THE LEGISLATIVE COUNCIL GOVERNMENT ADMINISTRATION COMMITTEE A MET AT HENTY HOUSE, LAUNCESTON, ON WEDNESDAY, 22 FEBRUARY 2012.

COST REDUCTION STRATEGIES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr JOHN KIRWAN, CEO, AND **Ms SONIA PURSE**, DIRECTOR OF FINANCE, NORTHERN AREA HEALTH SERVICE, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Ms Forrest) - Thank you for coming along. Everything you say is transcribed on *Hansard* for the purpose of our report in the future and also becomes part of the public record. What you say here is covered by parliamentary privilege. If you repeat anything outside, that may not be the case. If either of you want to give evidence that you consider to be of a confidential nature, you can make that request to the committee and give some reasons as to why that is the case and we can consider that.

We have the one term of reference, looking at the budget cuts. We have spoken to John previously, more at the beginning of the process when the cuts had been announced and the changes starting to be implemented. Since then there have been some changes made. Some of the cuts are starting to have more of an impact. We're particularly interested in the process around how you have determined the cuts - we have heard some of them from John previously - the impact they're having and other areas that either of you believe could be targeted for cuts, particularly looking forward. We have heard that the savings as required by the Government won't be met in this current financial year. What implications do you think that will have, particularly for the Northern Area Health Service?

Mr KIRWAN - Unlike at the first hearing, which was a bit different, I have prepared a number of handouts. These are all on the public record. Sonia is our Director of Finance and has been with the hospital for a little longer than I so she has been through various iterations and knows our finances intimately. I have provided here an overview of the Northern Area Health Service. It explains the facilities we have and the services we provide. It is a public document and is updated from time to time.

To put it in context, because people tend to focus on just Launceston General Hospital, which, given our size and dominance, is appropriate, but unlike the two other areas we have eight 24/7 inpatient sites surrounding us. What tends to be forgotten is the north-east coast, certainly the St Marys, St Helens area. The distance there is as far from us as we are from Hobart, so we tend to forget some of those issues.

The emergency department has been very busy since late week and we are currently having some issue finding beds for people, which I'm sure will be one of the questions. When we go there we might have to do it in two groups, depending on how busy they are. It is likely you will see people you know, given that up to 30 per cent of our patients can come from the north-west, so please keep confidentiality in areas such as the acute

medical unit or the other areas we will go to. It's one of those areas where I know people will know things, and particularly politicians, but what you see inside the hospital obviously stays inside the hospital.

The staff bulletin provides more detail of the range of the reductions and lists of most of the 61 savings strategies that are now underway. The next one is a table that we have prepared. It is a question that is often asked and is a discussion we've had regularly with the ANF: what is our bed stock, what is available, what is closed and why? It does require some definition because it is fluid. Even as we talk it is fluid as of yesterday by four beds, but also it becomes a definition of what there is. It's one of the banes of Sonia's and my life, to constantly keep track. It is very important for all sorts of reasons, particularly when you discuss things such as occupancy levels, what is available and why some things are closed.

CHAIR - John, do you want to define a 'closed bed'?

Mr KIRWAN - We have beds closed for a range of different reasons. We are fairly precise and prescriptive on our staff for telling us when beds are closed. Not only because of the issue of what is a 'closed bed' so far as our percentage of occupancy, but also as to a whole range of other efficiencies and reporting. Beds, for us, have been closed for historical reasons. That is, we would have beds that were closed quite some time ago, under previous regimes, because they weren't seen to be needed. Probably the biggest example in Tasmania would be the closing of the stand-alone maternity and children's hospitals. Those hospitals were closed, brought into the area because they simply didn't seem to have the level of deliveries. We would close beds now in areas such as 4K - the children's ward - because of the change in models of care. We now have fewer beds in that area because most of the work is being in outpatients. As you would appreciate, if a child is ill, it is best that you treat them as an outpatient so they are still at home and still at school, if possible, rather than in an inpatient setting. That is a similar model to what we have seen in oncology, where very little is done inpatiently now; most is done outpatiently. Renal dialysis is another classic where 10-15 years ago people would have been admitted patients.

There is whole range of things with models of care that we have closed beds. That is not to say that they couldn't be opened if there was a demand. There is an area where we have closed some because of capital works, simply because there has been a hole in the wall and that's not a particularly good place for a patient to be. We often close beds for infection-control reasons - MRSA and VRE cleaning - a minimum normally of 24 hours. We would see those as a closed bed, particularly because we have a dominance of four-bed wards, so that takes four beds out of our bed stock. When you are running in the high 90 per cent occupancies we need to know that, particularly for the bed allocation and the planning of the hospital.

Then there are the budget saving strategies. These probably fall into two categories for us. There are pre-existing budget beds that have been closed and we came into the situation with a number of those beds that had been closed for reasons such as benchmarking done with the ANF, and 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.

CHAIR - That was pre cuts, though?

Mr KIRWAN - Yes. The discussion I had with the ANF is to focus on what has just been effectively closed since October. This means that there is still an underpinning there of a number of beds that could be opened. It is best to try to do this reconciliation so people know exactly what we have. Just to confuse it, we have since opened additional beds. We have transferred beds from 6D into the Acute Medical Unit. In some areas we tend to flex up. In the emergency department there are 43 bays that will be staffed up to need, and that's done on the ratios. The emergency department has bays rather than beds - they are not admitted as such - so there are short-stay opportunities.

CHAIR - You don't count those as beds, though?

Mr KIRWAN - We count them as bays, trolleys. The Acute Medical Unit is a short stay because that is designed to be up to a three-day stay, so it is admitted patients. Although we're not operating any at the moment, in areas such as surgery you will also operate 23-hour beds. Again, on a slightly different model, which we would like to go back to because it is a good model, but not possible.

This table gives a reconciliation of the beds. There are also other beds. We have 12 contracted beds with OneCare out at the Manor. They are aged-care transition beds, which we use. They are our patients, they are public patients. You will see that it is not as simple as it may look and that is why reconciliation like this is important, even for our purposes. We don't have contracted beds with the private sector, as does LGH, but Primary Health North, which is part of us, does. It contracts the palliative care beds in the Melwood Unit, so those are contracted beds as well.

The next table is a bit busy, but it's a question that is often asked of us about turnover. Again, you would appreciate that 70 per cent of our cost is with our workforce. The assumptions in some of the savings strategies, because they are whole-of-State assumptions, were that some of these targets could be met by simply reducing contract staff and you will probably see that in some of the minutes that you were given from the Business Control Team. That is, there is *x* amount of contract staff and all you do is simply not renew their contracts and that will make the savings. Apart from the fact that that does not quite work because it would mean we would end up with no doctors, which could be an interesting exercise, it also affects Sonia and myself as SES members so we have a vested self-interest. It doesn't work that way. What it does show is using natural attrition for us, when you look at those turnover rates, and the one you really do need to look at is the bottom one, which is permanent separations, because the top one picks up a lot of our contract staff, our transition-to-practice nurses and junior medical staff who by definition are fixed-term because they are in training positions. You will see those rates of pay are probably amongst the lowest if not the lowest in Australia, so using natural attrition doesn't quite work for us. You also see there, given the comments made by the ANF, a high turnover of staff leaving. At this point we are not seeing that. It is not to say it won't occur but at this stage our turnover rates and others are very low.

CHAIR - We asked this question of Gavin Austin yesterday in relation to nursing staff particularly. He said that some have been taking voluntary redundancy and then the rest

who wanted to stay were redeployed into other parts of the hospital. Are you saying that is the same at the LGH?

Mr KIRWAN - I am unaware; in respect of redundancies we may have had one or two nurses. Because the redundancies up until now have been self-funded we haven't let many go and if they were nursing they would have to be a reasonably rare exception. In other areas we have had some of the RIPs, which is the up to $20 000 payment, and I think we have had up to about 20 of those, predominantly in blue collar and in areas where there are other issues. They have been on long-term secondments, they have been on long-term sick leave and others, so it is an opportunity to some extent.

CHAIR - Nurses we are talking about?

Mr KIRWAN - No, predominantly blue and white collar staff, not nurses. For us to lose nurses, we would very rarely, up until some of the closures let them go, plus what we have used is that permanent staff have come off the beds we have closed. We have given the first right of refusals to the new areas that are open, like the Acute Medical Unit and the expansion of ED. If they have the skills we have had vacancies in areas like the ICU and so in those areas where the staff have the skills or want to train in those skills we have used them there. We have also used them to replace contract staff whose contracts have simply been expiring naturally.

CHAIR - How many nurses have actually left and gone somewhere else - gone to the mainland or gone wherever?

Mr PURSE - It is in the memo that we have but also the data that we have from our HR team aren't just about the nurses whose contracts haven't been renewed. It is also people who would have chosen to leave for other reasons, family reasons, so the data we have is a total of all those who have left for a variety of reasons.

CHAIR - So you are saying it is hard to say those left purely because of the budget cuts and the uncertainty?

Ms PURSE - Yes.

Mr KIRWAN - It is confused also because a number of them have come back into our pool. As far as permanent staff is concerned, I think the answer is probably none. In respect to contract staff whose contracts haven't been renewed, a lot of that is now current so I am being a bit cautious. A lot of that is now being argued in the Industrial Relations Commission between the department and the ANF as to whether there was an expectation of ongoing employment so it is still a little bit unclear -

CHAIR - How many of those are there?

Mr KIRWAN - I think about a dozen are being argued at the moment in the commission but there is probably likely to be more. That is where they seemed to have had an expectation of ongoing employment after the expiry of their contract. Most of those have been settled but if it is an area we have since closed or is no longer needed and the commission says, 'I think they did have expectation', we would then accept that there is probably a payment required. We are not directly involved in that so I would probably

need to check those figures. That is a statewide issue as well, it is not just us. As I said, because we are a little bit different in that we have had the Acute Medical Unit open and the ED expansion, we have absorbed most of our staff from the closing of Ward 4D into the AMU and other areas and the same with the closing of the surgical beds and the theatre sessions. Those staff have been absorbed into those other areas.

CHAIR - Ward 4D is a medical ward?

Mr KIRWAN - Yes.

Dr GOODWIN - I think you have just said a minute ago that some of them have come back; what did you mean by that?

Mr KIRWAN - Into our casual pool. One of the reasons we don't have any agency or local nursing staff is that we effectively operate our own internal relief pool. It is a fairly traditional model - the nursing pool, under the executive director of nursing. We staff that with a whole lot of staff who apply or are appointed and are then allocated out for all the classic sick leaves, short-term leaves and other areas like that. Because our nursing staff are governed by a fixed ratio in agreement with the ANF and HACSU, we should not drop below that. In some instances, sometimes we drift a bit above that although we manage it quite tightly. So if we know that we have leave requirements coming up, classic things like school holidays or annual leave, we will staff it out of the pool. We will also staff out of the pool areas of increased acuity. If we did not have the pool we would probably have to use agency and other staff but, again, we are quite fortunate that is a good model that works for us.

CHAIR - John, did you have high use of agency staff prior to the cuts?

Mr KIRWAN - No.

CHAIR - So it was not an issue.

Mr KIRWAN - At LGH, before October, which is really the date I use as probably the major kick-off, I do not think we had any agency nursing staff. In the past we had some in the surgical ward and some in ICU. That was a bit of an aberration. Before that we had not had any or had a few, but we had some expansion issues, plus we had to keep the theatres open because of our elective surgery targets. Again, we were successful in recruiting into all those other areas.

What tends to happen, where we have had nursing vacancies, I use intensive care as the example where it is difficult to recruit generally. It is done by overtime and double shifts. Again, it is acuity-based, it depends on how busy they are.

CHAIR - Have you been able to reduce that?

Mr KIRWAN - Yes. Across the hospital our double shifts and overtime are reducing quite significantly.

CHAIR - By using full staff?

Mr KIRWAN - Yes and a range of other initiatives, particularly aggressively recruiting. Again, that is where sometimes looking at the figures can be misleading, because if you are replacing locum or agency staff, be they nursing or medical staff or allied health, with permanent staff, if you look at one set of figures it shows that your FTEs are going up, so we get into trouble, but at the same time your overtime and actual costs are going down. So you have to net them out. We still have some agency locum staff in some of our district hospitals but, again, that is declining fairly significantly too.

CHAIR - Why is it declining there? That is a huge issue of the North West Area Health Service, the agency staff in those rural areas.

Mr KIRWAN - I think it is multifactorial. My observation is that most of our sites are good places to work. I make that comment relative to other places I have seen in the Northern Territory and Western Australia which I am used to. There is probably not anywhere in Tasmania that you would find undesirable relative to some other places in Australia and I think it really does boil down to the quality of the management and the other staff. If you have quality doctors, nurses and other support staff it is far easier to recruit permanent staff into those areas. At the moment we have a pretty good group in all of our sites and that shows. That is not to say it has not been good in the past but sometimes you do suffer from some other instability issues, but at the moment it is all trending in exactly the right direction.

Mr HARRISS - Accepting what you say, John, as to leadership et cetera, what about overall staff morale as a result of budget cuts, as it were, forced upon you in terms of communication? We understand that the Government made its decision without any consultation and then all of the hospitals - all across the service, for that matter - had to implement the cuts. What is your engagement with the broadest range of staff and how that has affected morale?

Mr KIRWAN - I cannot comment objectively because I do not think we have surveyed it. To be able to respond to that in any scientific manner, you would probably have to go back to our Press Ganey staff satisfaction surveys which we have not done for a while. To give evidence to say it is better or worse, anecdotally people are not happy; people are not satisfied and I think you could make that comment from the CEO down. 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.

Mr HARRISS - Were you required to implement and did you implement any efficiency measures at an earlier time mandated by the then Treasurer, Michael Aird, and the then Premier, David Bartlett, or were the requirements made and not actioned?

Mr KIRWAN - Each year we get an efficiency dividend, and we can provide information. That was the extent of the cuts; that is, we got an efficiency dividend. There were numerous discussions over how we would manage those and what we will do.

CHAIR - Discussions between whom?

Mr KIRWAN - We were in different stages - either the LGH or the area or mixtures of, and the department, given at one stage we were run quite centrally by the department. When I first started I reported directly to the deputy secretary and it was very much a centralised department model. For example, all our positions for appointments at the LGH when I first started went to the deputy secretary of the department to be signed off. There was that level of micro-control in the department.

I am coming up to four years here; that was in place for the first couple of years. We then had a budget for both us and Primary Health North two years ago where they basically said we would get a sustainable budget. At that stage at LGH we were carrying about 110-120 unfunded FTEs. They gave us a budget that they said, 'Now you should be able to live within this' and then gave us a productivity dividend to make as well. Almost every year we have achieved savings greater than the productivity dividend but never quite met the total deficit so I think we have had a positive track record in the last three or four years.

There were no directions from the Treasurer that I was aware of other than to meet your budget, which included the productivity dividend. The first year, with the sustainable budget, was good; it allowed us to re-base everything. Primary Health went through a zero-base budgeting which allowed them to re-base everything but since then it has been a struggle.

Mr HARRISS - Given that you had met your productivity outcomes as suggested to you, we heard yesterday at the North West that they had got right on top of their waiting lists and so when extra requirements came as a result of these budget measures that did impact upon staff across the whole service at the North West, because they said, 'We're doing well'. You are meeting your productivity dividend requirements so what impact does that then have? You are tracking okay and then somebody comes along after another event and says, 'You've got to trim even more'.

Mr KIRWAN - Unlike the North West, who were meeting most of their KPIs, we weren't. The hospitals really aren't comparable because they have the Mersey component which really is a quarantined level of activity, which makes it an unfair comparison, plus they are different in size and scale. The KPIs that we have always met and prided ourselves on are in my view the mission-critical ones; that is, the emergency department category 1s and the emergency surgery and the category 1 surgery. The others in respect of category 2 elective and category 3 elective surgery have always struggled, in part because the number of additions have equalled or have been additional to the number that we can do. Having said that, in elective surgery we have continued, certainly for the last three or four years, to record higher levels of elective surgery. If you look at our activity levels, you will see that even through our capital works program when we lost one theatre, we were still operating effectively with one theatre less and we will do so until the end of

this year or early next year. We have maintained that level of activity and that is a credit to our staff in those areas.

The issue of the budget saving strategies, most of our big hits really started from the end of December. That was a decision that we took in part because we weren't allowed to share the saving strategies with our senior staff until October. It is not possible in an organisation of our size and complexity to do these things quickly, particularly when no-one wants to do them. We have to go through that process, which is not easy, but also the natural rhythm of an organisation like the LGH - some of the other health services are slightly different - is that we will go hard into Christmas - that is normal - and then we will have a natural period of time that slows us down in January. I would say that that is still the case, certainly in Launceston. I think there are natural periods in the Launceston area. You only have to speak to the local shopkeepers in January and September where there is actually quite a large outflux of the population where they go to their shacks or somewhere else. So we actually do slow down a fair bit and we use that natural rhythm to slow down. That was going to happen anyway, and effectively as of last week when schools went back, we are now trying to maintain those lower levels of activity as part of our main saving strategies in those areas. That is yet to bite, although we are starting to see the problems at this point already. We already have unacceptably long waiting lists in categories 2 and 3 surgery and as I think I said in the first hearing I would urge you not to just focus on those areas.

CHAIR - John, is it across the board in every discipline?

Mr KIRWAN - It varies a little but it is a capacity issue. You only have so many theatre sessions, so many surgeons, so many nurses, so many beds.

CHAIR - You say it is starting to bite?

Mr KIRWAN - We will not have the data until probably March, so we will have the first two months. January you have to take a little bit carefully and compare it with the previous Januarys, rather than saying this is wonderful, we've done all these things, when in fact it's not a fair comparison. The end of February figures will be important for us, and the end of March. What we are seeing for the first time now - since I have been there anyway - is that we now have patients in ED waiting admission who are surgical patients.

CHAIR - Who are already on the list?

Mr KIRWAN - Who are waiting to go to surgery but can't go to surgery until there is a bed post-operatively available for them, because we don't have those beds. At the moment there are about five or six in ED.

CHAIR - And they are emergency cases, not elective?

Mr KIRWAN - They are emergency surgery in that that have to have their surgery done.

CHAIR - But were they already on the list for the surgery they were going in for today?

Mr KIRWAN - Probably not; I don't know, I would have to check that. We are not seeing a large number of people and you wouldn't expect it given that this is only effectively from

January. Our emergency surgery rates have been increasing over the last five or 10 years. They are 35-36 per cent at the moment but they have grown from about 30 per cent over the last five or six years, but they are relatively stable at around that. They are just slowly increasing as you would expect with the type of population we serve - older population, large co-morbidities. Will we see a peak because people aren't getting into elective surgery? If we continue, unquestionably.

CHAIR - John, this is a comment that was raised yesterday. When you have bed blockage effectively these patients are waiting in DEM for surgery but can't have the surgery until there is a bed available post-operatively, then that means there are fewer beds available for elective surgery. Are you seeing elective surgery that hasn't been wound back as part of the cuts, or are you seeing that flow-on that even planned elective surgery is now being slowed down because of this?

Mr KIRWAN - Most of our elective surgery is day surgery so for those areas the answer should be no. For the other areas it is still too early but I think the trends are that we could have some difficulty, yes. We have some other strategies. To us the critical period starts at Easter, that is what we are planning for. Easter is when we start seeing the first respiratory, the first other areas, and problems with staffing because of sick leave. That is our winter management strategy. It starts at Easter and takes us through to the end of September school holidays. That is the period we are planning for; it is different to the rest of the year.

CHAIR - I note with the North West Area Health Service, Gavin Austin was saying their decision to cut elective surgery revolved mainly around the hip and knee replacements because of the expense of those operations, so that is where you can make the bigger savings most quickly. Where have you made your cuts and in what areas?

Mr KIRWAN - Again I need to be careful because the North West isn't my area of responsibility. My understanding is that they also were ahead of their targets in those areas so to some extent they can maintain their credibility and the KPIs and obviously the chance of gaining elective surgery reward money. We have taken a different approach. We looked at the category 3s and category 2s. As I think I mentioned at the first hearing, the LGH has a position that we would prefer to have a category 4. That is where we are focused and it is not just surgical patients, as I repeat; it is medical and other procedures so it does affect other areas. It does affect dental and it has a minor impact on mental health so what we will continue to focus on is emergency surgery in category 1 and so that really still picks up a lot of those. At the moment, unlike the Royal, a lot of our major orthopaedics is categorised as category 2 but if they are delayed for much longer, understanding they are already over boundary a lot, then obviously if there are pain issues and others they will be advanced by the surgeons and their GPs to category 1.

CHAIR - You are saying that the cuts that the LGH has chosen to make are more across the board in all areas of elective surgery, particularly category 2 and 3?

Mr KIRWAN - Yes, and not just surgery.

CHAIR - What areas of medical cuts are you making?

Mr KIRWAN - All the areas that come through the day procedure areas, so again there is some balancing work there in respect to the various scopes and other work like that. Again, that is actually harder for us at another level because that is an area where the waiting lists are actually far longer, in part because they are not measured because they are not rewarded by the Commonwealth Government. That is an issue that we have been taking up for quite some time - and dental as well, as you have heard from the ADA.

CHAIR - So we are talking about medical procedures that are being wound back or -

Mr KIRWAN - The work that comes through our theatres, because again we have moved from nominally six theatres down to four theatres.

CHAIR - When you take a scope through the theatre why is not a surgical case as opposed to a medical case?

Mr KIRWAN - That's a very good question. It would be probably where the procedure came from originally and there is a list of approved and reported procedures. Just to put it in context, in our day procedure unit, which at the moment is one unit, about 50 per cent is medical and 50 per cent is surgical. The 50 per cent that is surgical is well measured and reported and that is what the Commonwealth and, dare I say, the politicians and the media get excited about, and the 50 per cent that is medical just sits there.

CHAIR - We politicians are interested in that.

Mr KIRWAN - You will get a lot of support from me because, from an equity-of-access approach, the truism of 'what gets measured gets done' applies. I don't argue, for example, for emergency surgery category 1 surgery nor for category 1 and probably category 2 in ED presentations. It would always be nice to be in boundary on every other area but the focus on those areas alone means that there are other areas. If mental health were here and dental health and others I think they would be arguing even more strongly that it does create a bias in the system.

CHAIR - Could you outline the medical procedures that are undertaken? We talk about the scopes, the endoscopies and -

Mr KIRWAN - There is a range of those that will require both general anaesthetics and local anaesthetics, so it would go through a range of the gastroenterology areas, the cardiac areas and there would be a range of others and we could probably provide that list.

CHAIR - It would be helpful to make that distinction because clearly if they are not actually part of the big picture and measured it makes it difficult to know -

Mr KIRWAN - They are measured by us.

CHAIR - Yes, but not by the Commonwealth, obviously.

Mr KIRWAN - If you look at the reporting to the Commonwealth they are focused around ED and elective surgery. You could ask questions in a range of other areas. We do have measures, for example, in oncology, as you are probably aware and the reason we have a third linear accelerator is so that we can now treat patients within the approved times.

Until the third linear accelerator came onboard, we had about 20 per cent of patients not seen in the recommended time and obviously, once diagnosed with cancer and recommended for radiation therapy, delays are unacceptable.

Dr GOODWIN - With some of those scope procedures that you are talking about, are some of those around diagnosis of cancer or other conditions?

Mr KIRWAN - Yes.

Dr GOODWIN - So it is quite important from the patient's perspective that they get it sooner rather than later?

Mr KIRWAN - Yes, but I do not know if this has been raised in your discussions with the Royal, but this is unfortunately not a new issue and has been subject certainly to media and other comments because of the waiting lists at both the Royal and the LGH. It is a bigger issue because it goes back to the whole range of Commonwealth programs and screening programs and where they put those in place but they never put in the resources at our level -

CHAIR - So the bowel screening example?

Mr KIRWAN - Exactly.

CHAIR - It is a great initiative but you have to back it up.

Mr KIRWAN - Testing everyone to identify whether they have a genetic or a family disposition and then saying, maybe you should do this and then saying, but you have to wait three years to get in to see the specialist and then another year to get in to see the gastroenterologist, is not quite fair I would suggest. But it is not new, it has been going on for five or six years and it is across Australia, it is not unique to Tasmania.

Mr HARRISS - John, earlier you mentioned that you have some planning in place which you have documentation for as to the coming winter period and the like. We probably trust your judgment as to whether you said you could make that available. I do not know what that is going to tell us or whether it is going to be in any great way helpful to mugs like me, but we are all aware of what happened in the south over the weekend with the Royal, reopening beds because of a hiccup. Nobody can be certain in the winter months just what we might be confronted with health-wise. In relation to that planning which you have documented there, what extra planning is incorporated in it against some of those greater emergency-type events?

Mr KIRWAN - What I have just given you is our winter management strategy from last year. The evaluation of it has just finished at the moment and two things are occurring. One is that we are now factoring in so that we can go into Easter with a new plan and what is being factored in is now the impact of our closed beds and the other strategies. The other thing we are doing is working with the department and the department is working with one of the UK universities - sorry, I have just forgotten its name. They have already done some quite interesting computer modelling of demand management. It is of interest that we have said, 'Surely we can get this in Australia, this cannot be rocket science.' But the answer was, 'No-one has done it.' Given the range of variables

of inputs and controls and outputs, what we really want to do is focus on some advanced health economics modelling. Some of the UK universities have done it. Some of them have a model that is a little bit out of date but it looks as if it will work for us and then our working on, from the information we are providing, what is likely to happen. For example, it is the day-to-day management which is difficult, and it really gets hard when it is difficult day after day. But basically we do that and we do that well. It wears people down and that is where you do get into issues. A couple of years ago, for example, it meant that by the time we were into September, the number of nursing staff who were prepared to do overtime or extra shifts was at its limit, because they simply had had enough. We were struggling to staff shifts. We are a hospital that will try very hard never to close beds and we will staff them. That is one of the reasons we have gone over budget - we have to incur overtime out of the costs to keep the beds open because of the demand.

CHAIR - Nurses will not leave nurses out to dry, will they?

Mr KIRWAN - No, they will not. But even at the end of a long winter, after-hours nurse managers are ringing the thirtieth or fortieth person and they are saying no - and that is not because they do not want to support their colleagues, they just have had enough.

CHAIR - They are exhausted as well.

Mr KIRWAN - It is a long winter. That strategy is there. The modelling we are doing with the university and the department will be critical. What we cannot factor in, but again we have systems for it, is what we had last year, was two norovirus outbreaks. Fortunately one of them was over Easter, which meant we closed a whole ward. Closing the whole surgical ward over Easter, if it was going to happen it was the best time possible, but it created tension for us when you are running at high-occupancy levels. Those are the factors that worry us, and particularly they would worry us if the other hospitals were in similar problems at the time. The other thing would obviously be the pandemic planning for a bad outbreak. As you have probably heard from the public health people, we are overdue for a pandemic and a bad outbreak; Australia is overdue. One of the advantages would be that Tasmania, hopefully, would get some forewarning of that. Our disaster management planning for those sorts of disasters is quite good. As much as it would be hard yards and very tough, I think we would get through it. The more difficult period is that gradual increase, particularly given the beds we have closed and the capacity we've taken out of it. At this stage we would have to say we have planned for it, but until we get there we will not necessarily see how we'll go. The last two years when we have run these strategies it's got better for us and I think we're getting far more sophisticated and are far more responsive to these areas. We have had some quite innovative suggestions from our stuff.

There are also other advantages occurring at the moment. We were able to secure some additional Commonwealth funding so we didn't close our 12 transitional aged-care beds. That has given us that advantage to stay in the system, where that was originally one of the potential savings strategies. The Acute Medical Unit, which is in early days of operations and which you will have a look at this afternoon, is looking as if it is working very well. About 90 per cent or more of the acute medical patients are being discharged back to where they have come from - nursing homes, homes or others - rather than being admitted.

CHAIR - Which is up to a three-day stay?

Mr KIRWAN - Yes. That is very exciting and works in conjunction with the Emergency Department. The question is whether that going to be enough capacity, given everything else we've done. We are yet to see that, and we probably won't see that until about Easter and then we'll know what the size of the task is.

Mr HARRISS - Given that bed management is a dynamic and fluid component of a hospital's operation, how would you handle a similar situation to that which confronted the Royal Hobart Hospital over the weekend? In terms of the fact that you have beds closed because they are budget-saving measures, how would you respond to a similar circumstance?

Mr KIRWAN - The opening of closed beds is dependent not on having the facility but on having the staff. If the staff were available, we would probably do something very similar. The difficulty is in accessing those staff. The challenge for us is to see the trend lines - there will always be blips and the occasional days when we struggle. Fortunately, as you will see, we have a new Emergency Department that can handle a lot more. Given it has more than doubled in size and gone from 18 to 43 bays and is not cluttered and overcrowded, we can hold a lot more in ED. We have always philosophically had an approach, albeit internally there is some conflict on this, that the best place to be held awaiting admission is still the ED, not in corridors and not going over census on wards. You will rarely see our ward censuses go over 100 per cent. Again, there are differences in how you would do that. On the mainland, for example, they will go over census on wards. We don't think that is the right option. In a 30-year-old hospital our wards aren't modern, spacious wards that can handle extra trolleys and give line of sight for nurses and nurses' stations. They are not the best if you go to that situation.

Mr HARRISS - So what is the internal conflict, in your own words, as to ED?

Mr KIRWAN - Our Emergency Department physician is led by the College and others would say that once a patient is ready to move, you move them so we can deal with the next one. We would say that's all very well but that potentially transfers the problem, if the staff and the other areas aren't able to deal with the level of acuity or the volume. The Acute Medical Unit gives us a half-way house to some extent for medical patients. There is some discussion that surgery might look at something similar. Womens and childrens is different and mental health is different again. I think we are yet to see how we will go, as I said, and I do differentiate between the Saturday afternoon/Saturday night peak because people can't get into GPs. When there are sporting injuries in the middle of winter and a couple of car crashes, we just have to manage. We and Ambulance Tas and others just have to deal with it and get through it to when we have that four or five days in a row and we are seeing people in ED for up to two or three days because there isn't a bed.

CHAIR - During that circumstance now, as Paul suggested, with the beds closed, is that when you take the opportunity, provided you could staff them of course, to open beds to move them out of ED?

Mr KIRWAN - Once it gets to a critical level we have a decompression policy which would be based on dealing with those issues in the short term so that patients are safe and the staff are safe. If it continues for a longer period we would have to then consider all sorts of options and our options would include moving patients to our district hospitals if there is capacity, using the private sector if there is capacity and particularly the privately insured - we would always encourage them to use that option - to bring them back to their nursing homes and a range of other services, so there is a range of options. Opening closed beds is always an option but is not necessarily as easy as the others are.

CHAIR - John, wouldn't those strategies be used any way, regardless of health cuts?

Mr KIRWAN - Yes, and in fairness we have opened closed beds in the past. Some of those beds that I have mentioned that were closed because of previous budget strategies we used as overflow beds for the Emergency Department, staff them out of pool - again, one of the reasons we were over budget in previous years - and to some extent if we are starting to see that trend and that cost we would obviously have to engage with the department about what that means for our bottom line because, as I said, we are predicting at this stage that we won't go into a deficit.

Mr HALL - John, you talked about that overflow going out into the district hospitals, do they always have the capacity, have you found? Generally, how does that work?

Mr KIRWAN - Sometimes not the capacity but they are very good about it, particularly for patients that have come from their areas. They're a little bit more sensitive really for out-of-area patients but we try not to do that. We got caught a couple of years in moving someone to St Marys who had never had any visitors from their time at the LGH only to find that the family took some great exception to that so the number of ministerials and others after that was interesting!

Laughter.

Mr KIRWAN - Most of our district hospitals, as long as they don't have other commitments - and I am aware, for example, at Deloraine they work very closely with us - might on occasions have two palliative care patients. If they have two palliative care patients on a minimum of staffing levels of two-two-two, it means afternoon and night shift they are probably committed even if they might have vacant beds, their ability to actually then take more is difficult.

CHAIR - It depends on the acuity of the patients then as well as the number of beds they have.

Mr KIRWAN - Yes, and we work closely with all of those and there is never a problem in respect of transferring patients, particularly if they are going back to those areas. Sometimes it is a bit of an issue otherwise and one of our earlier initiatives would be to move them out there.

Mr HARRISS - We were talking about the expanded capacity in your Emergency Department, has that alleviated any ambulance ramping and if it hasn't what is the impact of ambulance ramping on the efficiency of the service?

Mr KIRWAN - I understand that the full Emergency Department has really only come on stream in January. We built the new bits around the old bits then demolished the old bit which was in the middle of the new bits and then opened the new bits just to make life exciting and dirty and dusty and particularly for the staff below, who had things falling through the ceiling. We have a policy that we don't support ramping as a strategy. We would always prefer to bring the patients inside the Emergency Department. Because the department didn't collect ramping data for us, we have requested that they do that and just recently we have agreed on the definition because, interestingly enough, there isn't a national definition. The definition is 15 minutes from the time of triage when they should be inside so the ambulance can go somewhere else. We are in some discussions with Ambulance Tasmania. They want to count somewhat differently to that. We ramp on those peaks. Unlike the secretary of the ANF's evidence, our figures show that in January it ramped three times, not 60 times.

Dr GOODWIN - Could she be using a different definition?

Mr KIRWAN - She is. We obviously want to use the same definition as the Royal because we are often compared to or like to be compared with the Royal, but it makes sense on the one island. To have two different definitions would be just too -

CHAIR - So the definition is 15 minutes from the time they -

Mr KIRWAN - From the time the patient is triaged and then should be brought inside, but are then kept in the ambulance unnecessarily or delayed. So that delays the ambulance. I understand and we are quite sympathetic to that. I think the northern ambulance service is the busiest of them and, not only that, we have to work closely with them. They have a new apron there so they park eight ambulances. I do not think they have eight ambulances, but that is not to encourage ramping. Of course, a lot of the ambulance officers are our former staff or married to our staff. So there is a close relationship there and a good working relationship. The CEO of Ambulance Tasmania on occasions, when there has been ramping in the past, particularly in the peak of winter, has never hesitated to contact me and explain what that means but it is relatively rare for us and we would like to think it would continue to be so.

With the new ED open and staffed there should be, again, relatively low levels of ramping but on those peak days when you will deal with 130 to 150 - and I think 160 to 170 was our peak on one day - you almost cannot avoid it because it just not designed for that peak load.

CHAIR - So the patient is triaged in the ambulance and at that point how quickly do they get triaged?

Mr KIRWAN - The triaging occurs quite quickly. They do not wait in that exercise.

Dr GOODWIN - So the ones that come in the ambulance are always triaged in the ambulance; is that how it works?

Mr KIRWAN - No, it depends on how busy it is.

Dr GOODWIN - But they have to be triaged within a certain time of arriving in the ambulance?

Mr KIRWAN - Yes, it depends on the category. Categories 1, 2, 3, 4 or 5 have different time frames to be triaged.

Dr GOODWIN - And who makes that assessment?

Mr KIRWAN - The triage nurses. It depends on the system they are coming through.

CHAIR - But don't they rely on the information from the ambulance officers bringing the patient in?

Mr KIRWAN - To help with the assessment, yes.

CHAIR - Going back to a couple of points you made earlier, John. You talked about being required to implement productivity dividends. Is there any acknowledgement that the service professions like health and education are inherently low productivity areas because of that one-to-one contact? At this stage we are not replacing nurses with robots, for example. Is that factored in at all?

Mr KIRWAN - I am not too sure I agree with the premise of the question. Health can show productivity in its areas quite easily. By the use of diagnostic-related groups we know what our costs and our unit costs are and because they are benchmarked, based on the original algorithms that sit behind a diagnostic-related group that originally came from America, you know in relative terms whether you are efficient or inefficient relative to peer hospitals, as long as you have the critical mass. For example, dedicated eye hospitals that will do thousands a week, potentially, versus an area that will only do 50, is not a fair comparison. Productivity for us can be measured, particularly in inpatient areas. It is harder in the community service obligation areas, particularly with the small district hospitals, harder in the block-funded areas or where the data does not give you that level of detail. But certainly for inpatient areas, we know what we do, we know what the costs and the comparative costs are. Plus, for most of our areas there is various benchmarking, either through their royal colleges or subset areas, so they know what their standards are and they know what their quality standards and others are. So there is quite a comprehensive suite of those areas.

I would challenge previous claims that we are inefficient or unproductive, and certainly at the national level as we move to a nationally efficient price, that is the game. We have to know what we are and where we are doing well and where we are not.

CHAIR - But there are certain areas that you cannot change fundamentally.

Mr KIRWAN - Yes. Our highest expense areas would be intensive care, one-on-one nursing. Then you would go to the next level down, two-to-one nursing. Health, by definition, is very complex. We are labour-intensive, capital-intensive, transaction-intensive. There is no other industry in Australia like us, other than probably defence when they are fighting a war. Otherwise they are Monday to Friday, with Wednesday afternoon off for sport. The reality is that we are 24/7 and that makes us an economic

difficulty because most areas are one or the other, or sometimes two. Some areas, such as farming, can move from labour-intensive to being capital-intensive. That is not us.

CHAIR - That's the point I am making. You were asked to make additional savings, so does that make the challenge even greater, given the reality of the way health operates?

Mr KIRWAN - It always is, always has been and always will be. The reality is that the demand, particularly with an ageing population, is always going to outstrip the supply and the finances. That makes us no different to anywhere else. In world terms, Australia has a relatively efficient health system. With the outcomes, the access issues, there are many countries in the world that would envy us, even with the price escalations and other things, for what we still do for the price we do it.

CHAIR - What level of consultation was there at the outset when the budget-savings strategy was announced in the Budget last year? From that period until October, when things started, what consultation was there between you and the department and you and the minister?

Mr KIRWAN - Just to get the chronology right, in early July we received the written copy of our budget allocation. There had been no negotiation on that, as there hadn't been the year before. We were given the allocation and told, 'That's what it is'.

CHAIR - So you didn't get your budget until 1 July?

Mr KIRWAN - It was the first or second week in July.

CHAIR - I assume you're the same as the North West Area Health Service; you don't have the budget for next year yet?

Mr KIRWAN - No, although the upcoming year is going to be different for a range of reasons. We received the budget and then realised that the budget allocation and the savings tasks were at odds with what it was going to cost us to operate the Northern Area Health Service, the two component parts of it. We had been aware that we were facing, across LGH and Primary Health North, about a $20 million savings target. We had savings strategies in part for approximately half to $15 million of those. When we realised that on first cut the savings strategies targets were closer to $40 million, potentially, we made it clear to the department, unions and our staff that that was a very big ask. At that point in time the unions went public - not us - and we were then chastised somewhat for saying that we wouldn't meet our savings target. We were then called into various discussions and it was made very clear, verbally and in writing, that there was no option other than to deliver no deficit.

CHAIR - Who were those discussions with?

Mr KIRWAN - With me, from the secretary of the department. There were subsequent meetings with the chief finance officer, Sonia and myself. We were also directed to develop suitable savings strategies to achieve no deficit. Once we evaluated all other options and reduced the target down across the two areas to $28 million, we were then directed to go away and deliver for the department and the Government's consideration what that would be. That is where the now 61 savings strategies come from.

CHAIR - Did you have any meetings with the minister or was it all dealt with at secretary of the department level?

Mr KIRWAN - A meeting with the minister specifically over budget savings strategies, no, I can't remember one. I can remember that we were called before the budget subcommittee and Cabinet, which I am not able to comment on because it is privileged. That was about it.

CHAIR - So effectively you were given a savings target and told to go and do it?

Mr KIRWAN - We were given our budgets and at that stage the savings target had been reported. At that stage we indicated that the savings target was greater. It depends on how you construct the budget. The approach taken was, 'Here's the budget allocated. This is what you now need to make,' but we look at the budget somewhat differently. We look at what it is going to cost us to keep current operations going and we factor in line by line all of the known costs, the known escalations, increases in rates, increases in awards, everything that is unavoidable because we stripped out anything that was avoidable, I can assure you, and that left us then with a difference between if we did nothing and just simply kept going we would go $28 million over budget. 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.

CHAIR - Effectively you were given the task: you weren't told how to cut or where to cut, you were just told this is what you have to meet and it's your job.

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.

Dr GOODWIN - Right, so they were literally just hit with it in October and told, 'This is what you have to deliver'?

Mr KIRWAN - Yes. They had some inkling that things were not, shall we say, kosher, but as far as the details were concerned in almost every example they were prepared in isolation from our senior staff.

Dr GOODWIN - How did they receive the news?

Mr KIRWAN - Not well.

Dr GOODWIN - Not surprisingly.

CHAIR - The program suffered a fair bit of push back, I would imagine. Is that a fair comment?

Mr KIRWAN - There was a logic between all the strategies that we chose. A lot of them we'd prefer not to have chosen but the underlying and overriding logic is they were cash savings. That was the direction.

CHAIR - To make savings quickly.

Mr KIRWAN - Effectively, my assessment was that you make the savings this financial year and we were looking at 10 per cent over a whole year that we had to make cash savings so we are not talking about productivity, we are not talking about health planning, we are not necessarily talking about what is logical and whether this is a deferred cost that will cause problems in the future. When we questioned all of that, the response back was that everything was on the agenda; there was nothing that would not be considered to achieve the target of no deficit and that is how we responded.

Dr GOODWIN - When you were told - in no uncertain terms by the sound of it - that you weren't allowed to consult with your senior staff on the actual saving strategies, was that connected to what had happened previously with the unions getting involved or was that the standard practice as you understood it across the three area health organisations?

Mr KIRWAN - I am probably the wrong person to address that question to.

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 -

Dr GOODWIN - It is pretty clear.

CHAIR - How many ways can you interpret that? John, were there consultations and meetings with you and the budget control team?

Mr KIRWAN - 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. We then were told to go away and we were back once, maybe twice afterwards, but in the context of, you need to understand that this is the direction.

CHAIR - When we spoke to the department - you were there at the time - and then we spoke to Treasury and it seems there are differing of opinions here as what the task is. It seems that only getting your budget on the first week of July, if you determined at that point that you could not continue to provide services within that framework because of the health inflationary costs which we know are significant, is this where the difference lies? You are already behind the eight-ball with your budget and then having to put the costs on top of that. Is that where the difference lies?

Mr KIRWAN - In relative terms, the LGH would come in at less than 2 per cent overrun. We are travelling okay, but Primary Health North isn't because they have fixed costs and they really just do not have anywhere to go. Across the area we did realise their difficulty but we went into it without really any significant structural deficit. Mind you, that was after a year of some fairly hard decisions. That was not such a big issue for us. I am not trying to allocate blame here but with the actual inflationary and fixed costs in the system there is a view that when we get indexed by 3.5 per cent, that is enough, yet it does not apply to all the areas. There are other additional costs and so to them we simply say, 'Okay, anything above that is your job to absorb.' It is a good response, if you can get away with it, but it means that when you have to make the savings, given we have moved from historically a deficit-funded system where the overruns have been funded, have not been carried over - and we can all wear the blame for that at all different levels - to then simply say, effectively cold-turkey, what you have is what you have and do not go over it. In fact, next year when we move to an activity-funded, capped model in respect to funding with independent boards, in 12 months we will have moved and from a cash-based, non-accrual accounting basis probably faster than anyone in Australia. It normally takes three or four years to do this.

Mr HALL - To clarify that, John. Historically, you have had 3.5 per cent index increases?

Mr KIRWAN - It varies. Sonia can probably explain more on indexation.

Ms PURSE - We get certain indexation on our salaries and wages. We also get indexation on our medical goods and services and so that is where the difference lies. So each year you get a different percentage on different categories of your expenditure.

Mr HALL - Right.

Mr KIRWAN - Not all fund types are indexed, are they?

Ms PURSE - No, only the consolidated funds that come from the Government receive indexation.

Mr HALL - I understand.

CHAIR - John, looking at other areas that have perhaps suffered from the cuts. One in the Launceston areas is the hospital-in-the-home. To me, as a nurse, I find it hard to understand how that could be a cost saving. I am just interested in how that decision and what impacts that has had and what the future of that is?

Mr KIRWAN - Is it an area that we would have preferred not to have closed? The answer is yes. But it is relatively underutilised. There had been several attempts. It is a service that only applies to the inner city area of Launceston and when looked at, it is a model that we will try to maintain in other ways, particularly using the Acute Medical Unit for some of those patients or clients who are not best treated as outpatients at the hospital or others. The reality is that the utilisation was low. There had been several attempts to increase the utilisation. The cash savings for us in a six-month period was $175 000, and double that over a full year period. In the context the direction we were given to save cash, what we did was go through all of our areas and ask whether they are fully utilised or could we get funding from other sources. If they are not fully utilised, can we increase the utilisation and funding sources from other areas? If not, there are some hard decisions and unfortunately that was one of the areas where there was a hard decision.

CHAIR - Can we talk about the attempts to increase the utilisation of it and why they did not work?

Mr KIRWAN - I think there is a range of reasons. It's a service that not a lot of the doctors refer to. It's a service that because of its restriction in respect to inner city - I think there is a 20-30 minute drive - I think it is best to now have a model that is patient- or disease-group specific to provide those sort of outreach services. There is not a problem with hospital-in-the-home, they are good programs, but they have to be cost effective. The other thing with this group of clients is that we weren't denying them a service, they will just get the service in another way. In my way of thinking, they have been used to a very good service. Do they like it? Yes. Is it cost effective? No. Are we withdrawing the service? No, because they will still get the same services. Does that then allow me to keep other services open? If we weren't going to find those savings, we would have to close other beds or do something else, and that does deny people access.

CHAIR - Looking at the doctors not referring, I am interested in the reasons that may or may not be the case. Let us look at one of the savings strategies that was implemented in the North West Area Health Service, which Gavin Austin referred to as the *Gray's Anatomy* approach, where registrars were ordering every test known to man because they were concerned about not doing something a consultant might want. A decision was taken that they would only order the obvious tests and then the ones that may be nice to have but not necessary would have to be signed off by the consultant. It took out of a whole heap of costs, in imaging particularly, and possibly pathology, which they pay for separately. That was a doctor behaviour thing. Is there room here for a bit of doctor behaviour modification?

Mr KIRWAN - I am probably the wrong person to ask, but I would say that we have a track record of doing that. If I use the example I used earlier with paediatrics, moving from an inpatient to an outpatient model, I think there is clear proof that we have done that in those areas. If you look at the changes over the years in oncology there is clear proof. If you look at the changes in dialysis, movement from an inpatient in-hospital type model to home-based and other modalities, there is example after example of where we pursued that. It may simply be that there just isn't enough demand for a hospital-in-the-home type program to justify that area and there wasn't if we come back to the timing and the lack of consultation, but this is a program that had been under review for some time. They realised that their occupancy levels were low and that there were other alternatives for them. Would we revisit the program and put something similar in place in the future if funding allowed? Probably yes. Probably not the same way, though, because it would have to be targeted.

The issue of the savings, to say it costs less, we are not talking about productivity or efficiency, we are talking about cash savings. 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.

Mr HALL - John, given that we are where we are and you've had the directive as to the budget savings from the State Government, have you some anxiety or are you looking forward with some trepidation to the next State Budget? If it is not favourable and we are faced with more budget constraints, will your system be able to cope?

Mr KIRWAN - We do not know at the moment. Under the new legislation we need to have our service agreements agreed with the department through the chairman of the board, and hopefully an interim board, by June. So, unlike previous years with the budget cycles and the Budget itself - I think the year before we did not get our budget until September or October - it is a difficult process but under our new model particularly, because the Commonwealth is stepping in as a direct joint funder, we will know earlier. In fact, we will probably know earlier than Parliament what the budget is looking like, certainly in respect to the inpatient and the DRG in the case-mix funded activity. Until we know that, until we know what is the pool, until we know what the allocations are, do we think we can maintain for a third year in a row these types of saving strategies and take more out of the system? It is going to be very difficult.

Mr HALL - Yes. When do you reckon you will have a clearer indication?

Mr KIRWAN - My advice always to governments is that if you are going to make saving strategies and others you need to have made the hard decisions by the end of March because you actually need to have them in place at the beginning of the financial year, and preferably before and not in October.

CHAIR - You have lost a quarter of year there already.

Mr HALL - It has been put to us that quite a lot of people obviously have private health cover but because of the elective surgery cuts they are presenting themselves and not getting themselves through the system more quickly by having private health cover and therefore quite a few people are dropping their private health cover. Have you had any evidence of that and, if so, will that put more pressure on the public system?

Mr KIRWAN - It should have the reverse effect on us. If you are privately insured and it is the type of operation that can be done at Calvary or at other places - they can go to the mainland - that should in fact encourage people to keep their private insurance and to use it because the work is not done with us. The type of patients we would deal with are the ones, for example, like deliveries. We are the only hospital in the north that does deliveries so private and public are dealt with by us and patients have the right of election. We don't have a right to enforce that nor do we have a right to do a few other things. I would argue that for waiting lists and other electives, as long as you don't have a pre-existing condition, private insurance is very good and I think for that reason it is likely to probably have the reverse effect. Whether some of the other issues are causing problems, we are yet to see. I would have to say I have a personal concern about what is happening in those areas. Again, it is very important for us to have a strong and vibrant relationship with the two Calvary hospitals and the private sector. Launceston has a very good blended model between the private and public sector. All but one surgeon and in fact all but one doctor work both in private and public so it really is a very good well-balanced model. The trouble with any well-balanced model, given everything else that is happening, is that if you start skewing it one way or the other there are probably unintended consequences. We really couldn't afford a collapse of the private sector or a drift to us of any significance.

Mr HALL - With regard to what has occurred, obviously that has quite a lot of effect on morale within staff. Anecdotal evidence is that we are losing a lot of our best and brightest young nurses to the mainland; they are going to seek jobs there. It is not only anecdotal; I know it is a fact. Is that a concern and the knock-on effect of that in the medium and longer term?

Mr KIRWAN - People need to be aware that UTas always trains more nurses than we can employ, so we need to be a little bit objective about what some of the data really is telling us. We pride ourselves as an acute teaching hospital. We have tried as much as possible and certainly not targeted specifically any of our undergraduate or postgraduate programs as cost saving strategies. We have been able to protect the undergraduates in most areas. We might be short a couple in the transition-to-practice in nursing at this stage but we will try as hard as possible to maintain those figures. What is likely to occur is, once they go through that period, are there jobs then available. I tabled the turnover figures earlier. It was always going to be tight anyway and again that is where I would say we don't guarantee jobs simply because we aren't an employment agency. We are actually a health service and if we don't have the vacancies we can't employ them. We do actually have a demographic that is in the system that does mean that in the future we will need more staff than what we are probably recruiting, so it is in our vested interested to give them the best learning experience they can to graduate, to make sure they are happy and make sure that they want to come back. Having said that, for most health professionals spending time away is not necessarily a bad thing.

CHAIR - That is the problem with an ageing demographic. What is the average age of nurses? I do not know whether you would know that within your hospital as such but I know Tasmania has one of the highest.

Mr KIRWAN - I can check on that but it is about on the State average. Again, you only have to look at the turnover figures. I may have mentioned at the first hearing that at the end of last year for our 25-year awards the minister presented across the area to 140 staff - 2 500 years of service.

CHAIR - That is dedication to service.

Mr KIRWAN - That is massive amounts, but it is an ageing work force. It does vary though. We have some areas where it is obvious but in some areas it is quite a good blend. The demographics of what people are doing now is also a bit unclear as to whether people do get to the gold watch stage and retire or whether what we are now seeing increasingly is more people phasing down in their hours rather than phasing totally out. I suggest the economic situation has a fair bit to do with that.

CHAIR - You thought you were going to come in basically on target this year; is that right?

Mr KIRWAN - The current prediction is subject to what the February and March figures have but we are already seeing the trend lines in the right direction, given most of our major strategies started at the end of December.

CHAIR - Do you think you are going to meet your savings strategy targets?

Mr KIRWAN - All things being equal, yes.

CHAIR - So the Northern Area Health Service will come in on budget?

Mr KIRWAN - Yes.

CHAIR - We heard evidence yesterday from Gavin Austin that the primary health area of the North West Area Health Service will be $500 000 over budget basically because of all those fixed costs that you mentioned. How does primary health sit within your northern area health services?

Mr KIRWAN - They will come over budget with a figure of, at this stage, $3.6 million.

CHAIR - Are you absorbing those losses or that overspend in other areas?

Mr KIRWAN - Through the other initiatives.

CHAIR - Primary health has not really had a heap of directives thrown at it as to what savings could be made in these areas. Is that true?

Mr KIRWAN - At this point in time, yes, but there is a practical reason for that. Again, the direction was the cash savings this financial year. It does not just apply to primary health but to all parts of the LGH as well. To make the savings and changes that are required, the lead-time is longer than what was effectively given, which was 12 months but a

kick-off of nine months. There could be additional savings made in those areas but, again, only if the decisions were made. They have another disadvantage. With their two-two-two rosters fixed, it does not matter what the staff or what the patients are, you really then would be getting into situations of significant reconfiguration or closure. But those decisions, being absolutely pragmatic, are not things you can do in six or nine months.

CHAIR - Those things that are going to be considered, have you a number in your area health service? Are there a number of quite small hospitals in the regional areas?

Mr KIRWAN - We do not know yet.

CHAIR - It is not off the cards; it could be on the cards?

Mr KIRWAN - We do not know yet. The reality is that their deficit will only get worse. Particularly under activity-based funding, the ability for the area to cross-subsidise those areas on 1 July is gone.

CHAIR - How do you deal with that?

Mr KIRWAN - We present the options to the government of the day. That is all we can do. I just do not know. I am aware of what the Premier said in Oatlands but at this stage that part of the question I would have to say is the same as other parts of LGH as well. If there are further reductions of the percentage that we are seeing, it is unlikely we could do much more. In fact, it is probably not necessarily something that we would be supporting. So I think there are going to be gaps next year. What they are we do not know, not the will of the department and the minister and, in fact, the boards, because there is now another player come next year.

CHAIR - So the $3.6 million is a significant amount obviously and I am sure that is not lost on you at all. Do you break down across the primary health sector where these overruns are happening?

Mr KIRWAN - Yes.

CHAIR - Can you provide the committee with that information?

Mr KIRWAN - Yes. You may have some difficulty if you're looking for comparisons, for a range of reasons which I am happy to explain. We have always kept Primary Health North separate from the LGH, operationally reporting otherwise. The others have gone into a more integrated reporting model where our services are integrated but we have kept the management and the reporting in the book separate for a range of reasons. That is relatively straightforward for us to provide. It is not meshed in, in part because we never really established a separate area health service management model. It really has been mainly because of the size of the LGH, the LGH picking up responsibilities for the area.

CHAIR - So how far down does the breakdown go? Does it go into each health facility?

Ms PURSE - Yes.

Dr GOODWIN - In one of the handouts you provided on e-health and the statewide shared electronic health record, what has happened with that?

Mr KIRWAN - I included this because there was criticism in various submissions that you have had. It goes to your testing, pathology and radiology question in respect of the north. We have been fairly innovative in this area. We are currently waiting for the final contractual negotiations with the two preferred tenderers. We have done a lot of work already in other areas. This is quite exciting to us. It underpins an integrated care model and a more productive, safer and more efficient system. I would never go so far, when you're talking about ICT, as to say it is going to save money because I think everyone who says that is found to be wanting - in part because what we will find is far more capacity. It is very exciting, particularly when you overlay it with telehealth and other opportunities. Although it has gone far slower than I would like - and it frustrates me and some of our staff - it is at the final stages now. It is just a pity that we have also hit such a budget problem, which has made it quite difficult. I suspect we will go in small steps rather than courageous steps as we would have liked to have taken, but it holds huge potential, particularly for those areas that are connected to the NBN. Once that is fully connected through, the functionality will be quite exciting.

Dr GOODWIN - So it is in progress but it may be at a slower pace than you would have liked?

Mr KIRWAN - The cold, hard reality is that it will happen. There is an option of whether we are doing it at a pace that our clinicians, clients and customers would like us to or do we sit and wait until everyone else has done it and in 10 years time pick it up from others?

CHAIR - 'Everyone else' being other jurisdictions?

Mr KIRWAN - Yes. There is a risk for us in doing that because we want to keep our clinicians - our bright, clever doctors in particular - but also our nurses, allied health and others who train in other sites are used to coming with a degree of functionality and being able to access things and have things at a fingertip. When they come into our systems, which are clunky - being generous - we won't keep them when they are used to that. Their ability, as Dr Gauden said in this morning's *Examiner*, for him when he is doing a clinic on the north-west coast or elsewhere is to simply open his laptop, pull everything up for the client and it is there, rather than having to bring paper and run the risk that the one report he wanted isn't there.

CHAIR - And that does happen, John, as you are well aware.

Mr KIRWAN - It does. Oncology, through the ARIA system, is leading some of the charge in that area. They have a very good radiation therapy system which they are now flowing out into medical oncology. It is very good and it is important for the patient. If an oncology patients fronts up at the hospital, it is important for the ED or the GP to know what their treatment regime is.

Mr HALL - In regard to the new emergency department and staffing, how are we going there?

Mr KIRWAN - I wish you'd asked me this question a week ago. I could have said it is going reasonably well. It has been quite tight this week and remains tight. Based on the nursing-hours-per-patient day, we have increased the nursing staff and we will staff to what the need and the level of activity is. I do not know where the ANF has got its information from. We will, if need be, open all the areas, but at the moment the activity hasn't required that, understanding that when we built the ED it was built to handle future capacity as well. It is not much value spending $12 million of the taxpayers' money only to then say in two years time we need to expand it. In part, there is nowhere else for it to go to unless we start putting tents out in Charles Street, which would not be a good idea. There was always some redundancy or future growth capacity there. There was also another reason for that. We needed to expand it and put the foundations down so we could do the two levels above, so that will be expanded and that is an area where staffing hasn't been restricted and won't be restricted because we need to deal with it. But the activity until this last week has not been growing at the same rate we have seen before, which is optimistic but we are cautioning our clinicians that it could at this stage only be a blip.

CHAIR - Do you have any idea why? Has something changed? Is there greater access to GPs?

Mr KIRWAN - No, not here.

CHAIR - Is there a plan for a super clinic?

Mr KIRWAN - No. There is an out-of-hours clinic, just a small deputising service. Is it an ageing GP work force? Yes. Is it hard to get in to see a GP? Yes. We really do need to see what other things are occurring out there and see a longer period of time but we suspect it is only a plateauing anyway, unfortunately. In particular, once the four-hour rule starts getting some traction we will see a natural growth.

CHAIR - Are you funded on the basis of the four-hour rule?

Mr KIRWAN - In part. We have some incentive money from the Commonwealth but because that was an area we were expanding. Again, it is an expansion that should have occurred a long time ago. It is probably fortunate, more from my perspective than the staff's perspective, that it was delayed because it allowed us to do everything else as well. So in that respect it was probably a better timing, as the Standing Committee on Public Works heard, but it does now allow us to deal with that demand and with the new models of care. A fast-track model and a short-stay capacity in an acute medical unit really does give us the full suite at the front of the building.

CHAIR - The incentive payments that you mentioned, I know that some are related to elective surgery and DEM. Can you tell us how the Northern Area Health Service has dealt with that? Have they met their challenges and received incentive payments?

Ms PURSE - We received an allocation from the State Government. They did all the negotiations with the Commonwealth on our behalf. We received five components under the package of the National Partnership Agreement for improving public hospital services. There was some capital money that related to elective surgery and we were

using that to go and put all new capital equipment in our areas that are yet to be constructed, as John has already mentioned, including theatres and ICU. We then got some money to put into elective surgery as well - the recurrent costs. We then got some capital money that we put into capital equipment that we have purchased to put into the Emergency Department and that is all in place now. We received some recurrent money towards elective surgery recurrent costs, which the Director of Medicine put into a medical assessment unit and then we actually got the sub-acute care money that we will be putting into the John L. Grove Unit, say, with the five tranches of money we got.

CHAIR - This is State Government money?

Ms PURSE - No, Federal Government.

Mr HALL - National partnership money.

CHAIR - So they're incentive payments.

Mr KIRWAN - No. Most of these are not incentive; they are payments for equipment -

CHAIR - Under the EBA.

Mr KIRWAN - A small amount of recurrent in some areas. With the incentive payment money for meeting our targets in the ED and elective surgery, the ED incentive payments haven't kicked in yet, I don't think.

Ms PURSE - No.

Mr KIRWAN - We, as with the other areas, have met our targets on the elective surgery up until now. Going forward we think it is going to be problematic.

CHAIR - How much did you get in incentive payments on your elective surgery targets?

Ms PURSE - $1.033 million.

Mr KIRWAN - In the last payment.

CHAIR - How many payments have you had all up?

Mr KIRWAN - It goes back over many years and that is actually an issue we have been discussing with the department in other areas. The elective surgery funding money that has allowed us to do the record levels of activity, as the other areas have, hasn't been recurrently funded. It has been underpinned by these bonus payments. That creates a real difficulty for us because it means you establish the system at that level and then bringing it back you can't maintain it. Specialist surgeons and specialist theatre nursing staff and others just don't grow on trees. With the exception of some of the private sector, such as the eye hospital where they have more capacity to ramp up and down, we don't. We are ramping down at the moment but for other reasons. The positive sign is that once we finish our capital works development we will have the capacity to ramp back up, assuming we get the recurrent funds.

CHAIR - So there is also incentive payment money, as I understand it, for sub-acute care into the future?

Mr KIRWAN - Not for award funds; I think for payments for admissions we are putting in place such as the 20 sub-acute. We didn't have sub-acute beds as such in Launceston. It was a gap in our service delivery, hence you would find that some of our longer-stay patients in areas such as the rehabilitation ward and others being there simply because there wasn't an alternative option, as there was in the south - in part because the south had picked up the old Repatriation Hospital. It was a different configuration with different opportunities. This now allows us to open 20 sub-acute beds, which is in the process of going to tender. We are encouraging the existing non-clinical and other staff out at John L. Grove to find somewhere else to live and that will be refurbished and used as a 20-bed sub-acute facility, which will be good for us. It will give us a nice continuum in that area.

CHAIR - That's all Commonwealth funding there as well, under an MPA?

Mr KIRWAN - Yes.

Mr HALL - While we are on that subject, John, and you may or may not be able to answer this, you mentioned the Commonwealth provides tranches of cash every now and again to the State. It was put to us in earlier evidence that the State has been missing out on money because the DHHS systems have not been up to scratch to provide the right data to get their applications up. Are you aware of any of that happening?

Mr KIRWAN - My memory of that evidence you were given was from Mental Health.

Mr HALL - I might be wrong, but I thought it was emergency services.

CHAIR - Mental Health was one area that raised it.

Mr KIRWAN - I can't comment on Mental Health, whether they have missed out or not or what their systems are because they aren't within our bailiwick. From my perspective, I am unaware that we have missed out, as such. Where we may have missed out is where we thought we had a bid we could put in but we were told that the only bid going forward would be for the new Royal Hobart Hospital development. We were told to take it back. We can't complain, we got $40 million the year before - you can't be parsimonious about these things. As you will see in the capital works development, we have done $105 million to $110 million (*audio unclear- please check figures)* of capital works development plus others. As you will see in a hospital that has been rebuilt, we still require more funding. There are 30-year-old wards, not air-conditioned, still mixed gender, so there are still some issues we have to address. I think you would have to be ungrateful to complain about what we have received from capital works from the Commonwealth and State over the last five years.

Mr HALL - I think it might have referred not so much to capex but to actual program incentive payments.

Mr KIRWAN - In the areas where we measured, we are pretty sharp. As I said in the earlier discussions here, it is the areas we have not measured that are giving us concerns, which

are over equity of access arguments. I can't comment on Mental Health; I don't know what their funding levels are. It is a long time since I last had an involvement in it so it would be unfair to make those comparisons now.

CHAIR - John, could you give us a bit of an overview of how you see the future. You have the savings tasks for this current financial year imposed on you, with an inability to consult with your senior staff. Obviously the Government is proposing further cuts that will be required to be met by each and every health service. Do you want to give us a future view from where you sit as to how that is going to impact on your operations?

Mr KIRWAN - It is going to be different for the upcoming financial year. We have moved, as I have said, from a deficit-funded, cash-based model to activity-based funding in a very quick time, so the negotiations with the department and the governments will really be based on activity and what that means, what is a fair or efficient price for that. They obviously cannot purchase what they cannot fund. They cannot come to us and say, we would like you to do 150 but I am only going give you money for 100 because the independent board, at their first meeting, is going to say, 'Now which turkey has recommended we sign up to this one?' and I suggest I would be unemployed very quickly! The reality is that it will put some transparency into the system that we probably have not seen before and I would say accountability at all levels we probably have not seen before either. I am not too sure that some people understand all of what that means from the Commonwealth down, given the promise of all this additional funding and that everything will be better. Certainly, from where I sit in the scheme of things, I am yet to see some of that flow through. From my observation from both LGH and Primary Health North, I think the reductions are, unfortunately, not one-off. They have to be made sustainably and so we really have to go through some serious health planning once we get through the current fairly mad dash for cash which I would have to say probably is the best description of it. We need to do some serious planning as we then scale down our services to come in with what the State and the Commonwealth governments and other funders believe is affordable.

CHAIR - And they are willing to pay for.

Mr KIRWAN - I cannot sit here and say they could pay for something they cannot afford, that would be irresponsible. But I think we need to be very clear about what we want to buy and I am not too sure that level of seriousness in the discussion has been had yet.

CHAIR - But do you think that is one of the places we need to start, John, to look at what we provide, where? We have known for a long time that we tend to duplicate in Tasmania, everything, everywhere, pretty much. Obviously there are some things we do not. We do not do neurosurgery anywhere outside of Hobart and with neonatal intensive care, the only major unit is in Hobart

Mr KIRWAN - No, we have neonatal intensive care unit.

CHAIR - At the same level as the Royal now?

Mr KIRWAN - They have a paediatric intensive care unit. They have a slightly higher level because their specialists come over.

CHAIR - Yes, that level. There are a few things that we only provide in certain parts of the State. But we need to have this discussion about what we provide, where and have those discussions about people travelling. We heard of people yesterday being referred for endoscopies from the north-west area by their GPs to the north and south. Now they are seeing that there is no waiting time pretty much almost or very low waiting times at the North West Area Health Service at the Mersey where there is an endoscopy clinic. Now the GPs are realising that and saying, 'You may as well go here; your outcome is just as good and you get your endoscopy done in a much more timely manner.' Do we need to start thinking more about this?

Mr KIRWAN - I think the answer is yes, but it has to be in a structured debate and there are other countries in the world and other health systems that have had that. New Zealand has; parts of America and Canada have. The English have in some of their models. But the intention of the COAG reforms of ending the blame game, unless you get some of those mechanisms right, you can have many of those discussions as you want and you will still get someone riding in as a white knight and buying the hospital.

CHAIR - I know. We won't go there!

Mr KIRWAN - The national reforms were intended to end the blame game and to get a simpler funding system so that the funding could follow the activity and the decision would be devolved as close to clinician and patients as possible. We have to get that right. There is a chance of our getting it right and there is also a chance of our getting this wrong. But if we get it wrong, we will just have more and more of these discussions. I do not argue the point and in the end I have a vested interested and obviously I will argue in respect of the patch that I represent. But if we do not, some of these things are fall over simply through attrition and that is not a good result either.

CHAIR - Certainly we need a critical mass to make things viable too, as we know and for the ongoing professional development and maintenance of accreditation and everything for health professionals.

Mr KIRWAN - My urge would be for this sort of debate to probably look at where the future health systems are likely to be. Far more academic and informed writers and commentators than I have made comments about the fact that our health system really has not changed much in the last 100 years - how we deliver care, our systems and structures. That is not quite right. Technology has changed and we do not have Florence Nightingale wards. But in a lot of other areas they are not dissimilar.

I would urge the discussion to look at some of the new models of care, the success, hopefully, of areas like the AM Unit, the ongoing success of that, telehealth, the NBN and others because I suspect where we are going to is probably a far bigger step and far bigger challenge than even these budget savings strategies because it really does deliver a very different model. I would also probably suggest that is hardly a discussion that people of my generation can necessarily lead. I think we are talking about the clever, young 30-year-old consultants and others because they are the ones who are going to embrace it or, if we do not, they are simply going to go to a country or a State where they can do so and they are our future.

CHAIR - Let's not lose them from the State then. Any other comments or questions or closing remarks you would like to make, John or Sonia?

Mr KIRWAN - No thanks.

Ms PURSE - No.

CHAIR - Thanks for your time and the frankness of the discussion and I can see the front page of the *Examiner*, 'Mad Dash for Cash'.

Mr KIRWAN - Yes, as soon as I said it I regretted it.

Laughter.

CHAIR - I think it gives a very good description of the process that has been undertaken. But thank you and we will see you up at the LGH in the Emergency Department entrance, is that where you want to meet us?

Ms PURSE - We will meet you at the Charles Street entrance at the reception.

CHAIR - Thank you very much, look forward to that. Thanks for your time.

THE WITNESSES WITHDREW.