone to clarify that figure for me.

Ms HOLDEN - Yes, it is a sick leave weight.

Ms O'BYRNE - Sick leave weight.

Ms HOLDEN - That is a percentage of total FTEs.

Ms O'BYRNE - Stress-related workers compensation claims in total across the system are down from 63 to 36.

Mr VALENTINE - That is encouraging.

Ms O'BYRNE - It is, and that trend down is across each of the areas of the departments.

Mr VALENTINE - The last question. Aged care patients have been talked about in other hospitals. Is there an issue down here at the Royal? Are people waiting to be placed into aged care facilities and sitting in corridors, as we have heard sometimes in the past?

Ms O'BYRNE - Historically that may be the case, but not now.

Mr VALENTINE - Not now. So it is simply not an issue.

Ms HOLDEN - In the south, no. We have got some vacancies in our nursing home beds at the moment which we are using but we are waiting for patients to try to access a bed.

Ms O'BYRNE - I was asked, Chair, to provide details of occupancy rates for the regional facilities. I would point out that this is to 30 March 2013. We have in the last couple of months increased that occupancy and engagement with community facilities. Beaconsfield is at 100 per cent;

Campbell Town 69; Deloraine 62; Flinders 32; George Town 56; Scottsdale 55; St Helens 43; St Marys 39; King Island 23; Queenstown 32; Smithton 56; New Norfolk 61; and Midlands 90. We have contract beds obviously in a number of other facilities. These are certainly higher than that now because we have been clarifying our transition out in order to free up beds in the acute space. We are utilising our sub-acute beds in a far more strategic way across the system.

Mr VALENTINE - Sorry, there is one last question about the records management system. That was a bit of an issue going back. How is that? Are they catching up on the backlog of records?

Ms O'BYRNE - Yes, absolutely.

Mr VALENTINE - Can you give us a précis on that?

Ms HOLDEN - We have a digital medical records system in the south. Our records there are scanned and on the system now within 28 days; I do a regular report on those. They can be pulled out for outpatients and then put back. That is something we have been monitoring and is working very well.

Mr VALENTINE - What is the backlog like these days?

Ms O'BYRNE - We were getting them all from the paper based system on to the digital system.

Ms HOLDEN - All the current patients who are admitted.

Mr VALENTINE - All current patients - but I was just wondering if there was an attempt to take the past patients and put them on as well.

Ms HOLDEN - No, by and large all patients that we are now treating are either on the system or are put on when they leave.

Mr VALENTINE - So they are put on when they present.

Ms HOLDEN - Yes. So we have not had a backlog.

Ms O'BYRNE - We are encouraging all of them to sign up for their individual e-patient cross-record number because that will make it easier when they present at any health facility for access to their data across the system.

Ms O'BYRNE - Or stay healthy. That is another thing.

Mr VALENTINE - Thank you, Chair.

Ms FORREST - I am just interested in your statement of cashflows on Table 23.6. You say on goods and services the budget for this year is up. You also have cash receipts which include your commonwealth own-purpose expenditure. I am wondering why there is increased revenue coming in those areas, not the jump from this year to last year, 2012-13, in the fund cash receipts but more the drop in 2013-14 in the forward Estimates.

Ms O'BYRNE - The jump is probably more because of the mental health transition.

Ms FORREST - I am not so worried about the big jump, I am wondering why from 2013-14 onwards you are not expecting to get own-source revenue from the sales of goods and services. I would expect that to continue to increase with usage. Also, why are your other cash receipts dropping away? I'm worried about the forward Estimates.

Ms O'BYRNE - These are hospital-derived numbers and there is a better assessment of what the hospitals are likely to receive in cash receipts. I am advised that it is better Estimates on future income. It is a more accurate estimate into the future than we have historically had but it also includes some COPES, is what we have been advised.

Ms FORREST - That is the other cash receipts. Effectively, you are looking at $2 million less in the sale of goods and services. The budget for this year would have affected this year's I would have thought. It is the only THO that has not dropped.

Ms HOLDEN - It is other revenue, which does not take us much further, it is COPES. The various contracts through the COPES funding comes across as other revenue and that can change as we might get new contracts or fewer or something like that. That is what we know.

Ms FORREST - What about in your sale of goods and services?

Ms HOLDEN - That is the one we are talking about. Inside of that is something called 'other revenue', which is roughly $2 million.

Ms FORREST - But that is accounted for under other cash receipts, I thought, according to your footnotes.

Ms HOLDEN - It is under 'other revenue' items and it is a drop of roughly $2 million.

Ms FORREST - The COPEs falls under 'other cash receipts'.

Ms O'BYRNE - In the interests of time, Chair, do you want us to get that information for you?

CHAIR - We will get back to it. Minister, you indicated earlier when we were talking about the *in camera* matter that we could cover in a different forum or setting.

Ms O'BYRNE - Only if there is one that is appropriate.

CHAIR - We can do it now or, rather than clear the room and come back in, leave it until the end of the session today if Gavin is available.

Ms O'BYRNE - Are you able to wait until the end?

CHAIR - He is saying yes, so let us leave it until the end.

Ms O'BYRNE - That will be great, thanks.

CHAIR - It looks like we can move to ambulance services. We are done with the THOs, thank you.

Output group 3
Statewide Services

3.1 Ambulance Services -

Ms O'BYRNE - I table the sick leave percentage area by rate program, Childrens Services and the consultancies over $50 000.

I welcome to the table Dominic Morgan, CEO, Ambulance Tasmania.

CHAIR - There has been a challenge in regard to ramping. Where are we situated at the various

venues around the state with regard to that matter please?

Ms O'BYRNE - Ramping occurs after 15 minutes, which is a standard that other jurisdictions do not use. Other jurisdictions use around -

Mr MORGAN - It varies. Some are 30, some are 40, and some are 20.

Ms O'BYRNE - There are different ways of ramping if you calculate it. We are the only one that uses such a short timeframe for ambulance offload delay. Part of the problem is that we do not have other hospitals, so you cannot go on by-pass, as mainland hospitals regularly do. We have received significant funding around trying to resolve the issue, including development and implementation of clinical protocols. I can give you the current figures. The north-west cannot currently validate any of the numbers because it is not something they have historically done. They have not had a ramping issue in that they lay in the north-west. I think they are setting up a protocol now to be able to get that shared understanding about what a ramping might look like and when we would be concerned.

Royal Hobart Hospital, in July last year, the number of ambulance rates ramped was 266 and in March this year 250.

The Launceston General Hospital, the number of ambulances ramped last July was 120 and in March it was 48. I will refer to Dominic if there is any other commentary around ramping. There has been a suggestion that we move to a more nationally consistent amount. Our figures would suddenly look brilliant but it would be seen to be changing our playing field a little because we always have calculated on a 15-minute wait.

Mr MORGAN - Yes, that is an important point to pick up on. It is fair to say from the Chief Executives of the THOs and myself, the view is not so much about whether our target is *x* or a target is *y*; there is a great degree of support amongst the four of us to ensure that as little ramping as possible happens. One positive is that there is an in-principle agreement that goes throughout the organisations that in the event of a major medical emergency coming in, where the ambulance is the otherwise closest available vehicle, staff in ED will release that ambulance to respond to it. That is one of the bigger challenges.

Within the other jurisdictions, that does not always happen because, of course, they have more ambulances. However, in our jurisdiction sometimes the only ambulance in Burnie or the only ambulance in Devonport, could be the one that is affected. So there are multiple strategies about how demand is recognised within emergency departments and how the senior staff are notified to put in place a chain of events to get the ambulances cleared as soon as possible.

Ms O'BYRNE - Demand on ambulance has increased. If you do not include the non−emergency patient transport system, in 2009-10 we had 67 396 ambulance responses. We are at 63 738 year to date on 1 May and we have seen 67 000 to 70 000 to 71 000, so we have seen an increase in demand on ambulances. It is part of the reason we have run the campaign to ensure people are phoning ambulances when they need them as opposed to some of the concerns we have had around the usage and call out of ambulances. The triaging work at the call centre is assisting in ensuring an appropriate response.

CHAIR - We look each year at the performance information. Minister, you have just mentioned the non-urgent patient transport isn't provided. Is that a figure you can provide?

Ms O'BYRNE - The non-emergency patient transport responses? We didn't collect them in 2009-10, but in 2010-11 it was 7 463; 2011-12 -

CHAIR - Are you looking at table 5.3?

Ms O'BYRNE - Sorry, I am giving you an updated figure from now, so where are you?

Mr MORGAN - That would not be in the budget papers, they are in the fact sheet. In short we undertake approximately 800 non-emergency patient transports state-wide now. Ambulance Tasmania, as you would probably be aware, formed a single statewide health transport service in 2009-10. On1 July 2010 it merged, so the figures are not available before that. It has been pretty steady over that time and there was a policy decision fairly early on that Ambulance Tasmania would confine its activities to DHHS and government work, transporting patients to and from and between DHHS facilities.

CHAIR - Have you been through all those, minister, or do you want to table that document?

Ms O'BYRNE - Why don't I table them?

CHAIR - That would be fine, thanks.

Ms O'BYRNE - That will give you response times as well - total ambulance, emergency ambulance and urgent ambulance responses along with non-emergency and total ambulance incidents.

CHAIR - That will be useful, thanks. Tragically sometimes there are reported cases of what many people in the public are led to believe are avoidable deaths. Have there been any this year because of delayed response times? I am thinking of one a year ago in the far south of the state with an airway blockage.

Mr MORGAN - No. It is a complex scenario that you are referring to and in no way do I want to trivialise the loss of a family member in the passing of a dearly loved one, but there are legal proceedings afoot by the family. What I can say is the Coroner's decision was released and there were no adverse findings against us.

CHAIR - Is that the only one during this past year?

Mr MORGAN - Correct.

CHAIR - Has there been any recent assessment of the comparative cost of a greater utilisation of the private non-urgent patient transport service, compared to our own?

Mr MORGAN - Yes, towards the end of the last calendar year we issued a panel to the commercial market to see whether any private providers would be interested in a supplemental service for non-emergency patient transport services to government in the event that at a future date our demand was unable to be met by our existing resources. One thing that was quite clear is that the commercial providers, despite nearly 12 or 13 years of subjective questioning as to whether the government was cheaper at providing these services, it has unambiguously come in that the commercial services are more expensive than the health transport service for Ambulance Tasmania.

CHAIR - That is for the service provided, as you said, Dominic, within DHHS facilities?

Mr MORGAN - Correct, and we do not to, from or between. We may have a non−emergency patient transport go from the community to a DHHS facility, but we do not do private to private or a private residence to a private hospital or anything like that.

Ms O'BYRNE - What occurred in the system reform we did is that we got better at managing those transfers, so instead of having ambulances being in demand at unrelated times we could say, 'This person from the LGH has to go to Burnie, and if you wait half an hour you could pick up this person from Burnie and take them to the Mersey'. We got better at coordinating our time, which

impacted on the private providers who had supplemented in that area. We continued to give probably a little more work because we did not want to have an impact on their business. However, with the health budget the way it is we will always have to use the most cost-effective system.

CHAIR - There has been some discussion in the past regarding an ambulance levy, given that we are in very difficult financial circumstances. What is the current policy?

Ms O'BYRNE - There is not a health minister in the country who does not want more money. Having said that, we had this discussion primarily around what has happened in Queensland. Queensland has always been a model where a levy has existed that we could copy. However, Queensland has recently moved away from the levy system. The argument around that was the belief that because people paid for the service there was deemed a sense of entitlement for the service. They were probably using the service more as a result of having paid for it, so there is still some research going on around that. I would like to see the outcome.

The last thing I would want is to introduce a levy and then put double demand on the system, because people say, 'Well, I've paid my fee so I'll call the ambulance now', when we are really trying to create a culture to only call it if you need it. That has been based on the Queensland work. I am not sure whether we have had any further information on that, other than we would like to see whether moving away from the levy changes the demand, because demand is one of the biggest things for us.

Mrs HISCUTT - I have one question with regard to your volunteers because volunteers do play a large part in the ambulance service.

Ms O'BYRNE - Absolutely, and we love them desperately.

Mrs HISCUTT - How are you tracking with numbers and the sort of care that you give them and the training? How are you going with all that? Do we have enough?

Ms O'BYRNE - We could always have more. We have decked out an old ambulance that we take around to Agfest and different shows and use as a recruitment tool for people to participate. A lot of people show interest and some of them then make the call. I popped in to see the guys at Agfest and they had a number of people showing interest.

Mr MORGAN - We have this fully refurbished, state-of-the-art recruitment vehicle.

Ms O'BYRNE - It is good because people get a feel of what it might be. We operate volunteers across the state, from 42 different locations and 600 volunteers. They arrived at 2 353 incidents during the 10 months to 30 April. They are absolutely fantastic. We do everything we can to support them, but of course we want more. There are some areas where we would like to set up services. It really requires that community buy-in and that is challenging.

Mrs HISCUTT - There is not a big rollover of volunteers; they are usually stayers?

Ms O'BYRNE - Like most volunteer organisations, it is an ageing group.

Mr MORGAN - We have surveyed the volunteer workforce; generally speaking the profile is 43 years of age. We have done an awful lot of work around volunteers in the last four years, principally driven by the fact that we appointed a coordinator of volunteer strategy, which was the first time we had set up a peak position. Until then it was largely done off the side of people's desks. We were able to do a comprehensive clean-out of exactly who our volunteers were and where they worked. Probably as little as three years ago the numbers were down as low as 450. Now we are confident we have over 600 volunteers in the state. That makes us the second-largest emergency service volunteer base in the state.

There is always quite a lot of churn around volunteerism, but basically we have gone up by 25 per cent in a very short period, so we are quite happy with that. The problems we have are always around small rural and remote towns. For example, we have in excess of 32 volunteers at the Wynyard station, which is fantastic. They virtually fight to get on the vehicle, but at places like Rosebery and Tullah it relies on the goodwill of a few individuals. We have campaigns to get people on board.

In the last few years we have put on three more volunteer educators to supplement the one that we historically had. We have introduced forums now where at least once a year there is a local regional forum dedicated purely to volunteers and volunteer issues. That culminates in a gathering that we have at the Volunteer Ambulance Officers' Association which comes together once a year. As the minister said, we have the community education volunteer recruitment vehicle and that has been very successful along with online tools for recruitment that we have introduced in the last 12 months. We have done a complete rewrite of the volunteer ambulance officers' manual; there is a whole review going on at the moment about how we manage volunteers; and we are getting all their course accredited with a registered training organisation. The idea behind that is that we can give people a qualification that they may be able to use in their personal life as well. That helps us to keep them and retain them for longer.

This year we have established a volunteer exchange program with South Australia and with Victoria. We sent two of our volunteers last month to South Australia to spend a week with their volunteer service and to come back, give a report and give us new information about how other people are dealing with volunteerism in a fairly innovative way.

Ms O'BYRNE - What is the statistic of the amount of ambulance response points that we had?

Mr MORGAN - We currently have 53 response points throughout Tasmania, which means that because of the model of how we do ambulance service, it gives us the most response points per capita in the country It because we are able to use a tiered system now since we have brought in community emergency response teams which are a volunteer with a sedan in our really small towns where, in our view, they are too far away from a normal paramedic crew to back them up so we send someone out. Having community emergency response teams, the sedans, volunteer ambulance services, branch stations, which is a paramedic with a volunteer and then our urban stations gives us a good tier of at least being able to turn out somebody with some clinical background to a medical emergency.

Mrs HISCUTT - How many FTEs do you have working full time?

Mr MORGAN - 372 FTE.

Ms O'BYRNE - 0.06.

Ms FORREST - That is a very small person.

Ms O'BYRNE - Me.

Members laughing.

Mrs HISCUTT - That ratio is okay - acceptable?

Mr MORGAN - No, we definitely need many more.

Members laughing.

Mr MORGAN - We are hoping to get more volunteers this year. We have a plan to roll out

more of the community response teams. It was one of the findings of our modelling review that we did with ORH - Operational Research in Health - in 2010. But obviously you need to be careful in the timing because it is all about the buying in of the local communities. But we would be hopeful to roll out additional serve teams throughout the state this year. If we do that basically in every town our volunteer numbers go up by 10-20 each time.

Ms O'BYRNE - Our response times are still tracking very well. If we saw a significant drop-off in our response times we would need to re-evaluate our position and how we position people. But emergency response times in 2010-11 were 11.47, in 2012, 11.17 and year to date they are running at 11. It does not mean that they will not grow because demand is increasing but our response capacity has been phenomenally good. In fact, credit to the staff.

Mr MORGAN – It is critically important that there is a direct corollary between increases in demand and increases in ambulance response times. If we see demand we usually look to see our response performance deteriorating. I would echo the minister's words that those improvements in response performance are down to the staff and the way that they have embraced change and innovation.

Ms O'BYRNE - Fantastic.

Mr MORGAN - Very much so.

CHAIR - Any further questions on ambulance services?

Mr VALENTINE - I have interested briefly, in the information system.

Ms O'BYRNE - How about we just invite you down to have a look at it? It would be quicker because it is really cool. It is really the sort of thing you need to come and see.

Mr MORGAN - The in-vehicle information systems.

Ms O'BYRNE - But also the state coordination.

[5.30 p.m.]

Mr VALENTINE - I have had a bit of contact with that so I do not really need to know about that one.

Ms O'BYRNE - It is probably a little bit quicker, Chair, if we invite the member down to have a look at it.

Mr VALENTINE - No, that is okay; I am more than happy to do that.

3.2 Population health services -

Ms O'BYRNE - I invite to the table the Director of Population Health, Dr Roscoe Taylor. Does anybody have a lolly for him, a bit of sugar? There you go, a special basket just for you. We have had long conversations about the impact you can make on health and reduced sodium consumption. Whilst we will have this debate it would be an interesting conversation whether you were going to act on sugar or sodium first - and I am not sure. Finland is really interesting; in Finland they used to be saying, 'Have you had a heart attack yet?' because the heart attack rates were so high and they reduced the percentage of sodium and iodine in manufactured goods, so anything that you purchased had to have a reduced sodium level and what was the percentage they cut? I think it was something like within three years they had cut the heart attack rate by 30 per cent or 40 per cent.

Ms FORREST - I read a research article the other day that would dispute that.

Ms O'BYRNE - I was wondering who funded it though. I saw the research article and I did wonder who might be paying for it.

Mr VALENTINE - Clearly not the people that produce sodium.

Ms O'BYRNE - No, but it does go back to that issue around demand on the health system based on choices we make in diet and exercise, which leads probably perfectly to where the first question is.

CHAIR - Are we going to come back to population health? That would be good.

Ms FORREST - Minister, I think you mentioned a bit earlier some of the work being done regarding tobacco control and I have read almost all of the State of Public Health 2013 report, which is a really good report. Aside from the ban that was announced at Risdon Prison today, which is good news, such social marketing that is going to go around tobacco control measures and reducing tobacco use, can you tell us a bit more about what you are planning to do there?

Ms O'BYRNE - We received additional funding in the budget and one of the things that has changed in the years - and we have led the way in tobacco reform - if anyone has missed it, we recently won a national award for excellence in this area, so congratulations to the team. One of the things that has changed is the amount of social media that you have to collect just before an impact is delivered so there has been quite a bit of debate around what your targets might need to be, so we are responding to a shift in it that. Roscoe might want to talk a little bit about that work.

Dr TAYLOR - Social marketing. The issues that Tasmania faces with smoking rates are that they are very high in young males in their 20s to 30 years of age; still too high in young women as well but particularly young males and particularly high as well in pregnant women. We seem to be winning in the secondary school age group with declining cigarette-smoking experiences there over the years. But the smoking in young people and the smoke-free young people's plan is under development at the moment through the Tobacco Coalition.

Ms O'BYRNE - That is the smoke-free work Legislative Council supported, the children's commissioner has been doing some work on it and the Tobacco Coalition has been actively supporting it, which is Professor Jon Berrick's artwork from Singapore.

The problem is that our baseline was so appalling. We are still at 23-odd per cent which is way too high for smoking rates but when you look at where we have come from, it is actually a significant shift. The jurisdictions will gradually leapfrog each other. Tasmania has consistently led the way in denormalisation reform and that is the big issue that we have to tackle. Really, you are appealing to two markets: there is the market that have never smoked and that is where denormalisation is, and that is why you do not want kids thinking it is okay to smoke and I have yet to find a parent who has said that they would like their children to smoke - that is one market. The other is the market that is significantly addicted to a highly addictive product and it is a different conversation with them around how to access quit programs, how many times it might take for them to quit.

Different social media campaigns have had different responses. The campaign with the crying child who could not find his mum which was about three seconds of filming and the mother in it was the child's real mother. It was done from a number of angles so it looked like the child was alone for a period of time and the tagline was if this is how distressed your child is when they cannot find you now, what if you were never there - if you died from smoking-related diseases.

We had to increase funding to Quit Tasmania by $30 000 to deal with the number of people who called them at that point because that was one of those triggers that worked, and different social

media campaigns have different impacts on different cohorts.

Ms FORREST - Is there any particular program you are looking at for pregnant women?

Ms O'BYRNE - Yes, there has been quite a bit of work done and staff in Health are looking at some international work that is being done in the UK and Canada, particularly around smoking and pregnant women. So there is a campaign and I can provide data for you on that.

Dr TAYLOR - Other strategies in place: the midwives have been trained in the last two years or so, in supporting young pregnant women on cessation.

Ms O'BYRNE - There is a little IT program that GPs and the midwives can flick through to people that is nice and easy to manage.

Dr TAYLOR - There is brief intervention training online which has now trained 1 300 staff. Also there is the indigenous early childhood development funding from the commonwealth that has been going towards Aboriginal women and their smoking cessation support.

Ms O'BYRNE - The last Indigenous Health Report we tabled in parliament last week had, although it is slightly dated, Tasmania having a low significant reduction in smoking in indigenous women. Our numbers are small so it does not take much to create that variation. But smoking for women, the rate of decline is still slow but has been declining in recent years and in under 20 years, 46.8 per cent.

CHAIR - Am I right in understanding that there has been some suggestion that restricted areas imposed by councils might be subject to some legal challenge and if that is the case do you have any advice?

Ms O'BYRNE - We are working with Treasury on that at the moment; it is to do with a regulatory impact statement that is required.

Dr TAYLOR - Even before the legislation was passed by parliament to enable pedestrian malls and bus malls to be declared smoke−free, councils moved ahead with an excellent strategy, except there are areas where the question hinges on whether or not council, as occupier of the street or a footpath, has the legal right to declare an area smoke-free. That is a legal question that is being posed - is the council the occupier of some of the areas that they have gone ahead and declared smoke-free? Some of these are outside pedestrian malls. That is one of the issues.

The other issue has been the delay in our own capacity to produce the regulatory impact statement the Treasury requested which will be coming along shortly.

Ms O'BYRNE - That will be finalised next month, provided to Treasury, and then governor−in−council can make the regulations and the act will then follow. So we are close to resolving that issues.

CHAIR - The other matter related to smoking is particularly around sports venues and arenas, golf courses for instance. Have there been any prosecutions with regards breaches of those areas?

Ms O'BYRNE - No, when we do those sorts of changes the reason that we step slowly is that we are looking for behavioural change because of the capacity of the police overall. In the same way with smoking in pubs and smoking where people are serving food, when you make incremental changes you change behaviours. We are still working with some clubs, probably less golfing, it would be more bowling, around how they structure their organisation particularly with an older community to ensure that they are meeting their requirements around competitions. We are being as supportive as we can through the transition so there have been no prosecutions. What we are seeing is

behavioural change.

CHAIR - How are you measuring that behavioural change?

Ms O'BYRNE - Anecdotal, predominantly.

Dr TAYLOR - There are still some issues in the putting green area.

Ms O'BYRNE - And the definition of competition in golf poses some challenges but it is about de-normalisation. Where children are playing sport, and that has been the main focus, we do not want kids to see smoking as part of what you do when you go and play sport.

Dr TAYLOR - We have been at carols by candlelight and have had observers virtually at each one.

Ms O'BYRNE - Yes.

Dr TAYLOR - The behaviours there - there have only been two or three individuals found to be smoking in proximity to the carols by candlelight area and they moved away when asked to do so.

Ms O'BYRNE - We are a frighteningly law-abiding community. When people say the rules have changed, predominantly within the smoking framework, it is adhered to. One of the reasons is incremental change.

CHAIR - Yes, Roscoe mentioned the tracking of that sort of stuff is anecdotal, as feedback from clubs - do you actively seek that feedback? They would not phone you up to volunteer the fact that it is a good thing working for them, would they?

Dr TAYLOR - No, but we sometimes -

Ms O'BYRNE - They are more likely to ring if they are unhappy but tobacco control officers visit and discuss this issue with sporting organisations. We have had a lot of requests, more so from bowling facilities which are smaller, asking for assistance in how they can manage being able to watch the game and manage their smoke-free areas and that has been more challenging than golfing. Golfing has probably got a bit more media because there is a particular interest in a couple of people but I would say the biggest challenge is that in the older bowling community.

Mrs ARMITAGE - How many tobacco control officers do you have in each of the regions?

Ms O'BYRNE - Anyone can be designated a tobacco control officer so you can do that. If anyone would like to be a tobacco control officer do let us know but currently we have -

Mrs ARMITAGE - It is interesting you should say that because I have been one for about 15 years and have not heard from them for the last 8.

Ms FORREST - The member for Windermere is doing all the work for you I reckon.

Mrs ARMITAGE - It is interesting because the parliament has not contacted the tobacco control officers for the last 8 years.

Ms O'BYRNE - You are a nominated tobacco control officer through council?

Mrs ARMITAGE - No, through the department, from a long time ago. I did have a card but I have not heard from them for such a long time.

Ms O'BYRNE - Two different things. One is our control officer, the other are the nominated ones. I will let Roscoe explain.

Dr TAYLOR - That is right. In terms of the full-time equivalent staff within Population Health it is 0.6 in the north and 0.1 in the south. I might have it the wrong way around, sorry, with additional staff called in as required where there is a need to do extra surveillance activities.

Ms O'BYRNE - So at a particular event and monitoring change.

Dr TAYLOR - Following amendments to the Public Health Act it enabled us to declare classes of persons as nominated officers. That has probably changed since the time you would have been made designated, nominated, obviously.

Mrs ARMITAGE - We would be more the McDonald type.

Dr TAYLOR - Yes, that is right. It means that those nominated officers could now act within the scope of their workplace, for example, at the Royal Hobart Hospital, and do their activities there so we have a significant number of those staff around.

Ms FORREST - I am going back to another area of public health, population health, the alcohol issue. I noticed again in the state of public health, the 2013 report, it makes the comment that 'Liquor licensing boards need a discretionary power to consider public health in approving liquor licences. This brings up the interplay between national competition policy principles which in this case may militate against the public health good, because of the effect of the NCP is to put pressure on state and territory governments responsible for the content and administration of liquor acts to replace the needs-based test for new licences with public interest tests'.

The comment goes on 'This legislation specifically spells out the need for public health harm reduction as an objective in forming decision making. Sensible liquor licensing can be challenged on the grounds of being anti-competitive'. So it presents a challenge but as far as doing that public interest test with a new liquor licence - and this may be outside your area.

Ms O'BYRNE - This is probably something for Minister Bacon to address but one of the issues from a national perspective is the ability to consider public good as part of a regulatory impact statement that we would have to submit in most areas. We have challenges with that.

I sit on the Council of Australian Governments Legislative and Governance Forum on Food Regulation, which is where the alcohol labelling and such issues might sit. Also where a number of other issues sit, it is a complex area. One of the biggest challenges we have had is when we have attempted to initiate and work with the public good models, is how do you do that within a regulatory framework that does not associate public good and some of the challenges we have had around food labelling and alcohol labelling for pregnancy warnings have come in contact with those challenges.

But in terms of the fat licensing, it will be an issue. We are making progress nationally. We have a food ministers' council, rather than that long title, in the next couple of weeks where we will be getting an update on the labelling for warnings on pregnancy on the basis that we'll be moving to a system of either we do it voluntarily or we will ram it down their throat. There are two ways of dealing with that; one would be what appropriate advertising will be needed on the bottles of alcohol and what might need to be our point of sale and the broader education campaigns around that.

It is a bit different from selling tobacco. When you sell tobacco the person who buys it knows the rules and there is signage everywhere. You might be a pregnant woman purchasing alcohol for a dinner party, which you don't intend to drink. We don't want to have instances of women feeling under pressure or shamed for doing so. There has been quite a bit of work happening around what needs to be on the labelling so we're not judging someone for what is not an illegal behaviour, but

there is a view in society that you can drink some alcohol when you are pregnant. There is no evidence of a safe level of alcohol consumption while you are pregnant. That's been the challenge there.

Ms FORREST - So, there is ongoing work in that area?

Ms O'BYRNE - Yes. One of the problems with ministerial councils is that the faces regularly change at the table but historically Tasmania has led the way quite strongly with South Australia. I would imagine we're going to get reasonably good support at the council this time. I am not hearing any feedback of a push against it. That and traffic lights are the two moves – not necessarily traffic lights but food warnings. Also, as mentioned before, the validity of health claims on food, which is a really significant piece of work that's being undertaken. You will have to prove your health claim before putting it on the food item that you sell. Particularly when dealing with food for children, we need to be very up front about what might exist in a packet of cereal, for instance. It might be called healthy cereal but it can pretty much be sugar.

Ms FORREST - Obviously, one of the big challenges is obesity.

Ms O'BYRNE - Yes.

Ms FORREST - I have to say it is a growing problem in Tasmania.

Laughter.

Ms FORREST - That's one way to put it.

Mr VALENTINE - An expanding problem.

Ms O'BYRNE - Yes, it is nationally and internationally too, a big challenge. It has to do a lot with the choices made around food and exercise. Our participation rates in exercise are up. One of the biggest issues that we have is the sort of decision making around food. I think all of us choose what's easy and the shift really has to be how do you make the easy thing the good thing. That's a real problem. You can be in a rural community with a significant vegetable growing industry but you can't buy the vegetables at the local shop. That impacts on families. We talked about baby food before; we're often massaged into thinking that because this thing says it has all these extra vitamins and minerals and good things for your children that somehow it is better than spending on vegetables yourself.

One in four children and over half the adults in our community are now obese or overweight. Throughout Australia and internationally, that's increasing. The first results from the 2011-12 Australian Health Survey found 63.4 per cent of Australian adults were overweight or obese; 65.6 per cent of Tasmanian adults were overweight or obese, which is an increase from 2007 and 2008 where it was round about 61.3 per cent nationally and 64 per cent locally. The health costs associated with obesity - I touched on it before - the infrastructure spends that we are now making, let alone the acute care costs for obesity in our community.

Ms FORREST - Is there any particular approach that you plan to take to try and address it?

Ms O'BYRNE - One of the known interesting pieces of work from the national health preventative health lives was if the entire Australian collective didn't suddenly decide to eat unhealthily; there hasn't been a snap decision and all of a sudden we've moved into poor diets. We have had a cultural shifting over many years in the way that we consume food and the way we exercise. It will probably take many years to deal with that. We are focusing very much around children because if we don't get that right, we're never going to be able to afford our health system in the future.

Move Well Eat Well is not only in schools now; we have rolled it out into childcare centres so we're getting far better dietary choices made there. In workplaces, we've got the healthy work initiative in workplaces. There is the Tasmanian heart plan for physical activities, dealing with those sorts of things, and the Tasmanian food and nutrition policy. The national partnership for preventative health is rolling out a number of initiatives that we partner with. We make assumptions around health literacy and engagement, and we assume that people are dealing with the same level of understanding and information that we might have at this table, and that is not the case.

Ms FORREST - We need to have a bigger focus on education.

Ms O'BYRNE - Education on health literacy, absolutely. A big part of the work that the national commission is dealing with, the funding from the Australian Government, is around improving health literacy so that we are making those better choices. There are a couple of stories I am famous for telling, one of which is about the fast food outlet in Invermay, in my community. It has 50-cent cheeseburgers and the staff there were saying that people were coming in and buying 50 cheeseburgers and putting them in the fridge because they were cheap and easy. That is the issue around what is easy. Why aren't people in country areas buying vegetables? Because you can't get them at the local store. That is the challenge. That is where community gardens and partnerships with schools and those programs work.

I was engaged with a community garden a few years back where 78 per cent of the grade 5 children in the program were the primary meal preparers in their home. They were 10 years old and 11-years old and they were making decisions about every meal that the family was eating. Our problem historically has been that we have targeted our message at us, who arguably are, I would hope, reasonably health-literate people. The message has to be easy for kids because that is where the changes are going to have to come.

We are seeing in the community garden projects, the Stephanie Alexander projects, you are seeing over the years that it is engaged in the schools the shifts that are happening in the communities associated with it. The one that is at the Collingwood School next to the tenement towers is already starting to see longer-term data around nutritional change decisions of the families living in the tenements as a result of the school program and the community program there. It is education all the way through.

Mrs HISCUTT - Just one question on childhood vaccinations: we have heard in the media of late that some childcare centres might not in the future accept some children.

Ms O'BYRNE - Apparently you can do that in Tasmania. In New South Wales they are implementing a ban that if you haven't been immunised you cannot go to a childcare centre. We have here a capacity under our regulations for the childcare centre to ask for the vaccination certificates. They can choose not to have you. What does tend to happen, though, is they simply exclude you at times when there might be a particular viral outbreak. That allows them to readily identify those children who are at greater risk of carrying infection. That has been the case for a few years now.

Our vaccination rates in Tasmania are comparatively very high. We can get the immunisation rates for children aged zero to seven from the national data. The percentage of children fully immunised in the 12-month age group in Tasmania increased from 91.56 per cent to 92.81 per cent in 2012, which is above the national average. Fully immunised children in the 2-year age group slightly decreased by 0.29 per cent. Part of that is some of the work that we are doing around the CHAPS service as well, about making sure people are getting to those appointments because that is where you can follow up on immunisation. The 5−year age group increased by 1.57 per cent and we have consistently been on par or above the national average for immunisation.

I disagree with the article in today's paper around you should be able to choose not to vaccinate.

The public health approach that we have taken is very much about protecting the entire community.

Mrs HISCUTT - If Tasmania goes down that road to say you cannot put your child in there if they are not vaccinated, doesn't that introduce discrimination laws? Have you looked that far?

Ms O'BYRNE - I understand that it doesn't impact under the discrimination laws because it is a service that you are purchasing, but it is not a decision we have made. New South Wales will need to determine that under their decision making. At this stage what we have said is that want within childcare centres we want to have the right of identification and that has been the case since 1997. If there is a particular outbreak of a condition that a vaccine is provided for, we would ask people to stay home - the same way we ask kids to stay home if they have head lice or a really bad cold. This is about the broader public health initiatives.

Mr VALENTINE - Iodine. Has anything been done in that space?

Ms O'BYRNE - Yes.

Mr TAYLOR - Tasmania, as you know, has had a long history of iodine-deficiencies. It is endemic and led to significant health issues in the 1950s and that was redressed through school ? programs, after nine or 10 years of effort at the national level through the equivalent of the four in one food regulation that the minister described. Tasmania was able to succeed in supporting a national reform to introduce mandatory iodisation of the salt used in bread making. That took place in 2009. Since then we have been carrying out regular childhood school-based surveys over the decade. We had a voluntary bakery program that started back in 2002 which pushed up at a sub-optimal, just adequate levels and now what we have demonstrated in the last 12 months is that for the first time in ages the childhood population in Tasmania has adequate iodine levels. So the national fortification has tipped it even that much further than our own voluntary program had.

Ms O'BYRNE - It is disappointing the media have left out that good news story.

Dr TAYLOR - A really good story. Recently the researchers published an association between maternal iodine sufficiency and subsequent NAPLAN scores in the children.

Mr VALENTINE - Where you are getting a move away from sliced bread to specialty breads and all those sorts of things that is not presenting an issue in that regard. Are they mandated? Do they have to use -

Dr TAYLOR - Organic breads, so called, are exempt from that mandated national requirement but it is a minority of the population.

Mr VALENTINE - If they are not getting their iodine through that method what are they getting it through?

Dr TAYLOR - There is still what you get from a diet including seafoods and if one were to use iodised salt in any added salt, which of course we don't recommend, that would be another way. They are at a greater risk of being sub-optimally iodised those people. But it would have to be a niche market of people who solely rely on that those sorts of bread.

Mr VALENTINE - Someone was suggesting that might be the issue. The problem for people that use speciality breads rather than sliced bread.

Ms O'BYRNE - If it took out a greater part of the market then that would be something we would need to monitor and go back to the regulator. Milk is another source.

Mr VALENTINE - It is in milk as well?

Dr TAYLOR - From the iodophor disinfectant used in custard that has a lot of milk in it. It has entered the milk supply.

Mr VALENTINE - Thanks for that.

Ms FORREST - One thing I am pleased to see is the rural breast screening clinics that you are rolling out, which is great. It is often a deterrent for women in rural communities to get -

Ms O'BYRNE - The other deterrent is the belief that it hurts. The new technology is so much better than the images that people might have of old technology.

Ms FORREST - It might not hurt quite as much.

Ms O'BYRNE - It doesn't hurt much.

Ms FORREST - That's true. The point I want to make, minister, is that for women who have had breast cancer and require mammography following that, if they have had a mastectomy or still have got the one breast to be screened or whatever, they can't use the screening facilities. They have to go through the radiology. This still remains a challenge for women in rural communities and some of them delay, defer, avoid because of the costs associated with going to radiology. Is there,

Ms O'BYRNE - I will take that on notice and get some information around whether or not we are meeting that demand better. I know it happens. I will certainly take that on board. One of the things that we want is women engaging easier and the investment that we have made in breast screen in recognising is that for all women in particular to take.

Ms FORREST - It is great that we are doing it and hopefully we pick up earlier but then those women then fall out of the group of women who can use that service. You can no longer use that service once you are diagnosed.

Ms O'BYRNE - I will follow up because it is not a population health deal. It is a broader issue. I will talk to the lead clinicians group around where that might sit in purchasing.

Ms FORREST - You mentioned the Tasmanian medical locals as well that have been funded for $13.3 million across four years to contribute to reducing inequities and inequalities in health and improving health outcomes across Tasmania. Can population health access some of that funding or is it for TML to run its rollout program.

Ms O'BYRNE - We have got a heads of agreement or memorandum of understanding with TML but each of the individual agencies are signing up to their own specific agreements with TML but TML I understand is negotiating with everyone to find ways that it can deliver on its funding and costs.

[6 p.m.]

Dr TAYLOR - It would be worth adding that there is a steering group for this component of the TML funding which has me, as a representative of population health, on the steering group. We are able to input what we see as evidence-based strategies for the TML to select from. That process is going quite well.

Ms FORREST - So you are looking at areas where there is most need.

Dr TAYLOR - Yes, in terms of population health advancement where some good buys might sit. Then it is over, of course, to the TML board beyond that to approve the allocation for

expenditures. It is not really practical for me to comment on what they are looking at.

Ms O'BYRNE - The team have also worked with the advisory board I have had on health and wellbeing, which Roscoe also sits on. One of the things that historically happens in every government is that a bucket of money appears and you have other time frames and you try really hard to get money out the door. If there is a benefit in having less money at the moment it is that it allows us to spend that time and say, when money arrives, what is our absolute priority and where is the best bang for the buck.

Mr VALENTINE - A much better way to go.

Ms O'BYRNE - Yes. Anyone would argue that we should always have done it that way. The reality of government funding across every jurisdiction has been that when money flows you spend it. This has made us smarter with the asks we make and the decisions we make.

Ms FORREST - In relation to the budget for this year's population health forward Estimates, there is a significant decrease of $3 million. The footnote says this reflects a more accurate allocation of overheads to the health services system management output. What has shifted there? $20 million is quite significant. What is not considered under the population health that was before? It is page 5.30.

Ms O'BYRNE - We had [inaudible 6.02.46] health expense transfer. That includes the National Blood Authority and the Postgraduate Medical Council, which has moved from population health output to health services system management. The former is the way the money comes through to buy blood products.

Ms FORREST - Why was it shifted? What was the major reason for that?

Ms O'BYRNE - It is more of a procedural purchase arrangement rather than a population policy.

Dr TAYLOR - There is another element which is that in the appropriate place in the budget it is more able to access indexation.

Ms O'BYRNE - The self-indexation for medical and surgical products is a higher indexation rate.

CHAIR - The capital investment program.

Ms O'BYRNE - There is not a hospital in the state that has not been, or will be, a building site at some stage over the last 12 months or the next 12 months and for many years into the future.

CHAIR - Members have their mind around what is happening at the Royal, so we will not prolong the issue. Ruth, can you remind the committee of that matter you were wishing to raise?

Ms FORREST - The additional costs associated with providing services in the north-west as a result of some of the contractual arrangements they have to deal with up there.

The committee adjourned at 6.05 p.m.