THE LEGISLATIVE COUNCIL GOVERNMENT ADMINISTRATION COMMITTEE A MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART ON THURSDAY 5 APRIL 2012.

COST REDUCTION STRATEGIES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr DAVID SMART WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Ms Forrest) - Thank you for coming along, David; we appreciate you taking the time. The hearings are being recorded on *Hansard* and will form part of the public record and will be placed on the committee website. What you say before the committee is covered by parliamentary privilege but if you repeat things outside they may not be, so please keep that in mind. If there is anything you want to discuss that you feel is of a confidential nature, you can make that request of the committee and we will consider it. You were recommended to us by Dr Frank Nicklason. Would you like to give us a brief overview?

Dr SMART - I am a social professor and visiting specialist at the Royal Hobart Hospital, and medical co-director of the diving and hyperbaric medicine facility at the RHH. I am also a specialist in emergency medicine and director of the Calvary emergency department, so I see across both sectors with my work. I have another hat as branch council with the AMA, so I have some input there and the potential to see some information from them that brings together a bigger picture for me.

I came back to Tasmania from Western Australia in 1994 as an emergency medicine specialist and took over the role of Director of Emergency Medicine at the Royal Hobart Hospital from late-1994 through to 1998, when I moved into my current roles. I have switched from being a staff specialist to a visiting specialist now. The other role I have is that I consult professionally to the diving industry around Australia and the world, and also the navy. That was the reason for moving in the direction I did - because of the skills I had in that area.

Perhaps I could put forward a couple of perspectives. Looking at some of the issues that have resulted from cost cuts across the public sector, I believe that the public sector has become a little bit introspective and not looking outward for solutions. There are a number of solutions where cooperative liaison with the private sector could make quite a significant difference to the public sector's workload and to how its services are delivered.

Hobart is in a fairly unique position in relation to emergency medicine. In Australia there are about 7 million-7.5 million emergency attendances per annum and only 6 per cent of those are seen in the private system. In Hobart, there are two private EDs and they actually contribute between 30 per cent-33 per cent of the emergency caseload. The Royal Hobart sees about 48 000-50 000 patients a year and the private sector sees around 24 000 patients a year, of which Calvary has about half of those, so we see one-sixth of the emergency patients.

Over the last decade there has been a process evolving at the Royal Hobart where it has been recruiting only staff specialists who don't work across both sectors and that has been positive for the Royal Hobart but it has also led to an ageing of the general medical workforce in the community. Examples of this are Dr Robert Nightingale and Dr Rob Beattie, who recently retired. Their contributions to private-sector general medicine enabled in the 1990s and early 2000s a vibrant and effective private-sector roster for general medicine which fell apart about 2005-06. As a result of that, the private sector has struggled to recruit general physicians and specific specialists, which has led to an overflow of patients who have private health insurance that would normally access the private sector going to the Royal Hobart Hospital, and those patients are often complex medical cases that take up a lot of time, a lot of beds and, understandably, many of them don't access their private health insurance when they go to the Royal Hobart because they say, 'It's just failed me; why should I have private health insurance?'

Some of that is a significant effect of the way recruitment strategies have occurred over the last decade at the Royal Hobart which has led to quite a number of specialties having their service only at the Royal Hobart. For example, respiratory medicine is only at the Royal Hobart; there is no private respiratory service now. Rob Hewer was the last of the respiratory specialists who moved into the public sector. Neurology only has a public-sector setup, and endocrinology and infectious diseases both have very limited private-sector coverage and currently, even cardiology, which has previously been well served in both the private and public sectors, has had deficiencies in the private sector.

When patients come into emergency departments and have private health insurance they are 'serviced' by the emergency department, for want of a better word, and provided with clinical service and their health needs are met, and then it's time to refer them if they need admission. When they need admission there is a deficiency of general nursing, general surgery, and some of the subspecialty medicine like plastic surgery and now cardiology, which creates problems for the private sector dealing with these patients with private health insurance.

CHAIR - They end up in the public sector anyway.

Dr SMART - Yes.

CHAIR - Could you just explain the role of the staff specialist as opposed to - what is that term you used?

Dr SMART - A visiting specialist?

CHAIR - Yes.

Dr SMART - Staff specialists are appointed as full-timers at the Royal Hobart and, as such, my understanding is they have their practice restricted to just the Royal Hobart and certainly that appears to be the case in practice. Services for general medicine, for example, are not provided by the general physicians who are working at the Royal Hobart.

CHAIR - Do you know if that was a strategic decision? You might not know the answer to this but we can ask these questions. Do you have an understanding as to why that decision was taken that they were to recruit particularly staff specialists and restrict them to that?

Dr SMART - I am very much aware that there were deficiencies in key specialties at the Royal Hobart and a recruitment strategy was set in place in the 1990s to deal with that. I think that has been successful from the point of view of the Royal Hobart recruiting local graduates into those positions and they are good quality staff members that have been put into those positions.

CHAIR - So it was more about shoring up the Royal's position.

Dr SMART - Yes, it shored up the Royal, but because Hobart is such a small a town and because there is still 40 per cent private health insurance in Tasmania, the private sector in the past has relied on specialists in the town covering both sectors and the visiting specialists tend to do that. For example, Rob Nightingale and Robin Beattie, when I was a resident - and this is going way back - were visiting specialists, they consulted to the Royal Hobart with their ward rounds and they weren't there full time and they consulted to the private sector as well. So those services crossed both sectors and, for a small town where you might have some niche specialties and things like that, there is potentially enough work for those individuals across both sectors and it also mean that there is a balance between how the patients are distributed when they are admitted to hospital.

CHAIR - I find it a little bit odd in some respects, David, because the money is made in the private sector pretty much by medical specialists. I know that up in the north-west we have colocated the private hospital with the public one in Burnie and that has been the selling point, I guess, in some ways of getting people to come there in the first place, in that they can do their private practice and that is where the money is to be made, when we get down to tin-tacks. Then they have the public practice as well and I think some of them see that as community service because their private practice is what draws them there. So how do you get the balance?

Dr SMART - I think, as far as I see it, there has not been too many visiting specialist positions created.

CHAIR - It is about creating positions?

Dr SMART - Yes, it is about how the positions are created and offered for people to return to the town. If I can take it a little bit further, there does not appear to be any workforce planning strategy for the State and where this responsibility would rest is potentially one, I guess, of debate, as to whether or not the Health department should have this strategy or for organisations such as the AMA or others all having input to one area. I am unaware of any census or documentation of the State's medical workforce's needs and I am unaware of any strategic planning for the future needs of the workforce in this State.

Another example of this is some of the key specialties like ear, nose and throat surgery, where some of the surgeons are ageing and at some stage will pull up their stumps. Is there a strategy to recruit Tasmanian graduates to get them back to this State to replace that service? If we lose a key service like that which is medically-led, the next step is

they either go intrastate, up to Launceston, or they go to Melbourne. So that is one area that I believe is a matter of urgency which needs to occur to get a snapshot of where the medical workforce is in this State at the present stage, where there are deficiencies and how to correct those deficiencies in the future and deal with the issue.

Another area, I guess to give you an example of reactivity, is that I am also unaware and there has not been any articulated strategy for dealing with the increased numbers of graduates coming through our medical school. There is a disconnect between Federal funding of the university, which has increased its places in the last five or six years, and the ability of the State to fund the intern positions that they need to complete their training and then, subsequent to that, the resident positions. These junior positions all form the basis of the pyramid which then feeds into our medical workforce. The confidence in that has been significantly affected in the last 12 months by reductions of some areas of these resident positions at Royal Hobart. Regardless of the numbers that are argued over - I was quoted 18, but I believe it is less than that, positions that were stopped at Royal Hobart for the coming year - the effect of it was a lack of confidence by the doctors in their future medical prospects and the workforce in this State and a lot of them chose not to stay here next year.

I will give you an example of a very strange paradox. The key area of general medicine, which has always been short, is even shorter this year and was, I understand, two residents short in its intake, so they are deficient in those positions. In that area Calvary Health Care has a Federally-funded position for a medical registrar to rotate from Royal Hobart out to Calvary and that position is currently unoccupied. It has money but there is no money going to anyone because the Royal Hobart was short of residents and registrars, so they chose to not rotate someone to a funded position, yet they are having cost cuts of their own medical full-time equivalents.

CHAIR - Is this a resident or registrar?

Dr SMART - No, it is a registrar - $100 000 funding from the Federal Government for a position at Calvary, which is unoccupied at the present time.

CHAIR - A registrar in what?

Dr SMART - A registrar in general medicine - the key area of deficiency for the future.

Mr WILKINSON - So that is $100 000 that was offered by the Feds - how much extra would the State have to tip in?

Dr SMART - Nil, it was completely funded.

CHAIR - To share a registrar?

Dr SMART - Yes, they rotate from Royal Hobart Hospital - and they were rotating every three months last year but this year, because of Royal Hobart Hospital's shortage of doctors, they decided there was no-one to rotate out to Calvary.

CHAIR - So you're saying that it's the budget cuts that employed less registrars to save costs?

Dr SMART - Yes, they did.

CHAIR - But they're not taking up this $100 000-funded position because of that, so they've cut themselves short?

Dr SMART - What has happened is that because of a lack of confidence in the system there was a shortage of applicants for positions. The cuts have come to the point where the doctors say, 'I'm out of here. I'm not staying on at Royal Hobart because I'm uncertain of whether or not the positions will be cut'.

Mr WILKINSON - But with this one it's fully funded, the State doesn't have to tip in any money?

Dr SMART - No, they don't.

Mr WILKINSON - The Royal Hobart will get a general registrar and that registrar would also be able to work at Calvary?

Dr SMART - Yes.

Mr WILKINSON - So there is a position begging for somebody, without any money at all being paid by the State?

Dr SMART - It's not necessary for the State to pay anything.

Mr WILKINSON - And the State hasn't done anything about it?

Dr SMART - No, because I guess nobody is seeing the bigger picture here. This is Federal money that would circulate in the community and it's a solution to funding a position in this town that the State doesn't have to worry about.

CHAIR - But you're saying that the registrars aren't coming now because of the bigger concern about budget cuts and access to experience.

Dr SMART - That's right; that happened from last year - they voted with their feet.

Dr GOODWIN - So you can't get anyone to fill that position, is that what you're saying?

Dr SMART - No. There will be, say, 20 positions potentially - I don't know the correct number, so I place on record that this is not me quoting a number that someone should take up - 20 doctors might apply to those positions and get them, so they will be occupying all 20. Then they rotate through different specialties for experience, so one of the rotations goes out to Calvary in general medicine. So as a result of perhaps only 18 people applying for the 20 positions, two are short and one of the positions has been not filled, so a choice has been made at a local level not to rotate the person out to Calvary.

CHAIR - So in your view it's a choice that has been made by the Royal Hobart Hospital not to fill that position? How many general medicine registrars would the Royal have?

Dr SMART - I can't quote you that because I'm not responsible for training.

CHAIR - But there would be more than one?

Dr SMART - Yes, there are potentially a dozen.

CHAIR - So we are looking at a specific number of medical registrars and one of those is potentially a fully-funded position that's not being utilised because they are saying there wasn't an applicant for it?

Dr SMART - Yes, that's right.

CHAIR - But you could say, 'Dr *X* is a medical registrar', and put him or her through that?

Dr SMART - Yes, and presumably because there's a shortage they are also focusing on service delivery at the Royal Hobart Hospital and if they move one person who is in a position at Royal Hobart out to Calvary they lose that service at the Royal Hobart.

Dr GOODWIN - From a training perspective, though, there'd be advantages for a registrar to go to Calvary and have that experience?

Dr SMART - There are big advantages; they get a different experience out of it and in the long term they have perspectives from the private sector that may well feed in to the workforce of this State that corrects key workforce shortages that are currently there.

Mr WILKINSON - When you said approximately 20 positions, that's a figure that you say is a bit rubbery because you don't know exactly -

Dr SMART - I'm not responsible for that training program.

Mr WILKINSON - I understand that - but they didn't have enough applicants for all those positions and therefore it's up to the Royal where they put these applicants?

Dr SMART - Yes.

Mr WILKINSON - It would seem the Royal is saying, 'We are short in however many specialties, therefore these applicants are going into those and not into general medicine', even though if it was general medicine they would be fully funded and could share with Calvary?

Dr SMART - Yes. The position is one of a suite of choices for general medicine, so it's not been taken up, I guess.

Mr WILKINSON - Do you believe that there are people who would be willing to take that up if it was offered to them?

Dr SMART - I think it comes down to a greater degree in reestablishing confidence in the system. There is a distinct lack of confidence from even the medical students I have talked to about the future. The funding of intern and resident positions is a mismatch between the number of graduates who are going to come through and, because that is

funding at State level, the medical students who have had a choice have voted with their feet and they are seeking to find jobs interstate and security and career paths interstate.

Mr WILKINSON - Do you believe that the specialists, people like yourself and others within the medical world, have had any say? Have they been asked to give their opinions as to what is the best way out of this or has it been more Treasury and department run?

Dr SMART - I think there has been very little chance of having any input.

Mr WILKINSON - Do you believe that if this input was given to the medical specialists et cetera that there would be more confidence within the area? Firstly, because they would own the decisions because the decisions would be partly theirs and, secondly, they could then enforce that confidence right down to the students because they would say that these are our bosses that are having a say in this and obviously they are going to look after our future uppermost, as opposed to other things?

Dr SMART - Yes, I think so, if there is a straight budget cut and it is going to cut services and it is not an area that I am going to own and I am told where the budget cut is coming. I think with the input from specialists and particular medical fields there is the opportunity of working a lot smarter than we are currently working with the system. The system is not accessing all of the capability as a result of what is available in the private sector to take some of the pressure off the Royal Hobart.

If I can give an example, if the emergency departments close, and the deficiency of key specialists can potentially tip this over to closing, because neither of the private EDs make a profit and you are talking of the order of millions of dollars lost. The advantage to the private sector is as a result of the admissions that the emergency departments create for their beds because emergency cases in the private sector are underfunded by a substantial amount. They tend to be done for reasons of the bed access but if there are alternative ways to get access that becomes under threat too. Also the number of admissions generated is deficient because if there are not key specialists available to take the patients then they are also not viable.

There are 6 000 medical inpatient bed days currently serviced by the private sector. Just divide that by 365 and you end up with roughly a 20-bed medical ward for the whole year.

CHAIR - But you can't you use it because you have no medical -

Dr SMART - No, what I am saying is that creative solutions are assisting but it is very vulnerable. If, for example, the EDs close and those bed days of medical patients were transferred to the Royal Hobart, it would implode. With 24 000 patients a year seen by the private emergency departments, if they closed the Royal would implode because it has been, as I said, a unique position. If we went back to only 7 per cent of the patients being seen in the private sector EDs - the national average - I guess the Royal Hobart has been able in a way to be supported by the private sector over the last 15 years in a unique way compared with the rest of Australia. If it was anywhere else it would be seeing 70 000 emergency attendances a year.

CHAIR - What is the solution here then? There is greater collaboration. We did ask the department for some evidence about the number of privately insured patients who were transferred from the public hospitals to private nearby. They did not provide some of the information we asked for but that is another matter. It seems that they have not been tracking that. They have not really got a clue as to how many come across and why. Obviously they are not going to come across from the Royal to Calvary or others if the specialist service is not available there, but what is the solution? How do we get this to work better when there is availability in the private sector that could be used?

Dr SMART - That is right. The first one is to change the recruitment strategy and have a mixture of visiting specialists in all of the speciality areas, and staff specialists. That then would enable the visiting specialists to service both sectors.

Mr WILKINSON - Is that more an employment plus, as far as a medical practitioner is concerned? To me, it would be. If I was coming to Tasmania to take up a medical registrar's job, I would be looking for something. Yes, I would work in the private sector but I would also work in the public sector -

Dr SMART - The registrars are fully employed because they are in training positions.

Mr WILKINSON - Thank you. But, to me, it would be a real plus to be able to have this ability to work both in the public and private system.

Dr SMART - It certainly is the way I choose to work and it is an advantage to me because of my skills in the diving medicine field and the ability to consult to industry and the navy and other fields like that in the private. That is one of the reasons I chose to go the way I have gone for the mix of practice that I have had. I think individual specialities would have individual reasons but I think there is a significant advantage to having a foot in both camps around Tasmania in terms of the mix of the patients you see, the service delivery and the ability to service the community, which has needs because people have chosen to have private health insurance as well as the public sector. I am not berating the public sector. I think vibrancy in both sectors is important.

CHAIR - So how do you get greater synergies?

Dr SMART - I think talking to each other is an important one, certainly at high level. As you are aware, there have been substantial management changes at the Royal Hobart. Unfortunately, even at Calvary we have just lost our CEO and appointed another one. Our last CEO was there for four years, which is significantly longer than the average in the public sector. I think those meetings and synergies can be explored between high-level people in both sectors to identify solutions.

I think workforce planning and census is an incredibly important thing to do as a matter of urgency to find out what the needs are, what we have at the present stage and where we have deficiencies and then look at some sort of targeted approach for encouraging our own local brightest and best into key speciality areas that are going to be useful and helpful to our community.

CHAIR - You have to identify them first, don't you?

Dr SMART - Yes, that is right and some data in relations to the needs would help. The Federal Government GP superclinics are not going to have any impact whatsoever on emergency attendances.

CHAIR - Why do you say that?

Dr SMART - They are operational 54 hours a week. They see general practice cases. They have a one in 1 000 admission rate. Your average emergency department has between 250 per 1 000 and 400 per 1 000 admission. You are dealing with a completely different case mix that is going to be serviced by GP superclinics, less sick patients, GP cases and, in fact, they do not even provide a 24-hour service. They are only providing a 54-hour service. So that is not going to impact on ED attendances at all and that has been the case.

CHAIR - You still have to staff the GP superclinic with doctors -

Dr SMART - An enormous resource. In fact, some of those clinics could have the same budget as an emergency department.

CHAIR - Seriously?

Dr SMART - Yes. So I do not see those as a solution.

CHAIR - The GP superclinics are funded by Commonwealth?

Dr SMART - Yes.

CHAIR - Some of them in Tasmania have the same size budget as DEMs?

Dr SMART - Yes, potentially, as an emergency department.

Mr WILKINSON - And they are only open pretty well eight hours a days for seven days.

Dr SMART - There is a misconception that emergency departments are overflowing with category 5 patients who are actually general practice cases. They reason why emergency departments are buckling is access block, which has probably been mentioned by others in submissions, and long delays to access a bed for someone who has already been packaged and worked up in the emergency department.

CHAIR - It comes back to that lack of capacity to transfer to the private if you do not have that speciality in that area.

Dr SMART - That is right.

Mr WILKINSON - These superclinics are a Federal Government thing.

Dr SMART - Yes.

Mr WILKINSON - But each State is different?

Dr SMART - They are.

Mr WILKINSON - Are they okay for other States, but within Tasmania the money spent on those is not as good as the money that could be spent, let us say, on the Royal Hobart Hospital?

Dr SMART - No, I think it is a misconception around the whole of Australia that the GP superclinics will fix emergency department attendances. Certainly in Perth, which was one of the earliest models of these sorts of clinics being implemented, there was basically no impact on emergency department numbers.

Dr GOODWIN - Do they have other benefits?

Dr SMART - I am sure they do, in general practice, in more extended care et cetera, but I'm not an expert on the way those clinics operate. All I can say is this is the impact on emergency departments. They're not a solution to emergency department issues.

CHAIR - Can I put a proposal to you - and the Federal Government would need to consider this - if superclinics were to predominantly support allied health, and the benefit of a superclinic is to have allied health support for the GP there, if the money that was deemed to be to deal with the emergency cases above GP level, because the funding they are getting expects them to service those sorts of patients, if that was put into the DEMs of the various hospitals, would that be a more appropriate use of the funds?

Dr SMART - It would be very useful, yes. It would be very productively used, I can assure you.

I gave a presentation at last year's Tasmanian health conference in relation to this particular topic, so I have a few summaries. The private sector can be part of the problem or part of the solution, depending on how it's engaged. Medical recruitment and post-grad training should be seen as a whole-of-State and whole-of-city issue. The first three years post-graduate is an important component of retaining our medical workforce and I think that is what is being shattered at the present stage with the confidence in the system and the doctors who could potentially stay there.

I have mentioned the mix of visiting specialists and staff specialists. There is a disincentive with staff specialist awards at the present stage for them to undertake part-time practice. At the moment their award has a clip-on agreement, which has car and communications and other benefits that apply to a full-timer but no-one else, so if you go to 0.9 or 0.8 FTE you don't get a pro rata of that package.

CHAIR - So three-quarters of a car?

Dr SMART - Yes, that's right, or a selection from the suite, for example. It might be $20 000 worth but you get $15 000, which might include the car but you would forgo other things. That is a disincentive currently for people to move out of the public sector.

The other area is the university, and you have probably talked to people from there. There is not an integrated process with the university for appointments at the present stage. When I worked at the Flinders Medical Centre, university appointments were

truly conjoined; there were equal salaries, conditions et cetera for those who worked in the university but had a component of their work that was with the hospital. That is a challenge to sort out here and certainly if it was integrated better it would make for a far better educational setup and links between the public sector.

CHAIR - It's one way to look at addressing that - to rename all the hospitals in the State as Tasmanian University hospitals and get away from the Royal Hobart, the Launceston General, the North West Regional and the Mersey. That's my solution to that problem.

Dr SMART - There are a couple of other areas that I haven't mentioned. I will comment about hyperbaric medicine. We are a statewide service in diving and hyperbaric medicine and we support the industries in this State which generate probably $350 million worth of export income. If the chamber was to close, diving activity and abalone diving and particularly the aquaculture industry would close because there would be no emergency backup for them. We have to notify that industry if we have a shutdown of the chamber for any reason - when we do maintenance or something like that. Our service, being based at the Royal Hobart Hospital, seems to have to only be funded by Royal Hobart, and there doesn't seem to be - the way the State looks at its service delivery - where there is a State service that other regions either chip in for or those services that are statewide are actually funded as an independent entity because they have all three regions accessing them.

CHAIR - Because it is based at the Royal, the Royal would have to fund the entirety of that even if a west coast fisherman required service?

Dr SMART - Yes, or King Island or Flinders Island. As an example, over the long weekend of March, in the middle of the Sunday night I had to organise the retrieval of a diver from St Helens who came down by aeromedical evacuation for us to assess and treat at the Royal Hobart, so those are coming from other regions of the State. We have the on-call, the call-back, for providing that service, however there is no budget allocation for on-call, call-backs or leave cover.

CHAIR - So do you get paid?

Dr SMART - We do, but we run over budget because there isn't a budget allocation. That to me seems very strange and if that is a pattern that is more extensive it is no wonder budgets are being exceeded because what is required for the service has not been appropriately assessed.

CHAIR - How many times, on average, in a year would you be called out?

Dr SMART - We get about 50-plus call-outs out-of-hours per annum.

CHAIR - How much does that equate to in dollar terms?

Dr SMART - About $120 000 to $150 000. When a call-out occurs we need technical staff, medical staff and nursing staff.

CHAIR - That is $120 000 to $150 000 each call-out?

Dr SMART - No, crikey, no. Probably for a treatment that might last six hours that would be $3 000 for all of the staff, so you multiply that by 50.

Dr GOODWIN - So that $120 000 to $150 000 is not budgeted for?

Dr SMART - No, that's right.

Dr GOODWIN - And does that happen every year?

Dr SMART - Well, it has got worse because, I guess, of bracket creep with salaries that also do not seem to be incremented when budgets are allocated, so if an award to nursing gives them 3 per cent, their salaries are not incremented by 3 per cent.

Dr GOODWIN - So the budgets are unrealistic to start with because they can't ever achieved?

Dr SMART - That is my perspective. This year I am looking at a budget blowout of $280 000.

CHAIR - And $150 000 of that could be the call-outs that are unbudgeted anyway.

Dr SMART - Yes, and leave cover.

CHAIR - Leave cover?

Dr SMART - It is a 24-7 service. I have 1.08 full-time equivalents and I am using a retired doctor to cover leave at the present stage because I lost two fractional appointments last year that I was going to try to recruit to and they were taken away in the budget cuts. For service delivery I need 1.25-1.3 FTEs to enable a continuous statewide service and I only have 1.08.

CHAIR - What you are saying is that what you have been given as far as the budget cuts go is completely unrealistic as far as meeting your budget anyway?

Dr SMART - Yes.

CHAIR - And even before that it was unrealistic because there were certain aspects of the role that you fulfil that were unfunded.

Dr SMART - That's right.

Mr WILKINSON - You can use stronger words than that because history tells you that you get these call-outs each year and you've had them for however many years and therefore it should have been an obvious matter that should have been budgeted for.

Dr SMART - Yes, that's right. That also generates income, $500 000 a year from private patient bed fees, and the compensable patients who come in and are admitted to hospital. That is not taken into account in the allocation of the budget either.

CHAIR - The money doesn't come back to you, then?

Dr SMART - Not directly, no; I think it goes into general revenue. It is a challenge when delivering that sort of service and I am very uncertain and insecure about what is going to happen at the end of this financial year when the current sums are all totalled up. I might add also, just to complete that, if we transfer the divers we treat to Melbourne - and I have done the costing for this because we were under threat in 2008 - basically the whole cost of the unit would go on diver retrieval, because you're talking $30 000 per diver to transfer them to the Alfred, with concomitant delays in their service and potential bad outcomes. So for quadriplegics who we treat in the space of an hour-and-a-half and they get better, if they take six hours to get to Melbourne they stay quadriplegic.

CHAIR - We are just about out of time, David. We could talk to you much longer, I am sure, but is there anything you particularly wanted to raise before you leave?

Dr SMART - The Royal Hobart has 50 per cent of its surgery done as emergencies. Is there any way a reengineering of the model of surgery can take place to create a public elective hospital that independent of the emergency hospital? It is another two separate streams. One runs an efficient service that is like a machine, a factory with -

CHAIR - Dedicated elective surgery.

Dr SMART - Yes, dedicated elective surgery.

CHAIR - We tried to do that up on the north-west coast but someone intervened.

Dr SMART - Okay.

Mr WILKINSON - Would you believe that the biggest and the most important thing that should be done is for the people who are saying what the budget should be to speak with the medical fraternity and get something put from a medical perspective?

Dr SMART - Yes.

Mr WILKINSON - I don't know whether you have the read the book *Kokoda* but it would seem that the orders were made by people in hotels in Queensland who didn't have a clue what was going on at the coalface. From what you are saying and from other evidence that we have heard, could the same comment be made?

Dr SMART - Their engagement would certainly help a lot to get perspectives across and have solutions that probably have not even been thought of.

CHAIR - Thank you very much for your time, we appreciate it.

Dr SMART - Cheers.

THE WITNESS WITHDREW.

Mr MATTHEW DALY, SECRETARY, **Ms PENNY EGAN**, CHIEF FINANCIAL OFFICER, AND **Ms FIONA STOKER**, CHIEF NURSE, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Just for your benefit, Matthew, I know the others know the drill pretty well with the committee. What is being said is recorded on *Hansard* and will be a full part of the public and placed on the website in a few days but it then is part of the public record. Everything you say here is covered by parliamentary privilege. If you say stuff outside, it may not be. If there is any information you want to provide in camera, you can make that request to the committee and we will consider it. Otherwise, it is all public evidence and you are aware of our friends from the media here. Do you have any questions before we start?

Mr DALY - No, that is straightforward, thank you.

CHAIR - We are addressing the term of reference, looking at the cost-saving strategies. Sometimes some of the witnesses speak on areas broader than that during the course of the inquiry but generally we are trying to focus on the impact of these cuts and the decision-making framework around how they came to be. That means we will probably focus a lot of our attention on that today. Can you perhaps give us an update of where we are with the savings? We talked to the department before when you were here some time ago, leading into the commencement of the cuts, and it's evident that a lot of the impacts are only starting to be felt now, particularly the cuts to elective surgery.

Mr DALY - In terms of the financial position of the Department of Health and Human Services receiving that $100 million reduction, I think it is fair to say there was a delay in a number of the major delivery units commencing strategies to deliver that reduction. At this stage we believe we are on track for a department-wide unfavourability of about $25 million. Given the concerted effort that I know is going on right across the system, there is potential for an improvement in that figure, but all the data at this stage would indicate that $25 million is the probable outcome as an end-of-year result. As to the $100 million target, the department has been given latitude to deliver that $100 million recurrent cost reduction out by the second quarter of the new financial year. In assessing both the performance of the strategies but, more importantly, my assessment of the outcomes and the data that indicates those outcomes, would indicate that we should meet that objective by the second quarter of the 2012-13 financial year.

CHAIR - So the $25 million was the Supplementary Appropriation Bill that we dealt with last week in the Chamber?

Mr DALY - Yes.

CHAIR - What specific areas have not been achieved?

Mr DALY - The delivery units that will deliver that unfavourability are the three area health services. By my assessment I believe the Southern Area Health Service - and this is based on data at the end of February; we haven't had an opportunity to collect March to

make an assessment as yet - is probably looking at about $21 million unfavourable; the Northern Area Health Service is about $9 million; and the North West Area Health Service is about $6.4 million. There are some swings and roundabouts in the department right across the agency that would help balance that down to $25 million by year end, including some one-off cash that is available to bring the whole agency result down to approximately $25 million.

CHAIR - 'One-off cash' - what are you referring to there?

Mr DALY - It is from a variety of sources.

Ms EGAN - There is some funding that we carried over to deal with a couple of issues which we may no longer need to worry about. There is some funding we receive from rents from the Hobart Private and funding from some other areas. They are genuine revenue streams but they're not allocated out as part of a budget. We have perhaps $8 million to $10 million that will help us this year to bring that budget down.

Mr WILKINSON - Has the department at any stage got all the senior medical staff together and had a long discussion with them - maybe a weekend - to talk about ways the cost-cutting can be met in ways which are more acceptable to all concerned? In these committee hearings we have had a number of suggestions put forward by witnesses as to where savings can be made, but these people are saying they haven't been spoken to and have been left out of the equation. To me, that would be the first job that should be done; getting the senior medical people in and seeing what they say in relation to cost savings. Has it been done?

Mr DALY - In the eight weeks since I have been in the job I haven't done that. I have met with a number and variety of clinicians at a number of our facilities right across the State and clearly budgets and the impacts upon them are part of the conversation, as well as trying to look forward beyond the current position we find ourselves in. I know that the chief executives, who frankly do carry and should carry that responsibility to meet with their clinicians - medical nursing and allied health - to look at alternatives, do so on both a formal and informal basis on a very regular basis. Most chief executives have very senior clinicians as part of their management and executive team and, whilst particularly in a big place such as Royal Hobart and, to a lesser extent Launceston for a CEO to consult with every medical practitioner can be a little bit difficult.

Mr WILKINSON - I am not talking about everyone but the senior ones in the areas. I hear what you are saying but they are saying otherwise, so something is happening. Either they are talking and they are forgetting they have had these chats or it is not happening.

CHAIR - There is very clear evidence from the Northern Area Health Service CEO that he was given instructions not to discuss the cuts with any clinical staff. He was to make the decisions of where to cut, how to cut and when to cut in a vacuum, almost, without talking to senior clinicians. The CEO, who was acting at the time, of the Southern Area Health Service took a different approach. We did not actually distribute to the question to the North West Area Health Service acting CEO either. But that was clear evidence to the committee, so do you say that is not the case?

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

CHAIR - Did that happen?

Mr DALY - The written instruction was delivered?

CHAIR - Yes.

Mr DALY - No. No written instruction came from the department. I asked Mr Kirwan for a copy of that because I intended to take administrative action within the department from whoever issued that written directive. I can assure you that none was issued and Mr Kirwan has advised me he has received nothing. I was not here at the time and from my picking up conversations there was a very strong desire to go back and formulate plans without distressing and creating anxiety both within the hospital communities and the general communities because, as I read it now retrospectively, a whole host of strategies came up from the chief executive - and remember these are the chief executive's strategies - and some of them were outrightly negated by Government because they were unreasonable or unacceptable to Government to take certain steps.

CHAIR - Are you aware whether the minister then issued a directive to the CEOs?

Mr DALY - I am not aware of any directive from the minister, no. Frankly, I would have given the same advice. There is no point in scaring the horses back at the farm around things that are never going to happen. Having done this many, many times in my 30 years in health, you cannot do it without appropriate consultation and buy-in - and that is just management 101. My reading is that the messages got a bit mixed from what was intended, which was good advice around distressing staff and communities around things that would never get off the ground, and appropriately consulting senior clinical staff of all ilk in order to make the best options out of a very tight financial position.

Mr WILKINSON - Because looking from afar somebody could easily conclude that the decision was that our budgets have real problems therefore it was a knee-jerk reaction and a panic reaction. We have to cut it by *x* and that was a Treasury and Government decision. It was a decision which was not made with proper consultation with people who really know how you can cut it - that is, those people who are at the work face.

Mr DALY - I think all our chief executives have learnt a lot from this process and I trust they will never have to go through it again to this extent, but if they remain in Health one thing I can guarantee is that they will be managing finite resources with endless demand in reality. That is the very difficult lot of any senior health manager in the system in any State in this country, if not the world. It is a tough gig.

Mr WILKINSON - I understand that, but if you can get some ownership from the clinicians and the senior clinicians you get ownership as well and they start to then do all they can because it is their decision to own what is happening and to work within what is happening. But if they believe they have no real say in what is going on, they do not

have that ownership and they do not have the ability, I don't think, to work in a fashion in which they should work with the confidence that they should need to continue on.

Mr DALY - I totally agree in terms of the philosophy but the nature of medical communities, in my experience, is that there is never a single view, never a single voice. Whilst I have talked to clinicians who have a similar view to what you have just described I probably talk to an equal if not greater number who have been well embraced by their CEOs in one form or another and actually do have a sense of ownership. So I think to say that no clinical staff have any ownership to these decisions would be being a little bit harsh towards the three CEOs concerned, to be honest.

CHAIR - I think we probably interrupted you there when you were talking about how the savings were going to be made. Can you clarify for the committee the internal processes that you use to identify and manage the cost savings and the budget generally. Is there a similar group to the budget control team which has representatives from each department's output groups and the chief financial officer that meet regularly or has it been done basically in silos which each area doing their own thing?

Mr DALY - Again, looking at documentation before I arrived here, there a process of the department with some input from Treasury et cetera that were looking at budget strategies coming forward from each of the chief executives. Once those were signed off by the minister, they came back and were monitored through that business control team, as they were called. I took a slightly different approach when I arrived here to focus on the outcomes of those strategies rather than trying to measure strategies. The difficulty in trying the measure some of these strategies is the data and certainly our data systems in health generally are very poor in being able to tie every dollar back to source. So I was looking at the key indicators and outcomes that indicate the budget is performing in terms of expenditure levels, activity levels, FTE movements, which is the biggest contributor to health, as you know. I was looking at the outputs to guide my advice to government on where I think the budget is going to end up and what additional measures we need to take and what time line it will be delivered, rather than focusing on the strategies which the CEOs are all working very hard to deliver.

CHAIR - Are you saying that you are taking a helicopter view, basically, and the CEOs are still doing their bit within their areas?

Mr DALY - Yes, I believe I have some agency-wide responsibilities around structural reforms that have lead times, as opposed to fairly heavy responses in terms of reducing staff numbers or elective surgery or whatever each CEO chose. But I guess more than just a helicopter view I was focused on looking at the outcomes from those in terms of expenditure levels, tracking goods and service consumptions, which is a predictor of future expenditure levels in terms of inventory levels. I was looking for outputs and evidence because I was struggling to find sufficient evidence on my arrival here to commit to a position to advise government. If I am not confident doing it, I will not give an opinion.

CHAIR - With the budget control committee, you said 'as they were called.' Are they called something different now?

Mr DALY - No, it still exists. It has not been meeting as frequently. I think it was meeting weekly or fortnightly and you get to the point where you start getting in the CEO's road to deliver what they need to deliver. So it still has an oversight role. We have a regular meeting around finance anyway, so there is a little bit of duplication. But given that there are other agencies with an interest in health, as it is 35 per cent of the budget ask on Government, you have to provide forums for them to be reassured that we are on track.

Mr WILKINSON - In relation to CEOs, are they on a salary with incentives if they meet certain targets?

Mr DALY - I understand that our senior executive salaries work by way of potential progression along a band that someone was on and any progression along that band is subject to a satisfactory performance management review.

Mr WILKINSON - In other words, if they can cut the budget by *x* million dollars, they get an incentive payment as a result?

Mr DALY - The performance agreements I am putting in place with them clearly will have financial targets. They will also have quality and patient safety indicators. They will have activity targets for the return on investment that they expend, as well as a host of other measures for them to perform towards. So there is a host of KPIs that they perform to and finance in certainly one of them.

Mr WILKINSON - So if Jim Wilkinson is in charge of the southern area as a CEO and I cut the budget by *x* million dollars, I get a payment, over an above my salary, by a stated figure, is that right?

Mr DALY - If you delivered on that, if you delivered on your clinical indicators around elective surgery and emergency department performance, if you delivered on all your patient safety indicators - both the State objectives and particularly now the Commonwealth objectives - and anything else you and I would have negotiated, but in the future you and the board and the THO chair, would you have indicated that you have the capacity to take a step along your salary band.

CHAIR - So an ongoing increase in their salary. They go up a level and they're on a higher rate from then on, is that what you're saying?

Mr DALY - Yes, they move a step up.

CHAIR - Do they drop back if they don't perform?

Mr DALY - At the end of every contract, I understand, we have the capacity to reset someone on the band. Most contracts are five years, so if you perform in a two-year performance agreement you can receive approval - I think it goes through the Premier, but I don't know that; I am very new to this - that would allow you to step up. There may only be three or four steps in that band so by the end of your five-year contract you could be at the top of the band, which means there is no scope for any further salary change or growth. I was told only yesterday that there are examples in this State where people have been offered a new contract but have been reset at the beginning of the bad they're on in order to provide a financial incentive?

CHAIR - So taking a reduction in salary?

Mr DALY - Yes.

CHAIR - Just going back to the budget control team, the committee asked the department previously for some information regarding the minutes and details of the budget control team's meetings, communications, correspondence and that sort of thing. Some of it was provided and a lot of it was blacked out. We had an agreement that the department would provide this evidence to the committee in camera but that still hasn't happened. Are you aware of what is happening with that?

Mr DALY - I asked about it this morning and I was shown a pile of paperwork that we are going to provide to you in that format. So the only advice I can give you is that it's impending.

CHAIR - It's in the mail.

Mr DALY - No, it's not in the mail because I saw it on someone's desk.

CHAIR - So we can expect to receive that very soon?

Mr DALY - Yes.

Dr GOODWIN - I have a question in regard to the projected deficits for the three area health services. You have outlined what they are: southern, $21 million; northern, $9 million; and north-west, $6.4 million. What happens when we transition to the three THOs? Do they carry those deficits with them? How does that work?

Mr DALY - Regardless of whether they are transitioned into the THOs or remain as we were, they would need to have recurrent budget strategies in place to address those deficits, which is why, as we go into the new financial year, the budget ask of these area health services will be more than what the forward Estimates presents. There will be factors such as delivering on the balance of their $100 million and using one-off strategies this year that aren't annualised - so they have to find it for next year - and those types of things. It is a wee bit more than what forward Estimates may indicate.

Dr GOODWIN - Why do you think they weren't able to achieve their targets? Was it a time thing? Did they need more time to get to the target?

CHAIR - Was it unrealistic to start with?

Mr DALY - That is a view that I've heard across the system in my eight weeks here. I think the biggest single indicator or explanation for that - and they have all said it to me, so I am not speaking out of school - is that they didn't think the Government was serious, that they have a track record of not managing to a budget going back many years. They believed they would be bailed out again, but the clear evidence of the seriousness of the State's finances are such that there was no cash to do so. When that penny dropped, some sooner than later, they got to work. That is why as all of agency we needed one to two quarters into the new financial year to give a full 12-month effect in terms of

delivering this $100 million. Some strategies, frankly, weren't effectively put into place until January.

CHAIR - Did they give an indication of why they thought that the Government wasn't serious? The Premier came out pretty strongly, I thought, and it was pretty clear - mind you, she and others had done so before this. I remember the former Treasurer in our place saying this is it and there will not be any more. Why did they not think it was serious? The evidence was there that the Budget was in trouble. Did they give an indication why they did not think it was a genuine action of government?

Mr DALY - I don't want to surmise why they formed the opinion that they did other than I guess drawing upon their experience of many years. The end result is what I am dealing with now, the reality of having to deliver something in a shortened period of time. If it was achievable over 12 months it is certainly not achievable over six months and I guess that was recognised by the flexibility of government to allow us into the second quarter of the new year, rather than undertaking more draconian steps that could have impacted on services more than anyone would have liked.

CHAIR - I will put in two ways, perhaps. The recognition of savings required was actioned back in 2008 when it was first talked about when the GFC hit. There was concern raised and expectations were put in place to save a certain amount and then the handbrake was taken off because of an election coming - shame about that, but there you go. Then we had it again and the rules were laid down that these are the savings we need to make and harsher this time, because of savings not being made in 2008. If the departments or the CEOs or whoever had taken it seriously and not thought they were going to get blown out -

Mr DALY - Not all CEOs, I might add; there was a differing level of response and engagement across our system.

CHAIR - Okay. This is one of the points we raised in budget Estimates last year. If you are going to make $100 million worth of savings across Health, realistically or otherwise, you are going to have to start on 1 July, and clearly we did not even see the budget strategies being put out until October, I think it was. Obviously there was some work done in that time but is that why we are looking at the problem we are now? As you say, you are only going to take the first two quarters to get it in line with the savings requirements. If you had started in July it would have been pretty close - is that what you are saying?

Mr DALY - I don't know whether it would have been pretty close. I don't understand the dynamics at that period of time. I am speaking from a point of ignorance. I would only be giving an opinion that is probably not based on sufficient fact, but $100 million was a very big target.

CHAIR - Where was the lack of credibility, which area are we talking about - north, south or north-west - that thought they were going to be bailed out?

Mr DALY - Reinforced through many years' experience, I think the whole system believed it would.

CHAIR - You said there was greater or quicker acknowledgment in some areas - where was the lag?

Mr DALY - I think that is evidenced by the pick-up of strategies. The latest strategies have really only started to bite in the north and that was a decision the CEO up there took to start those later in the year. The Southern Area Health Service started much earlier in the year and started to demonstrate that improvement well before Christmas, whereas the north is really just struggling to actually show the data to improve on that at the moment, but I am expecting in the March figures that we will see a much better improvement from the north.

CHAIR - The evidence we got from the north-west acting CEO was that when the acting CEO of the south was up there she put a lot of efficiency measures in place before the budget cuts were announced so that made their task even harder. Was the north-west moving as promptly, do you think, as well? You said the south jumped a bit quicker.

Mr DALY - Certainly the data would indicate that the north-west has made big inroads into its expenditure this year and I think the comment you made about the efficiencies that were put in place in the previous financial year has some validity to it, which is why, as we are looking to the new financial year, rather than taking a bland approach of 10 per cent of departmental activities and 5 per cent across the area health service, which was roughly how the approach was taken and I presume that was given as evidence earlier in this process, we are now taking a more discretionary look so that we don't disadvantage good performers for those who actually have been working on this for some time.

We are modelling various approaches which will obviously go to the minister around how any budget reduction into the new financial year will be distributed, based on the discretionary capacity to deliver, and there is an enormous amount of money that comes into our system. Commonwealth funds, for instance, are 30 per cent of our funding base or more, and clearly we have no capacity to cut back on Commonwealth programs because we will lose the money if we do not deliver on them. So if you have delivery units that are very successful in attracting Commonwealth funds you cannot just apply the uniform number to them because it will just disadvantage them and make it untenable.

Mr WILKINSON - Is the Government listening to what you are saying in relation to Health cuts and, secondly, acting upon what you say? It would seem to me that to have the three separate health organisations would have been totally contrary to what was believed to be the appropriate and most effective way of dealing with that matter.

Mr DALY - The Government is going through its budget formulation process at the moment. Certainly in all my conversations with my ministers and senior officials in Treasury and DPAC I have been very frank around what has happened this year, what future out-years based on estimates could mean and how we might be able to respond, given that potentially Health could bring down the whole State Budget, so it's a major responsibility to ensure that does not happen.

Mr WILKINSON - What would be the savings of having one health organisation as opposed to the three?

Mr DALY - I have given some thought to that -

Mr WILKINSON - Because that was Treasury's view, wasn't it?

Mr DALY - I believe so, but that was only corridor talk. I think the reduction would probably be less than what you might think. Yes, you would only have one chief executive and there would be some back-room administrative staff that would be saved. But as to the real dollars in terms of operating the Tasmanian health system as a single system as opposed to the way it is currently structured and operating, I think the saving opportunities are much more than just reducing from three CEOs to one. In my conversations with Graham Horton, the new chair of the THO, he also recognises the opportunity that he has as chair of the three to bring about more consistent system application and adoption, whether it be to improve patient outcomes or financial rebates.

Mr WILKINSON - What I am saying is that is just one area where it would seem to me that the Government for political reasons said, 'We're just not going to do that, we're going to have the three THOs as opposed to the one', which was contrary to advice. If they are turning their nose up at that, what else are they turning their nose up at, where money could be spent better in the delivery of health and the end result?

Mr DALY - I have not come across anything else they are turning nose up at. The Minister for Health has been very supportive of our putting in place some really difficult decisions that each of the area health services have to make and has made herself very available, from what I could see, to the community, probably at some personal cost. But it is important for my management teams to know that they have that support because it is really difficult.

Dr GOODWIN - Can I go back to those deficits that the three area health services have which they will need to address? How are they going to do that?

Mr DALY - Those that have put in recurrent savings strategies this year are going to get a good free kick next year because they will have a full-year affect. So things that might be implemented in the south that really only took effect from November or December and that have contributed to their improving performance - and it was projected much higher than that figure of 21 - will then, only by our maintaining that strategy, have a full year affect in the new year that they will not have to do anything else for. So the scope of additional strategies that have to occur there would be less than those area health services who are getting through this year with one-off strategies because they have not been annualised. It is a different set of circumstances for each of the three area health services at the moment.

CHAIR - On that point, you said that they get the full year benefit of those savings and in all three areas the biggest saving has been in cutting elective surgery. That is the big cut - cash out quickly and you see the runs on the board straightaway - and that was one of the reasons why that was chosen, and particularly orthopaedic surgery. We heard evidence from Scott Fletcher about the real impact that is having on their waiting times and their out-of-boundary cases. We, as members, and probably even your department, are hearing the pain from people who have now been taken off the surgery waiting list.

If you maintain the strategy to achieve a full year of savings benefits I hear you say that that means elective surgery is going to stay at the level it is at. We are still going to see these significant cuts. We are going to see waiting lists, waiting times and over-boundary cases blow out even further. We have seen a very direct response in reaction to that in the north-west where they have got down to about 9 per cent over-boundary, so is that what we are looking at? Are we looking at another year at least of these savage cuts to elective surgery so we will see this continuing blowout in people waiting and the flow-on effects that has to other surgery that has to be cancelled because there are no beds?

Mr DALY - I think we need to differentiate between cuts to elective surgery and cuts to elective surgery sessions. What we have seen is a number of elective surgery sessions taken out of theatres in all four of the major facilities, and that has facilitated the staffing reduction that has not been insignificant right across the Health system and the real savings occur through the staffing savings. Anecdotally I get a lot of advice from surgeons that I talk to that the existing sessions are now actually accommodating more theatre cases and we have all in Health appreciated that often a public list may carry six cases and a private hospital list on a fee-for-service basis may generate 10 cases. There is also an issue around training, I appreciate that, but that is not always an impediment to productivity. But the pressure of the waiting list has seen our theatre teams actually expand the number of people they are doing within an existing list, and that is just a productivity strategy that really every State in the country has adopted.

CHAIR - Can I just come in on that? If you take out two hips from a list you can fit a whole heap more in - that is what we are hearing. We are hearing that it is the hip replacements that are being removed from the list. You can do two hips one after the other but you really need to do something small in between in another theatre or whatever to fully utilise your -

Mr WILKINSON - That is that word again.

Laughter.

CHAIR - Yes, but knowing how these things work - and the set-up time and the clean-up time for a hip replacement is significant.

Mr DALY - Yes.

CHAIR - The issue is that if you take out these major cases which take a long time to set up, a long time to do and a long time to clean up after, of course you are going to fit in more cases but that means the people waiting for hip replacements will still keep waiting.

Mr DALY - Yes, I would agree with that. I am sure there has been a change to the mix of theatre activity, both in terms of greater concentration of the category 1s, the more acute, and a mix between the truly elective work. I would not like to think that anyone who needs surgery as category 1 is elective, but in category 2 there is some flexibility and discretion around when they are seen and in what order they are seen. I think each of the three CEOs have done different things around mixes to maximise the productivity of the theatre sessions that they have sometimes potentially with the dollar in mind about what they put through in terms of just pure patient numbers.

Dr GOODWIN - Yes, because if you have the less complex cases coming through then presumably they spent less time postoperatively in the beds so it helps with the bed-block situation as well. Is that the situation?

Mr DALY - Yes, if beds are short it would not be uncommon for a postoperative case requiring many days' stay to be cancelled as opposed to a short-stay or day-only. It is much easier to fit into the mix if you are short of beds and clearly there has been pressure put on beds and some decisions around who gets admitted is based on the capacity of the hospital to accommodate them, both within the theatre list and then postoperatively.

CHAIR - You said that if the area health services stay on track with the savings strategies they have they will meet their targets within the first two quarters, but we were told in the first hearing with the department that there will be additional savings required next year, and that was made evident in the Budget as well - that this $100 million was the first year and more savings would be required for the second year, possibly on top of the overruns that we are not going to be able to meet. Can you tell me what plans there are to achieve these additional savings targets? Included in that, has there been any consideration given to cuts and savings more broadly in the primary health area?

Mr DALY - On your last point, it is no more or less targeted at this stage, depending on my comment earlier around the discretionary spend. Primary care and chronic care is subject to the attraction of more Commonwealth funds than some of the more acute programs, so that would immediately mean that we would have a smaller discretionary base for us to apply a percentage, if that is the model the minister signs off on. We have to do this work to let her know what the implication is going to be. Population health, generally, in none of my conversations or even thinking processes has not been more or less of a target than anyone else.

CHAIR - What about our rural hospitals?

Mr DALY - Similarly; they are encapsulated all in the same grouping in my mind in terms of that component of care, and it is another group that is also subject to considerable Commonwealth support, to the point that they could be quarantined from it.

CHAIR - The rural hospitals?

Mr DALY - Sorry, I'm thinking about the rural clinical program.

CHAIR - I'm talking about the Queenstown hospital, Smithton hospital, Scottsdale, St Marys, Rosebery Community Health Centre, Ouse.

Mr DALY - Again, I don't know that I am in a position to direct any specific cuts to those hospitals. If there are opportunities for other different models of care to be put in place or reductions that have less impact on patient services than others, I have to be advised on that by the chief executives who are in touch with these areas on a day-to-day basis.

CHAIR - Are you aware of any savings strategies that were recommended by the CEOs that included some of the rural hospitals but were not accepted by the minister?

Mr DALY - There were many put up, it is my understanding, that were knocked back. I guess I have only paid attention to those that they're putting in place. I am not aware of any that have a major impact on those smaller hospitals, unless there is something I've missed.

CHAIR - When we look at the occupancy rates in some of these smaller hospitals and the costs that are required, the acute services are having to make huge cuts and it seems at this stage that the rural hospitals - although they are not really primary care as such - don't seem to have had to suffer any cuts. People have spoken to me in the community about various ways they believe savings could be made but not by closing beds or closing unit; these are savings made within the establishments as they operate and exist now, but it seems that these things aren't even being looked at. I am not saying they are not, but this is the impression of people out there who work in the facilities. There is still a savings target to be met next year and I still need to hear more about what the plan is for next year. Is this being looked at?

Mr DALY - I would imagine that each of our chief executives, who are very experienced and skilled individuals, would be looking at every opportunity to reduce costs. Because they didn't come up in a paper that was accepted by government to halve the size of the hospital or transform it into a primary health care centre as opposed to an overnight centre, because none of those proposals were accepted, I doubt very much that all opportunities for savings would not be their radar.

Mr WILKINSON - In your experience, do you believe that there can be savings made out of either stating to these rural hospitals, 'Unfortunately, we do not have the money to fund you'? Again, it is a political matter, I know, but do you believe that there could be some real savings made in those area hospitals we have just spoken about?

Mr DALY - I am cautious to respond for fear of appearing arrogant in my ignorance of the needs of particularly the rural communities of Tasmania. Tasmania is unique in a whole host of ways and for most reasons we thank God that it is. In others, in relation to our population, its dispersal, its affinity with its institutions in those small towns and the extent to which they rely on it as opposed to alternative forms of treatment, I think it would be inappropriate for me to comment other than my earlier comment that there is opportunity by the system operating as a system and looking for the broader State good, in terms of both patient outcomes and financial outcomes, which I think we have not cracked. Everyone I talk to has supported that view.

Mr WILKINSON - That view has been mentioned for many years now and yet nothing seems to happen with it. I hear what you say and I accept and appreciate it, but obviously hard decisions have to be made. Patient outcome to me is what should be the primary thing we should be looking for and you could still get that patient output and maybe a better patient output in another hospital.

Mr DALY - Yes, I agree. Where those opportunities are and where we should take action to deliver those improved patient outcomes, I think does require a degree of consultation that I have not undertaken, as well as support from government for me to go down that path.

Mr WILKINSON - Because if people realise that they are going to a better facility with a better outcome they would be going there, I would imagine, not with a frown on their face because they are moved away from their area.

CHAIR - And then you wake up. People do not always react that way, do they?

Mr DALY - I once had a discussion with a hospital around its emergency department role in a network of hospitals and the argument from this smaller hospital was, 'So, you're telling me that I'm better off in the back of an ambulance than being in an emergency department?'. To my surprise, an intensivist who was part of the conversation said, 'Yes, frankly, you are safer in an ambulance for a longer period of time getting to an appropriate care setting where the skills and resources are there to treat you, than you are being delivered into a care setting that cannot adequately treat you.'.

CHAIR - This was the whole discussion in the north-west when the Tasmanian Health Plan was being put in place and we still did not understand it.

Mr WILKINSON - I totally agree with what you are saying.

CHAIR - Yes, but did the public understand that?

Mr DALY - Certainly not in the State that I have just come from.

Mr WILKINSON - Or come to.

CHAIR - Yes, that is right.

Laughter.

Mr DALY - I am just reserving my judgement until I learn a bit more.

CHAIR - Is it possible to get a complete list of the proposed strategies that were rejected by the minister that were put forward by the CEOs?

Mr DALY - I think that is part of the request for information that was in the BCT request, wasn't it?

CHAIR - Are you saying that that information is winging its way to us at the moment?

Mr DALY - Yes. I think that would cover some of it. I am not sure it would cover all of it and, again, this is just me watching it from a distance and looking back retrospectively. There was a lot of discussion outside the actual formal process of tying down the strategies that were adopted.

CHAIR - Can that information be provided to the committee if you do not have it with you now?

Mr DALY - Within the normal confines of government operating, yes, of course.

CHAIR - Do you also have information on the number of patients who access different major facilities out of the three regions? Obviously the people from the north and the north-west have to access the Southern Area Health Service for neurosurgery and things like that. Do you have details about how many patients there are on waiting lists across the board that are outside their areas?

Mr DALY - Yes, we could do a data trawl on that to plot how patient flow works around the State.

CHAIR - And the reasons why they may be on the list. If it is neurosurgery they need it is going to be the south.

Mr DALY - Yes. Specialist services would be easy to identify. Patient election, and particularly GP referral, has a big impact on that. I am not sure we collect any data as to why, for example, someone is on this list for Hobart when they live 100 metres from Launceston.

CHAIR - You would have the number of people who are on the list, but not the reasons?

Mr DALY - Yes.

CHAIR - We will request that from you as well. The Tasmanian Health Plan was established a few years ago and was intended to roll out right across the State and we have elements of the plan that has been implemented. Is it still active and do you believe it still fits, particularly under the new THO model?

Mr DALY - Again, serendipitously, I asked this week for a progress report on the Tasmanian Health Plan and how it has performed against its objectives - I think there's a formal reporting mechanism for that but this was out of sequence of its reporting so that it was contemporary for my benefit - and how we take that planning process forward into the future, particularly through engaging with the State's Clinical Council, that I think needs a revamp. Certainly the clinicians I have talked to agree that it requires a greater and broader clinical focus and a more defined role with some teeth in terms of being a very active public voice and source of advice to me as secretary, as it will be to the minister and the Chair of the Tasmanian Health Organisation on statewide issues. Each of the THOs will have a clinical engagement mechanism and process for local clinical issues but this is the group that I would like to see take the Tasmanian Health Plan and put its weight behind moving it forward, as opposed to it being a bureaucratic process, which it hasn't entirely been, but I think it could have a greater clinician push behind it.

CHAIR - How do we avoid duplications and inevitable cost blowouts under the new structure we're going to be implementing on 1 July?

Mr DALY - Avoid them in total?

CHAIR - Ideally.

Mr DALY - It will be the role of the chair overseeing common governance arrangements through the three boards. That in turn will lead to the kind of macro decisions around common system application, and the IT system is a classic example at present, where we

are arresting the direction of the three individual area health services into a common signed-off system that has enormous immediate benefits in terms of licence numbers and licence fees, as well as a capacity for clinicians to interrogate the IT platform of a patient, whether they present at Mersey, Launceston or Hobart. Whilst we're ahead of the nation in having our population on a single patient identifier, which is a real attraction to the Commonwealth and why we should be milking that attraction as well as the uniqueness of Tasmania - which I am at every opportunity - to fund pilot projects around that, we have to get the platform right. At the moment our common platform isn't there, but we have achieved something no other State has in terms of a single patient identifier for its population.

Dr GOODWIN - We had some evidence from the Public Sector Management Office and Mr Ogle a couple of weeks ago about how many positions have been made redundant or how many people have received an incentive payment to leave, retire, or had their fixed-term contracts not renewed. What we did not get was a breakdown of what the different types of people were, what their roles were and what their work involved. Are you able to provide a bit more information on that for us?

Mr DALY - The short answer is today no but the long answer is yes, again through manual systems of drilling through data to do it. We have very antiquated IT systems. Health, as an industry across the country, in my opinion, is probably behind any other industry and partly because it is a cost centre and not a revenue centre. Tasmania, in my experience, is way down there with the rest. To ask what is seemingly a very simple question - that of 94 VRs that were given how many were doctors, how many were nurses, how many were clerks and how many were whatever - is a very sensible question to ask and one that may be managed at a local level and focused on individuals, and I would expect it would be, but in terms of us collecting that data and having an automated system, we don't. So we have the numbers and count the numbers but in terms of the professional background of each we don't readily have it available but we could certainly get that.

Dr GOODWIN - It is somewhat of a concern to hear that because we heard some evidence this morning about the need to really have a look at the health workforce across the State and do some workforce planning in terms of the age of some of the health professionals and the need to do some succession planning, so to not be able to tell us -

CHAIR - To identify the areas where speciality gaps are.

Ms EGAN - We can certainly provide some information by ward types and by areas.

Dr GOODWIN - That might help.

Ms EGAN - We have a lot of data we could pull together for you.

Mr DALY - And specifically with the question around redundancies. Is that what that is?

Ms EGAN - No, this is just total FTEs.

Mr DALY - We know how many nurses we have, for instance.

Ms EGAN - We do have a lot of data.

CHAIR - Could you provide that to the committee?

Ms EGAN - We can take it on notice and provide you with a response to the FT reduction by profession.

Dr GOODWIN - Yes.

Ms EGAN - That is the total FTE reduction across DHHS?

Dr GOODWIN - Yes, because we are also trying to get a feeling for how many corporate positions as opposed to nurses and doctors.

CHAIR - What would be the period you are requiring, Vanessa; since the end of the financial year?

Dr GOODWIN - Yes.

Mr WILKINSON - Leading on from Vanessa's question as well, are you going to do a census in relation to the workforce planning and the professionals - ages, people due for retirement in a few years and therefore are we recruiting the proper people to go into those areas? I know a couple who have retired in recent times - Rob Nightingale, for example, and a couple of others - and it leaves a void in those areas.

Mr DALY - Any workforce plan has to have the demographic data. In fact, any plan has to have to be driven by the date.

Mr WILKINSON - Have you got that now?

Mr DALY - We would have it. Has it been pulled into a single workforce plan? It is not a document that I have seen in my eight weeks.

Ms STOKER - Workforce planning is a real issue. Previously we had the AIHW workforce data, which has been reasonably incomplete but it has given us an overview of what our workforce planning needs are because that gives us doctors, nurses and allied health. It is not too good. Over the last few months we have been trying to pull together enough data so that we can start putting together a workforce plan. We have had a workforce plan in the past but it has been a bit motherhoody because we have had difficulty accurate data about our workforce. So we are starting to get a bit more accurate data around our workforce and we are linking into the national process which is through Health Workforce Australia that is also providing us with a little bit of money in order for us to do some project work so that we can get a better idea of what our workforce is and we will be developing our workforce -

Mr WILKINSON - Will that be the census like, Jim Wilkinson is 60 last December and he is probably going to fall off the perch in a couple of years, so who is going to take that position and are we training people up to take that position? Is that the plan that we are looking at?

Mr DALY - The data we have available is to group it by age brackets. We would never make an assumption that Mr Wilkinson is going to retire before he chooses.

Laughter.

Mr DALY - But we can make generic assumptions around age groupings of staff and factor in an informed opinion about what percentage would retire at 60 as opposed to 65 or as opposed to 70.

Mr WILKINSON - Because then you could get the best of the best, let us say, one would hope, who are the students and you could endeavour to tunnel them into those areas of expertise that are going to be needed because the others are coming out the other side.

Ms STOKER - There are far more mature students coming into medicine now. So even if we do a census on an average age, then a number of our students are coming in at 40 to 45 and we still have nurses who are in their seventies. I am a long way from that.

Laughter.

Mr WILKINSON - I knew that.

Ms STOKER - But it is difficult to say we have *x* number of nurses or doctors because, again, the structure of our medical profession is changing. We are getting a lot more females into the medical profession and they move in and out of the profession as well. It is just trying to get a better idea of what we currently have, what is the gender, the demographic and then what is our feed-through or our pipeline of what is coming through, and then pull that together for the future. The areas that you are focusing on are areas that we are very well aware of.

CHAIR - The other major issue of workforce planning and the reason we need a census is to identify the emerging areas of need, like ENT. The unfortunate death of Dr Stan Siejka has left a gap neurology. You cannot always predict death, obviously, and I hope we never have to, but identifying those areas of need. The suggestion was channelling some of our best and brightest students here into those areas of identified need. If you do not know where the need is, if you have not done a census to identify the need, then where do you start?

Ms STOKER - That is coupled with what Matthew was saying in terms of the Tasmanian Health Plan.

CHAIR - I have some questions about measures that are being taken by the department to ensure revenue collection due to the department is being collected, such as private patient fees and other sources of income or revenue. What are the services provided at a cost and how are these accounts managed and how are we ensuring that we are collecting everything that is due?

Mr DALY - In terms of debtor collection or in terms of how we encourage people to use private health insurance to generate revenue streams into our hospitals?

CHAIR - It is the whole shooting match. I would hope that every revenue source is exploited basically, so that you get as much in as you can. One of the reasons I ask is that Stephen Coombs gave evidence and he said something along the lines that estimated leakage in the health care industry was between 5 per cent and 10 per cent of the budget which could mean about $80 million to $160 million per annum in forgone revenue. That is an example of what he was suggesting. I know he has met with Penny in the past and his impression was that had gone nowhere, looking at an IT program that maximised the return of the revenue stream. I am interested in what the department is doing to maximise both private patient fees and any other source of revenue that the department is entitled to?

Mr DALY - I will let Penny comment on the micro and then I can make another comment about something I have started to do with Southern.

Ms EGAN - Certainly Mr Coomb had contacted me a couple of times and had been down to meet me and he has his own personal view and program around that. At the time we were collating all our saving strategies and so we have not taken that any further with him. But revenue streams are very important, as you know, for dollars that come in outside of what companies state. We have had an independent person come in. I know they have been to the Royal and are probably going to the north, whose background has been understanding revenue streams right through hospitals and ensuring that we are capturing revenue at every possible area. I know that the CEO of the STAHS has been very impressed with the work that he has put forward so far.

Often, it is not that we are missing revenue or that we are not charging the revenue, but there are a lot of areas within a hospital process where perhaps we are not always capturing at the right moment. My understanding is that the work he has done will be progressed right around the State between the three area health services. I think that will provide us with a lot of consistency

We have also looked at full-cost recovery from areas such as MAIB, for example. We have had a couple of discussions with them and I know one of my staff has met with their CEO. Their board is well aware that there will be further discussions to be had in the future.

CHAIR - That hasn't been happening?

Ms EGAN - We haven't achieved full-cost recovery yet from MAIB, but it is on the list of agenda items going forward. They have their own regulations that would need to be dealt with in the course of that. We are on top of looking at every possible avenue where dollars can come in. It is money for jam, so to speak, to get those revenue streams happening for a hospital. I suppose it's not just in Health, we are doing it for Human Services as well.

Mr DALY - Dr Paul Tridgell is the gentleman that Penny is referring to who has done some work right across the country in terms of appropriate revenue streams, whether they be private health insurance or Medicare-related revenue streams. He has this benchmarked data that shows we are behind a number of big hospitals across the country. That is an opportunity. He has now done that work and we are adopting it and are going to roll it out across all the hospitals, so we are attacking revenue rather than expenditure.

CHAIR - I reckon you have probably read the evidence of Dr Scott Fletcher. He was talking about the inefficiencies that are created by Commonwealth ownership and funding for the Mersey Hospital and the Burnie hospitals and the need for two on-call teams of registrars and the like. He informed the committee that there was a meeting coming up with the Commonwealth, which I assume has been had. Can you give us an update on those discussions, because clearly there are some savings to be made here if we are to work collaboratively with the Commonwealth?

Mr DALY - Yes, there was a meeting - I think it could have been with this week - where the Commonwealth was coming down to meet with us to talk about the clinical profile of the Mersey. I haven't automatically fallen into that camp of calling for the Mersey's closure.

CHAIR - No, neither have I.

Mr DALY - It is opportune that coincided with the Chair's view. I walk through that hospital, as I did last week, and I see an emergency department full of people. I think a pure clinical service planning perspective would call for such action but the realities of the numbers of patients going through -

CHAIR - I'm not talking about closing it. I am talking about enabling a greater flexibility between the Commonwealth and the State to enable one team to be on call for the whole region after hours. At the moment we have two teams and Dr Fletcher's concern was based on the college's concern of a safety issue from the medical professionals' point of view in the hours they are working. If you could streamline the services provided in each facility, and effectively do what the health plan was wanting to do - dedicated day surgery at the Mersey, more complex surgery at Burnie, and those sorts of things - that is the path they were wanting to go down. I am not wanting to enter into a discussion about whether we should close the Mersey or not. I am talking about the corporation and the fact that we get $71 million from the Commonwealth for the Mersey that effectively sits in this bucket here. The North West Regional Hospital has to service patients from that area because they do not do some things at the Mersey so we can't have these synergies and efficiencies because of that structure.

Mr DALY - You have raised a broader issue just beyond Mersey of rather how the North West Regional Hospital works in terms of joint on-call rosters, conjoined appointments. I am not across that level of detail of medical staffing at this point, but in terms of talking to the Commonwealth around allowing us to use the Commonwealth money they're putting in to support Mersey to support a single on-call roster is commonsense, in my opinion.

CHAIR - So you don't know what the outcome of the meeting was in that regard?

Mr DALY - No, I don't. The purpose of the meeting was more about clinical profile of the hospital. Whether that went into conversation around the detail of joint on-call rosters, I am not aware.

CHAIR - With all due respect, I think it should and could and probably did, because if you are talking about clinical profile you are talking about what you do clinically and where,

and if you are not providing after-hours emergency surgery at the Mersey you do not need to have an on-call team there, for example.

Mr DALY - I just don't want to say anything in this forum that I don't know to be fact.

CHAIR - Are you able to provide feedback from the meeting to us after you've had a chance to find out more about it?

Mr DALY - Yes.

CHAIR - I think it is a really important issue for the north-west but also a cost-saving issue.

Dr GOODWIN - I want to ask a question about cuts to elective surgery. You have provided us with some data on admissions on a monthly basis from July 2011 to March 2012 which was at the committee's request. I am trying to get a handle on potentially how many people have missed out on their elective surgery or had it delayed as a result of the cuts, and I suppose one way of doing that is to look at July 2011 as a baseline figure and then compare those numbers with October through to March and the numbers there. If you do that for the Royal, the LGH and the North West Regional Hospital it looks like about 1 600 people have had their surgery delayed potentially or missed out altogether. Does that sound about right?

Mr DALY - Is that the same one - the bottom figure as of March 2012, 1 230?

Dr GOODWIN - Yes, that is the statewide total, so just looking at the three, there is the Royal, the LGH and the North West Regional. The July 2011 figure for the Royal Hobart Hospital is 648 admissions, and then these cuts started to occur in about October so that figure is 559, and then it varies for those months, but if you have a look at the July 2011 figure and then compare it to those months - October, November, December, January, February and March - for those three hospitals, you end up with a figure of around 1 600 of the people who have potentially had their surgery delayed if you are doing a comparison with those July 2011 -

Mr DALY - Yes, and I would reword it, but essentially we are saying the same things, and that is that that number of people have not been admitted into hospital to have their elective surgery done compared to the same time.

Dr GOODWIN - Yes. Is that what the impact is, that those people potentially are missing out or having their surgery delayed because of the cuts - is that the direct result?

Mr DALY - Yes, the wait would naturally be extended from what it currently was. They are waiting longer.

Dr GOODWIN - I think you have said that these cuts will continue and the targets remain in place and this is a six-month period so potentially over another six months the figure could double?

Mr DALY- That is reasonable, yes.

Dr GOODWIN - When you look at the DHHS progress reports it appears that in a three-month period in our public hospitals upwards of 4 200 people are admitted from the elective surgery waiting list but, based on these figures, I think in three months including January, February and March this financial year, there are only about 3 376 people admitted from the elective surgery waiting list in total, so that is a reduction of almost 1 000 people from all public hospitals including the Mersey.

Mr DALY - If we provided the data to you I can only stand by its accuracy. I guess I would like to look at it to confirm that.

Dr GOODWIN - Yes.

Mr DALY - This paints the current picture. The difference is you are not comparing totally apples with apples because there is no pre-Christmas period and drop-off, so elective surgery is routinely reduced significantly, or in the north-west case I think cancelled it in toto this Christmas where it hadn't the previous Christmas, so it is not totally apples and apples; it can be a little misleading.

Dr GOODWIN - I suppose I am trying to come up with some sort of ballpark figure or idea of how the cuts have impacted on the people who are having their surgery delayed. I understand that it is a difficult task that but this gives us a ballpark figure. How long do you project these cuts will remain in place - how many financial years?

Mr DALY - At this stage all I can do is work on the forward Estimates that Treasury is putting forward. Naturally I would hope that those forward Estimates don't translate into a reality but government has to make that decision. I think the capacity for us, having put these cuts in place, is for the CEOs to revisit some of them once they are embedded and other things are embedded - some are delivering better returns than expected - and a capacity to rejig, given that we are performing on the national stage. In terms of the KPIs, I will be wanting to work with the CEOs on those KPIs and look at ways of addressing our current standing, which is inadequate.

Dr GOODWIN - We have had some very compelling evidence before this committee of the long-term implications of these cuts to elective surgery and the delays to people being able to access elective surgery, so it is obviously a concern to know how long it is planned to keep these cuts in place.

Mr DALY - I think it gives us the opportunity also to do some targeted reinvestment for the priority and high-risk areas in starting to work up the budget, and the opportunity to have some targeted investment to address those areas I think you are alluding to, where time can really make a difference in terms of outcome.

Dr GOODWIN - Orthopaedic surgery is a classic example, where people potentially may not be able to work while they are waiting to have their hip replaced, or whatever it happens to be, and that is a real concern.

Mr DALY - Yes.

CHAIR - I would like to look at the issue of overtime for nurses and medical professionals particularly. I would like an update on that. We have had some comment outside of the

committee process that we are seeing greater rates of overtime for nurses. That is always an issue for specialty areas, but there have also been some comments made in the public that we are seeing that across the board. The CEOs, however, have suggested that overtime hasn't been an issue because we now have more pool staff to call on and we don't need to rely on our nurses working double shifts, except in some specialised areas. Can you give us an update on that across the regions?

Mr DALY - My advice is that it has been constant or has been decreasing slightly up to the end of January. Obviously a reduction in overtime is a cost-saving return, so that is why when I heard a testimony about an increase in overtime it disturbed me because it's a contraindicator for saving money. The figures up to the end of January indicate that, agency-wide, at worst it has plateaued, but there have been areas where it has decreased. I don't have that broken down but I can have it pulled together relatively easily for you. If you give us a bit of notice we will add the February figures, which is far more an appropriate indicative month than January and December.

CHAIR - When will those figures be available?

Ms EGAN - Fairly quickly.

Mr DALY - If we put the February figures in there, I think that will be a better answer to your question.

Mr WILKINSON - Are you able to say how our overtime is going compared to previous States you have been in? Are we worse off, the same or better off - per percentage, of course?

Mr DALY - No, I'm sorry, I couldn't. I would like to say we are worse off because it would mean an opportunity to claw it back.

Mr WILKINSON - That was going to be my next question. So how?

Mr DALY - Yes. Through other uses of staff, whether it be a different mix of staff that does not draw upon workforce shortage areas, like registered nursing staff by nursing pools, casual pools - all the things this lady here is superb at doing.

Mr WILKINSON - She will be after a pay rise after you saying that.

Laughter.

Ms STOKER - We are currently doing an analysis on that but, as Matthew said, it is very difficult to go back too far. We have been looking at the area of double shifts and also overtime, particularly in the nursing area. The trends are looking as though are down but at the moment we are also trying to have a look and see whether what is happening here is comparative with what is happening in the other States as well, so that we have a little bit of context to put it into as well. But that is not quite ready -

Mr WILKINSON - Will it be ready by Estimates do you think?

Ms STOKER - Possibly just after Easter it might be.

CHAIR - I wanted to go to another area that has been raised by different parties, particularly the medical profession, that goes to the recruitment process to attract and retain medical staff. We heard from a witness earlier today that there seems to be a strategy perhaps, or it may not be a strategy, it may just be the way it has evolved, for the Royal particularly to engage staff specialists which then ties them to the Royal. Their package relies on them being full-time and there has been no consideration been given to whether they want to work 0.8 of the workload and get 0.8 of the package, which did not mean three-quarters of a car, we decided; it meant perhaps not taking the phone or whatever. But this has been seen by some as an issue in allowing a greater synergy between the public and private sector because if you have your specialists engaged full-time in the public sector there is no capacity for the private patients to use that facility, especially if there is no-one else doing it.

Mr WILKINSON - Plus they are saying that patients then go to the public sector because there is not the flow-on into the private sector which there previously was.

Mr DALY - I haven't interrogated that issue specifically. Certainly it is a common practice to have fractionated appointments to a public hospital to enable a clinician to work in the private sector as well.

CHAIR - There seems to be a problem here potentially causing great challenges.

Mr DALY - Right. I have not heard that but will be very happy to talk to the CEO. There is no impediment to it, as far as I am aware, in terms of our award or medical appointment processes. Whether there is a peculiar Royal Hobart policy on it -

CHAIR - That's the way it was suggested.

Mr DALY - I can only surmise why that practice might be there.

Mr WILKINSON - I think the backlog of the work that had to be done at the Royal Hobart Hospital may be one of the reasons those people were only employed to work at the Royal and not allowed to be able to work in the private system as well. Secondly, if you work 0.7 FTE in the public area, part of the contract of these clip-ons, with phones and cars and whatever affects that, but having the ability to work in both private and public is beneficial to all in the end. They were saying that probably you are going to attract more doctors wanting to do that and it is going to be better in the big picture for the State if you have that type of employment going on.

Mr DALY - Frankly, I would be surprised if it is not a strategy that is actively used for difficult-to-recruit areas for medical staffing at the Royal Hobart. I would be surprised if they don't already do that in some selected areas, but I have no evidence of it so I don't know how I should comment, really.

Mr WILKINSON - Other than to say it might be worth having a look at and then use your experience to say that you believe it should be changed or should stay the same.

Mr DALY - I am very happy to talk to the CEOs.

CHAIR - We will ask that one at Estimates.

Mr HARRISS - I have a related question. I am presuming there would be medical executive meetings with CEOs and so on around the hospitals. What role does the department play in terms of feedback or two-way communication with regard to those meetings?

Mr DALY - I am going to meet with that executive which includes the clinician executives and that means a direct feedback from me, the department, to them and vice versa, otherwise the main area of communication between the department and the hospital or the area health services is the CEO, but that is why I make it a practice to actually go to the hospital and visit it myself. Even in the new world where the department takes a step further back, and it will in terms of its roles in the operations of the THOs, I will still make it my business to meet with senior clinicians and other staff so I can hear what is going on at the ground because, ultimately, despite these changes, the system management role rests with the minister and clearly delegated to me. Whilst I will support the philosophy of both the legislation and the Commonwealth agreement about establishing these THOs as the delivery arms and to devolve functions and authority and resources for them to fulfil their responsibilities, ultimately the system manager role rests with my minister that I carry the delegation for, so I can't divorce myself into an ivory tower in Davey Street. That is my view. I am not sure I answered your question but I gave you my philosophy on it.

Laughter.

CHAIR - Do you want to ask another question, Paul?

Mr HARRISS - No, that's fine.

CHAIR - One other issue that was raised by a witness this morning was with regard to the medical registrar positions at the Royal. I am not sure how many registrar positions there are but there is a number, and apparently there is a fully-funded Commonwealth registrar position that does a shared arrangement with Calvary which is not filled and it is $100 000 going begging. Whilst I accept that when the registrar is over at Calvary he or she is not at the Royal, but this is a fully Commonwealth-funded position. There was allegedly a reduced number of applications for the positions to fill, I understand from what the witness said, but there were two positions not filled and so this one has gone begging. That is $100 000 of Commonwealth money, which is hard enough to get at the best times, so why are we not using that?

Mr DALY - That's a damned good question. I will take it on notice and find out the details. There could be a multiplicity of reasons why the registrar position is not filled, whether it is a training position or an accredited training position or just a workforce position or whether the Commonwealth will agree on the person to go into that is so tight we don't have any three-headed Martians that fit the criteria for it. Some of the nonsense that comes out of the Commonwealth that is tied to some of these funds you would not believe. If you think we're bureaucratic you ain't seen nothing yet! It could be any one of 100 reasons but I will find out specifically in relation to this case. I can't imagine we would have too many joint registrar positions across the Royal and Calvary, but I will find out and get a note back to you, if you like.

CHAIR - It raised the question for me and I am sure other committee members as well that if this is the sort of thing that has been happening, what else is there? What other access or avenues of other revenue streams, Commonwealth or otherwise, that maybe we are missing out on because it is not being fully utilised?

Mr DALY - We have to acquit for those funds and whilst, regrettably in past lives I have seen that a failure to actually deliver on a Commonwealth program means handing the money back, I haven't come across any examples here in terms of having to return Commonwealth funds - but you probably see a lot more of it than I have, Penny.

Ms EGAN - I have to say that in my three-and-a-half years I'm not aware that we've not been able to acquit correctly any funding that's been provided to us.

Mr WILKINSON - What he did say and the example he used was that there might have been 20 positions, 18 were filled, those people were put into certain areas and this area might not have been one that the Royal thought was appropriate for its planning and therefore didn't take up. But it still would seem that if you have somebody -

CHAIR - That's 20 medical registrars, we're talking about, not registrars across the board - 20 medical registrars but two not being filled, and the one that wasn't filled included one that had that joint -

Mr DALY - Yes. It's reassuring to hear that in three-and-a-half years we've not returned a Commonwealth dollar and we're certainly not going to start a new practice on my watch of returning Commonwealth dollars, so I can assure you we will lock that in, one way or another.

Dr GOODWIN - Going back to the transition to the THOs, will you have to go through a recruitment process for the CEOs or will the current CEOs of the north-west and the northern area health services just transfer over? Is there a provision for that in the legislation?

Mr DALY - I know this has occupied a lot of media space, which has done nothing but annoy one person in particular. Jane Holden was recruited to, offered and took up - with the full support of the chair of the southern governing council - that role as the chief executive. She was offered a five-year contract and that contract will flick over to be CEO of the southern THO on 1 July, along with probably 2 000 other contracts that will go over in name from the Southern Area Health Service to the southern THO.

So Jane is of no doubt, the chair of the governing council that has the responsibility under the legislation to make the appointment and recommendation is of no doubt, and so we're of no doubt as to what's happening in relation to the south.

Dr GOODWIN - So will the same process happen with the north-west and north, or do you need to go through a recruitment process?

Mr DALY - Given the carry-on, which is what it was, around Jane's appointment, my latest understanding in talking to Graeme Horton, the chair, is that he will formally put to his governing council the recruitment and/or appointment process of the CEOs to the north

and the north-west. We have been interviewing last week and the week before. We have the final round of interviews for the southern THO next week -

CHAIR - For the governing council members?

Mr DALY - Yes, so they can be appointed. He'll be able to convene a meeting of them probably in May to confirm the process to go through so that every 'i' and 't' crossing of the legislation is delivered with them being onboard.

Dr GOODWIN - So you might have to end up going through a recruitment process for the other two, depending on what the governing council decide.

Mr DALY - Yes, we still have to wait for the advice of the governing council, so he's going to go forward and get that advice then put it forward to the minister.

Dr GOODWIN - In terms of the cost of running the three THOs, is there any ballpark idea of what the cost of operating the governing councils will be at this stage?

Mr DALY - There are board sitting fees, of course, and they have been calculated - I didn't bring it with me - which I provided to Treasury and actually asked for more money for it, otherwise it's an impost on the area health service or the THOs, which I'm trying to minimise. So, yes, there is a cost and it's in accordance with government policy of council or its sitting fees - one chair, three boards of four members - so there have been fairly small boards or councils, as they're called, so there is a cost. I guess I could quickly add it up if I had a calculator if I can remember what the sitting day fees are.

CHAIR - Can you provide that?

Mr DALY - Yes.

CHAIR - Just on that, you said the governing councils required more funding to meet the needs of them functioning, that you didn't want to pass onto the THOs -

Mr DALY - In terms of the council members' sitting fees?

CHAIR - Yes.

Mr DALY - Well, they have to be borne from somewhere.

CHAIR - So this is additional funding that wasn't factored into any budget considerations?

Mr DALY - It has been, I have given the advice to Treasury. I will just take that Treasury advice and give it to you.

CHAIR - Vanessa started off with the question of how much it is going to cost if we are establishing three governing councils - one of the big discussions when the legislation was debated was one versus three versus two - and the costs associated with that. Is the reason that you're having to ask for more money to run these governing councils is because we have three? Why do we need more money than what was expected?

Mr DALY - The whole issue around transition is that it is not a cost-cutting exercise and I have to engage with staff in that. There are budget plans that are peripheral to the process of establishing the THOs and, as I have met with large groups of staff and as I go around and meet with executive teams, they need to know that this isn't an issue about cost-cutting. The challenge we have with the transition is just like every State on the mainland where they've had to move from a smaller number of delivery units to a larger number. We have gone, in essence, from one delivery unit to three and that creates the challenge and threat of an increased investment in administrative expenses or, in some cases, even worse than that cost is an inability to provide the technical expertise across three organisations. We have adopted a model that I used in New South Wales, having just finished doing this process there, that essentially develops shared service arms that are owned by the THOs, the three new organisations, so that we don't lose the critical mass, nor do we drive any additional administrative expense by having to split up a unit and send it north, south and north-west. There is a model that can overcome those two threats to the process in those areas where we can't just logically send the resources to each of the three THOs.

CHAIR - Are you needing to apply to Treasury for more money because we're going from one deliverer to three?

Mr DALY - No, we're going from a bureaucracy-governed organisation to the minister to a board or council-governed organisation, and that was at the basis of the Commonwealth-State agreements.

CHAIR - So regardless if it was one or three, you'd still be out there asking for more money?

Mr DALY - My job is to advocate for Health and this was an additional cost on Health. I am sure some years ago Health would have saved some money from closing down the boards if they were paid in those days, and they may not have been. We are now in an environment where board members or council members are paid determined sitting fees and this is a new cost on Health because we didn't have these governing councils before, so I thought it was reasonable to approach Treasury for funding it and I hope I will be successful.

CHAIR - Good luck with that. With regard to the still-increasing costs for consumables and supplies, what is happening with that in Health? One of the areas that was a bit unclear when we dealt with the Supplementary Appropriation Bill was what the $5 million in additional consumables and supplies related to. Can you provide some information about what is happening in Health with that cost?

Ms EGAN - We have been able to put in a number of statewide contracts this year. We now have 26 and are about to have 27 whole-of-agency statewide contracts. Some of those consumables we have dealt with this year is the photocopier contract, for example, and even office consumables. With the photocopiers, I think it is a $3 million saving over the next four years. When it comes to a lot of the other medical-type consumables, we have been having some discussions with HPV - Health Purchasing Victoria - and looking at the options available to DHHS to look outside of Tasmania or to work with other organisations to do some of our procurement activity. In doing that, you always have to be mindful of judging how you get a better deal if you go somewhere else and sometimes you can only do that if you do two things at the one time. But we do know already that

we get gloves at a much cheaper rate than HPV, for example. But those discussions are happening. Also with pharmaceuticals, we have been having the same discussion with them.

We are also looking at whether we might get some independent advice going forward on what would be the best procurement-type outcome for DHHS, going into this brave new world of THOs. Albeit we do some statewide purchasing now, is that still the best model going forward or should they all do the same or is there a bit of both? Do we try to hook into a number of other contracts that are happening? Of course, on top of that, we always have make sure that we agree or comply with Treasurer's instructions.

So I think, going forward you will see some change in the way that procurement happens within DHHS and to do that we get savings because of the options available to us. There are certainly some dollars to be made in procuring and also managing those contracts. So it is not just about procuring and getting the right price; it is managing the contract to make sure that you are paying the right price, that you are buying from the supplier that you procured with it. We have a little bit of extra work to do in that area but certainly we are on the front foot.

CHAIR - As far as the blow-out in costs of consumables and supplies across the government sector go, is Health making some savings? Are you making savings in this area?

Ms EGAN - I would not suggest that we have been blowing out our costs at all in some of those areas. Certainly prosthetics is something we have always tried to tackle. I think we are paying about $16 million to $17 million a year in prosthetics and there are obviously some savings that could be made there if we could procure a bit differently.

In general, I would not suggest that we are blowing out our costs. In the past year, certainly, where we have had increased demand, then by default you are not meeting budget in consumables because your demand increases so therefore you usage increases.

The other thing was that we do not always keep detailed records of everything that we procure. Sometimes we have to go back to the supplier if we want that information. So we do no go down to the nth degree but it is not my understanding that we are totalling blowing our budget on consumables.

Mr WILKINSON - The price of medical prostheses, stitching, have gone up a huge amount over recent times, hasn't it? I was talking to a medical representative whom I have known for years and he was telling what it cost 25 to 30 years ago to purchase some things as opposed to what it costs now. So not only do you have those cost increases but you also have the new developments coming onboard which cost a fortune. What should be looked at - it always should be looked at, I suppose - is not only the short-term way in which moneys can be saved but also a long-term approach as well because obviously health, as has been stated for many years now, is going to just about take up the whole budget, not only of Tasmania but of Australia, unless we do something to endeavour to rein it in because of the increasing costs of people staying alive, new medicines and new pieces of equipment to treat patients with. Therefore it is not only the initial period that we are looking at but it is also the period well in advance as well.

Mr DALY - Very true.

Mr WILKINSON - Is that what is being done - short-term and long-term planning?

Mr DALY - This is a slightly different answer but it is going to guide some of our purchasing decisions or give us the negotiating power, but as we move onto activity-based funding which is a purchase for a treatment, that will be a national average price that will be termed the 'efficient price'. It is not the efficient price but it is the national average price and that the Commonwealth will participate in funding us at that average price. That price will have a cost components and cost components will be things like consumables and particularly the real stand-out ones like prosthetics. If a typical joint replacement sees the average national price for that joint replacement as being a total of $16 000 and the prosthetic component was $6 000, then we go to the market and we only purchase prosthetics that are worth $6 000. Every clinician, as you know, has their preference to a type of clinician, a type of suture, a type of bandage, you name it, but we will be in a position where I will say, 'I am sorry, we are only being funded at a national level for a $6 000 prothetic. So you either adjust the type of prosthetic or you come into the room with us and negotiate with the prosthetic company's price to concentrate on their prosthetics, capped within that component to pay that is there. So it is going to change the negotiating position of hospitals right across the country, otherwise the whole nation has to move up before that price moves up - or a large proportion.

Mr WILKINSON - That in itself will be beneficial as far as purchasing is concerned?

Mr DALY - It will help little fellows like us, yes.

Ms EGAN - What we are doing with a lot of our contracts is putting the contract in for two to three years but with options at the end, so it gives us some flexibility. If other players come on the scene we are not locked into some five-year contract; we actually have some flexibility in there with suppliers. We can renegotiate or go back out to the market.

Mr WILKINSON - What is the situation in relation to hips causing trouble with the toxicity level?

Ms STOKER - Was it the DePuy one?

Mr WILKINSON - The one that caused all the trouble and there is a class action out at the moment, because the Commonwealth could well say, 'This is the way you should do hips'. It would seem to me that some medical practitioner might say, 'No, that's not the way because I believe that it's going to be a problem down the track'. I suppose that is a Federal matter but it could put not only the Commonwealth at risk but the State at risk as well?

Ms STOKER - There is a register for prosthetics. If there is an issue with prosthetics then nationally that tends to be highlighted, so there is a safety and quality mechanism in place.

CHAIR - Scott Fletcher in his evidence from the north-west clearly identified the very real risk of losing an orthopaedic surgeon up there because of lack of work because of the cutting to orthopaedic surgery, which then puts them back to the workload issues they are

trying to get away from and have worked very hard to avoid. Do you see that as a real risk and how can we avoid that?

Mr DALY - I guess where I have seen it manifest itself as a risk so far, which we have been able to mitigate when it has been brought to our attention, is around a drop in volumes that can have an impact on registrar training.

Mr WILKINSON - That's what he was saying.

CHAIR - No, specialist training in this case; he is still under supervision.

Mr DALY - Sorry, so registrar training towards specialist recognition.

CHAIR - It was my understanding that he was not a registrar; he is being supervised.

Mr DALY - I am leading to that. We have taken action and established a principle going into the new financial year that strategies that decrease activity in selected areas that are going to jeopardise training positions - because they are our future workforce - we need to rethink those. I don't think people gave adequate consideration to some of the decisions that they made at a hospital level in terms of areas to reduce activity. Consciously it could have an impact on training for our future workforce, so that is a principle that has now been established.

The issue you are particularly pointing to is about a volume of work for a specialist in terms of his livelihood and general activity. It is no less an issue around retaining those specialists. Clearly in making and putting forward budget proposals for reduction we have to ensure that chief executives are conscious of that. Who is to say that some or many of the proposals that the minister did not accept could have been around those areas where it was obvious to her. I don't know, but that would be a reasonable reason not to accept a budget reduction strategy, if it is going to either destroy training of a future workforce or actually lose the workforce altogether - unless that is the strategy, of course.

CHAIR - This is a strategy that was obviously accepted in the north-west -

Mr WILKINSON - Two per week as opposed to what, six or eight, was it?

CHAIR - I don't know but they have cut back enormously.

Mr WILKINSON - It was 32 down to eight over the month.

Mr DALY - Is this at the North West Regional?

CHAIR - Yes.

Mr DALY - From my experience that is a very large number of joints for a small hospital to be doing in a week.

Mr WILKINSON - As I understood the evidence, there was a backlog -

CHAIR - It wasn't a week.

Mr WILKINSON - No, it was a month. What they were doing was cutting back on the backlog of people who had been on the waiting lists - and they're doing an extremely good job of that. If you looked at the figures you can see that they were doing better than anywhere else, it would seem -

CHAIR - They were doing 20-30 joints a month and now down to four.

Mr DALY - Four per month?

CHAIR - Yes.

Mr DALY - So one a week. They might have gone a bit hard.

Mr WILKINSON - Yes, that's an understatement!

CHAIR - The requirement was to make the savings. This surgeon is from South Africa -

Mr WILKINSON - Yes, it was.

CHAIR - and he is under Scott's supervision still.

Mr DALY - Oh, so he needs his numbers.

CHAIR - That's right, and this is the problem. If he can't get the supervision, he'll go and why wouldn't you? He wants to operate without having the supervision requirement. He is a very good surgeon apparently from all accounts. I think there has been some negotiation up there that they are now going to go to two a week but it's still not going to meet the needs of this person we could lose. I can ask you what you think about that but I'd be interested to know what the minister thinks about that, but she's not here.

Mr DALY - I can tell you what she thinks about it because it was her bringing it my attention around the issue of volume for procedures for registrar trading. She asked me to intervene, so I suspect she would feel no differently around the supervision issue for the maintenance of a specialist in a hard-to-attract area. I am up at the North West next week or the week after and I am meeting a number of people. I'm happy to meet this gentleman to understand what his training and supervision requirements are to ensure that we don't lose him and it's clear what he needs to do as opposed to maybe what he'd want to do.

Mr HARRISS - Wouldn't you be speaking with Scott Fletcher as well?

HAIR - Scott Fletcher is the surgeon who's supervising.

Mr WILKINSON - I say that because he put forward a number of solutions, not just the problems. Everybody seems to know what the problems are because they're in the Press weekly at least, but he's come forward with a number of solutions which, to my mind, would be well worth looking at.

Mr DALY - That's Scott, is it?

Mr WILKINSON - Yes.

Mr DALY - I look forward to meeting him.

Mr WILKINSON - Because, again, he was saying in relation to getting rid of the backlogs up on the north-west coast. We were doing well; we had questions asked from people in the south about whether they were willing to go to the north-west to have their surgery done up there. We were able to do it and they're waiting to do; it doesn't seem to be something that was looked at previously. We can get rid of the backlog in the south by doing it. He said sometimes that is a problem with doctors because they don't want to deal with the problem if there's an infection when they're back here. They say, 'You're the one that operated, you deal with it', as opposed to us dealing with it down here. But those things can be sorted out, I would have thought.

He also spoke about the issue with the Mersey in relation to overtime. We believe that there could be a significant saving in relation to that so there were a number of matters that he brought up which I think are worth looking at.

Mr DALY - I look forward to it.

Mr HARRISS - At the start of this hearing we talked a little of the savings demanded of all government departments back in 2008 and then the ball was dropped pretty much through the whole process. Are you able to advise this committee what efficiency dividends were delivered by the department back then and what was achieved against the demands? If you are able to do that, can you then bring it forward to now and advise the committee as to whether your department made suggestions to Government about what was a sustainable level of service delivery, if you like, or were you just simply presented with the demand for $100 million in savings?

Mr DALY - I'd need to defer to the only corporate memory that I can think of to my right. I honestly couldn't answer any of those questions.

Ms EGAN - I would probably have to take some of that on notice. Certainly the efficiency dividend has been there in every budget and it is known that we were topped up in the budget last year and also a small part, I think $30 million, in the year before. Operational budgets are delivered with a reduction against them, so those areas that by default meet budget automatically achieve a quasi-efficiency dividend. It hadn't been the case across all operational areas. Going forward this year to find the $100 million it was quite clear that we had to do some pretty drastic things to take $100 million out of the system, hence the list of strategies that was published in October.

Mr HARRISS - We have that list and it is part of the public record now, but was the department given an opportunity to make its determination about what was a sustainable level of process? Or were you told you had to save $100 million, so tell us what you are going to do?

Ms EGAN - In the pre-budget discussions at budget committee we had put forward a range of various options over a period of time. We were never given an indication it was going to be $20 million, $30 million, $40 million, but the indication was it was going to be a

considerable amount. So the $100 million was really only known to us at the time when the budget was announced.

CHAIR - You found out when we did.

Ms EGAN - Pretty much the same time. We knew that it would be considerable but we were not aware of the quantum. At the time we said, 'If you really want to be serious about this, you need to be serious about the amount we have to find', but there was no indication what that was going to be.

Mr HARRISS - What I'm gathering from that is that there is no assessment on what is a sustainable measure here.

Ms EGAN - The $150 million over the four years is what was presented at budget time. We can't add much more to that. That is what was put forward to us and we've had to develop strategies to meet that. They weren't all recognised on budget day. There were a few that were announced at budget time and then over the next period of time, probably up until October when the final list was announced, work continued on what those strategies would be, when they could be implemented and how much could be found this year versus the ongoing effect of some of those strategies.

Mr HARRISS - Two questions flow from that. The strategies that you had investigated of your own process, were they costed?

Ms EGAN - Not to the detailed level, but certainly at a high level.

Mr HARRISS - Were any of those subsequently put forward after you'd been told about the $100 million? Did they form part of your package that is now in place?

Ms EGAN - Yes, some of them would be. Some of them were accepted at budget time, so probably at budget time most of them weren't around Health. The Human Services component of Health undertook quite a large component of the savings at the time around rent reductions, for example. We reduced indexation to the non-government sector, which brought in another $3 million. It was mainly the Health savings that we had to continue to work through over that short period of time. The costings for some of that were done by the areas themselves and some have been done with the assistance of the department.

Mr HARRISS - What has been the communication process? The areas have been able to identify their cost-saving strategies and yet we have been aware, and you have confirmed it, of it being top down. The Government simply said, 'This is your target. Do it'. What has been the secretary's role post that budget time announcement in terms of communication to the area health services?

Mr DALY - It was communicated from the acting, acting, acting secretaries.

Ms EGAN - Once the decisions had been made and it was publicly announced that a number of strategies would be put in place, the CEOs had to undertake those discussions with their areas about how that was going to happen. There have also been their own departmental strategies which have also had to be put in place. A lot of those strategies

were costed; we think this is what we need to find but how we will find it is a difficult task. As we have said before, the majority of our costs are employees, so if there is a strategy that says we can save *x*, *x* means that we have to be able to take those employees out of the system. That hasn't been an easy task. I think we have managed to take out 542 up until February, but to be effective perhaps some of those staff needed to come out six months ago. As Matthew said, the real savings will come into play in 2012-13 when we have 12 months of that saving ahead of us.

Mr HARRISS - Going back to the 2008 GFC issue, the Treasurer and Premier of the day gave their directive that there would be efficiency dividends. Were those requirements well documented or were they just back of the beer coaster and chuck it away? Bear in mind that the Premier last year said that many senior public servants did not consider the GFC serious or a reality. The efficiency dividends across the public sector were not achieved after the 2008 directive, so were there well-documented requirements?

Ms EGAN - It was early days for me but I think we might have had a $35 million find at the time across the agency. We put in train a number of initiatives as to how we would go about that, both Health and the Human Services side. Those were in train, but I can't remember them all off the top of my head. What happened then was that we were funded and people said, as Matthew rightly said, 'How serious were they? We started the journey and then you gave us the money to get us through'. I think that has been an issue, probably not just within DHHS, perhaps that is across government. I think people would be aware now that the Government is very serious about what needs to happen.

Mr HARRISS - Do the CEOs have autonomy to knock this process into shape or is there a requirement to report back through the secretary and from the secretary to the minister? The minister doesn't come and talk to us so we can't ask her what the Government's process is here. What is the process in terms of accountability and answers and getting messages back to the Government?

Mr DALY - I guess I am the conduit for that. Each of the CEOs put forward their plan. Remember, they are their plans. Some things were not accepted and they were sent back. They adjusted the plans and other strategies were accepted. Each of them came back with plans and when I arrived in January the advice from all the CEOs was that they will meet budget. I looked at the data myself and I couldn't see the data indicating that it would meet budget. I accept their advice that they have a plan to deliver collectively the $100 million that has been set, but what we needed and what they needed was additional time to do it - in other words, a full financial year of operating. I guess that was the leeway that we have been given and it's those plans to deliver that $100 million that we are monitoring very closely with them. We have flagged with them the need for them to start working up their financial plans for next year. The precise quantum isn't known. We are working on forward Estimate figures and they are working towards those figures for the new financial year. We haven't received the first draft of those plans yet.

Mr HARRISS - Matthew, you indicated that some things put forward by the areas were not accepted. Have they ever been costed out as to what the savings may have been from those, bearing in mind you said they were the plans of the areas? If they were, why weren't they accepted? Who didn't accept them?

Mr DALY - From what I can gather they weren't accepted by government for a variety of reasons, not the least of which would be community objection to it.

Mr HARRISS - So therefore read community objection as 'political'?

Mr DALY - In many cases also the return on that action was insufficient. One example was around the conversion of a hospital to a primary health care setting that ended up costing the department more in doing that whilst torturing the poor community about losing their hospital.

CHAIR - Rosebery and Ouse as well.

Mr WILKINSON - But that is a planning issue, isn't it? Prior to sending the spooks out to spook the community, if you plan it and then you realise what the costs were going to be, you do not do it and you do not spook the community. It is a lack of planning.

CHAIR - We are looking at a similar thing with the three THOs now. If you wanted access of a service outside the region that is available in the region, how is that going to be managed because it is activity-based funding? They almost have to fight for the resource that is available, so we are going to do so many of this and so many of that because it is all about how much of what you do -

Mr DALY - Also at what price we do it.

CHAIR - Yes. Are we going to see the North West trying to drag people in the northern region and say, we will do so many of these, or the north trying to drag patients from the north-west? How is that going to work so we do not see undermining of one region by another?

Mr DALY - There is no doubt that market forces will create those circumstances and those situations. The statewide role that I will maintain with the chair in a policy setting and implementing way will be looking to ensure that we maintain credible roles for hospitals that otherwise could be leached of core services. But it is a problem that is coming at us in 2014 anyway as we move on to Commonwealth funding, initially 40 per cent but more at the national average price. I will keep saying 'national average price' so we know what it is, rather than 'efficient price'. That is that the dollar and the cost will have a heavy influence in determining clinical service planning as to where services are on the capacity to deliver at that cost.

All the little fellows are covered under this environment because they will be block-funded, but hospitals with acute admissions above 4 000 a year, which takes in our four facilities with the exception of Mersey, will remain block-funded directly from the Commonwealth. There will be service exposures at each of the three hospitals as their costs currently stand. I do not think there was any coincidence that a leaked version of applying the national average cost across all States indicated that we were some $80 million above the national average price. Coincidentally, that is roughly what we are pulling out of our hospitals, which is a positive thing because, frankly, as painful as this process has been, this would have hit the Tasmanian health system, if not this year, then in one to two years time - without a doubt. It is coming like a freight train and, though not wanting to ignore the pain and discomfort and everything else that the system

has gone through, frankly I think it is better that it has happened now so we can imbed these new efficient practices and some of the new routines and new models of care that the CEOs have put in, and prepare ourselves to move onto the Commonwealth stage because that is where we are moving in a relatively short period of time.

CHAIR - You have a common chair and yourself taking that statewide view. You are going to have the three governing councils, which will have their own little areas to protect, with a maximum of four people from each area. How are we going to stop this hollowing out of services in some areas?

Mr DALY - The vast majority of them are covered by block-funding. I guess there are some more exposed areas than others - super-specialty areas like neurosurgery, cardiothoracic and burns, where we do not have the critical mass to compete at a national average price. They negotiated with the Commonwealth and it has very recently come back, last Thursday, that they had accepted all our arguments around all those specialty areas. They have accepted all our arguments around the rural hospitals to be block-funded. They have accepted our arguments around a regional loading for hospitals in Tasmania. The extent of that regional loading didn't go as far as what the minister and I wanted it to go. We met with them in Launceston earlier in the week and gave them the run down on our position, which we at this stage won't support when it goes to the ministers' meeting later in the month, so they are going back to receive a reminder proposal around how the regionality issue will help us. That is the real threat on the national stage. Whilst we are purely funding under our own regime we can make these investment decisions even if they are inefficient ones, but we make them for the reasons we so choose. But as the funding is split it would put an even far greater financial burden on the State to fund the full component of the inefficiency, both ours and the Commonwealth's. That will be a burden that no jurisdiction will be able to carry into the future, least of all a smaller one like us.

Mr HARRISS - Can I just come back to that matter about the strategies put forward by the area health services?

CHAIR - The costing of it?

Mr HARRISS - Yes.

CHAIR - We are getting a list of them.

Mr HARRISS - Yes, but they are the ones that were rejected by the minister.

Mr DALY - There were a number that were rejected.

Mr HARRISS - Are we getting those?

CHAIR - Yes, we are. Have they been costed or not?

Ms EGAN - Some of them at the time I know were not costed and some that were very high level.

CHAIR - Those with the high-level costing, you can provide that with the details of the strategies.

Mr DALY - It is all part of the documentation.

Ms EGAN - I think there is an issue in that we have to work out whether we are actually allowed to give that information to you. If we are allowed to, certainly I will provide it.

Dr GOODWIN - Can I ask a question on your list of savings strategies for last year. Have you been tracking them as individual savings strategies to say whether they have achieved higher than anticipated or less than anticipated and is it possible to get that information? Where it has the little stars - 'savings to be determined' - whether you have been able to quantify those amounts.

Ms EGAN - This list has actually been diluted again into a number of other strategies, albeit there has been someone here who actually changed over time because some of these may not have been as easily dealt with as not. We have quite a comprehensive list of strategies which we provide each month. It details all the strategies of what the original savings component was and where we are today. We keep track of all those and also the ones that are not able to be found this year - the reasons for it and whether they can be found in the following year. We could not provide you a list compared to this because, as I say, they have actually morphed over time and changed as we have gone through.

CHAIR - Can you provide the most up-to-date summary of where we are at with them?

Ms EGAN - As I said, if we are able to, yes.

Mr DALY - Can I just qualify that. This is why when I got here I didn't focus on that. By all means we are very happy for Penny to make her best guesstimate on that but in many cases they are guesstimates or purely advice from the CEOs. I was not happy with the advice that was coming through, not from Penny because I trust her implicitly, but from the variety of sources where advice comes from in the department, which is why I only focussed on the output indicators that actually showed expenditure was going down, showed that emissions were going down, showed that FTEs were going down and showed the cash flow budgets on goods and services were going down. If I didn't see that data, I didn't take it into my calculations. That is why I didn't hold myself as a slave to that process which was primarily driving the department late last year.

Dr GOODWIN - It would be interesting to see which strategies have morphed into something else -

Ms EGAN - It is probably a more difficult task than you think if you realise that, over the six months, even to get to this point in October they changed terribly.

Mr DALY - Some of it is really measurable and I have brought along a couple of examples today. We have knocked off 50 cars. We wanted to reduce travel across the agency and we have halved it in domestic and international travel. Those types of things are really measurable so it is very easy to report. Frankly I don't know how they ever thought they were going to measure some of it - anyway, I'm an old cynic.

Ms EGAN - We've been able to measure some of them, certainly, but for some we do take advice.

Mr HARRISS - Have you taken into your calculation the possibility of a pandemic?

Mr DALY - Every hospital has a disaster recovery plan and we have a statewide plan. Every hospital has flexed capacity in terms of its beds. It's whether it makes the decision to use them, which in a pandemic situation there would be no decision to make. It would just be made. Every hospital has the capacity to flex their beds up and down on a daily basis. Frankly, if anyone doesn't they are, in my opinion, not managing their hospital adequately.

Mr HARRISS - It is going to impact budget; that's the real issue, isn't it?

Mr DALY - Yes, but it depends if you view a bed as being a commodity for a single day a week as opposed to a set of beds to average out over a financial year and that can average to a financial target. If you stick with your 100 beds or whatever it might be and are not prepared to move it, regardless of demand, regardless of seasonal fluctuations, regardless of surgical conferences, regardless of Christmas and New Year when staff want to take holidays during the school break, if you're not flexing your beds down and doing it really assertively because people don't put their hands up and say, 'Hey, the whole department's going off on a month's leave for some conference in Vienna, so we're going to shut our elective surgery and we think we should close half our ward beds', no-one ever says that.

CHAIR - No, it takes leadership to do that.

Mr DALY - It's assertive management around your beds. It is a flexible commodity.

CHAIR - Thank you for your time and for the information that you've provided and will provide.

THE WITNESSES WITHDREW.