(No.18)

2012

PARLIAMENT OF TASMANIA

LEGISLATIVE COUNCIL
GOVERNMENT ADMINISTRATION COMMITTEE 'A'

INTERIM REPORT

INQUIRY INTO THE COST REDUCTION STRATEGIES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Members of the Committee:

Hon Ruth Forrest (Chair) MLC
Hon Paul Harriss MLC
Hon Rosemary Armitage MLC
Hon Vanessa Goodwin MLC
Hon Jim Wilkinson MLC
Hon Rob Valentine MLC

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INTRODUCTION

1. Government Administration Committee "A" (the Committee) was established by resolution of the Legislative Council and its operation is governed by Sessional Orders agreed to by the Council.
2. By resolution of 26 October 2011, a Sub-Committee was formed '*to inquire into and report upon the cost reduction strategies identified by the Department of Health and Human Services under their 'List of Savings Strategies' document of 4 October 2011, following the release of the 2011-12 Government Budget Papers, with particular reference to those strategies that may impact upon the delivery of acute and other front line health services within the three Area Health Services of the Department into the future*' (the terms of reference).
3. The Membership of the Sub-Committee at the commencement of the inquiry was:
    - Hon Ruth Forrest MLC (Inquiry Chair)
    - Hon Paul Harriss MLC
    - Hon Vanessa Goodwin MLC
    - Hon Jim Wilkinson MLC
    - Hon Greg Hall MLC
4. The Membership of the Sub-Committee changed part way through the inquiry in that the Hon Greg Hall MLC ceased his membership of Government Administration Committee 'A' as a result of his appointment to Government Administration Committee 'B'.
5. The Hon Rosemary Armitage MLC was not appointed to the Sub-Committee and therefore did not take part in the inquiry process.
6. The Hon Rob Valentine was appointed to Government Administration Committee 'A' after the substantial commencement of the Sub-Committee's inquiry and was also not appointed to the Sub-Committee and therefore did not take part in the inquiry process.
7. The Sub-Committee's report was tabled in a meeting of the Committee on 30 August 2012. **ANNEXURE A**
8. The Committee agreed to the interim report and resolved that the Chair of the Sub-Committee present the interim report out of session (in accordance with Sessional Order 27).

9. The Committee resolved that Members of the Sub-Committee be endorsed to speak publicly about the report in their capacity as Members of the Sub-Committee.

Signed this 30th day of August two thousand and twelve.

Hon. Ruth Forrest MLC
Committee Chair

ANNEXURE A – INTERIM REPORT OF THE SUB-COMMITTEE INQUIRING INTO THE COST REDUCTION STRATEGIES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Annexure

A

2012

PARLIAMENT OF TASMANIA

LEGISLATIVE COUNCIL

GOVERNMENT ADMINISTRATION COMMITTEE 'A'

INTERIM REPORT OF THE SUB-COMMITTEE OF GOVERNMENT ADMINISTRATION COMMITTEE 'A' INQUIRING INTO THE COST REDUCTION STRATEGIES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Members of the Sub-Committee:

Hon Ruth Forrest (Chair) MLC

Hon Paul Harriss MLC

Hon Vanessa Goodwin MLC

Hon Jim Wilkinson MLC

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ABBREVIATIONS

ADA	**Australian Dental Association**
AMF	**Australian Medical Association**
ANF	**Australian Nursing Federation**
BCT	**Business Control Team**
BPRT	**Business Process Redesign Team**
ECAT	**Emergency Crisis Assessment Team**
GP	**General Practitioner**
LHN	**Local Hospital Network**
NHRA	**National Health Reform Agreement**
NPA	**National Partnership Agreement**
NPP	**National Partnership Payment**
SPP	**Special Purpose Payment**
THO	**Tasmanian Health Organisation**

EXECUTIVE SUMMARY

1. Government Administration Committee "A" (the Committee) was established by resolution of the Legislative Council and its operation is governed by Sessional Orders agreed to by the Council.
2. By resolution of 26 October 2011, a Sub-Committee was formed '*to inquire into and report upon the cost reduction strategies identified by the Department of Health and Human Services under their 'List of Savings Strategies' document of 4 October 2011, following the release of the 2011-12 Government Budget Papers, with particular reference to those strategies that may impact upon the delivery of acute and other front line health services within the three Area Health Services of the Department into the future*' (the terms of reference).
3. The Membership of the Sub-Committee changed part way through the inquiry in that the Hon Greg Hall MLC ceased his membership of the Sub-Committee following his appointment to Government Administration Committee 'B'.
4. The Sub-Committee acknowledges the financial challenges currently faced by the Government, but notes that broad concerns have been expressed about the ongoing sustainability of the State Budget for a number of years, particularly since the impact of the global financial crisis became evident.
5. In commencing the inquiry, the Sub-Committee was concerned about the size of the savings target that was identified for the Department of Health and Human Services (the Department) as part of the 2011-12 Budget papers and later detailed in the 'List of Savings Strategies' document that was released by the Minister for Health on 4 October 2011 (the strategy) **APPENDIX A**.
6. The Sub-Committee was concerned about the sustainability of the savings target for the 2011-12 financial year and the increasing demand for savings of up to $150 million per annum to be found over the period of the forward estimates to 2014-15.
7. The Sub-Committee was also concerned about the ability of the three Area Health Services (who have responsibility at an operational level for the Royal Hobart, Launceston General, Mersey and North West Regional Hospitals), to continue to deliver sustainable health services into the future, in light of the budget savings measures.
8. The Sub-Committee was aware of the increasing demand and cost pressures the Area Health Services had already been experiencing prior to the announcement of the budget savings measures.
9. The focus of the inquiry has been in relation to the impact of the strategy on the three Area Health Services and has included specific consideration for elective surgery and other front line health services within the acute hospitals setting. The decision of the Sub-Committee to

focus on this aspect of the strategy was because it had the most immediate and apparent impact upon the community and because it was one of the major elements identified in the strategy to achieve short term cost savings.

10. The significant contribution made by other areas of the Department not referred to in this report, and the impact of the strategy on those areas of the Department's operations is acknowledged by the Sub-Committee.
11. Since the commencement of this inquiry, a major restructure of the Department has commenced in preparation for the introduction of the Tasmanian Health Organisation model (THO) on 1 July 2012.
12. Although the Sub-Committee has not dealt in any detail with the issue of the THO model and its funding arrangements, there were some overall efficiency based issues that were raised during the course of the inquiry that will be considered as part of this report. The Department's organisational structure prior to, during and after the establishment of the THOs is attached at **APPENDIX B**.
13. Prior to the commencement of this inquiry, Members of the Sub-Committee had received a number of direct representations from members of the Tasmanian community who were concerned about the consequences of cuts to the health budget for their families and their local communities.
14. Concern was also raised by a variety of health professionals and associations working within the Tasmanian public health sector, who expressed a wide range of significant concerns about the budgetary position of the Department and the strategy that had been released.
15. There were many areas of concern in relation to the Department's cost cutting strategy that were raised by stakeholders. Some of the concerns that were raised included:
    - the increased risk of adverse patient outcomes;
    - the impact on patients and their families (patient care);
    - whether the strategy would deliver cost and other efficiencies to front line services in the long term;
    - the effect on workplace productivity in Tasmania;
    - the wellbeing and retention of the public health workforce;
    - the impact on graduate teaching and hospital accreditation programs;
    - the impact on the private health sector;
    - an absence of strategic health planning in relation to budgetary and cost reduction decision making; and

- the ongoing challenges associated with the split funding arrangements between the State and Commonwealth.

16. This report deals with some of the major issues raised by stakeholders. The reader is encouraged to refer to the transcripts of evidence and written submissions that were received for further information.
17. The Sub-Committee received a range of submissions during the course of the inquiry and spoke with a number of witnesses at hearings that were convened across Tasmania. Lists of the hearing dates and written submissions are attached to the report at **APPENDICE C AND D**
18. The Sub-Committee resolved to release an interim report in order to place a range of important information on the public record in response to community concerns about the budget position for the Department and the strategy that was released by the Minister.
19. Since the first round of inquiry hearings was concluded in April 2012, there have been several notable developments. The Government has softened its budget position for the Department to some degree as part of the 2012-13 Budget. The 2012-13 Budget Papers revised the Department's budget position from a forward estimates savings figure of $127 million for 2012-13 to a continuation of the current savings figure of $100.2 million. The forward estimates figures also revised downwards to $110 million for 2013-14 and $120 million for 2014-15.
20. The decision supported the widely held view that the forward savings targets that were announced as part of the 2011-12 Budget were not achievable or sustainable.
21. The Government also announced a modest $4 million in funding for the 2012-13 year to fund endoscopy and elective surgery procedures.
22. In addition to the Government's revised budget position, the Federal Minister for Health recently intervened in order to inject an additional $325 million in funding over four years into the Tasmanian health system. At the time of reporting, detailed information was not available in relation to the conditions associated with the funding package, although the following components of the funding package were noted from the Minister's media release

    - *$31.2 million over four years for an elective surgery blitz providing about 2,600 additional surgeries targeted at areas where there are large numbers of patients whose surgery is overdue, such as orthopaedic and cataract surgery;*
    - *About $22 million to establish Walk-in Clinics in Hobart and Launceston that provide care for minor illnesses and injuries, for extended hours and at no charge to patients;*
    - *$48.7 million over four years to support better care in the community to prevent and manage chronic disease through the Tasmanian Medicare Local;*

- *$74.5 million over four years to provide better care for patients when they are discharged from hospital and better palliative care in the community;*
- *$53.9 million over four years to train more medical specialists in Tasmania and provide more scholarships for nurses and allied health professionals;*
- *$15.4 million over four years to address gaps in mental health services;*
- *$36.8 million over four years to roll out the Personally Controlled Electronic Health Record in Tasmania's hospitals and enable allied health, pathology and diagnostic imaging services to connect to ehealth;*
- *$42.0 million over four years to support innovation in clinical services that would enable care to be delivered more effectively and efficiently; and*
- *The establishment of a Commission on Tasmania Government Delivery of Health Services.*[1]

23. Whilst the Sub-Committee, in principle, has welcomed the interventions of both levels of Government, it has again highlighted the lack of a long term sustainable funding or service delivery model for the Tasmanian Health system that is based upon clinical decision making rather than short term political interventions.

24. At the time of reporting, there were a number of unresolved issues requiring further consideration by the Sub-Committee. Importantly, the impact of the strategy on the delivery of front line health services during the peak winter period was still to be assessed.

25. Secondly, a range of important information had not been fully considered by the Sub-Committee at the time of reporting due to the requested information not being provided by Departments and Ministers in a timely and cooperative manner. Due to the refusal of several Departments to provide information relevant to the inquiry, summonses were issued to the Secretary of the Department of Health and Human Services and Secretary of the Department of Treasury and Finance on 9 July 2012.

26. The Department of Treasury and Finance subsequently provided a bundle of documents related to the Business Control Team as summonsed. The Department of Health and Human Services claimed there were no records related to the development of the strategy other than the final documents presented to the Budget Sub-Committee of Cabinet.

[1] Media Release of 15 June 2012 – The Hon Tanya Plibersek MP, Minister for Health.

27. The Sub-Committee finds it difficult to accept that there were no Departmental records available in relation to the development of the strategy, particularly given the size of the savings task.

28. The Committee is writing to the Minister for Health to request the records held by her Office in relation to the development of the strategy.

29. It is the Sub-Committee's intention to complete a final report within the current financial year.

30. There were several key strategic issues that the Sub-Committee sought to clarify as part of the inquiry. This included the process by which the specific budget savings measures under the strategy were determined (including the full list of savings measures that were proposed), whether consideration was given to the sustainability of the measures that were proposed and the consequences (if any) of the strategy in relation to the delivery of front line health services. The question of sustainability was considered both on budgetary and clinical grounds.

31. According to the Minister for Health's evidence before the 2011 Parliamentary Budget Estimates Hearings, a methodical and consultative process had been put in place to identify appropriate and sustainable cost savings measures as part of the strategy.

32. After the Budget Estimates process was completed, the role of the Minister for Health became critical in the process that led to the 'List of Savings Strategies' document that was released on 4 October 2011.

33. The evidence before the inquiry was unambiguous in that a list of proposed savings measures was put to the Minister for Health by the Department following a process of internal deliberations. The Minister then made the final decision in relation to what proposals were acceptable or otherwise.

34. The Sub-Committee was unable to establish the methodology, if any, that was used by the Minister to inform her final decision making around the list of savings measures that were approved under the strategy. This was largely due to the fact that the Minister refused to attend an inquiry hearing to answer a range of important questions. It was however noted that there were a number of areas of the Department's operations that did not appear to have been specifically targeted.

35. The Sub-Committee received consistent evidence of a Department being required to identify and deliver unrealistic cost savings based upon the timeframe for the savings to be realised under the strategy, rather than on the basis of reasoned health service delivery planning or clinical decision making. One example sighted during the inquiry was the decision of the North West Area Health Service to reduce their orthopaedic surgery list in order to realise short term

savings, which contributed to the unfortunate loss of one orthopaedic surgeon to the State and the significant decline in their reportable performance in relation to this area of elective surgery.

36. Whilst initiatives such as a 'Business Control Team' were put in place to oversight the implementation of the strategy, which included representation from the Department of Treasury and Finance and the Department of Premier and Cabinet, there was little evidence of such oversight ensuring the savings strategy was achievable.

37. In support of this position is the fact that the Department has not made its savings target for the 2011-12 financial year, evidenced by the Department being provided with additional funding of $25 million.

38. In attempting to understand the process by which the 2011-12 budget papers were developed, the Sub-Committee was unable to confirm precisely how the figure of $100.2 million was determined for the Department. The most likely explanation was simply a figure derived on the basis of a recommendation made by the Department of Treasury and Finance in the absence of appropriate consultation with the Department, for the primary purpose of meeting the Government's short term fiscal objectives.

39. Mr John Kirwan, Chief Executive Officer of the Northern Area Health Service provided a reasonable summary of the process that had taken place at the macro level in the preparation of the budget papers.

> *The criteria for these 61 savings strategies are not ones that necessarily come from a health planning or policy background. They come from a cash background of a State that told us that they had no more money, they could not go any further into deficit, they had spent their reserves and Health was not to be the agency that took them into putting their credit rating at risk. That was the message we got and I think the Treasury submissions to you reflect that.*[2]

40. The Sub-Committee was also concerned by the consistent evidence that senior management were restricted in their ability to appropriately consult with Department clinical staff (particularly front line staff), in order to determine an appropriate list of savings measures from their areas for consideration as part of the strategy.

41. The Sub-Committee found it extremely difficult to comprehend how a sound review of potential savings measures was completed without a thorough consultation process involving front line staff across the Department.

[2] Mr John Kirwan, Hansard Transcript, February 2012, p. 22

42. During the course of the public hearings, the Sub-Committee found an inconsistent approach had been adopted by the Chief Executive Officers of the Area Health Services in order to identify their list of savings options for consideration by the Minister. The evidence of one Chief Executive Officer Ms Jane Holden indicated that she felt the restriction in relation to consultation to have been so unreasonable, that she ignored it to some extent in order to consult with a limited number of her senior clinical staff in the preparation of a list of cost savings options. By contrast, another Chief Executive Officer Mr John Kirwan did not consult with staff as he believed he would be in breach of a directive if he did so.

43. The Secretary of the Department Mr Matthew Daly was questioned in relation to this issue and advised the Committee that there was no evidence of a written direction restricting consultation having been issued. He said of this issue that the '*messages had been mixed from what was intended*'.

44. Based upon the conflicting evidence that was received, the Sub-Committee was very concerned about the confusion amongst senior management in relation to the process they were to adhere to in order to identify an appropriate and sustainable range of cost savings measures for consideration.

45. The Sub-Committee received a range of evidence from concerned front line staff that indicated they had a variety of innovative savings initiatives that they would have been willing to provide to the Department management as part of the review, if only they had been consulted from the outset of the review and provided with an opportunity to contribute. The ANF indicated that a very limited number of their proposed savings measures were accepted.

46. This and other evidence supported the view that the process of identifying possible savings measures was tightly controlled by the central Department, without providing the Area Health Services with sufficient time or discretion to fulfil their task in line with community expectations and the Minister's proposed process as outlined during the 2011 Budget Estimates hearings.

47. Although there was some evidence of Department wide savings initiatives having been identified through areas such as procurement and contract efficiencies, the majority of savings initiatives were left to the individual Chief Executive Officers to identify, with the final decision making being taken out of their hands and made by the central Department and ultimately, by the Minister.

48. During the course of the inquiry, the Sub-Committee also received evidence concerning the history of budget management within the Department. The Sub-Committee was extremely concerned by the evidence of Department Secretary Mr Matthew Daly that, in his opinion,

there was a culture within the Department of previous cost savings initiatives not having been taken seriously.

49. There was a belief that Government would intervene when requested to do so part way through a financial year, in order to overcome any budget deficit at the time, through additional funding being realised. In that regard, there was a lack of direct accountability for operating within a determined budget.

50. The Sub-Committee found this to be a remarkable admission of a lack of financial discipline within the Department, which also did not reflect favourably on previous Ministers or Secretaries of the Department.

51. Mr Daly's evidence was supported by the history of the Government's original efficiency dividend during 2008. The Sub-Committee received evidence that some areas of the Department, such as the North West Area Health Service, had undertaken major reform initiatives to deliver savings during that period. As a consequence, the 2011 savings task was all the more difficult for this area to deliver on, which may have been a significant factor in the decision to cut elective surgery volumes and close a ward on the North West Coast.

52. It was unclear what the consequences, if any, were for those areas of the Department that did not deliver the necessary reforms and dividends during 2008.

53. Significantly, had the Government ensured the savings be achieved in accordance with the 2008-09 Budget , the size of the dramatic 2011-12 budget savings for the Department may have been less.

54. The Sub-Committee also received consistent evidence that the Government had failed to engage appropriately with the community and key health sector stakeholders in order to find solutions to the current funding crisis.

55. There was no evidence before the inquiry of the Government having articulated a revised health policy in light of their budget position in which health and other programs were prioritised at a strategic level.

56. Instead, the decision making was left to the Department in the absence of a Government led health strategy, which has led to a high degree of confusion within the health sector in relation to the strategic direction of the public health system in Tasmania.

57. The Sub-Committee found the lack of direct engagement to have left many stakeholders within the sector isolated and disengaged and that it has been likely to place additional future

pressure on the Tasmanian health sector to successfully attract and retain a quality health workforce.

58. The Sub-Committee acknowledges the difficult budget position that the Government is in and also acknowledges the need for the Department to be required to find savings as part of the budget savings process.

59. The Sub-Committee does not however believe the level of savings that were identified for the Department and the timeframe to achieve those savings to have been sustainable. This has led to adverse outcomes for patients, the Department's workforce and the Tasmanian community.

PROCEDURAL CHALLENGES ASSOCIATED WITH THE INQUIRY

60. An important procedural issue arising from the inquiry has been the ongoing difficulties the Sub-Committee has experienced in obtaining a range of information from the Government through Departments and through Ministerial offices directly.

61. The Sub-Committee has been alarmed and frustrated by the difficulties in obtaining what should have been straight forward information during this inquiry.

The Department of Treasury and Finance

62. Significant amongst the lack of cooperation has been the Department of Treasury and Finance, who despite having played a pivotal role in the preparation of the budget papers and the level of savings required of the Department, has refused to cooperate fully with the inquiry and therefore the role of the Parliament.

63. This has included their failure to provide the Sub-Committee with information it acknowledges to be within its possession. The reasons given by Department of Treasury and Finance Officers for not cooperating has included its internal assessment as to the relevance of certain information and the view that information is duplicated within other Departments. In coming to this position, Treasury has sought to override the Sub-Committee in determining what information is of interest or relevance to the inquiry.

64. The difficulties associated with obtaining information from Treasury have continued, despite requests for the information extending over a period of many months.

65. This position was affirmed during the course of the inquiry by the Secretary of Treasury, who advised the Sub-Committee in writing on 20 April 2012 that he would no longer deal with the Sub-Committee and that all inquiries should be directed to the Treasurer in writing as the responsible Minister. **Attachment E**.

The Department of Health and Human Services

66. The Sub-Committee experienced difficulties in obtaining information from the Department of Health and Human Services. This included the timeliness of responses to requests for information.

67. The Sub-Committee was also concerned that some requests for information did not appear to have been actioned in full through the provision of all relevant records held by the Department.

68. A summons was delivered to the Secretary of the Department on 6 July 2012 for him to appear before the full Committee to produce the outstanding information the Sub-Committee

required. The Secretary attended the hearing and stated there were no outstanding documents he could provide.

The Treasurer

69. The Treasurer has also failed to cooperate with the Sub-Committee, most notably by intervening in order to prevent the Treasury Secretary from attending a second hearing date that was scheduled for 20 April 2012. She further refused to provide the Sub-Committee with a range of information requested of her.

70. The Sub-Committee outlined the range of concerns with the actions of the Treasurer and Treasury Secretary by correspondence of 26 April 2012 **Attachment E** . The correspondence included a request for the Treasurer to review the decisions of the Treasury Secretary in his correspondence of 20 April 2012, in order to prevent the need for a summons for the outstanding information to be issued to the Treasury Secretary.

71. To date, a response to these requests has not been received by the Sub-Committee.

The Minister for Health

72. Of most concern to the Sub-Committee has been the refusal of the Minister for Health to cooperate with the inquiry in declining an invitation to attend a hearing. The Sub-Committee invited the Minister to a hearing in order to clarify a range of important questions arising from the evidence received, that only the Minister was capable of answering.

73. Evidence received by the Sub-Committee had confirmed that the Minister reviewed the proposed options for health cuts and was the decision maker in relation to which cost savings options were to be adopted as part of the final strategy. This position was confirmed by the Minister during the 2012 Legislative Council Budget Estimates hearings.

74. The Sub-Committee had sought to clarify the considerations that the Minister had taken into account in finalising the list of savings and to clarify the full list of options that were under consideration.

75. The Sub-Committee had also sought to discuss the previous evidence of the Chief Executive Officers with the Minister in relation to the restrictions placed upon their ability to consult with staff about proposed budget saving measures. The Sub-Committee was concerned that this evidence was contrary to the Minister's public statements in evidence as part of the 2011 Budget Estimates Committee hearings, in which she indicated there would be full consultation in relation to the cuts prior to decisions being made.

76. In confirming her decision not to attend a hearing, the Minister requested the Sub-Committee direct all future inquiries to the Secretary of the Department by undated correspondence received on 9 March 2012 **Appendix E**. In light of the questions the Sub-Committee was seeking to ask the Minister, it was inappropriate to put these questions to the Department Secretary for a response, as he was not in a position to explain the decision making of the Minister or the Government's policy and strategy in relation to public health in Tasmania.

77. The Sub-Committee can only conclude from the Minister's decision not to attend a hearing that she is unwilling or unable to account for the decisions made by her or her Department.

78. Parliamentary convention does not provide the Sub-Committee with the power to summons a Minister of the Government within the House of Assembly. However, the Sub-Committee has noted that Ministers have historically cooperated with, and participated fully with the business of Legislative Council Committees when called upon to do so, which highlights the uncooperative nature of the Minister's approach to this inquiry.

79. In light of the Minister's refusal to attend a hearing, a message was sent to the Speaker of the House of Assembly by the President of the Legislative Council on 27 March 2012, for the Minister to attend a hearing. At the time of this report, the message remained on the Notice Paper of the House of Assembly and had not been dealt with by the Government, despite the Minister also being the Leader of Government Business in the House of Assembly and therefore responsible for the business of the Government in the House.

Government Position in relation to Committees of the Legislative Council

80. The Government position in relation to its dealings with the Sub-Committee more generally is also of significant concern, in that it has attempted at times, to divert questions in relation to the inquiry into the Budget Estimates hearings process.

81. As a result of this and other decisions the Government has made in relation to its dealings with the Sub-Committee, it has treated the Parliamentary Committee system in a contemptible manner by unreasonably attempting to limit the level of scrutiny and accountability placed upon Ministers of the Government and their Departments to the Budget Estimates hearings that are held annually. In doing so, the Government has ignored the powers afforded to the Committees of the Legislative Council upon their establishment and the role of responsible Government. The correspondence from the Premier and the Minister for Health confirming their positions in relation to the inquiry are attached at **Appendix E**.

82. The position of the Government has also been reaffirmed by the Department of Health and Human Services and the Department of Treasury and Finance in dealing with requests for

information as part of this inquiry. Whilst a number of requests for information have generally been cooperative, although often delayed, on multiple occasions they have sought to treat elements of the requests in which they are refusing to produce material, as the equivalent to a Right to Information request (freedom of information), rather than as a request for information from a Committee constituted under the powers of the Parliament of Tasmania.

83. This has included their refusal to produce information on public interest grounds or on the basis of unsubstantiated claims of Cabinet in confidence. At other times, the Departments have simply not responded in a timely manner to specific questions put to them in writing, which has caused significant delays in the inquiry process.

84. The apparent trend in Departments dealing with Committee requests for information in the same manner as a Right to Information request is disturbing, and highlights the basic lack of understanding on the part of Government Departments of the functions and powers of the Parliament. This should be the subject of immediate action by the Government to educate Departmental and Ministerial staff to avoid similar circumstances in the future.

FINDINGS

The Sub-Committee is deeply concerned about the significant impact of the Government's cost savings strategy on the public health system and on communities across Tasmania.

The Sub-Committee has noted that the Budget cuts are likely to have caused long term damage to the Department's performance and reputation.

The Sub-Committee sought to discuss a range of serious concerns with the Minister for Health and is disturbed by her decision not to participate in the inquiry as the responsible Minister.

The Sub-Committee has concluded the Minister's lack of cooperation with this parliamentary inquiry demonstrates a failure of responsible Government on the part of the Minister, on the basis that she is either unwilling or unable to account for her actions as the primary decision maker in relation to the Department's budget cuts.

The Sub-Committee makes the following interim findings:

1. The work of the Sub-Committee has been hindered by the lack of full cooperation on the part of the Department of Health and Human Services, Department of Treasury and Finance, Treasurer and Minister for Health, which has caused unnecessary delay and difficulties in the inquiry process;
2. The Budget savings task for the Department was too severe and not achievable, particularly under year 1 of the strategy for 2011-12,
3. The timeframe given by the Government for the Department to develop its cost reduction strategy, did not allow for an appropriate and considered structural review within the Department to be completed, in order to deliver a package of sustainable cost savings.
4. The Department did not respond in a timely manner to the task of developing the savings strategy. A culture had developed over time within areas of the Department, whereby extra funding was taken for granted rather than the Department operating within its allocated annual Budget.;
5. The Government failed to provide adequate strategic direction to the Department in relation to the prioritisation of its services and programs in light of the imposed budget cuts;
6. Patient outcomes have been adversely affected by the strategy;
7. Elective surgery volumes have dramatically decreased as a result of the strategy;
8. Ward closures have increased the incidence of bed blockages within the major hospitals;
9. Decisions associated with the strategy have been primarily based upon short term financial considerations;

10. The Government's 2011-12 Budget did not take into account a sustainable level of funding for the Department of Health and Human Services;
11. While the strategy may have delivered some short term savings, the long term costs associated with the strategy are likely to be much higher;
12. The Government does not currently have a sustainable funding model in place for the provision of public health services in Tasmania;
13. The Minister for Health initially claimed there would be significant consultation with stakeholders in the development the strategy but this did not eventuate;
    a. There was no consultation process agreed upon within the Department in the development of the strategy;
    b. The Chief Executive Officers of the Area Health Services were significantly hindered in their ability to identify sustainable cost saving initiatives as a result of the restrictions placed upon their ability to consult with stakeholders;
    c. The Sub-Committee was unable to ascertain who made the decision to restrict consultation and how that decision was communicated;
    d. The Government failed to engage appropriately with the community and key health sector stakeholders in order to find solutions to the current funding crisis; and
    e. The Government has failed to communicate the Department's strategy effectively with stakeholders, which has caused confusion and uncertainty.
14. The Minister for Health was the decision maker in relation to the final cost saving initiatives that formed the basis of the strategy;
15. The Department was unable to produce documentation that supported any analysis or modelling of the full range of cost savings options having been completed. Consequently, the Sub-Committee is unable to conclude whether the full range of savings options were in fact appropriately considered by the Department in the development of the Strategy;
16. Given the size of the cost savings task, the lack of documentation supporting the task is incomprehensible;
17. The strategy details savings tasks for the 'Operational Units' and 'Local Hospital Networks';
18. It is not possible to scrutinise savings tasks for the 'Central Agency' due to the lack of detail in the strategy. It is therefore difficult to scrutinise savings in non-clinical areas of the Department;
19. The Business Control Team was a unique arrangement amongst the Departments in response to the 2011-12 Budget savings task and included representatives from the Department of Treasury and Finance and Department of Premier and Cabinet;
20. The Business Control Team was not involved in the identification of cost savings options;

21. There was little evidence of the oversight role of the Business Control Team ensuring the savings strategy was achievable;
22. The Department's workforce has been adversely affected by the strategy, which has led to significant retention and morale issues. This risks the ability of the Department to maintain and attract a quality health workforce into the future;
23. Medical accreditation for areas of the health workforce has been put at risk through the reduction in surgery volumes;
24. The ability to attract and retain a quality health workforce is at risk in both the public and private health systems as many health practitioners work in both private and public practice in Tasmania;
25. The strategy has highlighted the ongoing challenges associated with the mix of Commonwealth and State public health funding in Tasmania. This continues to result in ad hoc funding interventions by the Commonwealth Government that are not based upon long term strategic health planning in consultation with the State Government;
26. There was no evidence of the Government having articulated a revised health policy in light of its budget position in which health and other programs were prioritised at a strategic level;
27. According to the advice of the Department of Treasury and Finance, the three Tasmanian Health Organisation (THO) model was not the most cost efficient model that was considered by the Government;
28. The THO model that has been established may create 'perverse incentives' over time due to the fact that the THOs will compete against each other for funded activity;
29. Departmental and Ministerial Officers do not appear to have an appropriate level of knowledge or understanding of the functions and powers of the Parliament and their obligations in performing their duties to the Parliament as public servants;

RECOMMENDATIONS

In consideration of the evidence received to date, the Sub-Committee makes the following preliminary recommendations.

1. The Government adopt a long term strategic approach in relation to the delivery of health services in Tasmania, including:
    a. A review of the Tasmanian Health Plan to support the delivery of sustainable health services into the future and ensure that periodic reviews are undertaken to ensure a long term strategic direction is adopted;
    b. An independent assessment of the Department's 'List of Cost Savings Strategies' to ensure all possible options for savings measures have been identified and evaluated.
    c. Access to elective surgery be prioritised to reduce additional costs to the Department's budget in coming years;
    d. An appropriate ongoing consultation process with all relevant stakeholders;
    e. A taskforce to develop a sustainable health workforce strategy in light of the significant impact the budget cuts have had on the morale, retention and recruitment of the public health workforce and that membership include employee, education, health and other stakeholders;
    f. In light of the complexity, size and increasing demand for public health services, a Business Control Team be established on a permanent basis to provide additional oversight and advice in relation to the Department's ongoing budget;
2. The Government continue to assess the funding arrangements and work to reduce the cost-shifting that currently occurs through the dual funding model, and work with the Commonwealth Government to achieve a single funder model;
3. The Department of Treasury and Finance undertake a cost benefit analysis of a one versus three THO model;
4. The Government review the record management procedures for the Department in response to the apparent lack of record keeping associated with the development of the 'List of Cost Savings Strategies';
5. The Secretary of the Department review his communication and reporting structures with the senior management group of the Department, including with the newly established THOs, to ensure actions and directions are clearly documented and communicated to the leadership team;

6. Government Ministers cooperate fully with the business of Parliamentary Committees and attend Committee hearings when requested to do so in order to assist the Legislative Council fulfil it roles and functions under the concept of responsible Government;
7. Department and Ministerial Officers undertake training in relation to the functions of the Parliament of Tasmania and their responsibilities as public servants in responding to requests for information.

HEALTH FUNDING IN TASMANIA

85. Funding arrangements for the provision of public health services in Tasmania is a complex issue that includes funding derived from State and Commonwealth sources. Although the issue of funding arrangements was not central to the inquiry, it was however important to note some of the key principles associated with public health funding in order to appropriately consider the List of Savings Strategy and the delivery of public health services into the future.

Key Principles associated with Health Funding in Tasmania

86. The Tasmanian public health system incorporates primary and acute health services, that are provided through the major hospitals, as well as through other areas of the Department such as Mental Health Services and Human Services.

87. Acute care is defined as '*the medical services such as surgery, intensive care, medical and nursing care, which are provided for the immediate assessment and treatment of patients*'[3].

88. Acute services in Tasmania are provided by the three major state owned hospitals, namely the Royal Hobart, Launceston General and North West Regional, as well as the Mersey Community Hospital.[4]

89. The Department has adopted the World Health Organisation definition of primary health care which is '*essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain….It is the first level of contact of individuals, the family and the community with the national health system bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process.*'[5]

82. The public health system is supported by General Practitioners (GPs) who receive some revenue through Medicare[6]. This funding arrangement between the GPs and Medicare is a Commonwealth funded system which does not form part of the Tasmanian State Budget for the provision of health services. Although not part of the budget, it does form an important part of the overall delivery of health services within Tasmania.

[3] Macquarie Dictionary Online
[4] DHHS Clinical Services Plan Update p. 22
[5] DHHS Primary Health Care Services Plan p. 13
[6] www.medicareaustralia.gov.au

83. GPs are also provided with incentive funding from the Commonwealth to meet specific targets under the Practice Incentives Program.[7] These programs are similar to some of the programs funded in primary health through the National Partnership Payments (NPP).

84. Tasmania's health budget is comprised of funding from the State budget as well as a combination of Specific Purpose Payments (SPP) and National Partnership Payments from the Commonwealth.

85. NPP's have been paid to Tasmania to form part of the health budget each year and are dedicated funds for specific purposes. These have included hospital projects and programs, infrastructure developments or purchases of specific medical equipment. NPP's arise from partnership agreements between the States and the Commonwealth and are often tied to incentive and performance.

86. National healthcare specific purpose payments are also paid each year to the States. These payments are specifically allocated to expenditure on the provision of health care services and are not tied funding like the NPP's.

87. In the future, this particular funding arrangement will no longer form part of the State budget and instead will directly fund the Tasmanian Health Organisation (THO) models through the National Health Reform Agreement (NHRA) in conjunction with an allocated amount of GST revenue.[8]

88. Health has traditionally taken a large proportion of the State's budget each year. Notwithstanding this, supplementary appropriation bills have been passed to accommodate the increase in spending in the Department of Health and Human Services in the 2004/05, 2007/08, 2010/11 and 2011/12[9] financial years.

89. Within the financial year 2008/09 the overall Health budget was $1.487 billion, with 14 percent of the budget being spent on acute health. The Commonwealth contributed $321 million towards the budget in national partnership and specific purpose payments. Despite this, the Department reported actual expenditure of an additional $112.5 million, resulting in an 8% increase above the original budget figure.

90. The 2009/10 budget followed a similar pattern with an initial budget of $1.612 billion. National partnership and specific purpose payments contributed 18.5% of the total budget. An

[7] www.medicareaustralia.gov.au – Practice Incentives Program
[8] Commonwealth Budget Paper 2010-2011 BP Vol 3, Part 2 – Payments for Specific Purposes
[9] Consolidated Fund Appropriation (Supplementary Appropriation for 2004-2005) Bill 2004, Consolidated Fund Appropriation (Supplementary Appropriation for 2007-2008) Bill 2008, Consolidated Fund Appropriation (Supplementary Appropriation for 2010-2011) Bill 2011, Consolidated Fund Appropriation (Supplementary Appropriation for 2011-2012) Bill 2012,

additional $70.9 million in actual expenditure was reported, being a total increase of 4% of the original budget.

91. The 2010/11 Health budget of $1.716, billion contained almost 35% contribution by the Commonwealth in national partnership and specific purpose payments. The large component of national partnership payments was exacerbated due to infrastructure funding to redevelop the Royal Hobart Hospital. A Supplementary Appropriation Bill was passed, increasing the budget by $105.7 million, being 6% of the initial budget.[10] This increase did not represent any new initiatives but was to fund recurrent expenditure such as elective surgery, emergency departments, disabilities and support for children.[11]

92. In 2011/12, the Health budget was set at $1.844 billion. A Supplementary Appropriation Bill was passed later in the year to provide an additional $25 million to the Department. The reasons given for the additional expenditure were noted as being '*…due to the delayed implementation of the savings strategies…*'[12]

93. In her Budget Speech for 2011/12, a new fiscal strategy with significant budget savings totalling $290 million for the financial year 2011/12 was announced by the Treasurer.[13] Of this total saving, $100.2 million, or 34.5 % of the total savings requirement, was to be found from within the Department of Health.[14]

94. During the Budget Estimates process in June 2011, the Minister for Health advised a Legislative Council Estimates Committee that the full $100.2 million of savings had not yet been identified due to the need to consult with clinicians and service providers to limit the impacts of the cuts on patient care.[15] The Minister further advised a House of Assembly Budget Estimates Committee that $27 million worth of savings had already been identified.[16]

> *…..that is the exact reason we do not have $100 million worth of savings identified already, because I could not make those decisions and we could not make them at a bureaucratic level and guarantee those outcomes. We need that to be in consultation with clinicians and service providers and our community and area hospitals, to ensure that the decisions we make are sustainable. Because if you turn off something in health, you have*

[10] Consolidated Fund Appropriation (Supplementary Appropriation for 2010-2011) Bill 2011
[11] Legislative Council Hansard Transcript, 13 April 2011, Second Reading Speech of Consolidated Fund Appropriation (Supplementary Appropriation for 2010-11) Bill 2010, D Parkinson
[12] Second Reading Speech, Consolidated Fund Appropriation (Supplementary Appropriation for 2011-12) Bill 2012
[13] Budget Speech, Lara Giddings, MP 16 June 2011, p 2
[14] Budget Speech, Lara Giddings, MP 16 June 2011, p 6
[15] Hansard Transcript, Legislative Council Budget Estimates, 27 June 2011 – Part 2
[16] Hansard Transcript, House of Assembly Budget Estimates, 28 June 2011 – Part 1

to be damn sure it was the right thing to do, because it is extremely expensive to turn it back on again.[17]

95. Mr Martin Wallace, Secretary of the Department of Treasury and Finance said of the role of his Department in relation to the management of the State's finances during the course of this inquiry

Essentially Treasury's role is to provide advice to the government of the day on the state of the finances, and particularly what is required to ensure that the services which the Government is responsible for can be provided on a sustainable basis into the future. We provide the Government with policy options advice and we analyse the trends in revenue and expenditure for that purpose. At the end of the day what we're concerned about is the ability of the State to deliver the essential services that it is constitutionally responsible for on a long-term sustainable basis.[18]

The 2011-12 Budget

96. The figures that were referred to in the 2011-12 budget document 'Budget Paper No 1' at table 4.1, referred to 'Agency Saving Strategies' for the Department over the period of the forward estimates as follows:
    - **2011-12 – $100.2 m**
    - **2012-13 – $127.3 m**
    - **2013-14 – $143.1 m**
    - **2014-15 – $150.0 m**

97. The Budget Papers detailed a range of broad strategies in which the Department was to focus on delivering budget savings. The initiatives were not prescriptive and were not costed. Importantly, there was no clear reference to the impact on front line services.
98. In the context of the savings strategy that was released by the Minister in October 2011, a variety of specific saving initiatives were identified in order to meet the $100.2 million savings figure by the end of the 2011-12 financial year.
99. The decision to find substantial short term savings through the reduction in elective surgery volumes was a measure adopted by the Department to achieve its savings target for the 2011-12 financial year and forward estimates. This would achieve an immediate and substantial saving to the Department's budget.

[17] Ms Michelle O'Byrne, Minister for Health, Hansard Transcript, Legislative Council Estimates, 27 June 2011
[18] Mr Martin Wallace, Hansard Transcript, 5 December 2011, p. 1

100. In light of the acknowledgement by the Government that the cuts to elective surgery were not sustainable over the long term, it was clear to the Sub-Committee that substantial alternative savings measures would need to be found in addition to the increased savings already required over the period of the forward estimates.

The 2012-13 Budget

101. Upon releasing the 2012-13 Budget papers, it was evident that the Government had altered its budget position..

102. The Department of Treasury and Finance Secretary Mr Martin Wallace said of the prospect of the Department not meeting its savings target for the 2011-12 financial year

> *From our perspective the main issue is that if they do not hit the target for 30 June, how soon after that will they effectively hit it. This is all about a set of strategies that deliver savings, so on that assumption if they haven't hit their budget it is because their savings from these strategies haven't built up to the level they are supposed to by 30 June. So it could be just a timing issue. As I said before, if it is just a timing issue then it just means that in the next year and the year after that of the strategy they would need to catch up. So it is not the end of the world from our perspective. Yes, we do everything we can to ensure we come in on budget each and every year, but in relation to the fiscal strategy and Health's role in it we would hope that this is a timing issue of very short duration. If you measure from the beginning of the year to the end of the year to generate $100 million in recurrent savings, you could be $10 million short on 30 June but have caught it up two weeks later.*[19]

103. A downward adjustment to the previous forward estimates savings target was determined and described in the Budget Papers as 'Budget Savings Relief'. The adjusted savings targets over the period of the forward estimates for the Department was as follows:

- **2012-13 - $100.0 m ($27.3 million reduction in required saving)**
- **2013-14 - $110.0 m ($33.1 million reduction in required saving)**
- **2014-15 - $120.0 m ($30 m million reduction in required saving)**
- **2015-16 - $120.0 m**

104. In addition to the adjustments in required savings, the Budget Papers included a one off allocation of $4.0 million for Endoscopy and Elective Surgery Procedures.

[19] *Ibid,* p. 10

105. During the course of the inquiry, Mr Phil Edmondson from Tasmania Medicare Local provided a useful historical perspective of health funding in Tasmania and the question of sustainable health services

> *Any sound-thinking Tasmanian would see that we are on an unsustainable growth train in respect to public service spending and that that cannot continue. We recognise that something has to be done. Having said that, this has been a freight train - and I will use a few analogies here that you have probably heard already - that everyone has seen coming for the last five or 10 years. Nobody has the right to sit here and say we did not know we were on an unsustainable expenditure pathway. It is convenient that people have forgotten or omitted to or chosen to defer action prior to now. I think that in some respects this is a situation of the system's own making. The expenditure overrun that has crept up on us has been evident widely to everybody within the health system. Everybody has known about it, everybody has spoken about it. It is not something that is new or unknown.*[20]

106. Associate Professor Geoffrey Couser also provided a perspective in relation to overall public health funding in Tasmania

> *The Tasmanian health system is in serious trouble. Anyone who thinks it will get back to business as usual after these budget cuts is wrong. Anyone who thinks that the current round of capital works programs will lead to an improved health system for Tasmanians is wrong. Services are only going to become more expensive and will decline in quality due to the community's inability to provide them and pay for them.*[21]

[20] Mr Phil Edmonson, Hansard Transcript, 2 February 2012, p. 52
[21] Associate Profess Geoffrey Couser, Hansard Transcript, 9 March 2012, p. 1

ELECTIVE SURGERY

107. Elective surgery is surgery which, '….*in the opinion of the treating clinician is necessary, and for which admission can be delayed for at least 24 hours'*.[22]

108. Elective surgery is categorised under three categories as follows:

- Category 1- Urgent;
- Category 2- Semi-urgent; and
- Category 3- Non-urgent.

109. Waiting lists for elective surgery are a register of patients who have been assessed for surgery. These lists are kept by the hospitals and waiting times are accrued from the date on which the patient was added to the list until the date of admission for surgery.[23]

110. Tasmania's aging population, socio-economic disadvantages, increasing obesity levels, remoteness, hospital and waiting list management as well as nursing staff shortages have contributed to longer waiting list times for Tasmanian patients in comparison with interstate hospitals.[24]

111. In 2008, the Department of Health and Human Services announced Tasmania's Elective Surgery Improvement Plan which aimed to reduce elective surgery waiting times and provided an additional $8.4 million to build greater elective surgery capacity in hospitals.[25] In 2009 it was noted that elective surgery represented 15 per cent of hospital activity.[26]

112. The National Partnerships Agreement (NPA) on the Elective Surgery Waiting List Reduction Plan, which Tasmania signed on 7 December 2009, sets out targets for Stage 1, 2 and 3 waiting list reductions, all of which, apart from Stage 3, were met in the 2010-2011 financial year[27]. The NPA offers incentives for meeting these targets each year which was $20.89 million in 2010-2011.

113. A facilitation payment is made by the Commonwealth to the States to initiate the programs and rewards payments are available for meeting targets. Any rewards payments not received are rolled over and are available in the next period if targets are met within that time.[28]

[22] DHHS, Tasmania's Elective Surgery Improvement Plan, getting our waiting times down, Summary, 2008, p. 4
[23] Parliamentary Research Paper, Elective Surgery, p. 2
[24] DHHS, Tasmania's Elective Surgery Improvement Plan, Getting our waiting times down, 2008, pp. 8-9, p. 45
[25] DHHS, Annual Report 2008-2009, p 23
[26] Ibid
[27] DHHS, Annual Report 2010-2011, p. 44
[28] National Partnerships Agreement (NPA) on the Elective Surgery Waiting List Reduction Plan, p. A-5

114. To receive additional incentive funding under the NPA, Tasmania must treat 74.3% of its Category 1 patients, 57.2% of its Category 2 patients and 86.1% of Category 3 patients within the clinically recommended time.

115. Historically, Tasmania has not achieved this level of performance. In 2008 for example, Tasmania was treating 72% of Category 1 patients, 46% of Category 2 patients and 62% of Category 3 patients within the clinically recommended time.[29]

116. As at June 2011, elective surgery volumes had reduced compared with the previous year due to the reduction in specific program funding to elective surgery as well as staff shortages, reduced theatre sessions and increases in emergency surgery.[30]

117. Departmental data also showed a decline in patient admissions in the period October 2011 to March 2012, a trend which is forecast to continue under the current funding structure.[31]

118. During the financial year 2010-2011, elective surgery targets were achieved by some hospitals, however the Royal Hobart Hospital did not achieve targets in any Stage and the Launceston General Hospital did not achieve its targets for Stage 1 surgery.[32]

119. The cuts to elective surgery announced on 4 October 2011 will decrease rather than increase elective surgery activity across the State. Given that targets were not met in 2010-11 financial year, the likelihood of Tasmania meeting the required targets in the 2011-12 financial year is be minimal.

120. Failure to meet the elective surgery targets set out in the NPA, specifically in relation to the number of patients on elective surgery waiting lists and increased waiting times for those patients, could financially disadvantage Tasmania's health system. The savings achieved through the Government's budget savings strategies in these areas could be negatively offset by reductions in the NPA performance incentive payments from the Commonwealth.

121. The savings strategy incorporated a reduction in elective surgery volumes in all three Area Health Services. The North-West was to save $2.4 million, the North, $8.5 million and the South, $10.7 million.

122. Despite the cuts in elective surgery, the Minister assured the community that

> *People waiting for elective surgery will continue to receive it; waiting lists will continue to be clinically managed by the area health service to respond to individual patient needs.'*[33]

[29] DHHS, Your Health and Human Services Progress Chart, September 2011, p. 8-11
[30] *Ibid*
[31] DHHS Letter to Committee of 26 April 2012
[32] DHHS, Your Health and Human Services Progress Chart, September 2011, p. 8-11
[33] Media Release, Minister for Health, 4 October 2011

Elective Surgery and Outpatient Clinic Data

123. During the course of the inquiry, the Sub-Committee received a range of evidence from witnesses in relation to the probable effects of the cuts on elective surgery waiting lists. A snapshot of the concerns that were raised by witnesses will be discussed later in this report.
124. The Sub-Committee sought the following information in relation to elective surgery and outpatient clinics.
    a. Quarterly elective surgery waiting list figures by category, hospital and median waiting time for the financial years 2008/09, 2009/10, 2010/11 and 2011/12 (YTD)
    b. Quarterly elective surgery admission figures by category, hospital and median waiting time for the financial years 2008/09, 2009/10, 2010/11 and 2011/12 (YTD)
    c. Quarterly Specialist/Outpatient Clinic waiting list figures by hospital, clinic and median waiting time for the financial years 2008/09, 2009/10, 2010/11 and 2011/12 (YTD).
125. Although the Department was able to fulfil the majority of the request, Acting Secretary Mr Michael Pervan noted in his response of 4 July 2012 that '*due to the current formation of the Agency's Data Management System, data relating to outpatient clinics is not readily available across time periods. The data that is at hand that I have provided is a snapshot as at 21 June 2012'* but that they were working towards improving their data in this area. The data provided is attached to the report at **APPENDIX F.** No explanatory notes were provided with the data to explain any of the broad trends that were noted.
126. The Sub-Committee was concerned by the findings of the data. Notable amongst the findings was the increase in the number of patients awaiting elective surgery or outpatient clinical appointments in the North and North West, since the announcement of the budget cuts.
127. By contrast, it was noted that the Outpatient clinical data for the South indicated reductions (in some cases significant) in the number of patients awaiting a variety of clinical appointments over the same period.
128. Given the reduction in elective surgery volumes generally, the reason in part may be attributable to a reduction in the volume of referrals from General Practitioners due to a belief that their patients will not be treated in the current circumstances and that referrals were therefore futile.
129. Another contributing factor may be that patients on the lists have simply been removed due to factors including them having given up hope of being seen or due to being treated in the private sector. There was no evidence of increased resources having been allocated to outpatient clinics that may explain the figures.
130. Of greater concern was the significant reduction in elective surgery admissions across all of the Hospitals by category. Although there were some exceptions by regional category, the

general trend was disturbing and provided a clear indication of the extent of the impact of the cuts on elective surgery volumes and the apparent contradiction in the position of the Minister for Health '*that people requiring surgery would continue to receive it*'.

THE DEVELOPMENT OF THE DHHS 'LIST OF SAVINGS STRATEGIES'

131. Central to the inquiry was the process by which the Government determined the budget savings measures for the Department that later formed the basis of the strategy.

132. At a whole of Government level, Department of Treasury and Finance Deputy Secretary Mr Tony Ferrall explained the reporting process for Heads of Agency to the Budget Sub-Committee of Cabinet

> *There are meetings with all departments. In fact, all departments are meeting regularly with budget committee as well in terms of through-the-year monitoring. For example, Treasury has to provide other parts of Treasury with reports how it's travelling on its budget. Martin had to attend budget committee in August or September or thereabouts to detail how he, as a head of agency, was implementing Treasury's budget management strategies internally and provide budget committee with his assessment as to how we were travelling and his view as to how things would be at the end of the year. All heads of agency went through that same process. That is in addition to the normal liaison meetings that we have.*[34]

133. At a Department level, the Minister for Health released the DHHS 'List of Savings Strategies' document (the strategy) on 4 October 2011 in response to the budget savings task for the Department that was first outlined in the 2011 Budget Papers. **APPENDIX A**

134. The Minister advised the House of Assembly on 30 August 2011 that $70 million worth of savings in Health had been identified.[35] The remaining $30 million in savings initiatives was released by the Minister as part of the strategy on 4 October 2011.[36]

135. Department of Treasury and Finance Secretary Mr Martin Wallace said of the budget position for the Department in the context of the strategy

> *….It has always been the case that the increases in health costs are unsustainable for any State government. When our revenue was running at 5 per cent per annum, our health budget was increasing at more than 10 per cent per annum and it was a third of the budget; now it is 40 per cent of the budget. Our revenue going forward looks like about 3*

[34] Mr Tony Ferrall, Hansard Transcript, 5 December 2011, p. 31
[35] Hansard Transcript, House of Assembly, 30 August 2011, - Part 1
[36] Media Release, Minister for Health, 4 October 2011

per cent per annum. So those difficult decisions always have to be made and there has been a lot of money in terms of increased allocations put into health over the last five or six years, yet everybody knows that we have to find a solution to this problem because it is completely unsustainable to have 40 per cent of the budget increasing at twice the rate of our revenues. So what is actually stopping that happening? What was to stop it happening five years ago, four years ago, three years ago; why is it suddenly a decision now? In any system, whether it is health or education, you are ideally looking at things to make changes to get your services on a sustainable basis.[37]

136. Mr Wallace went on to explain the savings targets for Departments as part of the 2011-12 budget papers

Basically we had an overall task for savings in agencies of approximately $270 million by the third year - the last year of the forward Estimates. Of that, Health's total by the end of the forward Estimates period is approximately $150 million, and in the initial year it is $100 million. That allocation of savings to the individual agencies was calculated in a way that was, in our view, the most equitable approach to sharing the burden across the range of different government services in order to reduce our expenditure down to a situation where our revenue matched our expenditure.[38]

137. Deputy Secretary Mrs Alice Burchill said of the Department wide process to identify savings measures for consideration by the Minister in response to the budget papers

We went through an extensive process of trying to identify savings and there was a whole range of things, ……considered down to the operating level and whether it was appropriate for their areas or not, but it was an extensive list from anything from saving paper clips to actually getting rid of hospitals, pretty extensive.[39]

138. The list referred to by Mrs Burchill supports the existence of a list/s of options that were provided to the Minister and which later formed the basis of the summons to the Secretary of the Department and was also supported by the Minutes of the Business Control team.

139. Ms Neroli Ellis from the ANF said of the process to identify savings from the perspective of staff working across the Department

What we are seeing now is this very short-sighted approach, knee-jerk decision making. There is no strategy. We have no idea and all of those working in the Department of Health, the nurses involved and nursing managers, really are unclear about where the

[37] Mr Martin Wallace, Treasury Hansard Transcript, 5 December 2011, p. 14-15
[38] *Ibid,* p. 1-2
[39] Ms Alice Burchill, DHHS Hansard Transcript, 21 November 2011, p. 31

Department of Health is going. What is happening with the service delivery, the amalgamations, the decentralisation or trying to bring specialised fields into one area, or maybe not trying to deliver everything everywhere, they are all the key strategic decisions that have been made in the health plan for further consultation. That has just gone out the window. We do not know what is going on with that.[40]

140. The Australian Medical Association (AMA) provided a similar perspective. Dr Tim Greenaway noted his observations as the Chair of the Medical Advisory Council at the Royal Hobart Hospital

…. what we were told was that the hospital administration argued quite strongly about the effects of the cuts but were told basically this is the budget you must meet. There was no direction as to how those cuts were to be made. It is my understanding that the hospital administration made it very clear to the Department of Health and to the Minister that the cuts would have significant adverse effects on health delivery. But they were told that they must meet those cuts anyway. If I take one step back, efficiencies in health systems do not actually save money. By that I mean that if you discharge patients promptly another patient will come in and consumables increase. There is a lot of evidence showing that good care, which we all need to provide and receive, does not necessarily save money in a health system. What does save money is, and this is what happens, is bed cuts, job cuts, so you save money by cutting jobs and by cutting beds and by restricting operating sessions. That saves money and that is the only way that they could do it. [41]

141. During the course of the inquiry the Sub-Committee requested the full list of saving options that were put forward by the Department for consideration by the Minister. The full list was requested to enable the Sub-Committee to appropriately assess the full range of saving options that the Department had originally identified, in comparison with the options that were released by the Minister as part of the final strategy.

142. In response to the request, the Secretary of the Department Mr Matthew Daly declined to provide the Sub-Committee with the requested information on the basis that

The Agency's cost saving proposals have evolved over time and have been discussed in a number of forums both informally and formally. Budget Sub-Committee of Cabinet was provided the list of cost savings proposals. Papers prepared for Budget Sub-Committee of

[40] Ms Neroli Ellis, ANF Hansard Transcript, 1 February 2012, p.4
[41] Australian Medical Association, 2 February 2012, p. 44

Cabinet and documents revealing the deliberations and decisions of Cabinet have not been provided.[42]

143. In the context of the strategy that was released and on the public record, the Sub-Committee noted that it was broken down into task lists by 'Operational Units' and 'Local Hospital Networks'.

144. An 'Agency Wide' task list was also included in the strategy, which detailed savings measures that affected the whole of the Department and that were not specific to any particular Output Group.

145. The 'Agency Wide' task list was understood to have included savings measures that affected the central Department. The following 'Groups' were noted at the time of the strategy's release, to make up the central Department:

- Chief Health Officer;
- Chief Financial Officer and Business Services Network;
- Chief Nurse and Allied Health;
- Government Relations and Major Projects;
- Commissioning;
- Chief Information Officer;
- Strategic and Portfolio Services;
- Care Reform.

146. It was not possible to assess the specific savings tasks for the Groups in comparison with the detailed task lists for the 'Operational Units' and 'Local Hospital Networks'. The Sub-Committee did not believe this approach to the formulation of the strategy to have been reasonable in the context of the ability to scrutinise the savings measures derived from the central bureaucracy's operations.

147. It was also noted that although the strategy extended into the 2013-14 financial year and had received a minor update in February 2012, that it had not been redrafted to reflect the savings strategy as it would apply under the new operational model for the Department, with the commencement of the Tasmanian Health Organisations from 1 July 2012.

[42] DHHS letter to Sub-Committee of 10 May 2012

148. The Committee received evidence from the Director of the Public Sector Management Office, Mr Frank Ogle, in relation to the whole of Government budget strategy related to state service employment and the reduction in positions arising from the Department's strategy.

> *The initial focus in any of this vacancy management is with the agencies to manage internally through natural attrition and redeployment within the agencies. We have set up a central group that, even before people might be declared, are looking at vacancies primarily before they are even advertised. So before you can go to the Gazette or to the newspaper you would need to get our clearance through the vacancy control group to get to that. You have to get approval before the vacancy is advertised and before that happens we look at people who are surplus, or even potentially surplus, even before there is a formal process. That has been going on from effectively June last year and we meet weekly on that with all the agencies. We have had some success with that - we call it vacancy matching across agencies - with about 57 matches.*[43]

149. Mr Ogle also explained the strategy involved options of redundancy or voluntary separations through the workforce incentive renewal program

> *The difference between that and redundancy is where you abolish the position. Workforce renewal is where, for up to $20 000, it is an incentive for people to leave but you don't necessarily abolish the position; you use it more for reprofiling.*[44]

The Business Control Team and the Business Process Redesign Team

150. Key to the implementation of the strategy was the role of the Business Control Team (BCT). The Minister said of the establishment of the BCT

> *we will be establishing a business control team to ensure that there is an appropriate governance framework put in place to guide those savings and make sure that those savings are done in a framework of safe, quality care; establishing a business process redesign team, which will be systematically re-evaluating the way we do business - our efficiency, our productivity - and looking for opportunities where we might improve that; and changing the culture in the system to focus all employees on savings requirements.*[45]

151. During the course of the inquiry, then Acting Secretary of the Department Mr Greg Johannes confirmed the role of the BCT to assist him in the implementation of the savings strategy.

[43] Frank Ogle, Hansard Transcript 19 March 2012, p. 1
[44] *Op. Cit.* p. 3
[45] Hon Michelle O'Byrne, Estimates Transcript, 27 June 2011

The person who has most day-to-day involvement with monitoring achievement of the savings strategies across the department is Penny (Chief Financial Officer) *and her team. I am supported in my role as acting secretary by a group called the 'business control team'. The business control team is currently meeting weekly. It comprises representatives of Treasury and Premier and Cabinet, providing advice to the secretary of DHHS on the implementation of the strategies. We are also reporting regularly to the budget subcommittee of Cabinet.*[46]

152. Department of Treasury and Finance Deputy Secretary Mr Tony Ferrall said of the budget savings process and the role of the BCT

the business control team is advisory to the secretary of the department, so it didn't have a formal role in identifying specific strategies. The department allocated the $100.2 million across various business units within the department and each of those business units brought back strategies or proposals to meet their component of the savings. They were referred to the business control team, not for approval but as part of a consultation process. The secretary in many cases took those forward to the minister on the basis of whether they had political or other implications, but some of those strategies would not necessarily have gone to the minister at that point. Subsequently, the minister has published all the identified strategies on the Health and Human Services website.[47]

153. Mr Ferrall also noted that the BCT was unique amongst Government Departments in responding to the 2011-12 budget

…..Only Health and that was put in place at the request of the secretary of the department. It was an arrangement where obviously the previous secretary had resigned and there was an acting secretary and at the time she was looking for greater support in terms of trying to deal with some of the complexities that she was attempting to manage.[48]

154. The Sub-Committee requested and after considerable delay, received some material from the Department in relation to the BCT, including the meeting documents for the Team. Some of the information that was received was treated as in-camera evidence.

155. According to the Minutes of the BCT, the Membership of the group was

1. *Secretary DHHS (Chair)*
2. *Chief Financial Officer DHHS*

[46] Mr Greg Johannes, DHHS Hansard Transcript, 21 November 2011, p. 28
[47] Mr Tony Ferrall, Treasury Hansard Transcript, 5 December 2011, p. 5
[48] *Ibid,* p. 21

3. *Deputy Secretary, Department of Treasury and Finance*

4. *Deputy Secretary, Department of Premier and Cabinet*

156. Members of the Team provided periodic updates to the Minister for Health, the Treasurer and Premier in relation to the Department's progress towards the delivery of the savings plan.

157. Three broad components were noted to form the core objectives for the Team under their terms of reference

1. *Focused cost reductions;*
2. *Systematic evaluation of business efficiency;*
3. *Systematic improvement strategies.*

158. Additional objectives of the Team were noted to be as a Steering Committee to oversight the work of the Business Process Redesign Team (BPRT), to ensure an appropriate governance framework was in place to deliver the required savings and to also

1. *Provide expert advice and support to the Secretary as necessary;*
2. *Assure appropriate governance arrangements are in place to implement the approved strategy;*
3. *Monitor performance on the achievement of the required level of financial savings;*
4. *Provide regular reports to Budget Sub Committee of Cabinet as and when necessary.*[49]

159. There were other participants who attended periodic meetings of the team from time to time. These included the Chief Executive Officers of the Area Health Services. The detail of their contributions to the Team was unclear from the papers provided.

160. Mr Ferrall said of his participation in the Team

> *With Health, I am part of the business control team and to date there have been 13 meetings of the business control team and at that meeting the department's budget is discussed and how they are travelling on their saving strategies. These meetings go back to May so it was through the period of developing and identifying particular strategies. A further three meetings are planned for December. So it is about every two weeks that I have been involved with these meetings. Between May and the end of this year there will have been about 16 meetings with the department so there is quite a lot of interchange with the department. As I said, the earlier meetings were around their identifying and developing the various budget strategies that were put forward*[50]

[49] BPRT Project Brief, p. 7 (in-camera?)
[50] *Op cit*, p. 10-11

161. Mr Johannes also commented in relation to the functions of the Team

> *The secretary of DHHS has always been the chair of the budget control team and the terms of reference of the BCT is to provide advice to the secretary on implementation of the budget savings strategy. It is not the role of the control team to identify the strategies; it is the role of the team to support the secretary in making sure that they are implemented and that there is appropriate reporting on their status.*[51]

162. The role of the BCT was closely linked to the work of another group that was established to deliver efficiencies across the Department. According to its project plan, the Business Process Redesign Team (BPRT) was established to deliver the following objectives:

1. *Undertake systematic evaluation of business efficiency/productivity;*
2. *Identify opportunities for improved efficiency/effectiveness;*
3. *Provide advice to Operating Units;*
4. *Monitor performance/compliance;*
5. *Report to the Business Control Team*[52]

163. The work of the BPRT was led by two externally appointed consultants.

164. Although the work of the Teams was in relation to the development and delivery of the savings strategy, it was clear from the material provided that the role extended to a broader strategic review of the operation of the Department from a whole of Agency perspective.

The Consultation Process

165. It was apparent from the documentation associated with the BCT and BPRT that the intention was for widespread analysis and consultation to take place across the Department in order to identify and then deliver the necessary savings.

166. It was therefore important for the Sub-Committee to gain a more detailed understanding of the consultation process that was adopted to identify the initiatives detailed in the savings strategy for the Area Health Services and that impacted upon the delivery of front line health services.

167. Initially, the indication was that consultation with staff had taken place through a thorough process. The Acting Chief Executive Officer of the North West Area Health Service Mr Gavin Austin noted

[51] *Op cit*, p. 28-29
[52] Business Process Redesign Team Project Brief, p7

we consulted with staff around the service reviews. I think the last one is just coming to an end now. There was a lot of consultation with the staff and their managers and the role redesign, as I said, it was very difficult because the North West was running quite leanly, but we have seen reductions in areas like finance, HR, quality, IT, data intelligence and our maintenance divisions.[53]

168. The Sub-Committee subsequently received concerning evidence from the other Chief Executive Officers of significant restrictions having been placed upon their ability to consult with staff in order to compile savings options within their organisations. Mr John Kirwan said of the consultation process

Dr GOODWIN *- Earlier you mentioned that you weren't allowed to share your budget savings with your senior staff until October, could I just flesh out that process a bit more. You were told you had to meet this target and then went away to develop these saving strategies; how did you actually develop them, did you consult with your senior staff?*

Mr KIRWAN *- No.*

Dr GOODWIN *- You weren't allowed to do that?*

Mr KIRWAN *- I went back several times and asked for permission to do that because we were getting into areas that were certainly beyond my comfort zone and beyond some of my areas of expertise. When we asked whether we could now share the actual savings target and the strategies, it was said that I would not be allowed to do so. I asked for permission several times.*[54]

And that

Dr GOODWIN *- It is just that that wasn't the impression I got from what happened in the north-west. The impression I got yesterday was that there was some consultation with senior staff in developing their saving strategies.*

CHAIR *- Not that they were happy about it.*

Dr GOODWIN *- Not that they were happy, no, but certainly that there had been the opportunity for consultation.*

CHAIR *- We will follow that up.*

Mr KIRWAN *- When you receive a written direction from the secretary that you are not to consult -*

[53] Mr Gavin Austin, DHHS Hansard Transcript, 21 February 2012, p. 4
[54] Mr John Kirwan, DHHS Hansard Transcript, 22 February 2012, p. 18

Dr GOODWIN *- It is pretty clear.*[55]

169. Chief Executive Officer of the Southern Area Health Service Ms Jane Holden acknowledged that she did undertake a limited degree of consultation with some of her senior staff but that significant restrictions on her ability to consult with staff was also in place

CHAIR *- Just going on from that, we are all aware of the lists that are published in October about the savings and, as you said, you were already on the way even at that time. What consultation did you have with senior clinical staff as far as implementing these strategies is concerned or even looking at strategies that could be proposed to the minister? Was there any of that before the decision was published?*

Ms HOLDEN *– I was working with small teams. Say, if we took the elective surgery, I was working with a small part of that leadership of the directorate. They were not in a position because I was not in a position to let them go and consult widely with every part of the surgical organisation.*

CHAIR *– You are talking about the senior clinicians in that group, though?*

Ms HOLDEN – *Yes, but they were not happy about it at all but I said, if I had to do this, how would it work, what would the impact be, I need you to help me build a business case around that. So, reluctantly, and very reluctantly, they were answering my questions but I did not let them go and talk to everybody else because I was not in a position to do that because that was the instructions that were given.*

CHAIR *– Who were those instructions from?*

Ms HOLDEN *– Via the secretary, I think, from the minister, who wanted to work through each of these plans because we put up a wide number of strategies that we were looking at*[56]

170. Ms Neroli Ellis from the ANF also commented on the consultation process from her perspective which supported the views expressed by some of the Chief Executive Officers in relation to consultation restrictions being in place

We have found that with this whole process being unilaterally driven anyway; the CEOs certainly have not been contributing and have been directed from above to implement those changes, and we all know that they are not in the best interests. There has been limited consultation with the clinicians and the CEOs in the first instance. We went to many

[55] *Ibid*
[56] Ms Jane Holden, DHHS Hansard Transcript, 9 March 2012, p. 32

meetings where the CEOs had to just put on the table the documents that came from central bureaucracy and said this is what we have to do[57]

171. Ms Ellis further stated of her observations at the time of the release of the strategy by the Minister that

The sheets of budget cuts that came out were delivered to the CEOs the same day they were delivered to us, the same day they went to the media by the bureaucrats or the spin doctors - there are four spin doctors in the Department of Health. Those sheets are a classic example; the CEOs had not even seen them before. On the day they came out I was sitting with John Crawshaw at a mental health joint meeting with all the stakeholders around the table and he was almost apologetic that he hadn't seen it and didn't know. He was the statewide CEO for Mental Health and he has now gone back to New Zealand. That is just an appalling management style, not even consulting, not having it signed off, not knowing that this was a strategic direction we had all signed off. To be doing that to your senior CEOs in the State is tough.[58]

172. The Sub-Committee was so concerned about the consequences of the restrictions that further clarification was sought from the Secretary of the Department Mr Matthew Daly. Whilst Mr Daly agreed that any such direction would have been unreasonable, his evidence contradicted the previous evidence of Ms Holden and Mr Kirwan.

Certainly, I have read Mr Kirwan's submission and I took it very seriously, of course. To give a written direction to the CEO not to take appropriate consultative measures in developing something like a budget strategy, I think was unreasonable, to be kind.

but that

No. No written instruction came from the department. I asked Mr Kirwan for a copy of that because I intended to take administrative action within the department from whoever issued that written directive. I can assure you that none was issued and Mr Kirwan has advised me he has received nothing.[59]

173. The Sub-Committee also sought to clarify Mr Kirwan's previous evidence with him directly. In response to the further invitation to comment, Mr Kirwan referred all further inquiries on the matter to Mr Daly for comment.

[57] *Op cit*, p. 3
[58] *Ibid, p. 37-38*
[59] Mr Matthew Daly, DHHS Hansard Transcript, 5 April 2012, p. 16

The Area Health Services

174. Given the focus of the inquiry, the Sub-Committee sought to gain a better understanding of the components of the strategy that were developed by the Area Health Services.

175. The Chief Financial Officer of the Department Ms Penny Egan, noted in her evidence, that the total savings for the 2011-12 financial year for the Area Health Services were:

- Northern Area Health Service - $20.67 million
- North West Area Health Service (excluding Mersey Hospital) - $9.1 million
- Southern Tasmanian Area Health Service - $29.7 million[60]

176. Under the strategy, the savings target for the Area Health Services was derived from a combination of costed tasks by Area Health Service and from an 'Agency Wide' component of the strategy that was not costed by Area Health Service. The Sub-Committee noted the difficulty in assessing the cost savings by Area Health Service due to the structure of the strategy.

177. There was also additional complexity in assessing the task for the North West Area due to the unique model for the operation and funding of the Mersey Hospital through a funding agreement with the Commonwealth. This required that the Mersey Hospital be excluded from the savings strategy in terms of any reductions to its budget, although the Hospital was not excluded from other broader efficiency based initiatives.

178. The Sub-Committee noted that the exclusion of the Mersey Hospital from budget cuts had again highlighted the current dichotomy within the public hospital system in Tasmania, which has created a two tiered health system.

179. The task of identifying savings initiatives commenced with identifying basic efficiencies in areas such as electricity and general procurement arrangements. Some of these assessments appear to have been completed centrally and others by Area Health Services.

180. The task then became far more challenging for the Area Health Services as they were required to consider cuts to service delivery elements of their organisations as the savings target became increasingly difficult to achieve.

[60] Ms Penny Egan, DHHS Hansard Transcript, 21 November 2011, p. 3

Northern Area Health Service

181. Chief Executive Officer Mr John Kirwan said of the process to identify savings for the Northern Area

> *So we have now developed a range of saving strategies to address those different areas, starting with maximising revenue wherever possible then obviously avoiding costs and making efficiencies. We have done quite well in some of those areas and there are some good strong examples, deferring and amalgamating some new initiatives some of which you will see today and which we would have liked to have brought on a bit earlier but we haven't, and then in the end looking at service reductions and staff reductions.*[61]

182. Mr Kirwan also noted in relation to the quantum of the savings task and the discussions with the central Department

> *On a couple of occasions we went there. The first time we went there and said that the task was too big. I think all of the CEOs - with the risk of speaking on their behalf - Mental Health Services and others all said the actual ask was higher and therefore at that stage the discussion was that we could just do it through efficiencies - turning the light switch off, travel, phones, all the normal sort of interesting-type things - but we said, 'No, the task is far bigger than that.' I am not too sure whether at that stage they actually realised the size of the task. There had obviously been some assumptions made that I think were incorrect and have subsequently found to have been incorrect.*[62]

183. Although the Northern Area component of the strategy included savings across a range of 'administrative' type initiatives including service cost recoveries, car park management and staffing establishment, the majority of the savings were found in relation to the provision of clinical services.

184. Most notable amongst the savings was the reduction in elective surgery volumes for the 2011-12 financial year for a total of $8.5 million. This initiative applied for the first year of the strategy only, with the equivalent savings to be found elsewhere within their budget over the remaining life of the strategy.

185. There were two other major initiatives for the Northern Area under the strategy. The first involved the 'reconfiguration of Ward 4D and use space to consolidate oncology services' (the closure of a ward) which was to realise a cost saving of $2.2 million in the 2011-12 financial year, increasing to $4.4 million over the remaining years of the strategy.

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[61] *Op cit*, p. 18
[62] *Ibid*, p. 20

186. Mr Kirwan stated in relation to the bed closures that

> *…..we had to allocate additional staff to the Emergency Department. There was no budget to do that from the department so that was done by closing four medical and four surgical beds and transferring those FTEs to the emergency department.*[63]

187. The second major initiative concerned the 'reprofiling of ICU shifts', which was to realise a cost saving of $1.035 million in the 2011-12 financial year, increasing to $2.27 million over the remaining years of the strategy.

188. In relation to the requirement to make the savings generally, Mr Kirwan noted

> *No-one is happy with what we are doing, no-one is keen on it and I think the question is, when will it finish? No-one is arguing that it probably can be reversed on a sixpence, but I think there is a fair bit of anger and disappointment. We have quite a stable workforce so I don't think we are likely to see a quick turnaround, but we also have an aging workforce and the demographics are against us. I think you can rely on their goodwill and commitment both to their profession, to their patients, to the hospital and their community, but you can't rely on it forever. This is our second really tough year of budget savings. Last year we put in fairly significant saving strategies and delivered a deficit of less than 2 per cent. We will put in the saving strategies this year and, all things being equal, deliver no deficit. It is very difficult for us; that means this year we will have to pull out 10 per cent of costs and others. That really does make the third year very difficult going forward.*[64]

North West Area Health Service

189. The task list for the North West was limited in terms of the number of identified tasks by comparison with the other Area Health Services.

190. The most significant savings task for the North West was in relation to elective surgery volumes, with an emphasis on orthopaedic procedures (hip and knee replacement surgery), which was noted in the strategy to realise $2.376 million for the 2011-12 year reducing to $1.056 million by 2013-14.

191. Acting Chief Executive Officer Mr Gavin Austin said of the decision to cut elective surgery volumes as part of the North West's strategy

> *In terms of elective services and reducing elective surgery volumes, the North West has reduced the sessions for elective services from 30 to 25 at the North West Regional Hospital. As a result of that the over-boundaries have gone up from 10 per cent to just*

[63] *Ibid,* p. 2
[64] *Ibid,* p. 6

under 18 per cent, so it is having an impact. As we predicted, we have no flex to be able to absorb that. Some areas are still excellent and I have graphs that show that the waiting times for people in the north-west are still substantially lower than they were in 2008-09.[65]

192. In addition Mr Austin noted that all elective surgery services were closed for a period of time

On top of that we shut down elective services for four weeks. We did that basically as a budget savings measure but that had quite an impact on the waiting list and on our elective surgery but it definitely meant that we had beds available over the Christmas period, so there was no bed blockage during that time or nothing other than what we call business as usual.[66]

193. North West Orthopaedic Surgeon Mr Scott Fletcher said of the cuts to orthopaedic surgery

From our point of view, our instructions were that we needed to make substantive changes. That involved closing one of our wards, and there are about 26 beds on a ward. We only have two surgical wards, so it is 50 per cent of our surgical wards that were closed. We were asked to reduce our activity in theatre and that meant a 17 per cent reduction of elective theatre lists. Also, because I am an orthopaedic surgeon, it had a significant impact on the amount of joint arthroplasty that we were doing. Before I left to go on sabbatical we were doing between 20 and 30 - say 24 to 26 joints - per month and now it has been reduced to a meagre four, or one per week, for the whole of the department. The wheels keep on turning so we are still doing the outpatient sessions and seeing patients who are needy and so we still put them on the waiting list.[67] P1

194. Associated with the cuts to elective surgery and as alluded to in Mr Fletcher's evidence, was the 'reallocation of beds across North West Area Health Service' by the closure of surgical ward West at the North West Regional Hospital. Mr Austin said of the ward closure

Surgical West was a really well run ward, fantastic staff, doing a great job. The North West was pumping through its elective services targets. They were part of that, they had a lot of good feelings; they weren't doing anything wrong and to have their ward closed is devastating. They just woke up one day and the ward was shut.[68]

195. The second major component of the strategy for the North West was in relation to locum and agency management (staffing). Mr Austin explained the strategy behind this savings initiative in the context of surgery

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[65] *Op cit*, p. 10
[66] *Ibid*, p. 10
[67] Dr Scott Fletcher Hansard Transcript 20 March 2012, p. 1
[68] *Ibid*, p. 5

By slowing down the elective surgery you get a slow down in the number of theatre staff you use. Whilst we may not lay off theatre staff, it means you have less pressure for overtime and less demand on agency staff. There are a lot of additional savings that come out of that slow down. We do a lot less overtime and double shifts. That has a positive impact in terms of financial negative if you're a casual relying on that work.

and that

Because of the budget cuts there are a lot of casuals on our books now who aren't receiving the volume of work that they used to receive. We have an excellent pool of casuals so we do not need agency staff.[69]

196. The other major savings initiatives for the North West were in relation to vacancy control and 'Systems and Procurement'. Mr Austin said of the vacancy control component of the strategy that

One of our major strategies is around vacancy control and management. We received input from the Allied Health Director that we could hold some vacancies in allied health. So we held vacancies there. It was not a matter of making anyone redundant - those vacancies were held over. That did, again, work in with the reduction of elective services around hips and knees. It was targeted to coincide with the patients that would not be receiving their hips and knees, therefore would not be requiring the physio associated with their recovery. There was reduction of staff there and the target for primary health was substantial and all we have been able to successfully do in primary health is around vacancy control[70]

197. Mr Fletcher noted that although he did not agree with initiatives that had been identified, the Chief Executive Officer was receptive to his views in relation to adjustments to the initial strategy.

The CEO certainly listens to me and I am comfortable that he does listen and the reason I have increased one joint to two joints a week is that we have discussed the statistics together and we see the issues together.[71]

[69] *Ibid,* p. 17
[70] *Ibid,* p. 1
[71] *Ibid,* p13

Southern Tasmania Area Health Service

198. The task list for the Southern Area Health Service was the most extensive in terms of the range of initiatives that were detailed. The majority of initiatives had projected savings well under $500 thousand per annum.

199. In a similar way to the Northern Area, there were a range of 'administrative' type initiatives, including service related cost recoveries or revenue increases, efficiency initiatives associated with service delivery and human resource initiatives in relation to leave, rostering and staffing levels.

200. Chief Executive Officer Ms Jane Holden said of the savings measures identified for the Area Health Service

> *Most of our savings have come from the way we work, so they have been about systems development, about processes, about rules around calling in overtime, approving extra shifts, approving leave so that we don't get seven people all wanting the same days. Actually putting systems into place. By far most of our savings have come from that area, where we buy our stock from, how well the pharmaceutical programs are going, getting people aware that when they are ordering pathology tests that there are some high-cost ones and are they ones that are actually going to help enhance the diagnosis or the treatment. It is a model that we have described inside the Royal as a back-to-basics, going back to what we do and making sure what we do is the best, most cost-effective* [72]

201. It was noted that the most significant savings initiative in dollar terms was in relation to the provision of clinical services through a reduction in elective surgery volumes. Unlike the other Area Health Services, the savings were forecast to increase for elective surgery volumes over the life of the strategy. In dollar terms, this equated to savings of $10.7 million for the 2011-12 financial year increasing to 17.3 million to the 2013-14 financial year.

202. Ms Holden said of the decision to make savings through the reduction in elective surgery volumes

> *No-one has said let us cut surgery to elective surgery and no-one has said, gosh we have run out of ideas or that is the best idea, that was a really tough decision to make. I think I said to you last time the only reason we picked elective surgery was because we could. It is our view that elective surgical patients have as much right of access to public services….. but it is a flow we can manage.* [73]

[72] *Op cit*, p. 24
[73] Ms Jane Holden, DHHS Hansard Transcript, 8 March 2012, p. 31

203. The Sub-Committee also noted from Ms Holden's evidence that a reduction in bed numbers at the Royal Hobart Hospital would be completed as part of the strategy, although it was unclear which aspect of the strategy the bed closures was costed under.

When we have completely finished this, which is March, it is 26 beds[74]

[74] *Ibid,* p. 43

THE IMPACTS OF THE COST REDUCTION STRATEGY FROM A STAKEHOLDER PERSPECTIVE

204. The Sub-Committee spoke to a number of stakeholders during the course of the inquiry and received a range of evidence in relation to the effects of the cuts on the delivery of front line health services.

205. Evidence was received from a range of health practitioners and other parties with an interest in the continuing delivery of public health in Tasmania. Many provided similar evidence of a lack of consultation in the formulation of the strategy.

206. Much of the evidence on face value was of significant concern, in terms of the level of concern and frustration expressed by many of the witnesses. The majority of witnesses were consistent in their acknowledgement of the need for major reform but not in the manner that had been undertaken.

207. At the time of the hearings, a range of the evidence was anecdotal, based upon the witnesses' observations and past experience due to the cuts being in the early stages of implementation.

208. The following provides a snapshot of some of the major areas of concern that were raised.

Patient Outcomes

209. A number of the witnesses expressed significant concerns in relation to the consequences of the budget cuts on patient outcomes. This was particularly in relation to the rationalisation of front line services, including reductions to elective surgery volumes.

210. The majority of evidence from stakeholders was received from medical and other health practitioners working in front line services within the public hospital system or within General Practice in Tasmania.

211. Ms Neroli Ellis from the ANF raised serious concerns in relation to the consequences of the announced bed closures associated with presentations through the hospital emergency departments

> *… the bottom line is that around 22 presentations at Launceston General every day need a bed and I think at the Royal it is about 40-odd. Every day those 40 people, as one of the 140 presentations, has to be found a bed. So when you start closing down acute beds and do not have enough beds and pre these cuts we were around 95 per cent occupied. So take away 40-odd beds - 50 beds at the Royal - it is not Einstein theory that we are going to have to be waiting overnight and longer and longer in emergency, waiting for a*

bed because we are just not discharging 40 to 50 people every day out of the remaining 100 beds.[75]

212. Ms Ellis also confirmed that as of February 2012, it was too early to be able to fully assess the impact of the cuts on patient care

We do not have that data and it is too early because the real cuts began in the north on Christmas Eve. That is when we started closing the extra 20 surgical beds and the theatre starting slowing down and the real cuts started when we started Surg West to close around October, November in the north-west and at the Royal it has only been since November-December the beds have been closed and theatre has been reduced. It is going to start impacting a lot more and we are already seeing certainly the first impacts. But from the next quarter we will really start to see a huge impact. Normally over January it is a quieter time because the slow-down with elective surgery with people being away.[76]

213. General Practitioner Dr Graham Alexander said of the impact of the cuts as of February 2012

The impact hasn't really hit full on yet and the reason is that over the holiday period rarely in any year is there a lot of elective surgery. For example, I doubt if very much neurosurgery was done over the two or three weeks of Christmas and early January - routine, elective neurosurgery. The neurosurgery ward would be full of general medical patients and every patient who needs a bed. Now, the neurosurgeons start up work again and those beds are taken up by neurosurgical patients. There will still come the pressure from the patients you can't avoid admitting - I shouldn't say it in that way but I think that's the way the Government looks at it. There are patients who will need admission and they will be taking up elective surgery beds. I think we got a warning sign recently from the Health minister, Michelle O'Byrne, that our figures are disastrous and they're going to get worse and we'd all better get used to it.[77]

214. Dr Chris Middleton from the Australian Medical Association (AMA) also provided the Sub-Committee with his opinion of the likely effect that the cuts to elective surgery volumes would have on patient outcomes, particularly when Tasmania's demographic mix was taken into account.

In Tasmania, we have a more elderly, more socially and economically disadvantaged population with very high rates of chronic disease, so we are already behind the eight-ball, and these recent cuts can only exacerbate that situation. We know that the Department of

[75] *Op cit*, p. 8
[76] *Op cit*, p. 12
[77] Dr Graham Alexander, Transcript, 2 February 2012, p. 4

Health and Human Services have been asked to save $100.2 million for the 2011-12 period and we know that $30 million of this will come from cuts in elective surgery. I understand that about 23 operating sessions have been cut each week at the Royal Hobart Hospital and about 21 surgical beds have been closed in an attempt to save $17.3 million from the Southern Tasmania Area Health Service budget and, not surprisingly, this has led to a reduction in services[78].

215. Dr Tim Greenaway from the AMA also noted similar concerns in relation to bed closures and the consequences for patient outcomes.

…..we are down an extraordinary number of beds, but you see the cuts are both to surgical beds and medical beds, and we have no elective surgery happening at the minute, so the place is full after the cuts because we have lost the beds. We are coming into the flu season which starts in late March/April, that kind of stuff, and I had a chat to a colleague - I had better not name him - about the infectious diseases with respect to what sort of flu season we might be expecting, and there is a chance it is going to be a bad flu season and the consequences of that may be diabolical if the hospital is full in January.[79]

216. Dr David Butler from the Australian Dental Association (ADA) said of the impact of the cuts on dental surgery lists within the public health system and the consequences for patients

It has impacted already. At the LGH already we have been told that in 2012 we will have no dedicated dental list. I've drafted a letter in response to the CEO and Director of Surgery outlining my dismay and very strong disappointment to such a decision. As far as I'm concerned it's not elective; it's mandatory and it's not an add-on thing. We don't have any alternatives here. It's not as if we'll just go and treat them under local anaesthetic, give an injection in the mouth and do it. It doesn't work like that. If we get a special cerebral palsy case, there is no way they can be treated in the chair. They have a major swollen face and we've got to treat them. [80]

217. Dr Len Crocombe from the ADA also noted with concern, advice that the ADA had received from the Director of the Oral and Maxillofacial Unit at the Royal Hobart Hospital

His general comment is that the already minimal State service has been reduced and the reliance on two private part-time visiting surgeons to provide a State service for weeks on end is not viable and has already downgraded care to a dangerous level. There are some

[78] Australian Medical Association, Transcript, 2 February 2012, p. 32-33
[79] Ibid, p. 47
[80] Dr David Butler, Transcript, 2 February 2012, p. 80

times when it's not manned which is against the COAG agreement so don't break your jaw…. [81]

218. Ms Driver from the ANF said of the cost cutting on community service programs

Because they're cutting back frontline case managers, all the community teams had to lose two full-time case management positions - and there are more cuts coming. You have an increased case load and you can just imagine the flow-on effect. You also have clients who don't have case managers because there are no case managers there. Because of the closure of ECAT (Emergency Crisis Assessment Team), which was Federal funding, and its merging with our crisis teams, we have an ever-expanding interim support list. You have a situation where you need to get all this done. We have asked how we're supposed to change our model of care or how we're supposed to do our case management differently to allow for the cuts. The risks for staff and clients and their families are going up and we're seeing more presentations to DEM, longer waiting times in DEM and more people being discharged earlier because there is more pressure on beds. There is a lot more bed blocking now than there used to be.[82]

219. Ms Ellis also cited the example of the impact on patients as a result of the decision to shut the 'Hospital in the Home' program

A classic example of poor decision-making is the removal of hospital-in-the-home service in the Launceston General Hospital, where clearly that was an efficient service that was meeting the community's needs. I think you have probably seen quite a bit of public campaigning. There were 1 309 care days that kept somebody out of hospital to have their IV antibiotics at home or their complex wound care at home rather than being in the hospital. That equates to around $1.5 million to $1.8 million of saved hospital beds, and that's now being axed. That service was at a cost of $175 000 to meet the needs of people with cystic fibrosis and early discharge into the environment. Ironically, that same hospital-in-the-home service is now being investigated to start up here at the Royal Hobart Hospital as one of the strategies to alleviate the Emergency Department. So we are closing it down in one area but it's now being seen as an effective tool and being potentially started up here and being maintained on the north-west coast. Up there it is very successful.

220. General Practitioner Dr Graham Alexander said of the probable impact of the cuts for his patients that were already awaiting elective surgery procedures

[81] *Op. cit.* p.83
[82] *Ibid,* p. 19

I have a patient whom I know has diagnosed gallstones. They have gallstones, they need the gall bladder out, they are having pain recurringly. I now look at them and know they will probably never be operated on electively, ever. Equally, a patient with a hernia will probably never be operated on. The only way they will get operated on is if they get a serious complication. That is now, today, before these health cuts are really hitting hard. So I have to look at them and I have to manage them, assuming they will never be operated on. So I have to assume that they will present to casualty, to A&E, goodness knows how many times. I have to assume they will be ringing our surgery early Monday; they need to be seen because they waited eight hours in casualty and could not be seen. They need more medication, they need more pain relief and the gall bladder is now infected. Then eventually they will have a much more complex, difficult and longer hospital stay. There are a vast number of patients I know will not be operated on. [83]

221. Dr John Davis from the AMA also noted the consequences of the cuts on patients as a General Practitioner

You also get the issue, as we were saying, they come back monthly, two-monthly or three-monthly for analgesics, they are having physiotherapy attendances, you end up having ramps and orthotic aids put into homes that are unnecessary if only the surgery had been done so the overall cost before they now even get to their operation is probably greater than doing the operation in the first place.[84]

222. Dr Chris Middleton from the AMA referred in his evidence to a letter from a Staff Specialist working with adult mental health patients at the Royal Hobart Hospital and their concerns with the budget cuts on the delivery of mental health services

A local staff specialist met regularly with local management in late 2011 to discuss the new plan for services as proposed by the local management in the context of budget cuts. Management outlined their belief that the current 42 acute beds, 10 step-down beds and 27 medium- and long-term beds could all be managed by three staff specialists employed to work at the Royal Hobart Hospital. They outlined their additional belief that backfill for positions for leave would be by the community psychiatrists who would then cover all their colleagues and all their clinical responsibilities while continuing to manage their outpatient clinics. Staff specialists who have met regularly with management are in unanimous agreement that not only are the backfill arrangements unworkable, unsustainable and unsafe, but that the total number of specialists employed to manage the impatient services

[83] *Op. Cit.* p. 8-9
[84] *Ibid,* p. 48

is manifestly inadequate and that this arrangement will undoubtedly lead to an increase in serious and sentinel events'.[85]

223. Associate Professor Geoffrey Couser, a Staff Specialist in the Department of Emergency Medicine at the Royal Hobart Hospital, raised the important issue of bed blockages and the effect on patients. He said of his experience

> *….the way the Royal Hobart gets beds created is that poor old Joe who has been waiting two years for his knee replacement gets rung up the night before saying, 'Mate, don't come in, we've got somebody with pneumonia who's acutely unwell'. But if there is no bed they stay in our emergency department so even though we might have 40 beds there, 30 of them could be taken up with people awaiting admission. So for the City of Hobart we have 10 active beds but the people still keep coming*.[86]

224. Orthopaedic Surgeon Mr Scott Fletcher also provided evidence of the consequences for patients of the reduction in elective surgery volumes on the North West Coast

> *What you have to realise is these patients just don't go away; they don't just get better. They sit there with a degree of discomfort, obviously, and they need to be done. So if they're not done now - it's like a debt that's owed to the bank; it doesn't go away, it needs to be paid at some time.*[87]

Cost Efficiencies

225. A number of the witnesses questioned the long term cost benefits to the provision of health services in Tasmania as a result of the budget cuts. In general terms, the evidence was consistent in the view that the decision making process was short sighted.

226. Dr Tim Greenaway said of the impact of the cuts on cost efficiencies

> *I don't like talking in terms of anecdotes but I'm going to because I was on last weekend at the Royal and the hospital was full, and this is the quietest time of the year. I can tell you - I won't name the physician involved - that patients are starting to be transferred out of the intensive care unit into the private system which is going to cost us because there are no beds available. This is in the quietest time of the year. The hospital is completely full; there is no elective surgery. What's going to happen when the flu season hits in a couple of months*?[88]

[85] *Op. Cit.* p. 34-35
[86] *Op. Cit.* p5
[87] *Op. Cit.* p. 11
[88] *Op. Cit.* p36

227. Dr David Butler from the ADA highlighted the impact of the decision to reduce funding to Oral Health Services on the broader issue of preventative health for the Tasmanian population

> *Oral Health is not separate to general health and if we get our oral health right then we can assist other areas of health in meeting their KPIs. In diabetes, adverse pregnancy outcomes or people post-stroke who are twice as likely to require urgent care. A lot of people with stroke can't be treated under local. They have to have a general anaesthetic or a heavy sedation if we need to take teeth out. It's a false economy, as I see it.*[89]

228. Associate Professor Geoffrey Couser said of the prospect of cost shifting associated with patient care

> *So it's a massive cost shift from dealing with this elective surgery and, sure, it may be saving money in one part of the health system but it's leading to costs in another through the PBS* (Pharmaceutical Benefits Scheme)*, through visits to their local doctor, through the Federal Medicare system, through presentations to the emergency department, to unplanned admissions to hospital. It is a range of things that leads to this really disjointed hospital system which leads to some perverse outcomes.*[90]

229. Dr Frank Nicklason also provided evidence of the false economies associated with delaying elective surgery, for procedures such as joint replacements, from his perspective as a Staff Specialist and Chairman of the Medical Staff Association at the Royal Hobart Hospital.

> *We have the oldest population in Australia, or nearly the oldest population in a State in Australia, and severe arthritis of the knee or hip is a really disabling, painful, demoralising condition and I have done quite a bit of consultation on the orthopaedic wards. I make a practice of spending two or three minutes with a patient who has had a large joint replacement just to see what their experience of how quickly it was that they were able to have their needs met with respect to joint replacement. It certainly seems to me that my overwhelming experience is that the people have waited too long. They have had to wait too long because we just do not have a system that is able to move people through that elective surgery in a timely way and when the operation is done, the orthopaedic surgeons will tell you that it is technically more difficult. The person has lost physical condition, they are often demoralised and the rehabilitation to get them back on their feet and out of hospital and doing well at home, that process is longer and therefore more expensive.*[91]

[89] *Op. Cit.* p.81
[90] *Op. Cit.* p. 6
[91] *Op. Cit.* p. 19-20

The retention and wellbeing of the health workforce;

230. The Sub-Committee received evidence of the effect of the budget cuts on productivity and the retention and morale of staff across the Department.

231. Ms Driver from the ANF noted her observations in relation to the impact of the cuts on productivity and workforce placements

> *…. we just saw an orthopaedic nurse sent to relieve in maternity. She's not a midwife so therefore she can't work as a midwife but if you look at the scope of practice you think,' Where's the decision making there if someone is bleeding or what if a midwife going to relieve in psych?' These are all recent cases. I get around the hospital a lot and I see people and say, 'You don't normally work here' and they said, 'No, I've been sent relieving'.*[92]

232. Ms Ellis also supported this position

> *They look at nurses as 'a nurse is a nurse is a nurse' and we all know that a nurse is not a nurse is not a nurse, as a midwife is not a midwife. You can't suddenly move someone from an acute surgical ward and put them into, say, ED and expect them to be fully functioning. There are quite speciality areas now that nurses work in and they've been working there for years. That is their chosen career pathway but are told, 'Sorry, we're closing the service down. You're a nurse so we'll redeploy you'. That is where we are concerned around people's potential scope of practice and duty of care.*[93]

233. Ms Ellis also said of the ANF's observations of the retention of staff within the Department arising from the cuts

> *There's an exodus. We can see from our membership - we obviously track where people are going, and we are losing so many nurses at the moment. Thirty nurses in the last two months we've lost. They've transferred to other branches so they're working still. We have about 20 who are just not able to find work anymore so they're the ones that you see in the media that have gone to work in other jobs, in Woolworths or wherever they can. There are a lot of the young nurses who have finished their 12-month Transition to Practice program and are told, 'Sorry, that's the end of that, there are no more jobs for you after that' - and yet they have mortgages, they have rent to pay and they have obligations. They have to work, and it is quite unheard of that we are seeing this.*[94]

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[92] *Ibid,* p. 20
[93] *Ibid*
[94] *Ibid,* p. 21

234. Dr Frank Nicklason, Chairman of the Medical Staff Association of the Royal Hobart Hospital advised the Sub-Committee that he had conducted a survey of Members to gain a better understanding of their concerns arising from the announcement of the cost reduction strategy. The survey results are attached to this report at **APPENDIX G**. Dr Nicklason said of the staff survey

> *I just want you to understand that that survey is a synthesis of lots of opinions. It is not my opinion, it is what other people have said to me. That is the important thing and the people who I think are on the money mostly are the senior people who really seem to know the workings of the hospital best and better than me. I identify that as the key issue, that there may be some unpredicted long-term, serious sequelae to do with our reputation and to do with our ability to perform at the level of a tertiary university teaching hospital, training and education.* [95]

235. Ms Ellis said of the impact of the cuts on the nursing workforce in managing shifts

> *The best system is obviously on the roster to identify the roster shortfall. At the moment, as an example, the Royal are putting out rosters with two to three roster shortages nearly on every shift because they have cut back the full-time equivalents, they have cut back the recruitment so the rosters are coming out with huge gaps and there are the shortages. The instructions have been not to fill those out of casual and pool, to wait for the day, that morning at six o'clock to call people in for those two vacant shifts, which we know is impossible to get the right skill mix, in case somebody somewhere may be spare and can be redeployed to that position for that one shift - somebody from somewhere else - which rarely happens because we are 100 per cent occupied now. The culture has to change. The HR system is really contributing to a range of issues around satisfaction and patient care.* [96]

and that in relation to leave management

> *The other issue is the nurses who cannot take annual leave. There is not enough relief factor and budget for the relief factor to enable nurses to take their full entitlement of annual leave so we now have a liability of accrued annual leave of over $6 million sitting there so there is x number of nurses with huge amounts of annual leave who cannot take their annual leave. They can't take their annual leave let alone the accrued annual leave that they have. We see annual leave being cancelled because of the shortages at the*

[95] Dr Frank Nicklason, Hansard Transcript 9 March 2012, p 23
[96] *Ibid*, p.28

moment. We have had examples certainly at the Launceston General and at the Royal of annual leave being cancelled more recently because they are so short.[97]

236. General Practitioner Dr Graham Alexander said of the effect of the cuts on the health workforce in Tasmania more generally

The workforce is depleted, demoralised and aging - fast. And yet what we have done here is virtually take a baseball bat to all our young workforce. I am sure that everyone here has family members who have done nursing training, family members who have are going to medical school, and all they can think of at the moment is how am I going to get out of here. How can I get a job on the mainland where I will have a future. That is all they think about, all they talk about. That will take us decades. Even if the Government reversed their decision tomorrow and said that they were going to adequately fund, they have done irreparable damage to our future workforce and you cannot run a health system without a workforce.[98]

237. Mr Fletcher noted his observations of the effect of the cuts on staff morale since the reduction in surgery volumes on the North West Coast

When we were working hard you could see the attitude in theatre, that people would turn up on time and be keen to work, and now the morale is not as good and as a result the productivity is not as good.[99]

Teaching and Accreditation

238. Dr Frank Nicklason said of the impact of the cuts on training positions at the Royal Hobart Hospital

Because in the area of surgery, if you take that as an example, the reduction in elective surgery means that the people who are going into the surgical training programs are not getting the practical experience that they need to get to satisfy the colleges that we will have an ongoing training program, so it creates an uncertainty about the viability of training programs.[100]

239. Supporting these observations, Mr Scott Fletcher spoke of his recent experience in relation to one overseas trained orthopaedic specialist and the difficulties associated with his retention due to the reduction in surgical procedures he was performing as part of his ongoing accreditation

[97] *Ibid, p28*
[98] *Op. Cit.* p7
[99] Ibid, p10
[100] *Op. Cit.* p. 17

With these cutbacks, one of the five told me just last week that he is actively applying for work elsewhere. This is a well-trained orthopaedic surgeon who sat his South African exams and passed. Recently in the last few years he resat his orthopaedic exams in Canada – and it is not a Mickey Mouse set-up over there, they really have well trained orthopaedic surgeons – he passed those exams and came to Australia and has settled here in Burnie with his family, and I can tell you that not only is he well trained but his operating skills are very good and his thinking is very good. He is logical and he is a nice guy and those sorts of guys don't come around very often.[101]

and that

He told me last week that he is applying to various places on the mainland because he can't get the joint surgeries he needs to get his Australian exam. I am supervising him here in Burnie at the moment and he needs to do a certain number of joints per month on a regular basis to be able to be ticked off by the College of Surgeons of Australasia. He is worried now that he is not having the throughput and that he will have to do another year of being supervised or be curtailed in some way to get his full fellowship in Australia, so he is actively looking to go elsewhere and that is as a direct consequence of these cutbacks.[102]

240. Subsequent to Mr Fletcher's evidence, the Sub-Committee was informed that the surgeon in question had in fact left his position.

241. Dr Nicklason noted further in relation to existing surgical positions

Certainly in the area of surgery, a surgeon is nothing if they cannot maintain their skills and reputation and they have to do that by operating and operating with appropriate technology and if those things are not available to them a surgeon will consider whether it is the right thing to do to continue working at the Royal.[103]

242. Professor Isabelle Ellis believed the impact on nursing placements to have been limited as of March 2012

…from the School of Nursing's perspective, we have still managed to get all of our students in clinical placements. It was an anxious time when we thought, 'Is this going to have a major impact on us?', but in fact we have not had as big an impact as we expected. We have been able to put students in different locations. We have 300 placements in Launceston and they have really gone all-out to make sure that students are in

[101] *Op.Cit.* p. 4-5
[102] *Ibid*
[103] *Op. Cit.* p. 18

appropriate but alternative placements. So they have taken a good hard look and found where placements might be appropriate and worked hard to see whether that would be a good experience for the students.[104]

243. Professor Timothy Skinner from the University of Tasmania Rural School of Medicine said of the impact of the cuts on student surgical placements on the North West Coast

We have had to reshape what we are doing, particularly around our surgical rotations, so they do surgical rotations in their fourth and their fifth year. One of our problems is that we have had to shift much more of the surgical rotations so that the students are having to yo-yo between the Mersey and the North West Regional Hospital to cover that rotation. We have also had to extend the amount of time they are spending on rotations so they get the required clinical exposure. That has created problems for us from the point of view that the Mersey is so reliant on locums and we are not allowed to use locums because our accreditation process is to do that supervision and training; they have to be contracted staff. That reliance on the Mersey is what has caused us the problem. We had a couple of students who were very proactive and started doing their surgical rotations during their summer holidays. We have managed that at the moment. At the moment we are probably at capacity to manage, without anything else going on. It has changed; we have had to move things around and students are doing more travel than they were.[105]

244. In line with these comments, Mr Scott Fletcher noted the broader difficulties in relation to surgical training and the maintenance of accreditation for medical practitioners on the North West Coast

…..simply put, they're not getting their experience. We do a ward round every Friday morning where we all get together, so there are five consultants, four registrars - which are the ones beneath the consultants - and then two residents, so you have a team of 11 doctors, and then you have physios, an occupational therapist, nursing staff and medical students, and yet we had just four inpatients to see on this ward round. It looks silly with all these highly trained people trying to keep their work practices together and four patients is just not enough to teach or to keep the doctors busy.[106]

[104] *Op. Cit.* p. 22
[105] Professor Timothy Skinner, Hansard Transcript 19 March 2012, p. 24
[106] *Op. Cit.* p. 5

The Consequences for the Private Health Sector

245. The Sub-Committee received consistent evidence of a false belief amongst some members of the community, that cuts to the public health system would not have consequences for the private health system in Tasmania.

246. Most notable amongst the evidence, Dr Frank Nicklason explained the interrelationship between the private and public health systems.

> *…. there is a great mutuality and interdependence between the private hospitals and the Royal Hobart Hospital in Hobart, in that many of the people who provide services, for instance, in ICU at the Royal Hobart Hospital also need to provide those intensive care services at Calvary Hospital. We just do not have the population of that group of people that we could have two camps of people, one servicing the private sector and one servicing the public sector.* [107]

247. Dr Nicklason also noted the possible consequences to the public health system if there were to be a retraction in the delivery of private health services in Tasmania

> *if we lose a viable private hospital intensive care, if we lose emergency department capability in the private sector, the Royal is swamped. That is a very important point and it needs to be borne in mind with any of the changes that might be happening.*[108]

Strategic Health Planning

248. Associate Professor Marcus Skinner observed the challenges associated with health planning in light of developments such as the budget cuts and the regional approach to the problem in Tasmania

> *…one of the things that has struck me is that there isn't a statewide approach to health care. A lot of the time I see it as three completely different models of healthcare delivery which creates lots of interesting problems and, to me, health should also be a whole-of-State issue*.[109]

249. Mr Scott Fletcher said of provision of hospital services on the North West Coast in the context of the unique arrangements for the funding of the Mersey Hospital through the Commonwealth Government

> *As you know, we have this two hospital system and there was a move some years ago to try to rationalise how we deliver services across the coast. Many people have looked into*

[107] *Op. Cit.* p. 18
[108] *Ibid*, p. 18
[109] *Op. Cit.* p. 29

and there has been report after report who have all concluded more or less the same thing. There are inefficiencies in it, the way we do it is not economically sensible, duplication is bad, and the way forward was the Tasmanian Health Plan.[110]

250. Mr Fletcher also spoke of the current inefficiencies associated with the operation of the Mersey Hospital in terms of the duplication of medical staff

We need to align ourselves with the college requirements, otherwise we are going to lose our accreditation for general surgery. We need to pool not only the registrars but also the consultants. We need to foster this 23-hour surgery. We can save some on-call money by not having on-call staff after-hours. We don't need two lots of anaesthetists on call after-hours or on weekends. We do not need two lots of general surgeons on call on weekends. We went through this process about five years or so ago with orthopaedics where we now do day surgery over there every day except Friday, which is our quality assurance day, but we do all the acute stuff both during the week and on the weekends in Burnie. It works well, we service the Mersey really well and we do the outpatient clinics there on Monday, Tuesday, Wednesday and Thursday. We do day surgery there on Monday, Tuesday, Wednesday and Thursday. So we have a very healthy, vibrant day surgery type of presence from Mersey but we do not do any big cases there and I suggest that is the way to go with general surgery as well. We do need to relook at what the experts have suggested we do and I think we should follow that and I think that is where we need to get our saving costs from and I think we can get some productivity gains as well.[111]

251. The Sub-Committee received consistently favourable comments from the medical profession in relation to the previous work done as part of the Tasmanian Health Plan. Ms Ellis from the ANF noted the digression away from the Tasmanian Health Plan in response to the budget cuts.

…the current budget cuts will not allow the health service to live up to this plan. It appears that there is no (or little) strategic direction in the Tasmanian Health Sector. Rather the health system appears to exist as a process of crisis/bandaid management with no clear state wide coordination; the strategic direction outlined in Tasmania's Health Plan is forgotten or ignored. This plan identified that 345 additional inpatient beds and 67 day

[110] *Op. Cit.* p. 3
[111] Op.Cit. p.6-7

surgery beds would be required by 2016 to meet projected demand based on Tasmanian demography. The budget cuts will reduce impatient beds by 100, this year alone[112]

252. Endocrinologist Professor John Burgess also noted with concern the digression away from methodical health planning associated with the cuts. He sighted the work completed by the Government as part of the 'Better Hospitals Plan' as an example of positive work that may come undone.

…..the current budget restrictions threaten to undo the lessons learnt in 2004, or the corrective actions taken over subsequent years. The budget pressure currently applied to the RHH risks undoing much of the rebuilding undertaken over the last seven years.[113]

The Dual Commonwealth and State Health Funding Arrangements

253. There was also consistent evidence received in relation to the inefficiencies associated with the split funding arrangements for health in Tasmania.

254. General Practitioner Dr Graham Alexander said of the funding arrangements

It has to be a single funder. The Titanic is sinking and we have to do something.[114]

255. Dr John Davis from the AMA said of the funding arrangements and the need for reform

We have to sit down and redesign the Tasmanian health system with one funder, one group responsible for funding health in this State and making decisions about how we integrate health care for the benefit of Tasmanians across the spectrum - the people of Tasmania and the government. If you read papers and watch television we all know that there is a financial crisis in the world and it's right down to Tasmania. We don't have enough money coming in to meet the expenses going out and we double up on a lot of those expenses. Now is the time to get it right, and if we do not we will be back next year and the year after and in five years and in 10 years. The trouble is that next year and in two years and in five years we will have less competent clinicians providing the care that Tasmanians need now, let alone in 10 years. That is something that the Government and the public has to take on board and there has to be a very serious debate about what health the public sector should provide in this State and how it can provide that to the highest level. Tasmanians deserve the same level of health care as any other Australian and we're not getting it at the moment.[115]

[112] ANF written submission December 2011 p. 1
[113] Written submission, Professor John Burgess
[114] Op. Cit. p. 5
[115] *Op. Cit.* p40

256. Dr Davis also noted the example of the unique funding arrangements for the Mersey Hospital in Tasmania

> *The Mersey is a great example. We already have a unique model of care in Tasmania in that the Australian Government provides the funds for the Mersey. We have already set the benchmark; we have changed the rules. We just have to keep changing them until we get the health system that works. Both sides of the Federal Parliament supported the Mersey model. John Howard introduced it and the current Labor Government has continued to fund it, so we are an advantage there.*[116]

[116] *Ibid,* p43

TASMANIAN HEALTH ORGANISATIONS

257. Following the commencement of the inquiry, the Government introduced legislation to the Tasmanian Parliament to establish the new Tasmanian Health Organisations (THO's) model. Although not central to the inquiry, it was important for the Sub-Committee to gain a general understanding of the circumstances surrounding the establishment of the THO's and in particular, the economic efficiency of the new model in the context of the budget cuts.

258. The National Health Reform Agreement and the National Partnership Agreement on Improving Public Hospital Services were signed by the States and Territories with the Commonwealth Government in mid-2011.[117] These agreements seek to establish national reform in the way that health services are provided and administered.

259. As part of the agreement with the Commonwealth, Tasmania is required to establish local area health networks with local control, greater efficiencies and improved response times to deliver more resources and better health outcomes for Tasmania.[118] The Commonwealth will contribute up to $350 million extra funding to the Tasmanian health system by 2020 under the reform.[119] It is a requirement under the agreement that the local area health networks will be established by 1 July 2012.

260. The Department of Treasury and Finance undertook a stakeholder consultation on the local area health network structures and advised that

> *'a more locally devolved hospital system must go hand in hand with greater efficiency, transparency and accountability is readily apparent in the language and content of the National Health and Hospital Network Agreement'*[120]

261. In accordance with this requirement, the critical consideration for Tasmania when determining the area health networks was that '*cost efficiency, financial transparency and performance accountability drivers'*[121] were appropriately developed in creating the local area health network structures, regardless of the number established.

262. After a period of consultation and analysis, the Department of Treasury and Finance advised the Government in September 2010 that:

> *'….using the criteria of cost efficiency, accountability and transparency, one or possibly two LHNs could be viable within the Tasmanian context. Simplicity of implementation, the*

[117] National Health and Hospital Network – National Partnership Agreement on Improving Public Hospital Services document, p. 1
[118] Second Reading Speech, *Tasmanian Health Organisations Bill 2011,* p.1
[119] *Ibid*
[120] Health Reform, September 2012 – Response from Treasury to Committee of 2 April 2012
[121] *Ibid*

reduced challenge of appointing suitably qualified members to governing councils, and efficiency would strongly favour a single LHN model.'[122]

and that:

'A three LHN model not only does not appear viable from an efficiency point of view, but could also lack the structural incentives to drive efficiency even if there are efficiency gains to be captured.'[123]

263. Department of Treasury and Finance Secretary Mr Martin Wallace said of the process to determine the number of THOs

That would be a departmental responsibility. They are the only ones who can measure the costs of one versus three, because it is not just the cost of the three boards and three organisations. It is about how you effectively deliver services to each region, what services are provided and procured centrally versus what services are procured and provided from the region, and the way in which central services are provided to the region or through the regional health boards. All of those things impact on the cost of a three THO model compared to a one THO model. Most of the costs are around the service delivery model, not the fact that you have three boards.[124]

264. In giving evidence to the Sub-Committee, the Acting Secretary of the Department of Health and Human Services Mr Greg Johannes was not prepared to commit to a preferred number of THO's, stating that central direction and delivery of clinician services should be weighed against cost-effectiveness.

'Should we be going to a single THO instead of three?....my response would be: the current system, a system with three THOs and a system with a single THO, if there is a strong central direction around the system and what it will deliver where all three of those systems could deliver the outcome that you are talking about, I do not think any one structure guarantees the right outcome…' 'so I think the existing system in either of the two THO models in principle could deliver the sort of statewide focus that you are talking about.'[125]

265. There was an understanding that the THOs were to deliver a more streamlined and structured ministry with clinical services and decisions being made independently by the THO's with local focus and implementation.[126] The efficiencies of this were highlighted by Ms Jane Holden:

[122] *Ibid*
[123] *Ibid*
[124] *Op cit*, p. 16
[125] Hansard Transcript, Mr Greg Johannes, 21 November 2011, p. 20
[126] DHHS Submission to Sub-Committee, p. 6

'….the least money we spend on administering health systems, the more that goes to patients. In that regard, the least expensive model of a single-governed THO, but I balance that strongly by increased local voice and I do believe that sooner and more convenient access to health gives better health outcomes because people tend to access it if it is close and convenient.'[127]

266. The CEO of the Northern Area Health Service and the Acting CEO of the North-West Area Health Service also supported Mr Johannes and Ms Holden's statements around an integrated Statewide approach and emphasised the importance of efficiencies; these being more crucial to the achievement of better Health outcomes than either one or three THO's.[128]

267. Concerns were raised by some witnesses about the new THO model. Ms Neroli Ellis from the ANF said of the new model

…..it is being thrust upon us and the time frame of that is 1 July this year. We do not believe the national health reform is going to improve patient care or people's outcomes. It is very much a governance and funding model as opposed to a quality of care model. What we are concerned about though, with the funding totally reliant under the national health reform, is activity-based funding. So the more you do the more funding you get. Task 60 per cent of the set fee to specific procedures and what we are very concerned about is how on earth we are going to rebuild capacity, the loss of skills and the loss of services and the loss of infrastructure. Some of our closed wards have already begun being moved into offices. All of the beds that have been closed at the Launceston General have been put off site and into storage. It is not short term; it is long term to be closing down the capacity.[129]

268. Ms Ellis also stated in respect of the new model in light of the current budget cuts

When national health reform comes in and we need that activity to provide the funding we just can't suddenly click fingers and get the surgical theatre nurses back in again and all the people back in that we have taken five or six years to recruit. That is the area that has been hit the hardest.[130]

269. Mr Phil Edmondson, Chief Executive Officer of Medicare Local in Tasmania, expressed similar sentiments about the THO model:

'I think…we have perpetuated this sense of regional competitiveness by going down the three THO path. I understand the rationale and the reasons but I don't necessarily agree with it because I think there's significant opportunity really to look at making consistent

[127] Hansard Transcript, Ms Jane Holden, 21 November 2011, p21
[128] Hansard Transcript, 21 November 2011, p. 20-21
[129] Ms Neroli Ellis, Hansard Transcript, 1 February 2012, p. 12
[130] *Ibid*

statewide decisions that are not going to be easy when you've got three independent boards and regions fighting for a limited bucket of resources."[131]

270. Despite advice to the contrary around the efficiencies and the viability of establishing three THO's in Tasmania, the Government introduced legislation in Parliament providing for a structure with three THOs across the State.

271. The Sub-Committee had sought to question to Minister in relation to the decision to adopt a three THO model but was unable to do so due to the Minister's refusal to attend a hearing. The evidence provided supported the view that the decision of the Government to implement a three THO structure appears to have been greatly influenced by the strength of the local community stakeholder concerns prevailing over possible cost efficiency and health outcomes that could have been achieved through a single THO model.

272. The Tasmanian Parliament passed the *Tasmanian Health Organisations Act 2011* on 24 November 2011, which has seen the implementation of three local area health networks take over health services within the State by 1 July 2012.[132]

273. Under the legislation, the Tasmanian Health Organisations will be established as State Owned Companies reporting to stakeholder Ministers of the Crown and will be directly accountable for hospital and health service performance.[133] Existing employees within the Area Health Services will transition to the THOs on 1 July 2012 and continue to be employed under the *State Service Act 2000.*[134]

274. A Government Selection Panel consisting of Secretaries of the Departments of Treasury and Finance, Premier and Cabinet and Health and Human Services as well as independent member, Mr John Ramsay recommended to Cabinet that the appointment of a single common chair across the three governing councils would increase communication and integration between the THOs.[135]

275. This view was strongly supported by Professor Raymond Playford, Dean of the UTAS Faculty of Health Science:

'the purpose behind the three THO's is to help give a local flavour but they should be working in an integrated way as well, hopefully through the common chairman, to make sure that there is cross-working across all the different sites'.[136]

[131] Hansard Transcript, 2 February 2012, p. 62
[132] Legislative Council Hansard Transcript, 24 November 2011
[133] *Tasmanian Health Organisations Bill 2011,* Fact Sheet
[134] Second Reading Speech, *Tasmanian Health Organisations Bill 2011,* p. 9
[135] Minute to Treasurer, 24 August 2011
[136] Hansard Transcript, Prof Raymond Playford, 8 March 2012

276. The funding of the THO's will be provided through both the State and Commonwealth with existing Commonwealth National Healthcare Specific Purpose Payments being directly paid to the THOs.

277. Associate Professor Timothy Skinner and Professor Isabelle Ellis of the University of Tasmania Faculty of Health Science also raised concerns about the model.

> ***CHAIR*** *- One of the issues with the three THOs and the activity-based funding is that we are going to see them competing for their bucket of money. Rather than saying there is capacity at the Mersey for endoscopies and arthroscopies, they will have to charge the other region. I am not sure how it is going to work but somewhere along the line it is going to create some problems.*
>
> ***Prof. ELLIS*** *- Perverse incentives really.*
>
> ***CHAIR*** *- Yes, so you will end up with no waiting list in the north-west and a growing waiting list down here.*
>
> ***Prof. SKINNER*** *- The problem with that is if you do get to that point where the surgeons are twiddling their thumbs, you lose the surgeons.*
>
> ***CHAIR*** *- And they lose their skills if they are not being kept busy.*
>
> ***Prof. SKINNER*** *- And potentially the knock-on effects from that for wider rural health care when you start losing those specialities.*[137]

278. The focus under the new model is on efficient based pricing for the delivery of health services and what services in Tasmania will be block funded as opposed to being funded by activity in the future.

279. Based upon the evidence the Sub-Committee was able to obtain, serious questions arise as to whether the three THO structure will be the most efficient operating model in the interests of all Tasmanians and given the current financial circumstances of the State.

280. During the Budget Estimates hearing the Minister referred to the need for Tasmania to be recognised as having special funding circumstances under the new model in relation to services that are to be block funded rather than activity based funded and the cost of providing the services in Tasmania

> *We have had some conversations with the Australian Government about how we might do an assessment of episodes of care because we need to establish not only for them but also for ourselves that we are costing appropriately the work that we do. We can then say*

[137] UTAS, Hansard Transcript, 19 March 2012, p. 36

to the Commonwealth that of this additional cost in Tasmania x per cent is the nature of being in a region and the cost of doing business on an island, and y per cent is things we can change and we can now identify where they are. Some of those things will also be the cost of doing business. We may have some more expensive models of care, simply because of the numbers we are doing or the places that we are doing it, or where we have to purchase the service from. A number of entities and services that we provide will be block funded because there is no way with the numbers that we do that we can be at the national efficient price for providing those services.[138]

281. The Sub-Committee believes this may be difficult to justify given the competing interests at a national level, if decisions are made on the basis of short term political objectives, rather than on the basis of long term strategic health planning.

[138] Transcript of Legislative Council Estimates Hearing for DHHS – 28 May 2012 (Part 1)

Signed this 30th day of August two thousand and twelve.

Hon. Ruth Forrest MLC
Committee Chair

APPENDIX A- DHHS 'LIST OF SAVINGS STRATEGIES'

List of Savings Strategies

4 October 2011

Department of Health and Human Services

Tasmania
Explore the possibilities

Agency wide

TASK	2011/12 $000	2012/13 $000	2013/14 $000
Suspend all non essential conferences, travel, training	905	905	905
Telecommunications - mobile telephones and data cards	750	750	750
Motor Vehicle Fleet	647	647	647
Review and redesign payroll administration and processing	*	2100	2100
Complete the strategic review of the DHHS accommodation plan	*		
Review all leased facilities due to expire in the next 4-7 years	*		
Extend Agency wide procurement activities	1560	3460	3460
Review procurement and use of single use surgical instruments	*		
Procurement of Prosthetics – volume/cost and number of suppliers	*		
10% reduction in non service delivery units	5800	5800	5800
Review MAIB facility fee	2500	2500	2500
Review the delivery of pathology services across hospitals	250	250	250
Review the delivery of radiology services	*		
Cease overtime for non-frontline positions	180		
Improved leave management / backfilling	500	500	500
Reduction in overtime by 5%	1300	1300	1300
Middle management reduction strategy	3000	3000	3000
Reduction in non-salary expenditure	3103	3103	3103
Rationalise staffing not engaged in direct clinical care	1300	1300	1300
Reprofile clinical staff and improve service delivery	*		
Review Departmental workforce profile	3000	3000	3000

Ambulance Tasmania

TASK	2011/12 $000	2012/13 $000	2013/14 $000
Re-use Ambulance Fitouts	200	200	200
Increase revenue by billing doctors on compensible medical retrievals	300	300	300
Increase revenue budget by taking into account billing for compensible non-emergency patient transports	300	300	300
● Deferral of annual leave reduction program	470	470	470
● Review of non-frontline and administrative support staff	304	304	304
● Maintain current levels of clinical and management supervision of communications centre	400	400	400

* *Savings to be determined.*

● *Denotes additions as at 4 October 2011.*

Disability, Housing and Community Services

TASK	2011/12 $000	2012/13 $000	2013/14 $000
Review service delivery through family violence (after hours service)	240	240	240
Rationalisation of administrative/ management positions	200	300	400
Reprofile maintenance budget on public housing	2000		
Cancel the housing rental 'holiday'	3022	3022	3022
Reform public housing rentals	-600	100	105
TAHL funds returned to Consolidated Fund	3000	3000	3000
Elder Abuse Strategy	285	288	285
Strengthening Community Service	482	482	482
Reduce NGO indexation	3372	3372	3372

Children and Youth Services

TASK	2011/12 $000	2012/13 $000	2013/14 $000
Review number of Child Health Checks	500	500	500
Increase charges for inter-country adoptions	150	150	150
Review structure of adoptions unit	170	170	170
Improved Youth Justice and Child Protection case management	255	255	255
Consolidation of accommodation (C&YS)	0	0	200
Review the cost and timeliness to initiate reunification strategies for children in out of home care	*		
Savings from merger of two Southern Areas (C&YS)	0	150	300
Review all funding agreements (C&YS)	0	100	200
Review models of care (C&YS)	*		
Review programs under Children Health and Parenting System (CHAPS) and improve service delivery	0	680	680
Review minimum AYDC client base for staffing levels (C&YS)	200	400	400
One-off administrative and staff savings	1735	0	0

Population Health

TASK	2011/12 $000	2012/13 $000	2013/14 $000
Align Needle Syringe Program sterile water provision with other states	40	100	100
Review staffing establishment	335	527	527

Northern Area Health Service

TASK	2011/12 $000	2012/13 $000	2013/14 $000
Savings from implementation of co-generation plant at LGH (500)	*	500	500
Complete the LGH Laundry tender process	0	350	350
Management options for LGH car park	*	1077	1077
Transition to staffed model in ED	500	1000	1000
Transition from the use of locum nurses with staffing from LGH nursing pool	180	180	180
Revenue - Food/CSD(Central Sterilising Dept)/Supply	150	150	150
Rent - 15% increase on 2010-11 recoveries	20	40	40
Antibiotic Stewardship	300	400	400
Review of teaching, training, research and development to ensure cost recovery	500	500	500
Minor service/process review (renal, TCP, staff taxi usage, relocation payments)	800	1000	1000
Revenue strategies - Bed Day / Prosthesis cost recovery	790	790	790
Undertake tender for 12 funded aged care transitional beds	245	365	365
Review of staffing establishment	750	1000	1000
Restructure of nurse rosters aligned with EBA	800	1600	1600
● Reduce elective surgery volumes	8500	*	*
● Reconfigure Ward 4D and use space to consolidate oncology services	2200	4400	4400
● Reprofile ICU shifts	1035	2277	2277

North West Area Health Service

TASK	2011/12 $000	2012/13 $000	2013/14 $000
Systems and Procurement, NWAHS	1000	1000	1000
Locum and agency management	2100	2100	2100
Vacancy control and management	962	962	962
Service review and role redesign	375	500	500
● Reduce elective surgery volumes	2376	1728	1056
● Reallocation of beds across North West Area Health Service	1015	2029	2029

Southern Tasmania Area Health Service

TASK	2011/12 $000	2012/13 $000	2013/14 $000
Savings from implementation of RISPACS system	330	730	730
RHH Reduction in Accommodation Expenses (associated with Locum reduction)	100	150	150
RHH Reduction in Locum in DMI (Dept Med Imaging)	250	250	250
Improve procurement of Nuclear Medicine Consumables	55	55	55
RHH – Savings associated with changed rostering: Orthopaedics and Neurosurgery	550	550	550
RHH – Annual leave management / sick leave management	500	750	750
Encourage 6 and 7 hour nursing shifts	1000	3000	3000
Review of RHH staff backfilling	100	150	150
RHH – Increase cafeteria prices 5%-10%	40	40	40
RHH – Increased Prosthetic Recoveries (Division of Surgery)	150	175	200
RHH – Increased Prosthetic Recoveries (Medicine)	290	290	290
RHH – Review in Surgery Administration Pool (non extension of fixed term contracts)	120	120	120
Efficiencies through the commissioning of the PET Scanner	100	100	100
Transitional Care Program Fee Increases	100	100	100
Traffic light system Pathology in ED	150	250	250
Review contractual arrangements for maternity and special care	75	75	75
Review contractual arrangements for ICU bed day rates	*		
Review maintenance in primary health sites	*	45	45
Review of all recovery of occupancy expenses from tenants of Primary Health administered sites	50	50	50
Review maintenance and other property costs allocation to business units to have them centrally managed	125	125	125
Review HACC revenue streams, align with activity and validate elligibility	108	108	108
FTE management reduction and control of all employment related costs including salaries, HDAs, MRDAs allowances, oncall call backs and FBT costs	400	1445	1445
Restructure wards 2DC and 2DS (cardiology/ cardiothoracic) and achieve better collaboration	140	250	250
Review service delivery models and role requirements		226	226
Review, design and implement lean support systems - strengthening internal controls and improving productivity	5500	10500	10500
Review formulary in pharmacy	500	500	500
Improve service integration across continuum of care (incl. community)	0	2000	2000
Review role design to improve workforce utilisation and productivity	3357	6895	6895
● Reduce elective surgery volumes	10700	17300	17300

Statewide and Mental Health Services

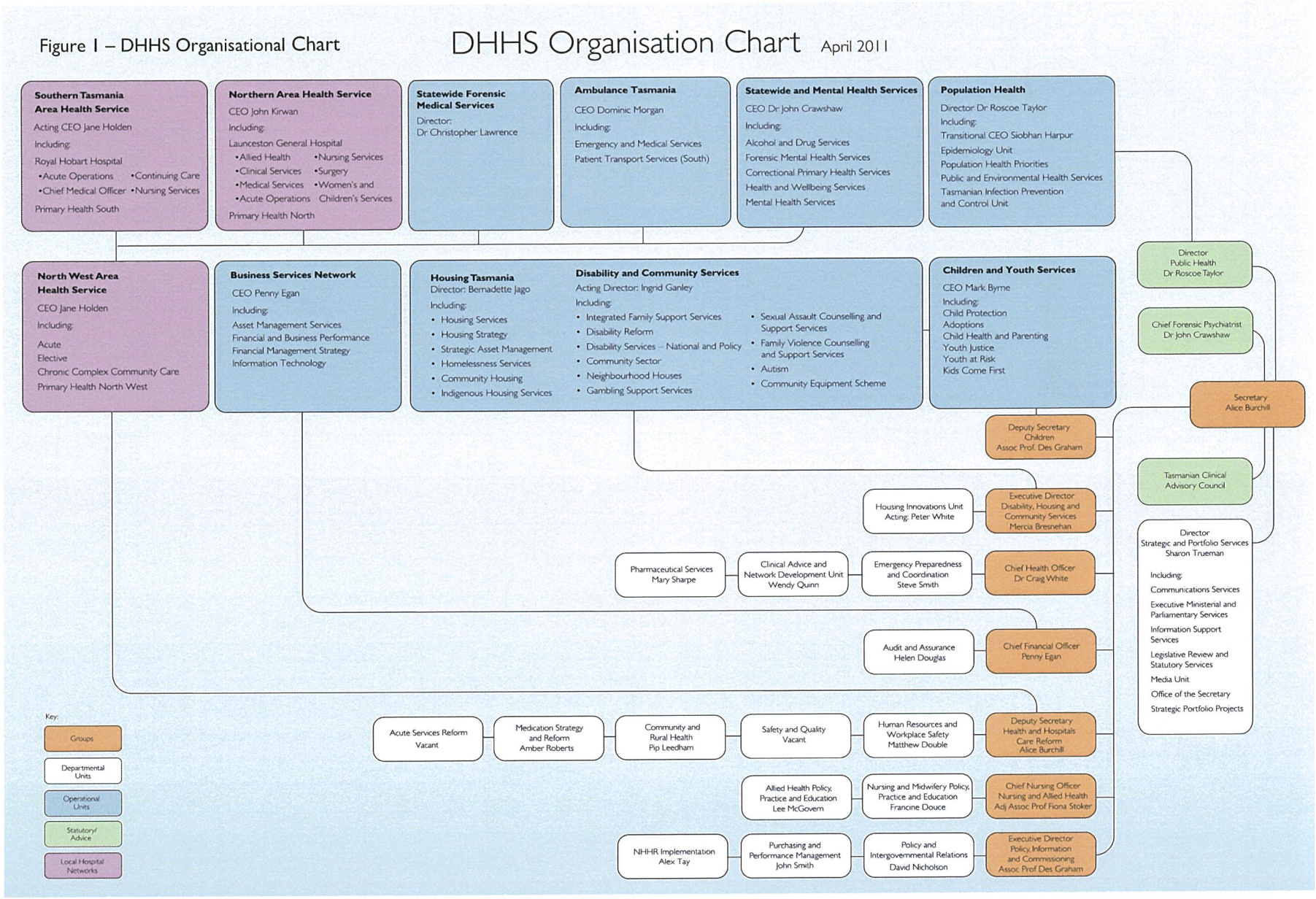
TASK	2011/12 $000	2012/13 $000	2013/14 $000
Reinstate beds at Roy Fagan Centre and allocate for use as sub acute beds	200	200	200
Relocate services into Drysdale House in Launceston	250	250	250
Reduced consumables	35	35	35
Review community education programs	12	12	12
Efficiencies in operational expenditure (HWB)	27	27	27
Review and restructure business processes, staffing and management arrangements in state office and area management units	1077	1077	1077
Improve medication management arrangements across Forensic Health Services	35	*	*
Progress implementation of shared care arrangements with private providers and other revenue options	300	1000	2000
Review and redefine role of extended treatment services in mental health services	500	1500	1500
Review of Community Sector Organisation expired contracts and recovery of any uncommitted funding	300	*	*
While maintaining quality outcomes for clients, achieve more cost efficient provision of mental health inpatient services through review of rostering, overtime and other cost drivers	1000	1500	1500
Develop a more integrated approach and statewide consistency of operation for Crisis Assessment Teams	400	400	400
Reduce operational costs across all SMHS Units in line with DHHS strategies	380	500	500
Strategic reform of mental health services including consideration of referral pathways, care coordination models and the role of clinical services and community sector organisations to ensure equitable access and referral to the right service setting at the right time	0	*	*
Reprioritise Future Directions initiatives for the Alcohol and Drug Service	840	885	0
Reduce travel expenses	43	51	51
Continuation across SMHS of DHHS vacancy control program to ensure only essential positions are filled	868	*	*
● State office efficiencies and restructure	800	800	800
● Statewide operational and staffing efficiencies	1590	*	*

* *Savings to be determined.*

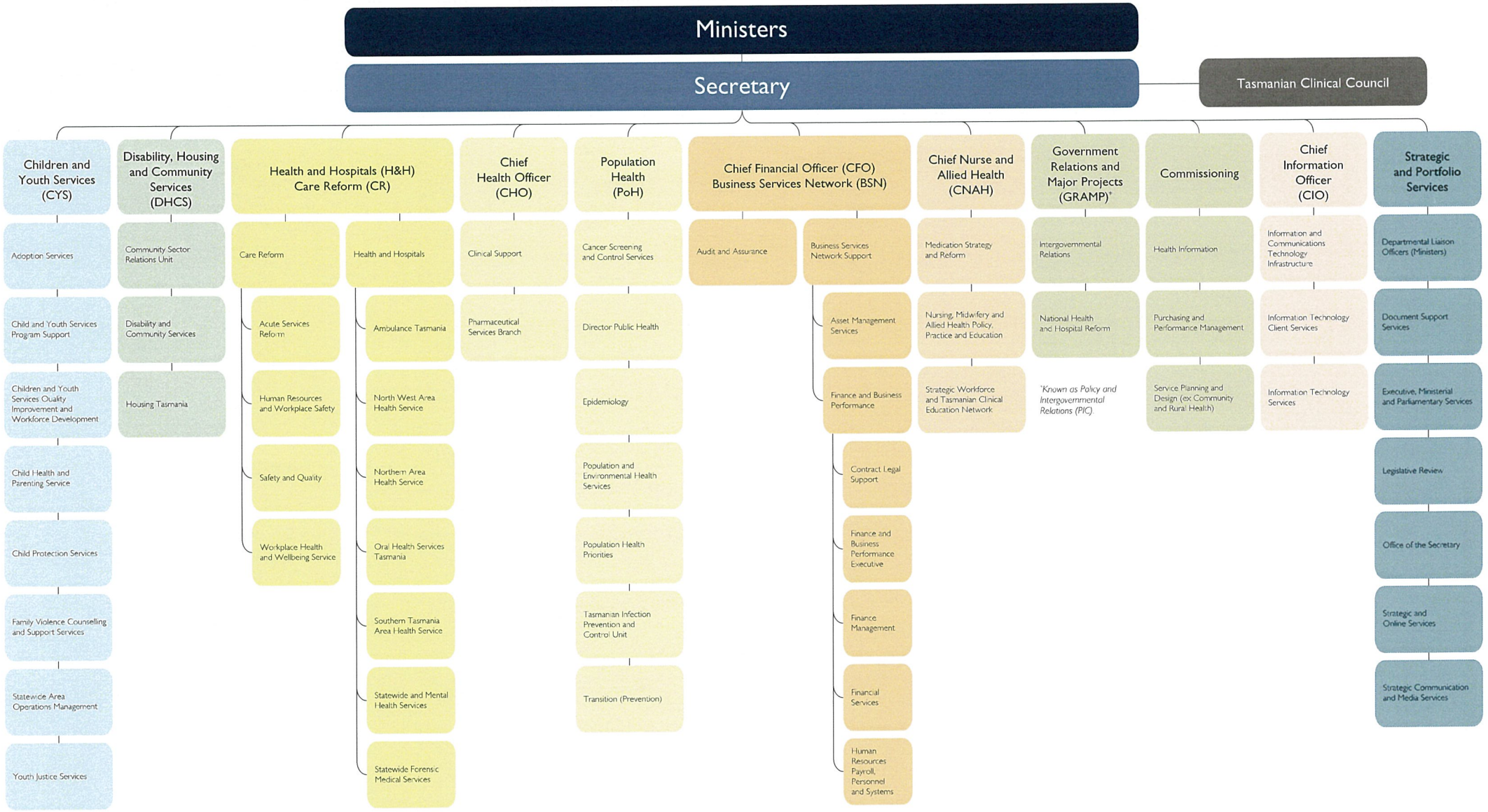
● *Denotes additions as at 4 October 2011.*

APPENDIX B- DHHS ORGANISATIONAL CHART

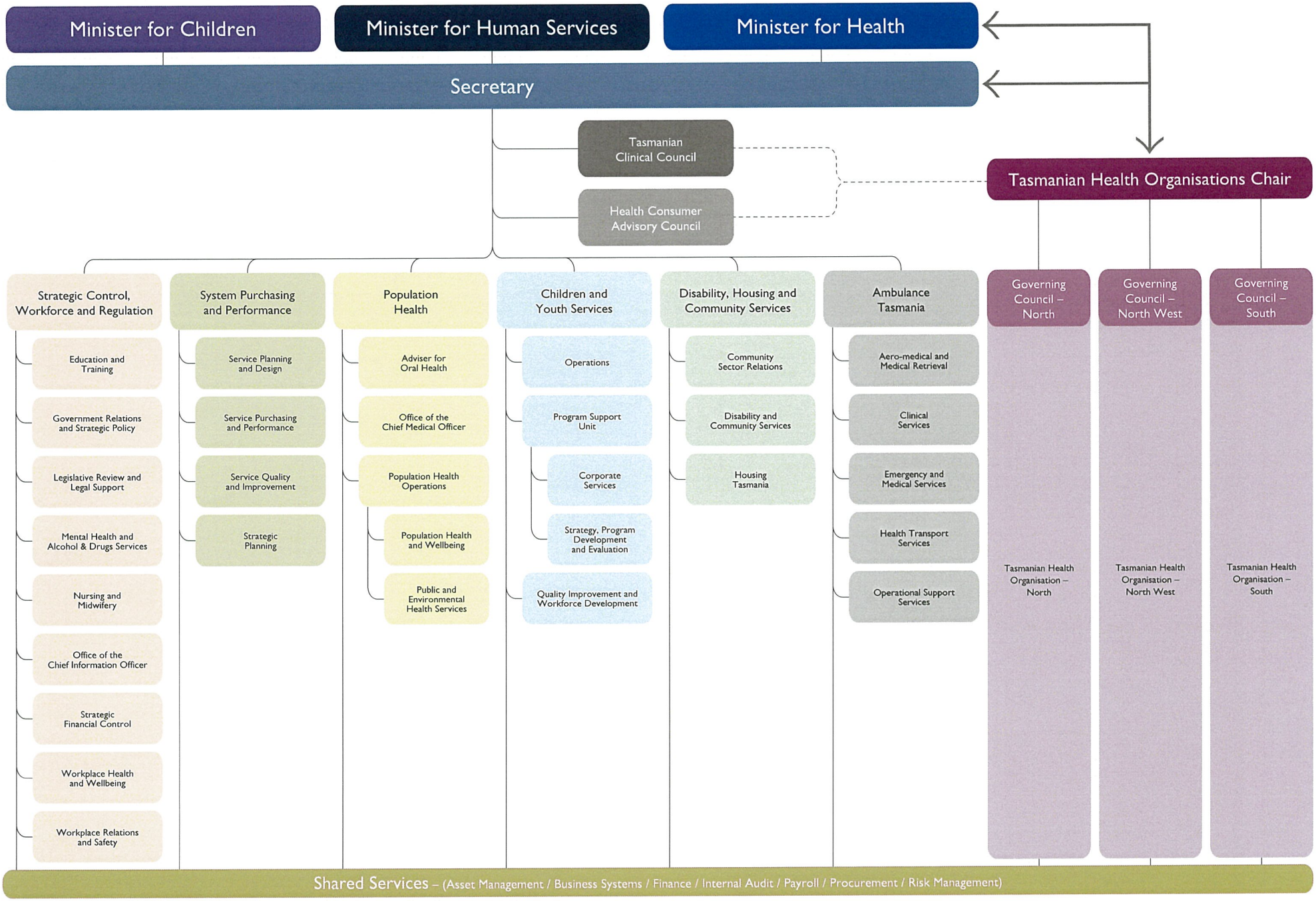
Figure 1 – DHHS Organisational Chart



Department of Health and Human Services February 2012



Department of Health and Human Services June 2012



APPENDIX C - SUBMISSIONS

No.	*Description*	*Date*
1	Bryan Walpole	15/11/11
3	Ambulance Private – David Watson	21/11/11
4	ADA – Australian Dental Association Tasmania	16/11/11
5	Nikki Madden	21/11/11
6	Lawrence Waterson	22/11/11
7	Stephen Coombs	25/11/11
8	Martyn Goddard*	25/11/11
9	Professor John Burgess	28/11/11
10	Association of Independent Retirees	28/11/11
11	SEARCH and TPEHN	28/11/11
12	Karl Goiser – Private submission	28/11/11
13	Associate Professor Geoff Couser	28/11/11
14	Nero Muscular Alliance Tasmania	28/11/11
15	Department of Health and Human Services	29/11/11
16	Dr Graeme Alexander	23/11/11
17	Mr Stephen Hayes	24/11/11
18	Department of Critical Care Medicine, RHH	08/12/11
19	Australian Nurses Federation	09/12/11
20	Marcus Skinner	06/12/11
21	Dr Frank Nicklason	06/12/11

* Supplementary documents provided in addition to major submission.

APPENDIX D – TRANSCRIPTS OF PUBLIC HEARINGS

Monday 21 November 2011:	Committee Room 1, Parliament House, Hobart
Monday 5 December 2011:	Committee Room 1, Parliament House, Hobart
Wednesday 1 February 2012:	Committee Room 1, Parliament House, Hobart
Thursday 2 February 2012:	Committee Room 1, Parliament House, Hobart
Tuesday 21 February 2012:	Oatlands Council Chambers, 71 High St, Oatlands
Tuesday 21 February 2012:	Burnie Council Chambers, 80 Wilson St, Burnie
Wednesday 22 February 2012:	Henty House, 1 Civic Square Launceston
Thursday 8 March 2012:	Committee Room 1, Parliament House, Hobart
Friday 9 March 2012:	Committee Room 1, Parliament House, Hobart
Monday 19 March 2012:	Committee Room 1, Parliament House, Hobart
Tuesday 20 March 2012:	Committee Room 1, Parliament House, Hobart
Thursday 5 April 2012:	Committee Room 1, Parliament House, Hobart

Note: Transcripts of evidence published by the Committee can be located at the following website:
http://www.parliament.tas.gov.au/ctee/Council/GovAdminA.htm

APPENDIX E – CORRESPONDENCE

Department of Treasury and Finance

The Treasury Building
21 Murray Street, HOBART, Tas 7000
GPO Box 147, HOBART, Tas 7001 Australia
Telephone: (03) 6233 3100 Facsimile: (03) 6223 2755
Email: secretary@treasury.tas.gov.au Web: www.treasury.tas.gov.au

Tasmania

Doc reference 12/54201

Hon Ruth Forrest MLC
Health Inquiry Chair
Parliament House
HOBART TAS 7000

Dear Ms Forrest

Questions on Notice from Health Inquiry Hearing

I refer to your letter of 13 April 2012.

I note the Committee's comments in relation to the responses to Questions 2 and 3. With respect to the comments on Treasury's response to Question 1, I ask the Committee to consider the following:

- The Committee's request was expressed as "a copy of records, including minutes, held by the Department of Treasury and Finance concerning the Business Control Team". My response has been that as the Business Control Team is a committee established by DHHS and as DHHS is the organisation responsible for maintaining complete and accurate records of the BCT, that the Committee seek that information from DHHS.

  I believe this response is the appropriate one for two reasons. Firstly, any copies of records of the DHHS BCT that may also sit on Treasury's files cannot be cited with certainty as being a complete or final record of BCT papers. Secondly, I have no authority to release to the Committee the records of another agency.

- I have already supplied to the Committee a copy of any papers originating in Treasury that were considered by the BCT or provided to DHHS in response to BCT matters. As noted in my previous response, excluded from this material were internal Treasury emails and accompanying notes that was not considered relevant, based on our clarification meeting of 20 March 2012. This material reflects personal views of Treasury officers, rather than agreed Treasury positions communicated to or through the BCT. Treasury positions on BCT issues are reflected in the documents I have already supplied.

Finally, I ask that the Committee direct any further correspondence, including any further requests for information from Treasury files, though the Treasurer as the responsible Minister of the Crown.

Yours sincerely

Martin Wallace
Secretary

20 April 2012

Tel: 03 6212 2250
Fax: 03 6231 1849
Email: stuart.wright@parliament.tas.gov.au

LEGISLATIVE COUNCIL

27 February 2012

The Hon Michelle O'Byrne MP
Minister for Health
10th Floor, State Offices
10 Murray Street
HOBART TAS 7001

Dear ~~Minister,~~ Michelle

Hearing: Inquiry into Department of Health and Human Services Costs Reduction Strategies

As you are aware, the Legislative Council Government Administration Committee "A" has initiated an inquiry in relation to the cost reduction strategies outlined in the Department of Health and Human Services 'List of Savings Strategies' document of 4 October 2011.

A copy of the Terms of Reference for this inquiry is attached for your information.

The Committee has resolved to invite you to a public hearing to discuss the cost reduction strategies in further detail. It may be that the Committee will also invite the Minister for Human Services to a separate hearing at a later time.

The Committee has resolved to offer you a range of options for possible hearing dates and times (2 hours duration) at Parliament House in Hobart, to accommodate your busy schedule as follows:

- Monday 19 March 2012 (until 4pm)
- Tuesday 20 March 2012 (after 10AM)
- Thursday 22 March 2012 (PM)
- Monday 26 March 2012 (PM)

It would be appreciated if you would confirm at your earliest convenience whether you will be accepting the invitation of the Sub-Committee to attend a hearing and if so, your preferred date and time for the hearing to take place. I would be happy to speak with you further about the invitation.

General enquiries in relation to this correspondence should be directed in the first instance to Committee Secretary Mr Stuart Wright on 6212 2250 or by email to stuart.wright@parliament.tas.gov.au

I look forward to receiving your early response.

Yours sincerely

Ruth Forrest MLC
Inquiry Chair

Cc: The Hon. Doug Parkinson MLC, Leader of the Government
Enc: Terms of Reference

gaa cor 120224 dhhs minister invitationtoappear sw

Minister for Health
Minister for Children
Minister for Sport and Recreation
Leader of Government Business

Ground Floor, Public Buildings, 53 St John Street, LAUNCESTON TAS
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Level 8, 10 Murray Street, HOBART TAS
GPO Box 1470, HOBART TAS 7001 Australia
Ph: +61 3 6233 0804 Fax: +61 3 6233 4980
Email: Michelle.O'Byrne@parliament.tas.gov.au
Web: www.dhhs.tas.gov.au www.development.tas.gov.au/sportrec

Tasmanian Government

Ruth Forrest MLC
Legislative Council
Parliament House
HOB ART TAS 7000

Dear Ms ~~Forrest~~ Ruth

I write in response to your letter of 27 February 2012 regarding Legislative Council Government Administration Committee "A" and its inquiry into cost savings strategies currently being applied in the Department of Health and Human Services.

While I am unable to attend a public hearing of the Committee, I welcome any further inquiries that you and your Committee may wish to make being directed through the Secretary of the Department, Mr Matthew Daly.

I look forward to any further contact you may wish to have in regard to the workings of the Committee.

Yours sincerely

Michelle O'Byrne
Minister for Health

Tel: 03 6212 2250
Fax: 03 6231 1849
Email: stuart.wright@parliament.tas.gov.au

LEGISLATIVE COUNCIL

12 December 2011

Mr Martin Wallace
Secretary
Department of Treasury and Finance
GPO Box 147
HOBART TAS 7001

Dear Mr Wallace,

Questions on Notice from Health Inquiry Hearing

I refer to the Inquiry hearing that was held on Monday 5 December 2011 and take the opportunity to thank you and your staff for your attendance at the hearing.

The following questions were taken on notice from the hearing.

1. The percentage of each Department budget that has been cut since 2008;
2. The total employee recurrent costs per Department;
3. The current FTE figure for the whole of the public sector per Department;
4. A copy of records, including minutes, held by the Department of Treasury and Finance concerning the Business Control Team;
5. A copy of correspondence to and from the Department of Health and Human Services concerning the Business Control Team;
6. A copy of any advice from the Department of Treasury and Finance to the Government, including advice provided to Cabinet, concerning the recommended model of local health networks to be established in Tasmania;
7. The efficient rating (comparative efficiency figure) for Tasmania as published by the Commonwealth Grants Commission;
8. A copy of the minutes and other records from meetings in relation to the current health reforms and in particular, the records in relation to how the Tasmanian model for the local health networks was arrived at.

It would be appreciated if you would provide your response to the questions on notice within 21 days of this correspondence.

Yours sincerely

Ruth Forrest MLC
Inquiry Chair

Cc: The Hon. Doug Parkinson MLC, Leader of the Government

gaa cor 111209 qon treasury sw

Department of Treasury and Finance

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Tasmania

Doc reference 12/40492

Hon Ruth Forrest MLC
Health Inquiry Chair
Parliament House
HOBART TAS 7000

Dear Ms Forrest

Questions on Notice from Health Inquiry Hearing

I refer to your letter of 28 February 2012 and our subsequent meeting on 20 March 2012 in which you sought a range of information from Treasury in relation to the budget management of the Department of Health and Human Services and the establishment of the Local Health Networks in Tasmania.

As indicated to you at our meeting on 20 March 2012, I have referred your request to one of the Department's Right to Information Officers so that a thorough review of Treasury records could be undertaken to identify any documents relevant to your request.

I will deal with each item in turn.

1. A copy of records, including minutes, held by the Department of Treasury and Finance concerning the Business Control Team

As advised in my letter of 5 January 2012, the Department of Health and Human Services provides the secretariat for the Business Control Team and is therefore responsible for the records, including minutes, of meetings of the BCT.

A search of Treasury's electronic document management system has confirmed that the large majority of documents held by Treasury in relation to the BCT were incoming documents originating from DHHS.

As indicated during the Committee hearing and at my meeting with you on 20 March 2012, while Treasury does have copies of records issued by DHHS, I have no authority to release the records of another Department. I therefore request that you direct this question to the Department of Health and Human Services through the Minister for Health.

Of the internal records originating in Treasury, the vast majority are emails, notes, working papers etc prepared by Treasury staff. However, the following documents prepared by Treasury and submitted to the BCT have been identified and are attached:

- an analysis by Treasury of the Budget Savings Strategies put forward by DHHS (October 2011)
- a review of the NAHS Budget Strategy (December 2012); and
- a preliminary review of the STHAS Budget Strategy (January 2012).

2. A copy of any advice from the Department of Treasury and Finance to the Government, including advice provided to Cabinet, concerning the recommended model of local health networks to be established in Tasmania.

As advised in my letter of 5 January 2012 and reiterated at our meeting on 20 March 2012, I do not have authority to release Cabinet documentation (including Budget Committee documentation). Any request for the release of Cabinet advice should be directed to the Premier.

In relation to other advice provided to the Government, Treasury (in its role as support agency to the Panel established to appoint the inaugural chair of the THOs) wrote to the Treasurer on behalf of the Panel recommending a common chair for the Tasmanian Health Organsiations. A copy of that minute is attached.

No other advice to Government from Treasury has been identified following a thorough search of our records.

3. A copy of the minutes and other records from meetings in relation to the current health reforms and in particular, the records in relation to how the Tasmanian model for the local health networks was arrived at.

A comprehensive search of Treasury's electronic document management system has identified more than 1600 documents that relate to national health reform. Given the number of documents and the fact that they are held electronically only, the task of even estimating the number of pages would be an unreasonable diversion of Departmental resources.

From our meeting of 20 March 2012, I understand that you are primarily concerned about records associated with the development of the local heath network model, and not the National Health Reform process itself (which led to the requirement to establish LHNs).

Treasury participated on a range of inter-jurisdictional committees and working groups in relation to National Health Reform, including:

- Health Reform Implementation Group (HRIG)
- Health Reform Implementation Group (HRIG) - HRIG Local Governance Subgroup
- Health Reform Implementation Group (HRIG) - Primary Health Care Subgroup - Home and Community Care (HACC)
- Health Reform Implementation Group (HRIG) - Activity Based Funding

As these meetings dealt with national reform issues, I have judged these to be outside the scope of your request and area of interest.

While Treasury participated in the Inter-departmental National Health Reform Steering Committee, this Committee was established and supported by the Department of Health and Human Services and, as indicated to you at our meeting on 20 March 2012, I have no authority to release the papers provided by DHHS.

The only area of the implementation of LHNs where Treasury took a lead role was in the selection process for the Chairman of the Governing Bodies. I chaired the Panel and Treasury provided administrative support. Two documents have been identified from that process that relate to an aspect of the final LHN model adopted by Government (the single THO Chairman) and are attached. These are:

- the papers for the first meeting of the Selection Panel; and
- the minutes from that meeting.

Outside the meeting papers above, there are literally hundreds of internal email exchanges, briefings, working papers and memoranda about various issues including the drafting of legislation, accounting and reporting issues, the governance of the LHNs (eg Ministerial charters, legal entity (SOC/GBE/Statutory authority), reflecting internal Treasury discussions on options and processes associated with the implementation of such a major reform. From a review of these records, the following have been identified as representing formal Treasury positions and are attached.

- Response to DHHS on the stakeholder consultation paper on the number of LHNs (September 2010)
- Discussion paper on the Case for a State-owned Company (April 2010)

Yours sincerely

Martin Wallace
Secretary

2 April 2012

Encl

Tel: 03 6212 2250
Fax: 03 6231 1849
Email: stuart.wright@parliament.tas.gov.au

LEGISLATIVE COUNCIL
PARLIAMENT HOUSE
HOBART, TASMANIA 7000

13 April 2012

Mr Martin Wallace
Secretary
Department of Treasury and Finance
GPO Box 147
HOBART TAS 7001

Dear Mr Wallace,

Questions on Notice and Invitation to further Hearing

I refer to the questions taken on notice from the Inquiry hearing of 5 December 2011 and your most recent correspondence of 2 April 2012 in relation the outstanding questions.

Response to Questions 1

The Sub-Committee has considered your response and the limited information provided. The Sub-Committee has also noted the ongoing position of the Department in respect of originating documents from the Department of Health and Human Services not being released to the Sub-Committee.

The Sub-Committee has also noted that the Department continues to hold a range of internal documents including '*emails, notes, working papers etc prepared by Treasury staff*' that have not been released as part of your response.

The Sub-Committee believes it is appropriate to point out to the Department that its powers to require the production of documents are derived not only from the Standing Orders of the Legislative Council, but also from the provisions of the *Parliamentary Privileges Act 1858*, one of the first pieces of legislation passed by the self-governing Parliament of Tasmania.

The provisions of the *Parliamentary Privileges Act 1858* make it clear that both Houses of the Parliament and their duly appointed Committees have the power to require the attendance of persons and the production of papers.

The wording of section 1 of the *Parliamentary Privileges Act 1858* is such that the summonsing power of the Houses is an absolute power as follows:

> *"Power to order attendance of persons*
> *Each House of Parliament, and any committee of either House duly authorized by the House to send for persons and papers, is hereby empowered to order any person to attend before the House or before such committee, as the case may be, and also to produce to such House or committee any paper, book, record, or other document in the possession or power of such person; and all persons are hereby required to obey any such order."*

In addition, the Standing Orders of the Legislative Council provide a specific authority for it to empower its Committees to require the production of documents. Standing Order 189 states that

"whenever it may be necessary, the Council may empower a Committee to send for persons, papers and records."

Legislative Council Sessional Order 4(19) (November 2010) governing the operation of Government Administration Sessional Committee "A" granted such powers as follows:

> *"**Powers of a committee***
> *In addition to any power conferred by law or order, a committee has power to -*
> *(a) send for persons, papers, and records; ....."*

The Sub-Committee therefore again requests that the Department of Treasury and Finance provide the Sub-Committee with the documents set out under question 1 which was for '*A copy of records, including minutes, held by the Department of Treasury and Finance concerning the Business Control Team*'.

Response to Question 2

The Sub-Committee has noted the information provided as part of the Department's response to this question. I confirm that in relation to the majority of the requested information, which has not been released, that the Sub-Committee will write to the Premier as requested.

Response to Questions 3

Given the volume of material the Department has indicated falls within the scope of the request, the Sub-Committee will give further consideration as to whether it may be possible to narrow the scope of the request and will advise accordingly.

Invitation to attend further Hearing

The Sub-Committee has resolved to extend a formal invitation for you and any other representatives from the Department of Treasury and Finance to attend a further hearing on **Friday 20 April 2012 at 2.00pm.** The hearing will be a public hearing which will be recorded by Hansard. The Sub-Committee has allowed up to 60 minutes for the hearing which will be held in Committee Room No. 1 at Parliament House, Hobart.

Would you please arrange for confirmation of arrangements for the Hearing to be provided no later than Wednesday **18 April 2012** to Ms Ilise Bourke by email (ilise.bourke@parliament.tas.gov.au) or by telephone (6212 2249).

Yours sincerely

Ruth Forrest MLC
Inquiry Chair

Cc: The Hon. Doug Parkinson MLC, Leader of the Government
The Hon. Lara Giddings MHA, Treasurer

Tel: 03 6212 2250
Fax: 03 6231 1849
Email: stuart.wright@parliament.tas.gov.au

LEGISLATIVE COUNCIL
PARLIAMENT HOUSE
HOBART, TASMANIA 7000

13 April 2012

The Hon Lara Giddings MHA
The Premier
Level 11, Executive Building
15 Murray Street
HOBART TAS 7001

Dear Premier,

Legislative Council Health Inquiry - Questions on Notice

As you would be aware, Legislative Council Government Administration Committee 'A' is currently undertaking an Inquiry in relation to the cost reduction strategies of the Department of Health and Human Services

Central to the Inquiry, the Sub-Committee invited the Secretary of the Department of Treasury and Finance, Mr Martin Wallace, to a hearing on 5 December 2011. A series of questions were taken on notice by Mr Wallace at the hearing. Since that time, there has been a series of correspondence between myself and Mr Wallace in relation to certain questions from the Hearing that remain outstanding.

One of the questions was for '*A copy of any advice from the Department of Treasury and Finance to the Government, including advice provided to Cabinet, concerning the recommended model of local health networks to be established in Tasmania*'. In particular, and as requested during a meeting between Mr Wallace and myself, it was made clear that this information included any costing of the various models as considered during the process. Mr Wallace has now advised the Sub-Committee that '*Any request for the release of Cabinet advice should be directed to the Premier*'.

In light of the advice from Mr Wallace, the Sub-Committee is now seeking the requested information from you directly in your capacity as Premier.

Given the significant delays to date in obtaining a range of information from the Department of Treasury and Finance, it would be appreciated if you would respond to the request within 14 days of this correspondence. The Committee would be happy to consider a request for the material to be treated as in-camera evidence as appropriate.

Please direct your response to the attention of Committee Secretary Mr Stuart Wright, Parliament House, Hobart.

Thank you for your cooperation with this matter.

Yours sincerely

Ruth Forrest MLC
Inquiry Chair

Cc: The Hon. Doug Parkinson MLC, Leader of the Government

gaa cor 120412 qon premier

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LEGISLATIVE COUNCIL
PARLIAMENT HOUSE
HOBART, TASMANIA 7000

19 April 2012

The Hon Lara Giddings MHA
Premier
Level 11, Executive Building
15 Murray Street
HOBART TAS 7001

Dear Premier, Lara

Legislative Council Health Inquiry - Questions on Notice

I refer to your correspondence of 19 April 2012 informing me that you have advised Mr Wallace that he should not appear before the Sub-Committee on 20 April 2012.

Whilst I acknowledge the current pressures associated with the impending State Budget, I am very concerned by this intervention, particularly given the late timing of your advice and the fact that Mr Wallace had already accepted the invitation to appear before the Sub-Committee.

There are a range of additional issues contained within your correspondence that will be considered by the Sub-Committee at its meeting tomorrow.

I will write to you again following the further consideration of the Sub-Committee in due course.

Yours sincerely

Ruth Forrest MLC
Inquiry Chair

Cc: The Hon. Doug Parkinson MLC, Leader of the Government

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Tasmanian Government

Hon Ruth Forrest MLC
Health Inquiry Chair
Parliament House
HOBART TAS 7000

19 APR 2012

Dear Ms ~~Forrest~~ Ruth,

Inquiry into the Cost Reduction Strategies of the Department of Health and Human Services

Thank you for providing me with a copy of your letter to the Secretary of the Department of Treasury and Finance inviting him and other Departmental representatives to attend a further meeting of the Sub-Committee established to undertake an Inquiry into the Cost Reduction Strategies of the Department of Health and Human Services.

I understand that the Secretary has already met with the Sub-Committee, has responded to a number of requests for information and has met with you individually to explain Treasury's response. Mr Wallace has also advised that a response to your most recent letter is currently being prepared.

As you are aware, the introduction of the State Budget is only four weeks away and is the top priority for Treasury and for me as Treasurer. I am concerned that Mr Wallace's further attendance before the Sub-Committee would take him away from the critical work associated with the finalisation of the budget. My advice to Mr Wallace is therefore that he should not appear before the Committee on 20 April 2012.

Should the Committee still wish to meet with Mr Wallace after you have considered his response to your letter of 13 April 2012 and you have had the opportunity to ask questions about these issues during Estimates Committee, I am sure he would make himself available.

Finally, I understand that you have repeatedly sought from Treasury the release of records relating to meetings of the Business Control Team. I concur with the Mr Wallace's previous advice that these records are the official records of the Department of Health and Human Services, not Treasury. Accordingly, any request for those records should be directed to that Department through the Minister for Health.

Yours sincerely

Lara Giddings MP
Premier
Treasurer

Premier
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Tasmanian Government

Mr Stuart Wright
Committee Secretary
Legislative Council Government Administration Committee 'A'
Parliament House
HOBART TAS 7000

23 APR 2012

Dear Mr Wright

On 13 April 2012 the Hon Ruth Forrest MLC wrote to me concerning an Inquiry being undertaken by Legislative Council Government Administration Committee 'A' in relation to the cost reduction strategies of the Department of Health and Human Services. In that letter she asks if I would direct my reply to you.

As I understand it Ms Forrest is requesting that I provide the Committee with "*A copy of any advice from the Department of Treasury and Finance... [provided to Cabinet] ... concerning the recommended model of local health networks to be established in Tasmania.*"

It has long been the practice of Governments in Tasmania (and other Westminster system governments elsewhere) to claim public interest immunity when considering such requests.

Cabinet documents, which include the advice provided to the Cabinet, are a class of documents that, irrespective of their actual contents, belong to a class which the public interest requires to be withheld from production. That this is so has been long-recognised by Parliaments and the courts alike.

Documents in this class are typically those which reveal the deliberations of the Cabinet or the views of individual members of the Cabinet expressed before Cabinet has reached a concluded and collective view on a matter of policy. In a well-known passage in Commonwealth v Northern Land Council (1993) 176 CLR 604 the High Court unanimously said at par 6 (footnotes omitted):

> *"But it has never been doubted that it is in the public interest that the deliberations of Cabinet should remain confidential in order that the members of Cabinet may exchange differing views and at the same time maintain the principle of collective responsibility for any decision which may be made. Although Cabinet deliberations are sometimes disclosed in political memoirs and in unofficial reports on Cabinet meetings, the view has generally been taken that collective responsibility could not survive in practical terms if Cabinet deliberations were not kept confidential. See U.K., Parliament, Report of the Committee of Privy Counsellors on Ministerial Memoirs ("the Radcliffe Committee"), Despite the pressures which modern society places upon the principle of collective responsibility, it remains an important element in our system of government. Moreover, the disclosure of the deliberations of the body responsible for the creation of state policy at the highest level, whether under the Westminster system*

or otherwise, is liable to subject the members of that body to criticism of a premature, ill-informed or misdirected nature and to divert the process from its proper course (See Conway v. Rimmer (1968) AC, per Lord Reid at p 952; Sankey v. Whitlam (1978) 142 CLR, per Mason J. at pp 97-98; U.K., Parliament, Departmental Committee on Section 2 of the Official Secrets Act 1911 ("the Franks Committee"), (1972), Cmnd.5104, vol.1, p.33). The mere threat of disclosure is likely to be sufficient to impede those deliberations by muting a free and vigorous exchange of views or by encouraging lengthy discourse engaged in with an eye to subsequent public scrutiny. Whilst there is increasing public insistence upon the concept of open government, we do not think that it has yet been suggested that members of Cabinet would not be severely hampered in the performance of the function expected of them if they had constantly to look over their shoulders at those who would seek to criticize and publicize their participation in discussions in the Cabinet room. It is not so much a matter of encouraging candour or frankness as of ensuring that decision-making and policy development by Cabinet is uninhibited. The latter may involve the exploration of more than one controversial path even though only one may, despite differing views, prove to be sufficiently acceptable in the end to lead to a decision which all members must then accept and support."

It is also pertinent to note that the Parliament has specifically recognised the special, and confidential, status of Cabinet documents in the provisions of the *Right to Information Act 2010* (RTI Act) and prior to that the *Freedom of Information Act 1991*. In particular I refer you to section 26 of the RTI Act which provides, *inter alia*, that:

> *"Information is exempt* [from disclosure] *information if it is contained in –*
> *(a) the official record of a deliberation or decision of the Cabinet; or*
> *(b) a record proposed by a Minister for the purpose of being submitted to the Cabinet for consideration; or*
> *(c) a record that is a copy of, or a copy of part of, a record referred to in paragraph (a) or (b); or*
> *(d) a record, the disclosure of which would involve the disclosure of a deliberation or decision of the Cabinet, other than a record by which a decision of the Cabinet was officially published."*

Despite Ms Forrest's suggestion that Cabinet documents could be provided as in-camera evidence, I intend to uphold the fundamental principle of Cabinet confidentiality, and I am unable to accede to her request.

Yours sincerely

Lara Giddings MP
Premier

cc Hon Ruth Forrest MLC
Secretary, Department of Treasury and Finance

Tel: 03 6212 2250
Fax: 03 6231 1849
Email: stuart.wright@parliament.tas.gov.au

LEGISLATIVE COUNCIL
PARLIAMENT HOUSE
HOBART, TASMANIA 7000

26 April 2012

The Hon Lara Giddings MHA
The Premier
Level 11, Executive Building
15 Murray Street
HOBART TAS 7001

Dear Premier,

Legislative Council Health Inquiry

I refer to your correspondence of 19 and 20 April 2012 concerning your decision to intervene in order to prevent the Department of Treasury and Finance Secretary Mr Martin Wallace from attending a public hearing on 20 April 2012. There are a number of issues arising from your correspondence that the Sub-Committee must respond to.

The Hearing

In your letter of 20 April 2012, you state that the Sub-Committee Secretary was advised that the request for Mr Wallace to attend the hearing '*would need to go to me as Treasurer for approval*' and that you received '*no such approach*'. I will deal with each of these issues separately.

The Sub-Committee Secretary has confirmed that he contacted the office of Mr Wallace on 12 April 2012 to make preliminary arrangements for his attendance at a further hearing, following a resolution of the Sub-Committee to recall the witness. The proposed date for the hearing was for 20 April 2012 and the options of a 2pm or 1pm timeslot were offered to Mr Wallace.

During the telephone conversation, Mr Wallace's office indicated their belief that he required the approval of the Treasurer to attend the hearing. The Secretary advised Mr Wallace's office at the time of the call, that the first invitation for Mr Wallace to attend a Sub-Committee hearing, which in this case was for 5 December 2011, was made through the Treasurer (copy enclosed). Mr Wallace's office was advised that following the original invitation, the Sub-Committee had continued to communicate directly with him and would continue to do so as appropriate under Committee processes. The Secretary confirmed that if Mr Wallace needed to discuss his attendance with his Minister then that was a matter for him to do at his discretion but that the invitation would be addressed to him directly.

Mr Wallace's office confirmed his availability to attend the hearing by telephone later the same day (12 April 2012) with a request that a copy of the correspondence to Mr Wallace be forwarded to your office. Mr Wallace's attendance was later confirmed in writing by his office via email on 18 April 2012 (copy enclosed). You will note from this email the advice that '*The following will be appearing as witnesses at 2pm on Friday 20 April*' and that Mr Wallace was one of the witnesses confirmed to be appearing on that day, along with Mr Tony Ferrall.

Any reasonable reading of these events would conclude that Mr Wallace had clearly confirmed he would be attending the hearing on 20 April 2012. The process that has been applied in the recalling of Mr Wallace is no different to any other Committee hearing and was the same process applied with the recalling of the Secretary of the Department of Health and Human Services as part of the inquiry. There was no such intervention by the relevant Minister in that recall or any other problem with the attendance of that witness, who was noted by the Sub-Committee to have been fully cooperative with the business of the Sub-Committee.

The Sub-Committee is also concerned and somewhat confused by statements contained in your correspondence of 20 April 2012 that a copy of the correspondence to Mr Wallace was not forwarded to your office as requested. This is simply an incorrect statement. The correspondence was emailed to Ms Maddy Plaister from your office on 13 April 2012 (copy enclosed) and a hardcopy was also forwarded to your office. The receipt of the copy of correspondence by your office would seem supported by comments contained in your correspondence to me of 19 April 2012 in which you state in the opening line '*Thank you for providing me with a copy of your letter to the Secretary of the Department of Treasury and Finance*'.

As an aside, the Sub-Committee has noted your comments that Mr Wallace was too busy with the State Budget to attend the hearing and that the Sub-Committee '*already have the information they asked* for'. The Sub-Committee acknowledges the significant budgetary pressures your Government is currently facing and the considerable work required in the preparation of any State Budget, however your comments suggesting that this was the primary reason Mr Wallace was instructed not to attend the hearing as agreed, raises some concerns.

The correspondence from Mr Wallace of 20 April 2012, in which he again refuses to provide material that he acknowledges to be held by his Department and that has been requested by the Sub-Committee since December 2011, not only highlights the importance of the hearing that was scheduled, but the Department's continuing lack of cooperation with the Sub-Committee Inquiry.

Committee Powers

The Sub-Committee is particularly concerned by the comments contained in your correspondence of 19 April 2012 that have implications in relation to the powers of the Sub-Committee.

The Sub-Committee believes it is appropriate to point out to you, as it has previously done to Mr Wallace, that its powers to require the production of documents or the attendance of persons before the Sub-Committee are derived not only from the Standing Orders of the Legislative Council, but also from the provisions of the *Parliamentary Privileges Act 1858*, one of the first pieces of legislation passed by the self-governing Parliament of Tasmania.

The provisions of the *Parliamentary Privileges Act 1858* make it clear that both Houses of the Parliament and their duly appointed Committees have the power to require the attendance of persons and the production of papers.

The wording of section 1 of the *Parliamentary Privileges Act 1858* is such that the summonsing power of the Houses is an absolute power as follows:

> *"Power to order attendance of persons*
> *Each House of Parliament, and any committee of either House duly authorized by the House to send for persons and papers, is hereby empowered to order any person to attend before the House or before such committee, as the case may be, and also to produce to such House or committee any paper, book, record, or other document in the possession or power of such person; and all persons are hereby required to obey any such order."*

In addition, the Standing Orders of the Legislative Council provide a specific authority for it to empower its Committees to require the production of documents. Standing Order 189 states that:

> "*whenever it may be necessary, the Council may empower a Committee to send for persons, papers and records.*"

Legislative Council Sessional Order 4(19) (November 2010) governing the operation of Government Administration Sessional Committee "A" granted such powers as follows:

> *"Powers of a committee*
> *In addition to any power conferred by law or order, a committee has power to -*
> *(a) send for persons, papers, and records; ....."*

The Sub-Committee requests that you ensure that the Department fully cooperate with the business of the Sub-Committee in order to avoid the need to summons persons, papers or records in the future. In that regard, the Sub-Committee requests that you review the position of the Department in the correspondence from Mr Wallace of 20 April 2012 (copy enclosed) and instruct him to produce the records that he acknowledges to be in the Department's possession, which includes records that he has concluded are '*not considered relevant*'.

The Sub-Committee Inquiry

It has also been noted by the Sub-Committee with concern that you have attempted to place restrictions upon the business of the Sub-Committee in that you have indicated Mr Wallace would likely make himself available to the Sub-Committee only '*after you have considered his response to your letter of 13 April 2012 and you have had the opportunity to ask questions about these issues during Estimates Committee*'.

In a similar manner to the Minister for Health, when she declined the invitation of the Sub-Committee to attend a hearing, there appears to be some ongoing confusion on the part of the Government with the current inquiry of the Sub-Committee. The current inquiry concerns the cost reduction strategies within the Department of Health and Human Services and is an inquiry under specific terms of reference. It is not part of the Budget Estimates process. To attempt to merge the current terms of reference with the Budget Estimates process is not only inappropriate but is seeking to undermine committee business within the Legislative Council more generally. Although Members of the Legislative Council will inevitably ask questions in relation to health cuts as part of the Budget Estimates hearings, the inquiry of the Sub-Committee is a separate inquiry process and should be treated as such.

Finally, the Sub-Committee wishes to note for the record that it is very concerned that the Government appears to be continuing to hinder the work of the Sub-Committee for the reasons outlined in this letter. As stated above, Members of the Sub-Committee are aware of the challenging financial position of the Government but are also aware of the significant impact that the budget savings measures continue to have on the ability of the Department of Health and Human Services to deliver front line health services to the community. On that basis, it was entirely appropriate that this inquiry was commenced in order to scrutinise the circumstances of the savings measures for the Department of Health and Human Services and for these reasons, your actions in intervening last Thursday are most regrettable.

Yours sincerely

Ruth Forrest MLC
Inquiry Chair

Cc: The Hon. Doug Parkinson MLC, Leader of the Government

Enc: 22 November 2011 letter to Treasurer
18 April 2012 email confirmation from Treasury
13 April 2012 email to Premier's Office
13 April 2012 letter to Department of Treasury and Finance
20April 2012 letter from Department of Treasury and Finance

APPENDIX F –

DHHS ELECTIVE SURGERY AND OUTPATIENT CLINIC FIGURES

Department of Health and Human Services
STRATEGIC AND PORTFOLIO SERVICES - OFFICE OF THE SECRETARY

34 Davey Street, Hobart, Tasmania
GPO Box 125, HOBART TAS 7001, Australia
Ph: (03) 6233 3530 Fax: (03) 6233 4580
Web: www.dhhs.tas.gov.au
Contact: Martin Hensher
Phone: (03) 6233 6420
Facsimile: (03)
E-mail: martin.hensher@dhhs.tas.gov.au
WITS No.: 70251

Tasmanian Government

Ruth Forrest MLC
Inquiry Chair
Parliament House
HOBART TAS 7000

Dear Ms Forrest

Subject: Inquiry into Department of Health and Human Services' Cost Reduction Strategies

Thank you for your correspondence of 19 June 2012 requesting data to inform the Inquiry into the Department of Health and Human Services' (the Agency) Cost Reduction Strategies.

I am pleased to provide the following data items for your consideration (refer Data Attachment):

1 Quarterly elective surgery waiting list figures by category, hospital and median waiting time, for the financial years 2008-09, 2009-10, 2010-11, and 2011-12 (YTD);

2 Quarterly elective surgery admission figures by category, hospital and median waiting time, for the financial years 2008-09, 2009-10, 2010-11, and 2011-12 (YTD); and

3 Surgical Specialty Outpatient Clinic waiting list figures by hospital, clinic and median waiting time, as at 21 June 2012 and 30 November 2012.

With respect to item three above, due to the current formation of the Agency's Data Management System, data relating to outpatient clinics is not readily available across time periods. The data that is at hand that I have provided to you is a snapshot as at 21 June 2012. To assist you in your efforts towards comparability, I have provided an additional snapshot of similar data that was previously extracted and release through a *Right To Information* request earlier this year. This data set was captured as at 30 November 2011.

The Agency is increasingly being asked for outpatient clinic related data, and we are building capacity in this area and putting in processes to make the extraction and comparability of this data possible in the future.

I trust that this is sufficient for your consideration.

Yours sincerely

Michael Pervan
Acting Secretary
4 July 2012

Enc: Data to Inform the Inquiry into the Department of Health and Human Services' Cost Reduction Strategies

Attachment One

Elective Surgery Waiting List

Total Patients and Median Waiting Time for Patients Waiting Ready for Care by Hospital by Category by Quarter

Royal Hobart Hospital

	2008-2009								2009-2010								2010-2011								2011-2012							
	30-Sep-08		31-Dec-08		31-Mar-09		30-Jun-09		30-Sep-09		31-Dec-09		31-Mar-10		30-Jun-10		30-Sep-10		31-Dec-10		31-Mar-11		30-Jun-11		30-Sep-11		31-Dec-11		31-Mar-12		31-May-12	
Category	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median
1	459	35	420	41	396	33	388	36	460	41	449	50	508	42	589	58	647	42	696	57	679	44	608	57	320	29	248	36	299	25	275	28
2	2392	216	2401	234	2512	260	2442	275	2544	233	2649	229	2660	250	2670	282	2610	295	2755	289	2759	266	2288	225	1863	187	1951	174	1906	207	1780	223
3	824	261	822	212	807	240	428	238	472	220	499	197	566	162	599	204	588	226	638	242	650	271	910	356	1298	327	1291	353	1268	363	1189	350
Total	3675	176	3643	192	3715	217	3258	224	3476	185	3597	183	3734	197	3858	216	3845	212	4089	221	4088	210	3806	210	3481	205	3490	206	3473	229	3244	232

Launceston General Hospital

	2008-2009								2009-2010								2010-2011								2011-2012							
	30-Sep-08		31-Dec-08		31-Mar-09		30-Jun-09		30-Sep-09		31-Dec-09		31-Mar-10		30-Jun-10		30-Sep-10		31-Dec-10		31-Mar-11		30-Jun-11		30-Sep-11		31-Dec-11		31-Mar-12		31-May-12	
Category	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median
1	80	9	44	14	66	9	70	14	56	9	59	17	76	8	67	10	106	10	75	16	97	14	79	10	87	11	72	19	119	12	114	16
2	760	93	730	100	779	105	745	96	875	68	994	86	1104	98	1099	104	1222	92	1346	114	1585	135	1602	130	1715	128	1681	157	1871	193	1871	226
3	1403	198	1328	177	1493	177	1490	176	1594	162	1585	183	1526	213	1519	204	1347	196	1381	225	1492	234	1273	228	1251	228	1186	222	1289	226	1313	248
Total	2243	146	2102	140	2338	139	2305	132	2525	113	2638	128	2706	140	2685	142	2675	130	2802	149	3174	162	2954	161	3053	156	2939	173	3279	193	3298	226

North West Regional Hospital Burnie

	2008-2009								2009-2010								2010-2011								2011-2012							
	30-Sep-08		31-Dec-08		31-Mar-09		30-Jun-09		30-Sep-09		31-Dec-09		31-Mar-10		30-Jun-10		30-Sep-10		31-Dec-10		31-Mar-11		30-Jun-11		30-Sep-11		31-Dec-11		31-Mar-12		31-May-12	
Category	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median
1	42	22	42	30	38	14	44	15	24	28	31	35	27	15	27	9	24	11	14	18	22	11	28	8	33	12	23	20	44	13	55	17
2	269	100	275	65	289	106	352	65	347	93	359	115	261	55	241	51	192	29	190	37	188	28	205	32	213	31	262	59	268	50	273	66
3	384	284	387	216	389	188	382	138	361	160	368	141	359	114	347	122	363	123	353	122	307	106	265	108	193	80	236	96	320	115	320	119
Total	695	163	704	114	716	124	778	91	732	113	758	116	647	79	615	76	579	64	557	79	517	45	498	50	439	38	521	67	632	68	648	88

Mersey Community Hospital

	2008-2009								2009-2010								2010-2011								2011-2012							
	30-Sep-08		31-Dec-08		31-Mar-09		30-Jun-09		30-Sep-09		31-Dec-09		31-Mar-10		30-Jun-10		30-Sep-10		31-Dec-10		31-Mar-11		30-Jun-11		30-Sep-11		31-Dec-11		31-Mar-12		31-May-12	
Category	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median
1	19	15	31	13	17	7	34	8	39	13	25	18	29	10	39	9	30	11	39	18	23	10	38	9	19	8	15	12	19	10	34	14
2	159	48	204	37	196	62	163	42	156	45	176	52	115	49	110	24	129	36	143	43	108	37	132	32	136	33	140	40	129	33	118	36
3	247	83	264	124	270	166	312	51	379	105	440	121	416	124	408	141	422	172	512	163	504	169	263	92	364	86	358	129	423	150	423	149
Total	425	53	499	90	483	103	509	42	574	79	641	85	560	109	557	91	581	122	694	91	635	142	433	50	519	67	513	86	571	95	575	95

Total

	2008-2009								2009-2010								2010-2011								2011-2012							
	30-Sep-08		31-Dec-08		31-Mar-09		30-Jun-09		30-Sep-09		31-Dec-09		31-Mar-10		30-Jun-10		30-Sep-10		31-Dec-10		31-Mar-11		30-Jun-11		30-Sep-11		31-Dec-11		31-Mar-12		31-May-12	
Category	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median	On List	Median
1	600	29	537	35	517	22	536	22	579	29	564	36	640	30	722	36	807	30	824	43	821	35	753	35	459	18	358	26	481	18	478	21
2	3580	153	3610	161	3776	180	3702	168	3922	143	4178	143	4140	163	4120	173	4153	163	4434	171	4640	172	4227	148	3927	131	4034	145	4174	177	4042	207
3	2858	208	2801	183	2959	195	2612	159	2806	150	2892	167	2867	169	2873	178	2720	186	2884	197	2953	213	2711	225	3106	221	3071	216	3300	233	3245	241
Total	7038	152	6948	153	7252	166	6850	140	7307	132	7634	141	7647	148	7715	153	7680	154	8142	162	8414	165	7691	151	7492	151	7463	160	7955	184	7765	204

Elective Surgery Waiting List

Total Patients and Median Waiting Time for Patients Admitted and Treated by Hospital by Category by Quarter

Royal Hobart Hospital

	2008-2009								2009-2010								2010-2011								2011-2012							
	Jul-Sep 2008		Oct-Dec 2008		Jan-Mar 2009		Apr-Jun 2009		Jul-Sep 2009		Oct-Dec 2009		Jan-Mar 2010		Apr-Jun 2010		Jul-Sep 2010		Oct-Dec 2010		Jan-Mar 2011		Apr-Jun 2011		Jul-Sep 2011		Oct-Dec 2011		Jan-Mar 2012		Apr-May 2012	
Category	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median
1	801	26	899	25	832	27	874	22	988	17	914	18	832	20	870	19	950	20	960	22	890	28	1005	22	926	22	728	17	730	15	516	18
2	659	126	643	105	633	110	720	139	730	133	683	101	736	117	733	92	718	72	615	59	713	98	815	101	847	89	723	82	641	90	479	95
3	135	205	172	515	136	397	553	252	116	64	133	105	112	35	118	88	125	121	104	213	73	67	100	213	136	132	185	289	172	262	184	412
Total	1595	49	1714	50	1601	52	2147	70	1834	32	1730	40	1680	39	1721	34	1793	34	1679	31	1676	49	1920	38	1909	40	1636	35	1543	41	1179	45

Launceston General Hospital

	2008-2009								2009-2010								2010-2011								2011-2012							
	Jul-Sep 2008		Oct-Dec 2008		Jan-Mar 2009		Apr-Jun 2009		Jul-Sep 2009		Oct-Dec 2009		Jan-Mar 2010		Apr-Jun 2010		Jul-Sep 2010		Oct-Dec 2010		Jan-Mar 2011		Apr-Jun 2011		Jul-Sep 2011		Oct-Dec 2011		Jan-Mar 2012		Apr-May 2012	
Category	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median
1	412	11	418	13	336	8	412	10	449	11	386	11	425	11	490	11	513	10	493	11	482	11	471	12	513	11	518	12	405	12	311	14
2	480	81	512	90	442	84	471	62	532	71	508	66	531	76	623	73	608	83	541	68	472	84	665	77	728	81	655	61	420	68	330	84
3	418	256	535	255	349	165	665	147	481	129	382	164	314	161	328	271	385	243	238	151	188	284	323	230	279	304	264	248	222	188	163	168
Total	1310	47	1465	61	1127	43	1548	54	1462	45	1276	43	1270	42	1441	37	1506	42	1272	34	1142	32	1459	46	1520	42	1437	33	1047	35	804	47

North West Regional Hospital Burnie

	2008-2009								2009-2010								2010-2011								2011-2012							
	Jul-Sep 2008		Oct-Dec 2008		Jan-Mar 2009		Apr-Jun 2009		Jul-Sep 2009		Oct-Dec 2009		Jan-Mar 2010		Apr-Jun 2010		Jul-Sep 2010		Oct-Dec 2010		Jan-Mar 2011		Apr-Jun 2011		Jul-Sep 2011		Oct-Dec 2011		Jan-Mar 2012		Apr-May 2012	
Category	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median
1	164	17	147	15	139	19	118	19	145	13	121	9	143	17	129	14	112	14	100	14	91	13	110	18	131	15	145	14	143	16	101	17
2	196	97	193	89	171	66	198	63	223	90	210	78	299	85	247	56	325	53	281	37	289	36	313	35	306	43	247	42	214	62	155	54
3	208	252	154	133	179	49	220	64	168	93	156	161	145	96	120	114	103	87	108	153	141	168	111	157	149	131	71	68	58	137	52	107
Total	568	76	494	51	489	45	536	49	536	62	487	54	587	53	496	43	540	39	489	36	521	40	534	37	586	43	463	31	415	45	308	47

Mersey Community Hospital

	2008-2009								2009-2010								2010-2011								2011-2012							
	Jul-Sep 2008		Oct-Dec 2008		Jan-Mar 2009		Apr-Jun 2009		Jul-Sep 2009		Oct-Dec 2009		Jan-Mar 2010		Apr-Jun 2010		Jul-Sep 2010		Oct-Dec 2010		Jan-Mar 2011		Apr-Jun 2011		Jul-Sep 2011		Oct-Dec 2011		Jan-Mar 2012		Apr-May 2012	
Category	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median
1	167	11	137	12	181	15	144	12	175	14	169	16	136	16	174	14	173	16	148	14	149	13	141	15	126	17	145	13	117	15	93	10
2	165	45	208	27	170	46	239	56	244	43	183	36	184	53	177	42	166	37	194	43	166	53	175	40	203	40	195	44	207	57	139	37
3	169	14	119	14	156	20	234	40	167	28	136	145	165	198	172	94	123	112	127	168	144	148	372	229	125	106	152	112	126	93	112	63
Total	501	17	464	17	507	24	617	27	586	26	488	32	485	42	523	29	462	28	469	30	459	41	688	84	454	32	492	30	450	35	344	28

Total

	2008-2009								2009-2010								2010-2011								2011-2012							
	Jul-Sep 2008		Oct-Dec 2008		Jan-Mar 2009		Apr-Jun 2009		Jul-Sep 2009		Oct-Dec 2009		Jan-Mar 2010		Apr-Jun 2010		Jul-Sep 2010		Oct-Dec 2010		Jan-Mar 2011		Apr-Jun 2011		Jul-Sep 2011		Oct-Dec 2011		Jan-Mar 2012		Apr-May 2012	
Category	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median	Admit	Median
1	1544	18	1601	18	1488	18	1548	16	1757	14	1590	15	1536	15	1663	14	1748	15	1701	16	1612	19	1727	18	1696	15	1536	14	1395	14	1021	15
2	1500	94	1556	83	1416	85	1628	90	1729	81	1584	75	1750	85	1780	70	1817	65	1631	52	1640	70	1968	63	2084	62	1820	57	1482	70	1103	69
3	930	144	980	229	820	109	1672	176	932	97	807	143	736	138	738	161	736	161	577	167	546	178	906	224	689	179	672	184	578	171	511	184
Total	3974	44	4137	46	3724	42	4848	54	4418	36	3981	40	4022	42	4181	35	4301	35	3909	33	3798	41	4601	42	4469	41	4028	33	3455	40	2635	43

Attachment Three

Outpatient Waiting Lists for Surgical Speciality Clinics

Total Patients Waiting and Median Waiting Time by Hospital as at 21 June 2012 and 30 November 2011

1. Waiting List Data As At 21 June 2012

	Royal Hobart Hospital		Launceston General Hospital		North West Regional Hospital		Mersey Community Hospital		Total People Waiting Acute Hospitals
	People Waiting	Median	People Waiting	Median	People Waiting	Median	People Waiting	Median	
Cardiothoracic	0	NA	0	NA	0	NA	0	NA	0
Colorectal Clinic	134	240.5	235	137.5	0	NA	0	NA	369
Dermatology Clinic	103	182	163	323	48	60.5	0	NA	314
ENT Clinic	1189	240	536	217	0	NA	0	NA	1725
General Surgical Clinic	593	190	459	182	83	21	158	35.5	1293
Gynaecology	187	27	365	85	15	112	182	63	749
Neurosurgical Clinic	567	305	47	352	81	276.5	0	NA	695
Ophthalmology	652	195	0	NA	1	876	204	82	857
Oral & Maxillofacial	78	63	0	NA	0	NA	0	NA	78
Orthopaedic	932	234	0	NA	232	59	0	NA	1164
Paediatric Surgery	2	116	0	NA	0	NA	0	NA	2
Plastic Surgery	492	203	131	78	0	NA	0	NA	623
Urology Clinic	112	90	260	137.5	0	NA	92	127	464
Vascular Clinic	38	92	15	31	0	NA	19	92	72
									8405

2. Waiting List Data As At 30 November 2012

Number of people waiting on surgical outpatient lists, including women and paediatrics (by hospital and urgency category)

	Royal Hobart Hospital				Launceston General Hospital			
	Cat 1	Cat 2	Cat 3	Total	Cat 1	Cat 2	Cat 3	Total
Cardiothoracic	2	0	0	2	1	0	0	1
Colorectal Clinic	69	69	71	209	7	76	95	178
Dermatology Clinic	42	127	16	185	3	62	85	150
ENT Clinic	332	632	29	993	37	173	277	487
General Surgical Clinic	75	361	270	706	20	205	137	362
Gynaecology	13	105	119	237	12	90	103	205
Neurosurgical Clinic	182	579	90	851	3	10	0	13
Ophthalmology	173	103	380	656	0	0	0	0
Oral & Maxillofacial	0	2	0	2	0	0	0	0
Orthopaedic	28	73	576	677	0	0	0	0
Paediatric Surgery	0	1	17	18	0	0	0	0
Plastic Surgery	68	309	174	551	43	69	40	152
Urology Clinic	18	231	92	341	11	125	130	266
Vascular Clinic	3	8	77	88	14	12	1	27

	North West Regional Hospital				Mersey Communnity Hospital				Total for All Four Acute Hospitals
	Cat 1	Cat 2	Cat 3	Total	Cat 1	Cat 2	Cat 3	Total	
Cardiothoracic	0	0	0	0	0	0	0	0	3
Colorectal Clinic	0	0	0	0	0	0	0	0	387
Dermatology Clinic	10	6	41	57	0	0	0	0	392
ENT Clinic	0	0	0	0	0	0	0	0	1480
General Surgical Clinic	14	28	1	43	40	75	25	140	1251
Gynaecology	6	42	22	70	24	61	1	86	598
Neurosurgical Clinic	11	32	11	54	0	0	0	0	918
Ophthalmology	0	0	0	0	0	0	0	0	656
Oral & Maxillofacial	0	0	0	0	0	0	0	0	2
Orthopaedic	7	93	122	222	10	73	75	158	1057
Paediatric Surgery	0	0	0	0	0	0	0	0	18
Plastic Surgery	0	0	0	0	0	0	0	0	703
Urology Clinic	0	0	0	0	9	23	50	82	689
Vascular Clinic	0	0	0	0	1	1	16	18	133
									8287

2. Mean Days Waited Data As At 30 November 2012

Mean days waited by patients on the outpatient waiting lists by hospital and category as at 30 November 2011												
	Royal Hobart Hospital			Launceston General Hospital			North West Regional Hospital			Mersey Community Hospital		
	Cat 1	Cat 2	Cat 3	Cat 1	Cat 2	Cat 3	Cat 1	Cat 2	Cat 3	Cat 1	Cat 2	Cat 3
Cardiothoracic	240.5	-	-	247.0	-	-	-	-	-	-	-	-
Colorectal Clinic	104.5	152.7	208.8	35.0	127.3	186.8	-	-	-	-	-	-
Dermatology Clinic	55.1	81.1	59.9	120.0	84.3	326.2	49.8	76.8	138.7	-	-	-
ENT Clinic	88.8	275.7	441.6	40.9	106.7	178.3	0.0	0.0	0.0	-	-	-
General Surgical Clinic	92.7	159.1	252.3	66.0	110.2	272.2	18.6	24.6	260.0	13.9	40.3	54.3
Gynaecology	8.6	53.1	45.3	18.6	46.2	56.6	42.0	28.0	56.2	16.3	48.2	10.0
Neurosurgical Clinic	111.0	305.1	274.3	162.0	230.8	-	236.2	379.7	395.7	-	-	-
Ophthalmology	41.0	197.0	398.9	-	-	-	-	-	-	-	-	-
Oral & Maxillofacial	-	182.5	-	-	-	-	-	-	-	-	-	-
Orthopaedic	8.2	241.8	191.3	-	-	-	43.9	56.4	68.2	23.2	31.8	51.6
Paediatric Surgery	-	177.0	128.6	-	-	-	-	-	-	-	-	-
Plastic Surgery	37.2	176.0	196.0	28.0	89.0	150.1	-	-	-	-	-	-
Urology Clinic	18.2	126.3	121.1	82.3	147.4	179.5	-	-	-	38.2	63.7	107.4
Vascular Clinic	39.7	49.8	67.5	94.8	119.0	381.0	-	-	-	276.0	3.0	89.0

APPENDIX G –

ROYAL HOBART HOSPITAL STAFF MEDICAL ASSOCIATION SURVEY

1. Please indicate the nature of your Hospital role from the following:

	%	Responded
VMO	22.0%	22
Staff Specialist	71.0%	71
University Academic	7.0%	7
Other:		
• conjoint • with conjoint appointment to UTas, whatever that means • conjoint • Also Head of Department		

2. The Royal Hobart Hospital is the states tertiary referral for Tasmania and a major university teaching and training hospital for Tasmania. Its funding must be commensurate with this role.

	%	Responded
Strongly Agree	92.0%	92
Agree	6.0%	6
Neutral	2.0%	2
Disagree	0.0%	0
Strongly disagree	0.0%	0
Answered question		100
Skipped question		0

3. Senior clinicians are able to provide valuable input to decision making regards service provisions and should be engaged in this process.

	%	Responded
Strongly Agree	79.0%	79
Agree	16.0%	16
Neutral	4.0%	4
Disagree	1.0%	1
Strongly disagree	0.0%	0
Answered question		100
Skipped question		0

4. Currently there is sufficient involvement of senior clinicians in ensuring that the health budget is distributed in the most effective way possible for the Royal Hobart Hospital.

	%	Responded
Strongly Agree	9.0%	9
Agree	8.0%	8
Neutral	17.0%	17
Disagree	29.0%	29
Strongly disagree	37.0%	37
Answered question		100
Skipped question		0

5. I have felt able to define clearly for health administrators and bureaucrats the potential negative impacts associated with the proposed budget cuts.

	%	Responded
Strongly Agree	7.0%	7
Agree	9.0%	9
Neutral	22.0%	22
Disagree	35.0%	35
Strongly disagree	27.0%	27
Answered question		100
Skipped question		0

6. Health administrators, bureaucrats and politicians need to recognise the implications for patient safety, education and training (including specialist college accreditation) and the functioning of well established and effective clinical multi-disciplined teams delivering clinical care. The damage from these health cuts may take many years to resolve.

	%	Responded
Strongly Agree	89.0%	89
Agree	8.0%	8
Neutral	2.0%	2
Disagree	0.0%	0
Strongly disagree	1.0%	1
Answered question		100
Skipped question		0

7. I have seriously considered withdrawing my services from RHH as a result of the proposed changes to the hospital operations as a result of budget cuts.

	%	Responded
Strongly Agree	21.0%	21
Agree	23.0%	23
Neutral	19.0%	19
Disagree	24.0%	24
Strongly disagree	13.0%	13
Answered question		100
Skipped question		0

8. The current health care crisis is the worst in my memory. I recognise that difficult decisions need to be made with respect to health care expenditure. I wish to be involved in seeking safe solutions.

	%	Responded
Strongly Agree	47.0%	47
Agree	35.0%	35
Neutral	14.0%	14
Disagree	2.0%	2
Strongly disagree	2.0%	2
Answered question		100
Skipped question		0

9. **My current mindset is:**

	%	Responded
Frustrated	21.0%	21
Optimistic	2.0%	2
Apprehensive	31.0%	31
Despondent	21.0%	21
Ambivalent	10.0%	10
Empowered	1.0%	1
Disempowered	14.0%	14
Other: (Comments as written)		
• APPALLED • anxiuos, distressed, incandescently angry • and despondent, for colleagues and patients • devalued • I have no longer any hope that the RHH /Tasmanian public hospitals will achieve anything like NSW public hospitals (where i trained) and i no longer wish to spend v much time in public • Busily scouring locum and other job advertisments • And frustrated and disempowered		
Answered question		100
Skipped question		0

10. **Any further comments:**

Comments as written:
Compare a similar size private hospital with teaching commitments and RHH. The administration is way smaller and they get the job done. Too many middle managers at RHH. Time to seriously down size them, not slow surgery and condemn patients to death as a consequence. 18/11/2011 7:22 PM
It's not about the money for me. It's about retaining and attracting quality staff. Once these people go, a lot of them will never come back. Even if more money is suddenly "found" in a year or two. These cutbacks will set the hospital back a decade. And yes, I do feel that nobody is listening. Or if they are listening all they seem to say is "well yes, but we have to save money somewhere", all the while refusing to acknowledge the long term effects of these measures. Feeling very frustrated and disempowered. And it wouldn't take much more for me to leave altogether. One of the big things stopping me leaving is the thought that this would actually make the government happy. One less salary to pay. 17/11/2011 12:34 AM
I am particularly frustrated with the management by the current CEO, as she parrots the DHHS and government line with little or no attempt to be realistic about the consequences. I think people would be more inclined to co-operate if administration was more honest and straight forward. As an example, if I have to read one more time about how budget cuts/job losses provide an "opportunity" I may shoot someone. 15/11/2011 10:25 AM
Whilst I acknowledge the plight of the Budget I think there should be a way

of quaranteening Health provision in some way. I realise this may be unpopular but means testing access to services and preventing patients with health insurance from opting to be public would in some measure be useful. also the notion of diverting a larger section of gambling profits to health and the initiating a lottery would be other ways of getting money for health flowing 14/11/2011 3:17 PM
These crises happen every few years. Suddenly in the next election year (2014) amazingly funds will be found to improve the situation. 14/11/2011 11:56 AM
Competition with higher salaries on mainland hospitals is making it very difficult to recruit staff, even those wishing to work in Tasmania. 14/11/2011 9:44 AM
If this were a private business, the first area that would be slashed would be sections that do not deliver core business. DHHS administration duplicates that occurring in hospitals and does not add value to health. It would be regarded as an overhead in a private business. It has also failed the Tasmania Community with strategic medical workforce planning. It should be the first area to receive budget cuts and consideration to its complete removal from the management structure of health in Tasmania. 14/11/2011 8:42 AM
Once more I feel somewhat disempowered and considering whether I should withdraw from the Royal Hobart hospital completely. It is not my wish to do this in fact I have always wanted to continue doing public service and working in the public sector. It goes against my inner beliefs to go fully private but if the Royal Hobart Hospital is to provide a service to the community which is sub standard compared to most of of the western world due to unrealistic cost constraints imposed on it then I will have to strongly consider withdrawing service on ethical grounds . The double bind however is that my position may not be filled for some time and even if it does the same ethical issues remain . Tasmanians deserve the same health care standards as all Australians and at present this is not the case and the disparity is likely to increase. 12/11/2011 11:36 AM
why was Richardson andd Wellington reports not implemented when there was time and some money to do reform? now we have an expensive and inefficient system we cannot afford and no money to do anything about it; all we can do is cut, which just makes a poor system worse....this is a downward spiral to implosion. 11/11/2011 4:35 PM
We need a list of all the health bureaucrats currently employed by the state and some indication as to their role and also an indication as to which 25% of these useless non contributors are to be "cut back" in keeping with the enforced cuts that everyone else is expected to wear! 11/11/2011 1:00 PM
There should be structured and wellthought desire in decions making for the future of the state health. A mere effort for the sake of saving a particular job or interest would not solve the situation. We all should be actively involved in non-egoistic and safe decision making and that should include the quality and cost effective way of using the available health service. 11/11/2011 11:41 AM
As a senior consultant, I have never felt more like a foot soldier. The only

thing that keeps me going is the suffering of the public patients, and I know that at 61 years of age, I am being taken for granted by the system. 11/11/2011 10:56 AM
Cuts hurt. Big cuts hurt more - especially for patients and junior doctor training, which is our hope for the future. 11/11/2011 9:45 AM
I have seen it before in Germany, it only gets worse if you let politicians rule the health care system. In Australia the bureaucracy is far to big and obstructive to make any constructive movements and decisions. If you start to cut corners in providing high quality medical care by reducing positions, ICU beds and theatre times the frustration of staff will increase very quickly and providing good quality medical care becomes a tremendous frustration. 11/11/2011 8:19 AM
The proposed cuts (and those 'actioned' to this point) will drag the RHH and Tasmanian health care back to (and probably lower than) the quality of the early 2000's with recovery likely to take many years due to the flow on effect on training and recruitment of quality staff/trainees. There will be an immediate impact on quality of training and trainee recruitment due to the sudden drop in inpatient numbers and resident/registrar positions. Trainees are already looking outside Tasmania for their training experience - clearly this will include high quality trainees. 10/11/2011 9:53 PM
what can I say its terrible and I am considering moving interstate. 10/11/2011 9:27 PM I have been through the 'Despondent' phase and realise that the priorities in the world of the politicians and senior government managers are significantly divorced from reality and little can be done to change this. If after 25 years+ at RHH (and LGH as well for a while) there is a glimmer of hope, as was engendered by our head of Divn Surgery, and last real CEO, a year or so ago, I could feel more optimistic and even empowered. 10/11/2011 7:55 PM
simply rationing systems is never going to work and will compound very quickly. one needs to come with outside the square decisions such as giving away elective surgery to the private system, making outpt investigations a priority for earning money by improving the efficiency of these services etc 10/11/2011 7:03 PM
If overgovernance can be downsized there will not be any need to cut health expenditure. A population of less than half a million cannot sustain two tiers of assembly with the associated expenses. What a waste of precious tax dollars. 10/11/2011 3:52 PM
The State system is one of topheavy bureaucratic control with inexcusable lack of forward committment and planning and a complete lack of care for the patients. It should be impossible that people needing simple joint replacements can be made to wait 10 years - I would suggest a change in the law that enables patients to sue the administration for bureaucratic delay and that the penalties are commensurate with being in a wheelchair for 5 years!! 10/11/2011 2:48 PM
These questions are borne out of understandable frustration in hard times, but are based on certain assumptions about which there might be reasonable difference, and skewed towards certain reponses. There are

tertiary services at RHH but it is also a medium sized general hospital, and for many things is not funded, nor does it provide, 'tertiary' services. The challenge is to provide appropriate responses to health problems in the three regions of Tasmania, hopefully a new health plan will address this, including what we expect of RHH. 10/11/2011 2:37 PM
The current climate of state budget cuts leading to a decrease in resources coupled with federal pressure to meet new performance indicators that actually require increased resource allocation plus the exponential rise in emergency department presentations makes for an increasingly stressful workplace environment. Given that Tasmania already offers substantially less in renumeration than other states, worsening workplace conditions will drive specialists out of the state. Unfortunately emergency medicine in Tasmania is proving more and unattractive. 10/11/2011 1:19 PM
I have no issue with efforts being made to increase efficiency within the public health system but stripping 16.9% from the Royal's annual budget will cause immense problems. For the Premier and Minister to have said initially that this would not cause a reduction in service delivery was worse than disingenuous and what little trust I had in the Government has been lost. Politicians must be held accountable for the effects that these cuts will have on the Tasmanian public. Years of little or no planning in health, political expediency and poor decisions with respect to the allocation of past GST revenues have resulted in the present crisis. The Hospital's future as a tertiary referral centre is at tipping point. I fear that the Government has already decided to "dumb down" health by funding the Royal as a regional hospital only. Many senior staff are considering their positions. If they leave they will not be replaced easily and pressure will increase on those who stay. Our ability to train future generations of Tasmanian health care workers is threatened. I have comprehensive private health insurance (as I would wager do the politicians). I fear for the health of the majority of Tasmanians who do not. 10/11/2011 1:01 PM
The services of the RHH are essential services. The RHH has been underfunded historically and needs to be appriopriately funded to fulfill its role. The current strategy will delay treatment to patients and hence adversely affect patient wellfare. The management of this hostital should change to "patient focus". 10/11/2011 12:45 AM
I work as a Cardiothoracic surgeon and the way things are going, I wonder if everything would come to a halt! 10/11/2011 12:11 AM
The public hospital system clearly need to change culture, create efficiencies and cut costs. No senior clinician I know of questions that. However time needs to be provided to make these critical changes. Objectives should be set by Government. Then the process needs to be led by clinicians and nurses, supported by accurate data. What we have are unrealistic objectives, no human values being inserted into the process of prioritisation, and almost no engagement of senior clinical and nursing staff. Thus we have unsafe cuts, being imposed on resentful and disempowered staff. The phoenix can rise from the ashes if the government will just back off for a year, allow us to carry over a modest deficit, and strongly angage and empower the senior staff to come up with a safe plan of savings. The gavernment must also be honest and up front regarding

what services the hospital system will no longer provide.
10/11/2011 11:53 AM

yo
10/11/2011 11:22 AM

There is nothing I have seen in the responses posted by the senior medical clinicans which in anyway suggests they have a clue about the financial constraints that the public health service is under. The state has been slow to stop in implementation of new ways of working and the RHH in particular must be the most doctor based hospital in the country. The idea of moving to a patient based service seems an anathema to most of the senior clinicians. If the service is in strive then a large part of this must be laid at our feet. The division between north and south is ridiculous and petty and is another great cause of financial mismanagement and we in the medical profession are responsible for stoking this. Hence the answers to the initial questions are limited by the fact that there is such a variation in the the ability of some colleagues to think beyond their own little silo.
10/11/2011 11:04 AM

There is far too much middle management - mainly recruited from allied health. Most administrators are not trained or are poorly trained and frequently not qualified for their role. Senior doctors and nursing staff are reporting to senior bureaucratic managers, usually elevated from allied health backgrounds. They lack appropriate skillsets and interfere through their ignorant decisions in patient care. They are so poorly qualified for their roles and so ignorant of what is required that they are a serious danger to patient care and the doctors' and nurses' careers. They are usually not capable of providing constructive input and make work rather than solve problems. The hospital is wasting millions of dollars with unqualified committees of inexperienced staff recruited from allied health or DHHS staff who have never worked in clinical services trying to design a new hospital. In the end they produce rubbish and the process starts again. Many new hospitals have been built interstate in the last 5 years and these plans could be used for STAHS and would result in massive savings for Tas. There have been days and days of pointless CEO organised workshops where the speakers have little to no expertise and there have been no usable outcomes. Why are they being run?? If any more Drs are lost from my area I can see that there will have to be 'doctor free days'.
10/11/2011 10:27 AM

Decision making seems to be based purely with the short term in mind; administrators seem incapable of understanding what effects will result 5, 10 or 20 years down the track. Tasmania is no longer an island backwater that is cut off from the rest of the world. It is in competition with the mainland for a limited supply of professionals with appropriate qualifications and skills. Present attitudes seem to be telling those people that they aren't wanted down here. The bureaucracy seems to be filled with ideologues and apparatchiks who don't understand that substantial numbers of Tasmanians using the Royal are also looked after by medicos working in the private sector and that public - private enterprises can potentially benefit both sides with regard to training and gains in efficiency. The relationship between the two sides is often needlessly poisonous. Suggestions from the private sector with regard to possible solutions to the public woes are often treated with scorn and contempt. Mistrust seems to be the order of the day. Makes one wonder why we should be bothered. Hobart is a lovely place to live, but not the only option in Australia.
10/11/2011 9:47 AM

The survey questions tend to suggest the answer....push polling as the Gruen boys call it. Nevertheles i support the survey. I am a 1 seession VMO, so fairly peripheral, but in 28 years this is the worst crisis yet, with save The Royal,(Fiend govt 1990s) we helped change the government, and had about 10 good years. They learned that we were underfunded for what we did. I think that there is no enthusiasm for a simlilar campaign, there is an air of despondency about. Sacking of Rayment/Pervan symptomatic of an out of touch government The DHHS/Govt should be meeting with senior clinicians/AMA and come to a clinical consensus about where to apply the kinfe.. We need an oregon style utilitarian debate, about what is marginal, and what is core. Decisions to cut elective surgery, or close the stroke unit are just too easy for the bureaucrats, wheras ICU (too many admissions going nowhere) Psych (too many PDs BPDs admitted for insurance against suicide) Paediatrics (social behavioural) frail elderly (admnit is a default option) Renal failure (age seems no loger a discriminatior) Mammograpy screening (useless,and harmful in low risk women Cardiac stents, (marginal over med/lifestyle changes), see latest Cochrane reports on the latter two.....all need attention, harder to do, but better value than the cuts proposed. The hospital badly neds academic leadership, we need to become an academic medical center, with UTAS health and DHHS combined,(Change name to University medical center,with 3 campuses) with a board,so appointments, credentialling, research admin all combined. Look at the great international health centers, Uni and Med cencer are one unit. B Walpole 10/11/2011 9:45 AM
Major changes to model of care need to be soundly based on commonsense and take into account the Australian and Tasmanian uniqueness which could be utilised to enhance outcomes and not try to force clinicians to practise models of care which have had only limited success in a different country / practice environment. MAPU has been less than successful because the resources to refine the model of care to suit our particular environment were never put in place. 10/11/2011 9:00 AM
please note that for some time, some senior clinicians (and their departments) have been more "equal" than others. we all know who they are. any proposed cut in staff numbers or remuneration should take these into consideration first. unfortunately, it becomes a matter of "divide and rule" in hard times such as these. 10/11/2011 8:52 AM
Clinician involvement in decision making is being sidelined. A culture of fear and disengagement is developing. The tertiary and teaching roles of the Royal risk of collapse. It's short sighted, it's a disgrace. 9/11/2011 9:27 PM
Hospital does not allow high income generating departments such as pathology and imaging, to work more independently and generate further funding from the federal government. 9/11/2011 9:03 PM
The general public also need to have it explained very clearly just what is at stake. It is more than just timely provision of much needed services to those unable to afford private health cover.We risk losing accreditation in many specialities, there are very serious implications for the medical school. We will have much more difficulty recruiting and retaining quality junior and senior medical staff. We have many excellent clinical service units at RHH and the results that they are able to achieve are dependent on

retaining the integrity of the teams and maintaining team spirit and morale. All this is threatened. We could easily reach a point from where it is not possible to recover for 10 years or more. 9/11/2011 6:34 PM
The financial problems should have been anticipated well before now and the blame for this disaster must lay with the DHHS. There are three health system problems at the core of the problems. One is that there is a major State structural inefficiency (three networks) that could save millions of dollars by coming together under one banner and good leadership but will not be corrected because of weak leadership at the political level and we are paying the price at the Hospital level. Secondly, there are Hospital structural inefficiencies around organisation of clinical streams that are barriers to correcting a number of system inefficiencies. All this needs strong leadership at the clinical stream and executive level. The current CEO I believe understands these structural and system inefficiencies and has the leadership abilities and experience to make the appropriate changes if given the chance and has my support. Lastly, the Hospital workforce are generally very efficient and hard working and are the only part of the health system that I have any confidence in for my patients. 9/11/2011 5:26 PM
TOO MANY DUPLICATIONS IN A STATE OF OUR SIZE, ENGENDERED BY POLITCAL STAKEHOLDING IS CRIPPLING OUR SERVICE eg A LINEAR ACCELERATOR IN N.W. WHO WILL RUN IT, SUPERVISE IT AND TROUBLE-SHOOT? DISTANCES ARE DIFFICULT AT TIMES BUT THINK OF Q'LD AND W.A. IN COMPARISON! PROVIDE SUPPORT STRUCTURES SUCH AS APPROPRIATE ACCOMODATION AND TARVEL ASSISTANCE BOTH ACTUAL AND FINANCIAL TO SUPPORT PATIENTS IN RURAL TASMANIA AND CENTRALISE THE MANPOWER AND FINANCIAL SUPPORT FOR HIGH COST, COMPLEX CARE WHERE IT CAN BE EFFECTIVE AND SAFELY DELIVERED. SUPPORT REGIONAL CARE FOR AN APPROPRIATE LEVEL OF EXPERTISE AND APPROPRIATE TO THE POPULATION BASE. 9/11/2011 5:26 PM
Unless the federal govt takes over all australian public hospitals 9/11/2011 4:59 PM
The issue of health expenditure must be addressed at a whole of government level rather than in isolation by the health department. 9/11/2011 4:54 PM
Management has an agenda which they want to implement irrespective of patient care, and the future of health care in Tasmania. The legacy of these cuts will remain with us for years to come - long waiting lists, increased burden on emergency services, poor staff morale, resignations, loss of trained health professionals moving interstate, and an inability to attract skilled medical staff to unfilled positions. 9/11/2011 4:51 PM
Statewide political concerns are over-riding patients' best interests. A clear example of this is maintaining the plan for three local area networks in health. We have been told that this decision cannot be changed for political reasons, even though it clearly triplicates the costs of bueaurocracy at the expense of clinical service delivery and financial efficiency. I appreciate that the current financial climate is very difficult and the CEOs position is not easy. However, the current management style is extremely alienating and adversarial. Surely a collaborative approach would serve the Tasmanian public better? 9/11/2011 4:46 PM

i have had enough. for years the new approach to public health has devalued the role of vmo surgeons. The system does not understand that we have private work and this pays in excess of twenty times what we earn in public yet we are expected to put the RHH first in terms of involvement in the system i am going to leave when my contract expires in December unless serious chanegs occur Greg Harvey 9/11/2011 4:43 PM
I currently work in the Emergency Department. We have actually had a funding increase via Federally imposed National Targets (previously known as the 4 hour rule). Whilst the funding is welcome and will assist, having the wider hospital effectively hamstrung will probably cause us to fail to meet any of these targets. Already the pressure of an under resourced hospital (to meet current community expectation) is severely impacting on the Emergency Department's ability to meet current demand. Without increasing resources or decreasing community expectation the Emergency Department will likely become a holding bay for just about everybody. This will make Emergency Medicine a nonviable career option in the local environment and the current staffing of Consultants, Registrars, Nursing and Allied Health will be decimated by moves to part time, resignations and iincreased sick leave. Sadly this is not a threat, but already a reality and will only become worse. I do not see any way that demand for hospitals will ever decrease. The public, as they age, will become more reliant on free, 24 hour care, which is ONLY available via public hospitals and the Ambulance Service. With no prospect for a wealthier or healthier society in Tasmania with current policy, a DECREASE to health funding can only accelerate the downward spiral. 9/11/2011 4:30 PM
I think the issue lies beyond how the health budget is distributed. The problem is the inadequacy of funding and the inadequate funding nodel used. your survey should address that. 9/11/2011 4:22 PM
The issues at the RHH can't be seen in isolation. The whole state health system is collapsing and there needs to be a whole of state response. The decision to fragment Health services further by having 3 LHNs is absolute insanity, driven purely by political and parochial considerations, and is counter to all recommendations made by numerous previous reviews 9/11/2011 4:12 PM
I know that the decisions have already been made. Meetings and surveys will just serve the formal role of keeping up appearances of "proper procedures". 9/11/2011 4:06 PM

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Skipped question	58