THE LEGISLATIVE COUNCIL GOVERNMENT ADMINISTRATION COMMITTEE A MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART, ON MONDAY 19 MARCH 2012

COST REDUCTION STRATEGIES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr FRANK OGLE, DIRECTOR, AND **Mr CHRIS MULCAHY**, PRINCIPAL CONSULTANT, PUBLIC SECTOR MANAGEMENT OFFICE, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Ms Forrest) - Thanks for coming, gentlemen. Everything you say is covered by parliamentary privilege while you are here but if you repeat anything outside, that may not be the case. If there is any information you wish to provide in camera you can make that request to do so and the committee will consider that request and then make a determination. The evidence you give may form part of our report and obviously it will be transcribed and put on the website in a few days' time as a public document - that is evidence not in camera.

Frank, I assume I address most of the questions to you initially. Can you give us an overview of the role of the PSMO, particularly in the staff management issues, how vacancy control is being managed and where your numbers are sitting right across the whole State sector? Then we will focus on health, if that is all right.

Mr OGLE - One of the roles of the Public Sector Management Office in the vacancy control is both to have initially developed and put together the Ministerial Direction No. 25 that outlines the processes associated with the whole vacancy control and also put together and negotiated the Targeted Voluntary Redundancy Program and the Workforce Renewal Program. So there are three elements to what we manage.

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

CHAIR - What sort of areas are they moving between - across the board?

Mr OGLE - Yes, across the board and across a number of agencies. It is really a match on the suitability of the person who is in, let us call it a surplus or potentially surplus situation. We then refer it to an agency that may have a vacancy, they assess the

suitability and then will take them - that could be temporarily or it could be permanently. That is one part of the process. There is in the vacancy control the formal part of the process which is where the head of agency, after going through an internal vacancy management process, might then recommend that someone is eligible for redeployment across the service. We have only had three of those so far.

CHAIR - You mean changing from Health to Education, something like that?

Mr OGLE - Formally. So you are made eligible for redeployment and then approved by the State Service Commissioner, so you get into a formal process of being redeployed and the end product of that is that if you cannot be redeployed then there could be a recommendation for retrenchment but we have not got to that. We have three declared and we are working with the agency to try to redeploy those people.

CHAIR - We are not likely to see a lot of those yet because the six months would not be up yet?

Mr OGLE- We have tried to focus on the internal vacancy management or through our informal process of moving people around agencies. As I said, we had about 57 we have been able to move across agencies. I do not have any figures about how many the individual agencies have moved themselves. In addition to that we have processed, since June last year, 83 targeted voluntary redundancies.

CHAIR - Do you have a breakdown of which areas they have come from?

Mr OGLE - They are pretty widespread. Some agencies have said no to any targeted redundancies, mainly because they are trying to manage internally, at least in this financial year. To give you some sort of breakdown, Economic Development, Tourism, the Arts - and this is since June last year - is 15; Primary Industry, Parks, Water and Energy is 11; Health, 83, and then there is Justice, 2; Premier and Cabinet, 1; Police and Emergency Management, 6; Infrastructure, Energy and Resources, 1; and the Skills Institute, 9 - that adds up to 128. But, as I said, there are some agencies that have taken a policy position during this year not to offer any redundancies because they are trying to manage internally, and one of those big ones is Education.

CHAIR - Are these paid-out redundancies?

Mr OGLE - Yes.

CHAIR - How much has that amounted to?

Mr OGLE - An amount of $6.2 million.

Dr GOODWIN - Is that for the total, 83?

Mr OGLE - No, for 128.

Mr WILKINSON - Frank, what are the estimated savings in that? Are you able to work that out?

Mr MULCAHY - I don't think we have a payback period on this.

CHAIR - Are you able to determine what the payback period is?

Mr OGLE - It is generally less than a year. I could get you that; I haven't got that.

Mr MULCAHY - The top end of, say, 48 weeks, close to a year, and at the bottom end it is sometimes 20 weeks.

Mr WILKINSON - So 20 weeks to 48 weeks.

CHAIR - We might just ask you to confirm that.

Mr MULCAHY - Yes, we will get that.

Mr OGLE - We have what we call the Workforce Renewal Incentive Scheme. The total for 2011-12 is 470 of those.

CHAIR - What does this really mean, Workforce Renewal Incentive Scheme?

Mr OGLE - The difference between that and redundancy is that redundancy is where you abolish the position. Workforce renewal is where, for up to $20 000, it is an incentive for people to leave but you don't necessary abolish the position; you use it more for reprofiling. To give you an example, the greatest success in that has been in the Department of Education where they offered this program to teachers and renewed it with -

CHAIR - New grants.

Mr OGLE - Basically, yes.

Dr GOODWIN - So they're often cheaper as well, are they?

Mr WILKINSON - They would all be, I would imagine.

Mr OGLE - They are all cheaper - that's the business case. They're clearly not going to pay out $20 000 if it is going to cost them. It is also about renewal in the sense of getting younger people, graduates, into the work force and adjusting the profile of, say, the teaching work force where the demographic is ageing.

CHAIR - We know the demographic is ageing in Health, too, so has that been used in Health?

Mr OGLE - Not terribly much. I think in Health I have only nine listed.

CHAIR - Are these nurses, doctors, administrative staff - what are we talking about?

Mr OGLE - I don't have any indication on the type but nine is not a lot and, from memory, they are just all across the board and if anywhere they are in Health.

Dr GOODWIN - That is nine out of 470?

Mr OGLE - Yes. I think those figures are skewed a bit because of the 470 -

Mr MULCAHY - I think it was 127 since June of that total figure.

Mr OGLE - I was just going to say that Health is 127 and Education is the largest by far of those numbers and that is of the order of just over 200.

Mr WILKINSON - What would the total savings of that be approximately, Frank? Are you able to say that, Chris?

Mr OGLE - We don't have a business case on it because they are managed by the agencies. There would be some savings but not in the order of a redundancy because that is abolishing a position whereas here you are really only saving the difference between a teacher at the maximum versus a graduate entry teacher.

CHAIR - Less $20 000?

Mr OGLE - You would save at least $20 000.

CHAIR - But $20 000 is the payout they get, so you have to add the $20 000 on to the saving.

Mr OGLE - Basically that is right because on-costs take care of that.

Mr MULCAHY - The average is about $14 000 a year.

Mr OGLE - It is up to $20 000 but Chris just mentioned that the average RIP is about $14 000.

CHAIR - Plus the $20 000 incentive that you give to the person who is leaving.

Mr OGLE - No, the RIP is up to $20 000 and you either take that or not.

CHAIR - Okay.

Mr OGLE - The $20 000 is incorporated in the redundancy program.

Mr WILKINSON - The $20 000, as I understand it, is to abolish the position?

Mr OGLE - No, it is the other way around. Redundancy is to abolish and the $20 000 in the work force renewal is to, as it says, renew with a lower payment.

Mr WILKINSON - And the payment does not have to be a saving of $20 000, it could be, as you say, $14 000, but with your on-costs on top of that there is going to be a saving, as I understand it.

Mr OGLE - Yes, that is right. You usually add about 21 per cent to a salary to get what we call a total package.

Mr HARRISS - That incentive separation I understand is $1 000 per year of service up to $20 000?

Mr OGLE - Yes, that is roughly the result; it is a graded scale, yes. We use that as a guide but, generally speaking, you are right, but it is negotiable.

Mr MULCAHY - It is the agency's call. It is not there to be just picked up and taken. It is to recognise that that person's skills need replacing. If they have a skill set they don't want to lose then they just decline the offer.

Mr WILKINSON - Are some of those done in a way where it is non-taxable as well? Is that $20 000 taxable on the individual?

Mr MULCAHY - Yes, the RIPs are conventionally taxed depending on the person's age - over 55 it is 16.5 per cent tax and under 55 it is the standard 33 per cent. TVRs are different. They are recognised by the ATO as a general redundancy and the position must be abolished or the ATO doesn't recognise it and then you get quite generous concessions with taxation based on the whole rolled-over amount.

CHAIR - Are there any other methods you have used to remove people from the workforce?

Mr OGLE - There is natural attrition that occurs and that creates the vacancies. That has slowed down somewhat over the year with about 410 through natural attrition.

Dr GOODWIN - Do you have those figures just for Health alone?

Mr OGLE - Resigned or retired - 170.

CHAIR - Some of those would have been replaced, though?

Mr OGLE - Yes. I think you have to add to that also the non-renewable fixed-term employees, so you would have 159 of those.

Dr GOODWIN - That's 159 of the 170?

Mr OGLE - No, plus 159, so you have 170 what I call resigned or retired, plus non-renewable fixed term, 159.

Dr GOODWIN - This is for Health?

Mr OGLE - Yes.

CHAIR - But you could argue, in fact, that it is relatively easy to get rid of 159 from Health that are on non-renewable fixed-term contracts. As far as tracking to achieve the savings and a reduction of salaried people through the whole government sector is concerned, are you likely to achieve the expected savings that were put forward in the Budget or are you falling short of that?

Mr OGLE - I think it is fair to say we would be confident that every agency is on their target, either through the vacancy management and the staffing situation or other savings they have made this year, and that could be through rental savings and a whole lot of other strategies. I am reasonably confident, and I think it has the subject of comments by the Premier in the state of the State that all those agencies are on target. Health is -

CHAIR - Not going to meet it?

Mr OGLE - Well, they are not on target.

CHAIR - The point I am making is that you are saying they are mostly on target and Health is not and the biggest cost is wages and salaries and other employment-related costs. A lot of the separations have been the non-renewable fixed-term or casual staff, agency staff and locums - and I am particularly focusing now on Health, which has not been on target. Where do you go next? It is easier to get rid of those people and not use them. They have a non-renewable contract, do not call in your agency staff and do not use the more expensive staff. If they have not met their budgets with those reductions, then where do we go next and how is this achieved?

Mr OGLE - I think the process from there is to go through the internal vacancy management and, if you like, negotiate a target, voluntary redundancies and you look at workforce renewal. After that process, then the issue is to recommend that people be declared surplus or eligible for redeployment and that starts the formal process of coming to our office and trying to formally redeploy those people.

CHAIR - If you cannot, then in six months time they are effectively let go?

Mr OGLE - Correct and, from memory, we have only had one from Health so far.

Dr GOODWIN - That is out of the three?

Mr MULCAHY - Two from Health and one from DPIPWE.

Mr WILKINSON - I am trying to get a picture of the total amount of people who were in the work force for the public service at the time the program came into being, to now?

Mr OGLE - Are you just talking about Health in that situation?

Mr WILKINSON - First Health and then right across the board.

Mr OGLE - The total reductions since June last year is 1 497 and we are talking about full-time equivalents, so these are positions, not necessarily people. As a vacancy comes up you might have redeployed a person -

Mr WILKINSON - Yes, I understand.

Mr OGLE - so it is purely position-based, and of those, 524 have been in Health.

Mr WILKINSON - What was the figure in June of last year?

Mr OGLE - It was 25 590.

CHAIR - Total?

Mr OGLE - That is 0.72 FTEs.

Mr WILKINSON - Are you able to give me - that is at 11 June - what it was at 10 June?

Mr OGLE - No, but I can get you that figure. We can get that out of the State Service Commissioner's report.

Mr WILKINSON - What I was after was June 2009 and June 2010. We have June 2011. We would have, I suppose, an idea as to what it would be for June 2012? There may be another 20 or 30 on top of that 1 497.

Mr OGLE - Yes, there would be some vacancy control that would occur. I would have to say that a lot of the agencies have already achieved their targets for this year, but I think it's fair to estimate there would be probably another 50.

Mr WILKINSON - Am I right in saying that it is okay to achieve the target, and you get a tick for that, but you don't really stop there if there are positions that can be sorted out? Once the agencies achieve their target, do they take their foot off the pedal or do they still look at savings that can be made, from your experience?

Mr OGLE - I think the task that agencies have is not just that they have targets this year but it's an ongoing forward Estimates rolling task. If you're going to reap the savings for 2012-13 you really want to start off at 30 June with the right number, so you don't wait until 1 July to be taking action, you need to have that in place, so you're nearly working at least six months in advance.

Mr WILKINSON - Are any above target, doing better than target?

Mr OGLE - I don't have those figures. There was a mixture of targets associated with savings, expenses and a range of strategies that were put in place. You would have to ask each individual agency because that was the subject of their presentations to the budget committee, which were signed off in a report.

Mr MULCAHY - It's probably worth adding that even if an agency is on target, the vacancy control process continues. A surplus within other agencies can be used to fill those vacancies, so even though they're on target they are still helping to share the load, as it were.

CHAIR - Are there any other efficiencies besides these measures which are direct movement of people rather than efficiencies within the State Service aimed at reviewing what you need and where you need it with a view to increasing greater efficiencies above and beyond or as well as -

Mr OGLE - I think you would need to ask each individual agency that in relation to their budget target but there is always structural reform occurring, whether that is directly linked to their budget target or just proper management of their resources. Even in an

environment where there are not tight budget constraints you are always looking at your priorities and structures.

CHAIR - You are or you should be?

Mr OGLE - Well, I can only speak for where I've been. As a manager, you generally look at your priorities and restructuring but not with the intensity you have during this sort of period. You're really looking at your priorities firstly and then other areas where you can amalgamate or find efficiencies at a managerial level.

CHAIR - You mentioned in a response to a question from Jim about the reporting from the budget review committee -

Mr OGLE - The cabinet budget subcommittee.

CHAIR - Can you outline the reporting you get from agencies?

Mr OGLE - Treasury puts together the report. Each of the agencies had a target and strategies to meet their target for each of the years, and that is a combination of staffing, expenses and all those sorts of strategies - and we compile the data associated with full-time equivalents, redundancies and work force renewal. We feed them into Treasury which then meets with the agencies, which I think report back every quarter at least.

CHAIR - Do you have direct contact with the agencies?

Mr OGLE - We have direct contact with the agencies when it comes to the management of vacancies.

CHAIR - How often do they report to you?

Mr OGLE - Monthly on these figures, but weekly on vacancies. We have a weekly meeting and vacancies and potential surpluses; we meet weekly before they can get a clearance on any vacancy that goes to the *Gazette* or to the department.

Mr MULCAHY - That also provides other agencies at the table to say, 'I have two people who may be suitable for that role' and make a referral.

CHAIR - So you have all agency heads there together at that meeting?

Mr MULCAHY - Representatives of each agency, yes.

Mr OGLE - It's been fairly successful in the spirit of cooperation within that environment. As I said, we've matched 57 people that way. That's not even the formal process; I think once they are declared and approved by the State Service Commission, we would get into a very formal process, but the 57 have really occurred through goodwill.

CHAIR - There's only three that have been declared, though?

Mr OGLE - Yes, we're still working very hard to redeploy those who work with the individual.

Mr WILKINSON - Are there any other ways, Frank, that have been discussed where you could look at other incentives? There are redundancies, matching, RIPs - are there any others that have been spoken about that you have decided at this stage are not worthwhile considering?

Mr OGLE - I think from our point of view, with that combination, we have looked at everything we can. I was pleasantly surprised in some ways by the Workforce Renewal Incentive Program that came up with nearly 500. It was beyond what I would have expected.

CHAIR - Do you track what happens with those people? Are nurses getting work interstate? If there were 127 in Health I would assume some of those would be nurses. Do they go into the private sector, do they leave the State? Do you have any idea what happens with them?

Mr OGLE - We don't track what happens but the answer to that is all of the above. Nurses, by the nature of their employment, work in both the public and private sectors anyway.

CHAIR - Yes, but the risk of losing skills - and this is not your problem, it's the Health department's problem - is that we have some highly-skilled people in operating theatres, ICUs and DEMs.

Mr OGLE - But we have replaced those. In that sense, if you have a speciality like that, they are replaced.

CHAIR - But you can't replace experience, not with a junior.

Mr OGLE - As far as I'm aware, they have not been used for the work force renewal program. My understanding is that we can't get enough of specialist nurses in ICU in the first place, so you're not really offering any incentive for those sorts of nurses to go. You have to look at nurses with a general application.

CHAIR - So you're saying it is more targeted, it is not across the board?

Mr OGLE - I think you would have to talk to Health as to what their strategies are. Each of the hospitals have their own individual targets, so they look at what they can do. As you pointed out, they are looking at the fixed-term casuals getting less hours, those sorts of things, before anything to do with permanent employees.

CHAIR - That creates other challenges, though, in that casuals are the ones you call when things get busy - say a pandemic or a major issue or a lot of staff sickness - you rely on those people. If those people are no longer around because they're not getting enough shifts so they have moved away or taken up other employment, do you think that could be a problem?

Mr OGLE - I have not had any reports from Health that it is causing a problem. You could look at it the other way: if more people are getting less hours, there are more of them available. We always have work for nurses. I think the way nursing works is that you need the permanent nursing work force and the fixed-term ones because they're replacing

nurses who might be away for a specific period - and maternity leave is part of that, but also sabbaticals, training and education are other reasons. You also, quite rightly, need your casual pool; those people at your beck and call who you can ring and ask, 'Do you want to come in today?' The difference with the casual pool is that they have the choice. If it doesn't suit them, they don't come in.

CHAIR - Then you end up paying double time. There are less of them so you end having to work double shifts; that is one of the issues.

Mr OGLE - I think the issue with double shifts would be that that occurs more in a specialty area than a general area because you can get the general people to come in casual or fixed-term. I think the double shifts occur with last-minute emergencies or very specialised areas where they are just not on tap.

Mr WILKINSON - Or an emergency that goes midway from a shift into the next shift, where the person who is dealing with it has to remain.

Mr OGLE - Generally they are not called 'double shifts', that is just overtime where you are taking it through to the next day. A double shift is when there is not a full shift.

CHAIR - There is plenty of that too.

Mr OGLE - I can only read what I read in the paper.

Dr GOODWIN - Can you provide a regional breakdown of any of the RIPs for Health or redundancies?

Mr MULCAHY - We probably need to get back to Health for that because only we only record totals.

Mr OGLE - If you record a question I am sure we could get you the answer.

Mr MULCAHY - It is probably worth mentioning the business case.

Mr OGLE - Yes, we go through the whole targeted vacancy. They have to put up a business case and first of all justify that the spend of the redundancy will reap the savings. As Chris pointed out, that generally has to be under 12 months, so it's like a pay-back within one year. But the important factor is that the likelihood of redeployment is limited.

Your question is relevant when it comes to areas. Some people might want move, so we might offer a targeted redundancy on the north-west coast because, even at something like a band 4 you might say they might be able to redeployed but not necessarily on the north-west coast or not necessarily at Smithton, while a band 4 in Hobart you would hope could be redeployed.

I think it is fair to say that our focus is on trying to redeploy the people who really want to be redeployed because we know a lot of people want to keep their jobs so our focus is in trying to find those people jobs. It is really a balancing act between redundancy and redeployment.

Mr WILKINSON - I understand that there has been a significant increase in FTEs in the State Service since the GFC struck. What I am trying to ascertain is that if that is the case, what has the increase been and are we back to where we were immediately prior to the GFC budget - or alternatively, is there still some difference?

CHAIR - Are you talking about the number of FTEs?

Mr WILKINSON - Yes. My understanding is there is still a significant difference between the number of FTEs that have increased since the GFC budget.

Mr OGLE - I do not have those figures but I can get them for you.

Mr WILKINSON - All right, thank you.

CHAIR - We really need to back from 2007 onwards because the GFC was in 2008.

Mr MULCAHY - One issue in relation to that is that those figures are drawn directly from the NPR payroll system on behalf of the State Government. They count different things so there might be some variation taken in account in terms of ballpark figures.

CHAIR - What do you mean when you say they count different things?

Mr OGLE - Firstly, what we call paid full-time equivalents versus structured. That would be the change from a structured, which was position-based to actual people-based or those on the payroll. I think we would have to give you those figures and tell you where that accounting changed.

CHAIR - What difference does the structured one make?

Mr OGLE - Structurally, it counts people who would be on leave without pay, or secondment, so they might not actually have been paid. That is what used to occur and I think the changeover was 10 June - but we can give you that.

CHAIR - Yes, give us some context around it. It would be nice to have comparable figures. That is what we are trying to establish here, some comparable figures which are -

Mr OGLE - But you could also look at the figures in the context - and you would probably have to drill down to the agency level - of the occupation groups where those increases occur. There is no doubt that a lot of those have occurred in nursing, for instance. That is one area where I know there have been increases. You just have to look at it and probably drill down rather than just look at the total. I think people just see the numbers as the bureaucrats, but the State Service covers 4 000 nurses and 5 000 teachers and that takes a fair chunk.

Mr WILKINSON - Sure. When you look at outcomes and where we were in 2007, there has been a significant increase in FTEs. You could look at whether there are any better outcomes as a result of that significant increase in FTEs. You could look at it that way and it may or may not help.

Mr OGLE - Your task is difficult because during that, if you are looking at it from an agency level, there have been amalgamations of agencies and those sorts of things.

CHAIR - But we can certainly compare Health with Health.

Mr OGLE - You can, but there is also the increase in workload in Health.

Mr WILKINSON - Yes.

CHAIR - Can you break it down by award? That would make it easier to see where the changes have occurred.

Mr OGLE - We would need to go back to TD and ask them to report on that.

CHAIR - To who?

Mr MULCAHY - The telecommunications division which manages the whole payroll system on behalf of the Government.

Mr OGLE - I am pretty sure we can drill down. We could get it straight out of the State Service Commissioner reports.

CHAIR - If you have it by award it would make it easier to see where the growth or reductions have been, whether you are looking at nurses or others.

Mr MULCAHY - It could be more difficult, I suspect, mainly because agencies haven't kept that kind of record.

Mr WILKINSON - If you could see what you can do that would be god, thanks.

Mr OGLE - I am sure if you went back through Estimates committee transcripts -

Laughter.

Dr GOODWIN - I have a question in relation to the RIP and particularly the 127 from Health because presumably this is targeted at older people in the workforce with the teacher example. Is that the same with Health and would it be possible to get an average age of those people?

Mr OGLE - You would have to ask Health; we don't keep that detail.

Dr GOODWIN - Do you do it across all of the people or not?

Mr OGLE - We approve them based on the business case. It is not necessarily about age but I have to say in effect that is probably what occurs, and obviously we can't discriminate, so if someone puts up their hand it is a matter of their capability and if there is something we can restructure, particularly more to bring in a younger person. That is where this started, as you might remember, really in the teaching work force.

CHAIR - Just on a slightly different tack, Frank, with the new THOs and the arrangements that are going to be set up there, how will that be managed and what will the implications be for current staff under the department in the new structure? We have heard about and seen pictures of a shrunken department in the THOs. How is that all going to be managed?

Mr OGLE - I can give you an overview but am by no means an expert on the THOs. I think that is really still being worked through and I think they are probably questions for the department. The three THOs - the north-west, the north and the south - will report to a governing council. As you know, one chair has been appointed to cover each of those THOs. Each THO will have a CEO and I think we announced the first appointment of those in the last week or so, but that doesn't actually come into effect until 1 July.

CHAIR - The governing council hasn't been formed yet.

Mr OGLE - So all we can do is appoint in a technical sense the CEO of the Southern Tasmania Area Health Service and when it comes into effect you would reassign those duties to the THO.

CHAIR - I think that the legislation required that the governing council and the -

Mr OGLE - I think there are transitional arrangements that can occur given by an interim chair who is the chair and part of that solution, but you probably need the tick of the governing council.

CHAIR - What happens then?

Mr OGLE - On 1 July there will be decisions as to what out of the department now gets placed in each of the THOs, so there have to be governance decisions around whether you fully devolve your workers comp area and make the THOs responsible and if that will happen from 1 July? I think a lot of people think when 1 July comes the world is going to change. I am only guessing but 80 per cent of your staff, if you are talking about what is in the Southern Tasmania Area Health Service now, will be part of the new THO but there are decisions then about things such as human resource management, finance, IT and all those sorts of areas. That is in the management area, but then you have to make decisions about the processing of payroll and those sorts of things. What will then occur is you will have a lean, mean ministry which will be the policy area that the secretary heads up. Then you will need to have service level agreements or some other arrangement with the THO and whoever is going to run, say, shared services on payroll.

CHAIR - Do the three THOs have to deliver their own service level agreement to the minister?

Mr OGLE - Yes.

CHAIR - So there will have to be another service level agreement for all the common or shared services?

Mr OGLE - There may be. You'd have to make some decisions as to whether you want each of the THOs to run their own payroll service or if it is better that you have one common payroll service.

CHAIR - In a State the size of Tasmania wouldn't you think it would be madness to consider three?

Mr OGLE - I have my own personal view, but you'd need to work through it. Part of the philosophy of the THOs is that they make decisions about the way they manage and their approach in each of their different areas. I think you have to go through and look at each of the different functions as to which is the best way to do that. You might have a view that shared services is something you would maybe not want to focus on on the processing side but there are also efficiencies and good management that might occur through proper management workers compensation, for instance, so you take the workers compensation component and manage it within your own THO. I think that's the sort of debate that has to happen, although I might have a different view about that compared to processing.

CHAIR - As I understand it, the Commonwealth's requirement is that these changes will be effected with no net gain in bureaucracy. What I'm hearing is possibly a shared service arrangement with the three THOs, all the governing councils, CEOs and ministry, which you would hope would be leaner -

Mr OGLE - Much leaner, I would suggest.

CHAIR - How will this impact on the staffing costs and the expectation that we are going to reduce costs in staffing in Health if we are going to see this growing bigger than topsy?

Mr OGLE - I think you have to look at it in the sense of when it happens and you have to make proper decisions. The point I was making before was that on 1 July you don't just say the THOs have the lot. You have to have the systems in place. You have to make business decisions, for example on payroll processing, and you might look at that and say exactly what you've said. It is probably better that the THOs don't necessarily be wanting to run a payroll service. They are more focused on delivering the service, so it might be a better outcome that you have a shared service level agreement. I think you'll find that the ministry will be much leaner and meaner, but there will have to be decisions made.

CHAIR - What's your role in watching this?

Mr OGLE - I am the chair of a joint union working group, but really that is more to do with the consultative arrangements occurring around that, not the detail of the governance structure around it. While we are part of the consultation, those decisions will be made with the governing council and the head of the Health department.

CHAIR - You have a concern with the size of the State Service, the number of people we are employing, and the cost of that. What will you be doing as the PSMO in watching staff numbers and our potential growth in this sector when we are not actually increasing service delivery necessarily? As I understand it, we are going to be sorting out what is done where and the governing councils will have that decision and say, 'We're going to

do so many hips here, so many knees there, so many hysterectomies there', and activity-based funding is how the funding is going to be arranged. How does the PSMO manage this to ensure that we don't see an increase in staff and wage costs as opposed to a trimming down? We are taking all these actions now that you have talked about to get people off the payroll, basically, and here we are creating this new structure, so what is your role in making sure that we don't end up with a blowout?

Mr OGLE - I think the primary responsibility is with the minister and the secretary of the Department of Health. We monitor, report and process the redundancies and if there were increases, but we don't get reports on the service delivery in the sense of how many are still in the bureaucracy versus the service delivery. That is really the responsibility of Health and the Minister for Health.

CHAIR - Have you noticed an increase in numbers across a department, whether it is in the service delivery area or the administrative area?

Mr OGLE - We get the grand total. We would report that and question it.

CHAIR - When would you report it and who would you question?

Mr OGLE - First of all, we would question the head of agency but if it was something else the budget subcommittee would be the area that the head of agency would have to be questioned about.

CHAIR - How often would you be looking at reporting these sorts of things?

Mr OGLE - It depends on the size of the agency and how well it is going but at least every quarter.

CHAIR - With Health, would it be more than every quarter?

Mr OGLE - Without absolutely knowing, I think they haven't reported more than once a quarter.

Mr MULCAHY - In terms of numbers they report monthly but in terms of -

Mr OGLE - Actual presentation.

Mr MULCAHY - Yes, quarterly - and Frank's right, if there was a sudden blowout in Health and at the same time was matching with TVRs we would be asking questions of the agency and be holding up the TVRs until that was clarified so there would be that monitoring process but, ultimately, it is not for us to tell agencies how to run their business.

CHAIR - No, but I am just asking about the monitoring of it, how bad it could get before someone says, 'Take a look at this'.

Mr OGLE - We are expecting figures to be going down so if they are not we are asking the agencies. We have that head of agency, the Director of Corporate Services, to report on that, particularly against their targets.

Mr WILKINSON - I suppose that would be monthly at the moment, Frank?

Mr MULCAHY - Yes, we have a monthly report.

CHAIR - But it is only formal reporting every three months, though - every quarter?

Mr OGLE - The formal report comes in but the actual presentation of the budget subcommittee is at least quarterly, because you have to remember we are dealing with the staffing numbers and the budget subcommittee is dealing with the whole budget target around all these strategies.

Mr WILKINSON - I hear what you say, that you are there to look at the employment numbers, the FTEs, and if there is a blowout you would notice that when you have a look at the figures, which is once a month?

Mr OGLE - Absolutely.

Mr WILKINSON - So if there is a blowout one month you get on to the agency and say, 'What's the story? Does that mean there is going to be a reduction the next month, et cetera, et cetera?' Is that as I understand it?

Mr OGLE - Yes, and you have to remember that the reporting on the FTEs is at the end of the month, so there can be issues associated with that point-in-time reporting.

Mr WILKINSON - I understand that.

Mr OGLE - You just have to be a bit careful about how that occurs, particularly around areas like - you can find some little hiccups when it comes to Education at the end of school terms and that sort of approach. You just have to know the environment and say that might have been at the end of a school term and therefore some fixed-termers might not necessarily be on the payroll but they might have to come back on the payroll in three or four weeks' time.

Mr WILKINSON - And that is common, isn't it, with Education?

Mr OGLE - That is one of the most common areas but it is common with Education, you're right.

Dr GOODWIN - I just wonder what is happening in the performance management space and how that it is all rolling out, because there may be opportunities for further gains.

Mr OGLE - It is not our target; obviously the target there is improving the performance. The legislation occurred and, as you know, they put out ministerial direction 26. We have negotiated the reporting of that through employee surveys so we have negotiated with an outside provider to provide the reporting mechanism by employees. We are just about to launch some guidelines. A lot of the agencies have commenced their training. I can only speak for the Department of Premier and Cabinet but it starts with the departmental leadership team and we are going through the training and that is occurring. You also have to remember that some agencies, I would suggest, already had in place reasonable if

not good reporting mechanisms, better than others, but there are still a few who have a bit of a way to catch up.

Dr GOODWIN - So it is still early days?

Mr OGLE - Yes, I have said to them that the reporting for June 2012 will be a certain level of reporting but for June 2013 the legislative requirements will have to be met. As you may remember, it is fairly detailed reporting around the linking of performance to your business plan, the training of people, the educating of people and having 100 per cent of people through performance management. So just a few systems to put in place. I am satisfied that we are a long way down the path, at least getting the systems, the process and the structure in place. But it is the next step of the doing.

Dr GOODWIN - Because it is always a concern that you lose the good people because they go off and get jobs elsewhere because they can and then what are you left with? Maybe people who are not up to scratch.

Mr OGLE - There is no way to answer that. You are right; good people will always be marketable. But I have to say there has been a whole slowing down of our wastage. I think that is a general trend. During these times, people seem to stay put. Remember, we were not focused on getting rid of people in the performance management; it was about improving performance. Will people be terminated at the end of it? I think we have to just wait and see; the mechanism is there. More importantly it is getting people up to speed or at least having a standard of performance that is acceptable.

Dr GOODWIN - I think it is a better strategy, though, if you are able to, in effect, sack employees who are not performing rather than perhaps giving them a glowing reference and moving them on to another department, which may well have happened in the past.

Mr OGLE - I cannot answer that. We cannot target people because of performance, in a redundancy program, because that is unfair. But we can target -

CHAIR - You can have a performance management program though?

Mr OGLE - Yes, that is a different process.

Dr GOODWIN - It is the point of having it, though, to make sure you do have people who are performing as they should.

CHAIR - That leads me into the 2 per cent wage cap. That has been agreed to, I understand, across the public sector?

Mr OGLE - We met today. They have agreed to the offer. We are still working through what the words in the agreement are. At the end of the day I think we can all get to the end point.

Mr WILKINSON - So you are more satisfied now than you were a couple of months ago?

Mr OGLE - I was always satisfied. It was persuading the other side that 2 per cent was a good agreement.

Mr WILKINSON - They are more satisfied, then, than they were a couple of months ago?

Mr OGLE - Yes, I think that was around three years, two years, one year - all those sorts of negotiations occurred. The issue around what counts in a productivity setting was always an issue that had to be worked through. When you talk about what was agreed, it covers 11 000 employees - the Tas State Service Award, the Health and Human Service Award and the Education Facilities Agreement, which are the groundspeople and the cleaners within Education. So it covers about 11 000 but there are a lot of agreements and awards that hang off those. We have about 10 to 12 other agreements that we are trying to work through.

CHAIR - Do you have any concerns that this could lead to problems in retaining good staff, as Vanessa is alluding to, particularly in the nursing area? Victorian nurses just had a significant win after significant industrial action where they were closing beds. It was not the minister; it was the nurses who were closing the beds. Do you think that if we find ourselves limiting the wage rises -

Mr OGLE - Our negotiations at the moment are around the Tas State Service Award, which is the general State Service, and Health and Human Services, which again is the general employer -

CHAIR - Not the nurses?

Mr OGLE - Not the nurses.

CHAIR - But you need also to be looking at the future in wage restraint, don't you? Are we looking at potentially the union coming back for a much bigger hit next time as a catch-up?

Mr OGLE - They will always try that but you look at each of the occupational groups. It is fair to say that Victorian nurses, and from my memory Victorian Police, were always bottom of the pile and have been for a long time. Obviously the decisions in Victoria were to lift them up.

CHAIR - Are Victorian nurses behind Tasmanian nurses?

Mr OGLE - They were. In a package sense, if you take into account shift and penalties and all the allowances, they are well behind.

CHAIR - So you think the wage agreement that the State Government adopted has been reasonable at this stage?

Mr OGLE - I have to manage it on the budget and there is 2 per cent in the forward Estimates for wages. I think all parties have shown reasonable restraint, at least for the next couple of years, around 2 per cent.

Mr WILKINSON - Are there any savings as a result of that? Within the Budget, was there an indication that it was going to be higher than 2 per cent?

Mr OGLE - It was always 2 per cent.

CHAIR - A couple of years ago it was back to 3 per cent. In 2008, the then Treasurer said it was going to be 1-2 per cent. Didn't he drop it down to 2 per cent and then put it back up to 3 per cent the following year?

Mr OGLE - You'd have to ask the Treasurer. I can't help you there.

CHAIR - I can remember that because it was like a belt was loosened in 2009.

Mr WILKINSON - That's why I believe there may be some savings from what is otherwise -

Mr OGLE - My understanding is that the salaries indexation for this year and the forward Estimates is 2 per cent and has been factored into each agency.

CHAIR - So is that four years of forward Estimates?

Mr OGLE - One year plus three.

Mr WILKINSON - And that was from last year's Budget?

Mr OGLE - Yes, that's all in the forward Estimates. If you asked, 'Do the agencies have the money to pay for it?', yes, because it is 2 per cent. We have also been negotiating with the unions but we haven't really hit on anything of substance yet. There was a 0.5 per cent for productivity but that was based around genuine cost savings, but we will keep working with them to see if there is anything we can do.

CHAIR - Nursing, teaching and police are the three biggies so far as employment goes; when are they up for renegotiation?

Mr OGLE - After my retirement.

Laughter.

Mr OGLE - Teachers are next - K-12 teachers - due from 1 March this year.

CHAIR - We are already passed that.

Mr OGLE - Yes, I know. We're still negotiating with those teachers. That has implications for the post-year 10 teachers and the Skills Institute, which is due in October. We have allied health professionals, ambulance -

CHAIR - Are they all this year?

Mr OGLE - That is all this year. There are a number of agreements that hang off the Tas State Service award and the Health and Human Services award, but they're what I would describe as small entities - like Government House and Port Arthur. They don't have a major impact but they would still require negotiation. I think nurses, police and fire all happen in the same year; I think it is 2013.

Mr WILKINSON - With the teachers, allied health and ambulance, was there a 2 per cent increase factored in?

Mr OGLE - Yes, all the budgets had 2 per cent.

CHAIR - So the 0.5 per cent productivity is included?

Mr OGLE - No, that is additional to the 2 per cent, but you have to find genuine savings, so in a sense you have to be able to pay for the 0.5 per cent.

CHAIR - Is that likely to happen in the ones that are being awarded now?

Mr OGLE - We have certain provisions that say that if you can achieve certain things then the 0.5 may occur, but we haven't signed off a 0.5 yet.

CHAIR - For anyone yet?

Mr OGLE - No, but in the TSS we have what is called a purchase leave scheme. It is conditional on so many people going on a purchase leave scheme, which is basically 10 extra days leave without pay. If that saves the equivalent of 0.5 per cent of the salaries bill then that may attract the 0.5 per cent increase but, in effect, that's then paid for by the cost savings.

CHAIR - Thanks very much, gentlemen. We will send you a letter with the things we want information on.

Mr OGLE - Yes, thank you.

CHAIR - Some of the matters may need to be followed up with the departments too.

Mr WILKINSON - It would be interesting, Frank, to look at in relation to Health, for example, the number of people who have been employed since whatever the date may be and - I know it can be difficult because of the seriousness of operations but let's say the operations remain the same - the output in relation to operations.

Mr OGLE - I think you're right, we also have to look at the occupational groups which is important in that equation. I think you'll find the minister's has gone up over that period and the rest has probably remained reasonably static.

Mr WILKINSON - Thanks.

CHAIR - Okay, thanks.

THE WITNESSES WITHDREW.

Professor TIMOTHY SKINNER AND **Professor ISABELLE ELLIS**, SCHOOL OF HEALTH SCIENCE, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Forrest) - I will explain how the committee hearing works. What you say will be recorded on *Hansard* and that will form part of our report, potentially. We're looking at the Health cuts, as you know. We would like you to address your minds to the requirements that there are. *Hansard* will record this and it will be transcribed and put onto our website as a public document. If you want to give evidence in-camera it will remain confidential, so you can make that request and we will consider it. That will not appear on the public website and it would not appear on our report. We may use some of it as evidence to relate in our report as far as the context but not quotes or anything like that. So feel free to speak as far as you are protected by parliamentary privilege while you are here but if you say the same things outside, you may not be, depending what you say.

Prof. ELLIS - I don't think I know anything controversial.

Laughter.

CHAIR - We are particularly interested to hear from the Rural Medical School, and I understand you have taken over the head of the nursing school which is not the area we expect you to be focusing on, it's more your experience of rural health settings.

Prof. ELLIS - Yes, sure.

CHAIR - I understand you have quite a degree of experience in that area and, whilst the current Health cuts and what we're focusing on is predominantly around the cuts to frontline services in the acute health setting, obviously the primary health settings and the flow-on effects back to the primary health service are important.

The other thing we have been hearing from other witnesses, particularly from the medical profession and to nursing to some extent, is the threats to training and training programs if the cuts are too severe in the accreditation training programs.

We would like to hear your views on any of those issues you would like to address your minds to and generally what impact you think these cuts could have on that, educationally, feeding into health services. Did you want to make an opening statement? It may help to describe what your roles are and what background you bring to the table?

Prof. SKINNER - I am the Director of the Rural Clinical School which is funded directly by the Department of Health and Ageing as part of the Rural Clinical Training Scheme. We have nine key performance indicators and they are basically around three things: providing undergraduate medical training in a rural environment and that has to be of high quality et cetera; establishing research evidence around how to optimise health for rural and remote communities; and also how we engage with healthcare professionals and the wider community about recruiting, training and retaining the medical work force. So it is not just the undergraduates, but how we support retention of the specialists and GPs who are working in the hospitals in primary care. So those are the three fundamental goals that we have.

CHAIR - In the primary care hospitals or the acute setting as well?

Prof. SKINNER - The remit is rural and remote health, so it is about how we have viable hospitals and viable primary care, and the job is recruitment, training and retaining staff to work across both those areas - basically, anything to do with rural and remote health and staffing and providing that. The Rural Clinical School is very much focused on medical parameters around doctors.

Prof. ELLIS - My background is a remote area nurse and I have also worked as a health service manager and an educator for many years, training Aboriginal health workers, people in the VET sector, the TAFE sector and also in the university sector across nursing, midwifery, public health and a whole range of areas. I was recruited to be the Professor of Rural and Regional Practice Development at UTAS and it is a conjoined appointment between the University of Tasmania and the Department of Health and Human Services.

CHAIR - I don't know how close your links are with the LGH. Are they very close there?

Prof. ELLIS - Mine?

CHAIR - Yes.

Prof. ELLIS - In my new acting role for the next months, of course I have to have some links with the LGH, so it is really about some discussions with them around how to support our students and staff, their staff in training and our staff in faculty practice.

CHAIR - Are the cuts having any impact and, if so, what impact are they having, both from the nursing perspective at the LGH and the north-west, but then also from the medical side of it?

Prof. ELLIS - Of course there is a clinical impact wherever they close services; we all know about that. But from the School of Nursing's perspective, we have still managed to get all of our students in clinical placements. It was an anxious time when we thought, 'Is this going to have a major impact on us?', but in fact we have not had as big an impact as we expected. We have been able to put students in different locations. We have 300 placements in Launceston and they have really gone all-out to make sure that students are in appropriate but alternative placements. So they have taken a good, hard look and found where placements might be appropriate and worked hard to see whether that would be a good experience for the students.

CHAIR - So placements for the 300 have all been within Tasmania?

Prof. ELLIS - Yes. We have 100 placements down here in Hobart and 300 in the north. But it is and has always been a struggle. I have come from the Latrobe University and we have large numbers of students there too, and actually finding the appropriate placements for students is probably the biggest challenge in running a nursing program because students are not all ready to go any placement at any one time. The way we train them is that they have a mental health and community education module and then we need to find an appropriate placement that follows pretty closely with what they have learned.

There are peaks and troughs with this and just making sure that all those things are there all the time we have a pretty big staff who work on that all the time.

Mr WILKINSON - So there were 400 placements that you had to find and you found them?

Prof. ELLIS - Yes.

Mr WILKINSON - And you found those 400 given placements, if I can use the phrase, at the same time in those areas - because that is the other thing, isn't it, that would otherwise be the case?

Prof. ELLIS - Yes, exactly. But our challenge, of course, is always to actually make sure that those placements are appropriate and that our students are well supervised in clinical placements. We have models of clinical supervision where we have student ratios of one preceptor to eight students and we have to work around that with the numbers of students we take on.

CHAIR - Does that present any challenge with the closure of wards at the LGH and Royal? The LGH has shut a whole ward and the Royal has amalgamated wards.

Prof. ELLIS - Yes, of course, it always creates a challenge, but it is a reality we have to work around and go, 'Okay, this is the case, we don't have that number of shifts that we can actually put students on and where else would we be able to put them, knowing that they are going to need to have the types of experience that those wards would have provided?'. But we have also opened up other areas like neonatal intensive care and the other spot at the LGH which is an A&E overflow area. They are extremely good acute care placements and we have had to do a bit more training in preceptors but people have been willing to think things through in as creative a way as possible.

CHAIR - Do you feel fairly confident that students will get enough surgical experience because elective surgery is the main area at the moment, and that component of the training would only be at specific times?

Prof. ELLIS - Yes, that is right. Surgical is part of what we call 'acute care' and acute care is across a range of experiences. It is both in acute surgical where someone has to come in and have an operation or someone is particularly unwell and they are coming in through the emergency department. The skills for nursing are really around assessing the patient, preparing them for the types of procedures they will be having and, as an undergraduate, they need to do a range of procedures themselves.

CHAIR - Like post-operative?

Prof. ELLIS - We can put them into a range of areas including post-operative, but it is really about making sure that they get that acute care experience and surgical is just one of those.

CHAIR - What about anaesthetics and scrub and that sort of thing?

Prof. ELLIS - Do they go into the peri-op environment?

CHAIR - Yes.

Prof. ELLIS - We used to do that quite a lot and put all students into a peri-operative environment but we don't put very many in there now, we mostly put them in recovery and they don't actually spend -

CHAIR - I remember fainting in theatre one year. I couldn't breathe.

Prof. ELLIS - When you and I trained long, long ago -

Mr WILKINSON - A long, long time ago.

Laughter.

Prof. ELLIS - the types of operations people had were fairly general, but now we have so many subspecialties that it is not necessarily the right spot for undergraduate students in the peri-op environment unless you can have a very major facility with a big training program, so usually we only put the super-duper keen ones in the peri-op environment but we will put them in peri-op in a smaller hospital where it is not so pressured. It is a fairly high-pressured environment and we don't need more people than are necessary -

CHAIR - There is a cast of thousands anyway.

Prof. ELLIS - to pick stuff up off the floor et cetera - they are not quite sure what they are doing so it is not the place for -

CHAIR - You know what an emergency for twins is like.

Prof. ELLIS - We do not need that for undergraduates.

Mr WILKINSON - Tim, with the placements we've just heard about with nursing, is it the same in relation to your Rural Clinical School with the medical students?

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

Mr WILKINSON - Is there any way that there can be a change with the locums?

Prof. SKINNER - It's not so much a question around their competencies or skills sets, it is just requirements that are linked to the AMC accreditation of the medical program which requires them to be staff and not agency for supervision and clinical accountability because there are the issues around supervision and training and who is responsible for that. We need that clearly delineated and locums don't have that same formal system. It has nothing to do with their skills sets or competencies, it is a function of the way the programs have to be accredited.

CHAIR - You're talking about the accreditation of a training program. I think there has been some confusion at times when we talk about different aspects of accreditation. So there is accreditation of a hospital under ACHS, accreditation of a program or a course of training and then there is accreditation of practitioners - surgeons accredited through the College of Surgeons, or anaesthetists or wherever they fit. Is that an issue with the course?

Prof. SKINNER - The issue is the MBBS undergraduate degree program is accredited by the AMC and they require the students on rotations to be supervised by contracted staff, in effect. You can't have them being supervised on placement by locum staff, so that's where the problem comes for us in how we manage the issue.

CHAIR - So that's a quality of care issue?

Prof. SKINNER - It is about quality but also about accountability and responsibility, because the locums are only there for a short period. Some may only be there for a week, some may be there for many months, but who is the accountable person and how does that responsibility sit within the system?

Prof. ELLIS - It's about delegation.

Prof. SKINNER - It's about having clear lines of accountability and responsibility. We need to be sure that if they are there for a four-week rotation they are supervised for those four weeks by the same person so we have continuity of instruction, education et cetera. Those are the issues. The surgeons are excellent and very well skilled but it is more to do with the requirements we have from the Australian Medical Council.

CHAIR - We have heard that the Mersey has improved so far as the reliance on locum staff is concerned. Would you agree with that or haven't you seen that happening yet?

Prof. SKINNER - I am not privy to the numbers to be able to say one way or the other. It's not something I engage with directly or have direct access to.

Mr WILKINSON - Some argue that the Mersey should be closed down completely.

Prof. SKINNER - Yes, you're right, some do.

Laughter.

Mr WILKINSON - Do you want to comment on that?

Prof. SKINNER - I agree that many people think it should be closed.

Prof. ELLIS - This is a big political issue in the north-west; you would be very aware of that. My personal view - and that is as being a nurse and working in country Australia - is that people have a real connection to their hospital and in order to reconfigure the services even that you are needing to provide as a State government, you need to work closely with the community to get them to understand that the building does not equal the services. So if it is called 'the hospital' even if you change it to be a multipurpose service, which they've done in many parts of Western Australia, everyone still calls it 'the hospital'. I think that that is one of the big issues that is going to be a challenge into the future for the Tasmanian Government, to work out what are the actual services the people need and then how do they get configured in the capital works that you have and the infrastructure to meet the community's needs but also for the community to accept that they are in fact not losing things but reconfiguring what they need to actually meet their needs.

'The hospital' is an image we have.

Mr WILKINSON - The hospital could remain but the services could be different to what we knew a hospital to be 20 years ago?

Prof. ELLIS - Absolutely, they have to morph and change because the community changes - the needs, the demographics change in different locations; we have different opportunities that we wouldn't have had before. We have the NBN happening in Tasmania that affords us enormous opportunities that we never had before - to have good broadband access to expert health services.

Mr WILKINSON - I'm throwing up a hypothetical, but if for some reason it did close, it would seem to me to create added strain on your facilities for placement with both nurses and doctors. When I say 'nurses and doctors', training nurses and doctors.

Prof. ELLIS - A lot of people have their education at the Mersey.

CHAIR - The reason these cuts are being proposed is that there is a lot of pressure on the budget at the moment, not just in Tasmania but other States and the Commonwealth as well. In an ideal world, how would you structure services more efficiently, do you think? Primary health has been, at this stage, left out of it but personally I think that is only a matter of time. The CEOs through your health service are saying that DHHS have made it quite clear they are very unlikely to meet these savings requirements this year. What do you think needs to change?

Prof. ELLIS - I think you need a whole-of-health approach. I don't think that you can separate out primary, secondary and tertiary care. A person is in the context of their life experience, their family. A woman who's having a baby will need to be able to access primary care during her pregnancy. They may want to have her birthing in the hospital, they may want to go back home and have support.

You have to think of health as a whole thing and in order to work out what is the best use of resources, you have to work out where you can move resources so that they are more effective and more efficiently deployed to do the job you need doing.

Having a background in primary care, I of course think that primary care is an area that is probably under-utilised. It's easy to put more money into acute care services and primary care often gets overlooked or it's an easy spot - 'because it's only small' - so we can just chop that tiny bit off. But, really, the savings are minor and the benefits are major if you are supporting primary care.

CHAIR - Do you think these duplications could be dealt with better to avoid this need for cutting elective surgery, for example, or are there greater efficiencies? You identified there needs to be this whole-of-health approach which, with all due respect to the current Premier when she was the Health minister she tried to do, was thwarted by a Commonwealth prime minister - but there you go.

But, in that, that was where it was heading. They started off doing an acute health services review and then a primary health services review.

Prof. ELLIS - Maybe they should have gone the other way around.

CHAIR - Yes, that's what I thought, but there you go. But is there a duplication that could be avoided or gaps that need to be addressed?

Prof. ELLIS - There are glaring gaps between how people go between primary care and then into secondary care. They use the Emergency department if they can't get into a GP. If the GP is closed at the weekend, they end up in the Emergency department. These are really big issues for providing continuity of care. There are lots of ways that other States have used to address that. I know that we have a few superclinics here - there is one in Burnie and one in Devonport - but there is that whole notion of making sure that you are providing the continuity of care for people in the setting that they need it. You don't want to clog up the Emergency department with people who really should be seeing a nurse practitioner, a GP, a diabetes educator or any of those primary care people. We have GP Assist in the State. The opportunity to talk to someone on the phone and get some advice is very important.

Mr WILKINSON - Should there be a monitoring system when people come into Emergency? Some people come into Emergency if they have a headache, say, or for very minor matters which could be dealt with by a person who has a bit of commonsense.

CHAIR - A mother.

Prof. ELLIS - A pharmacist, a mother.

Mr WILKINSON - Should there be and would it be a saving if there was a monitoring system?

Prof. ELLIS - It's called a triage. We have it already. The way we deter them is that we make them wait an inordinate amount of time, so hopefully they will get sick of it and go home. We have also said that we have to see everyone within a certain time, so we have put perverse incentives in the system all the time that say, 'We need to see everyone within this limited period of time', when in fact we are really busy looking after road crashes, someone with meningococcal and all the other things that are happening. We

then still have to see the headache person or the person who has scraped their toe and needs a bandaid.

Mr WILKINSON - Let's say Ruth Forrest comes to Emergency and I am a nurse, am I able to say to Ruth, 'You've just got a headache. Go down to the pharmacy and get some Panadol'?

Prof. ELLIS - If you were a nurse practitioner you could certainly say that.

Mr WILKINSON - So there is already that system in place you believe?

Prof. ELLIS - We would like to think that. It is in place in some places, but we have to have actual positions. There is a nurse practitioner in the Emergency department at Launceston General but they are not working around the clock, 24 hours. That system is only in its infancy at the moment.

CHAIR - You may not be aware of the history, but Tasmania has been a bit slow to take up the nurse practitioner model.

Prof. ELLIS - I was involved in the legislative changes to implement the nurse practitioner in Western Australia.

CHAIR - Was the AMA as challenging over there?

Prof. ELLIS - It was very challenging. We had probably one of Australia's top judges as the chair of our committee and it took an enormous amount of mediation and negotiation, and she was very skilled. Her name was Antoinette Kennedy.

CHAIR - It is starting here but we are certainly slow.

Dr GOODWIN - This is about protecting their turf.

CHAIR - Correct. Tim, do you want to make a comment about any of this from the medical point of view?

Prof. SKINNER - My background is chronic disease and diabetes care in particular. If you look into the diabetes, if we carry on delivering care, both across acute and primary care the way we are, by itself it could blow the Health budget within 50 years, when you look at some of the full costs with the increased rates of type 2 diabetes. We are not really having a whole-of-system approach as to how we reduce the impacts around foot surgery, eye surgery, kidney disease. It is also a major risk factor for dementia, heart disease, stroke, cancer. Just taking one condition, there is not a structured whole-system integrated approach being taken that that is just one condition that is going to have a serious impact, and the prevalence is increasing vastly. At the same time, it is one of the few conditions where we have the studies to say we know how to prevent it and we're not investing in that, because prevention saves vast amounts of money.

Prof. ELLIS - Yes, but it costs when you start.

Prof. SKINNER - Again, it is that whole-of-system approach and thinking about that. The other thing for me is that whole-of-system means whole-of-State rather than a north-west, northern or southern approach and, as an outsider to Tasmania - I haven't been here for a year - one of the things that has struck me is that there isn't a statewide approach to health care. A lot of the time I see it as three completely different models of healthcare delivery which creates lots of interesting problems and, to me, Health should also be a whole-of-State issue.

CHAIR - We have our own views on that and I think we are looking at a further segmentation of our health services with the three THOs. Using diabetes as one example because it has such a broad impact on other area of a person's health, have you any research or evidence that shows cost savings? I know there is an initial upfront cost of putting it in place but basically keeping people out of the acute setting is really what we are talking about here for as long as we possibly can. Have you any papers that show costings and that sort of thing on that?

Prof. SKINNER - Yes. There is an abundance of data out there on the potential cost savings of prevention of illness in the first place and also secondary prevention for improved care for those that have diabetes. We also have worse outcomes in rural and remote areas and that is one of the other problems. The latest set of diabetes indicators from the Australian Institute of Health and Welfare indicated worse scenarios for amputations and blindness for rural and remote health and, in actual fact, for blindness the figures have been improving in urban and inner-regional areas and have been getting worse in rural areas for the percentage of population with visual loss due to blindness.

CHAIR - Is this because of access issues or what is the problem?

Prof. SKINNER - There isn't enough data to know why we have the problem. We have issues of access, we have issues of poverty, we have issues of high rates of obesity in rural areas, and there is a multitude issues around that, but -

Prof. ELLIS - It is a cascading thing as well. As somebody starts to go down the spiral with things getting worse they become less active because it is harder to get around, their vision is starting to get blurrier, so of course it just becomes a spiral that actually impacts on people.

Prof. SKINNER - Looking particularly at illness prevention, the Victorian State Government has probably taken the lead in Australia in that they are funding a statewide diabetes prevention program and they have had 25 000 people go through that program with an average 40 per cent reduction in their risk of developing diabetes. The long-term potential savings from that are phenomenal.

CHAIR - Do you have any idea of the cost of implementing that program?

Prof. SKINNER - I don't know the exact cost of their program but I was part of an application that went to the Department of Health and Ageing for a national diabetes prevention program and across the country it was $21 million we put in for three years over -

CHAIR - For the whole country?

Prof. SKINNER - For the whole country.

Dr GOODWIN - What does that actually involve?

Prof. SKINNER - The Life Program is six two-hour sessions about a fortnight apart and Diabetes Australia (Victoria) are the lead organisation for driving that and they basically do the training for people to be life facilitators and then the life facilitators run the programs and there is a payment based on the number of people who attend the first sessions so they have those logs of attendance as a way of monitoring and they monitor all the outcomes of that program. Patients have their weight, lipids, blood pressure et cetera done when they enter the program so they know who has come through and what impacts that has had.

Dr GOODWIN - Do GPs refer them?

Prof. SKINNER - Anyone can refer them and they can be self-referred, so it is for anyone who is at high risk of developing diabetes, which is a large number of the population.

CHAIR - Do you have an idea how much it would cost to roll out something in Tasmania as a State?

Prof. SKINNER - I don't know but I could get you the figures. I know the application that went into DOHA put in a quote for what it would cost if you were to identify those people at high risk in Tasmania.

CHAIR - It would be helpful for us to have that.

Prof. SKINNER - I can send it to you. It was an application that came in from Diabetes Australia who are strongly advocating for diabetes prevention.

CHAIR - When was the Victorian one rolled out?

Prof. SKINNER - They were doing it all last year.

CHAIR - And they have already seen a 40 per cent reduction?

Prof. SKINNER - Of the people who turn up to the program you get on average a 40 per cent reduction in their risk of developing diabetes.

CHAIR - Do they look at people with diabetes at all?

Prof. SKINNER - No, these are people at very high risk -

CHAIR - Who do not have it yet?

Prof. SKINNER - who are likely to develop it. If I remember rightly, the group they are targeting are likely to have a 40 to 50 per cent chance of developing diabetes in the next five to 10 years and they are reducing that risk by 40 per cent. The best data to indicate the scope is in Finland, where they have had a 14-year follow-up on people who went

through that prevention program. They have five lifestyle targets which are relatively moderate targets to achieve and they have not had a single person who have achieved that lifestyle targets develop diabetes. Those targets are a reduction of fat intake, a reduction in saturated fat intake, 30 minutes' moderate activity five days a week, a 5 per cent weight loss only -

Prof. ELLIS - Which is small. If you think of somebody who is 120 kilos, 5 per cent is small.

Prof. SKINNER - They also have a high fibre diet. Another big study in the US and another one in China have shown almost identical figures for similar based programs. That is just one disease.

The Victorian State Government are now going down the route of asking us to change the life programs, so we also do cardiovascular disease prevention as part of the program as well as diabetes prevention. So there is huge capacity, but even just secondary prevention with people, once they are diagnosed with diabetes, the issues of the cost on the health services are huge.

Going back to the perverse incentives, primary care's incentives for care, are that if as a GP you get a patient with very well controlled diabetes, you are actually paid less for managing them.

Prof. ELLIS - You get paid every time you go and come back.

Prof. SKINNER - The guidance says that if they are well controlled you don't see them so often.

Prof. ELLIS - You do not want to see them - 'You're doing great, see you'.

Prof. SKINNER - It is going to interesting what happens with that activity-based funding and how that is going to engage because -

CHAIR - Because of the perverse outcome.

Prof. ELLIS - Absolutely.

Prof. SKINNER - In some contexts it could have completely the adverse effect and completely blow the budget because the activity is not linked to the outcomes.

CHAIR - It is not prevention, it is treatment.

Prof. SKINNER - But it is not linked to the outcome, it is linked to the activity.

Prof. ELLIS - The outcome is that you do not want to see the person, that they are well and off living their lives.

CHAIR - Apparently in America some years ago, in Boston, according to some health professionals there they had a similar thing around diabetes management and cardiovascular disease and that was mostly the nurse practitioners, all diabetes trained.

Prof. SKINNER - If you look at the statistics you'll find diabetes is not well managed at all anywhere in the world. The Australian Institute of Health and Welfare diabetes statistics which came out recently showed only 18 per cent of patients with type 2 diabetes receive a full cycle of care. The implications of that for the acute care is hospital cost. One in 10 patients in any hospital will have diabetes and will be there for diabetic complications.

Prof. ELLIS - So where there is a failure in the primary care system, you have to pick it up in acute care.

CHAIR - That is right.

Mr WILKINSON - What percentage of people who go to hospitals in Tasmania would be there for diabetes and cardiovascular conditions? If these prevention programs came into play here we are obviously going to save but are we able to put a figure on it?

Prof. ELLIS - You have about 10 per cent of your active patients with diabetes in a hospital in any one day, then you think about the number of times someone with diabetes has to go to hospital. As they go later into their life they will go more often and they will also have a longer stay with more complications. So if you have to take off someone's leg, for example, as a result of a complication of diabetes which started as a scratch on their toe, they have been in hospital for months and then they have had their leg removed and then they have post-operative care for months.

Dr GOODWIN - Also they probably cannot work after that, so it goes on and on.

Prof. ELLIS - These are major issues. I have been very involved in improving wound care outcomes for people in remote Australia and a lot of that has been about reducing amputation rates and really getting people much more proactively seen by wound care nurse consultants and by having the GPs referring to vascular surgeons early so that you get appropriate care.

Mr WILKINSON - So you're looking at 10 per cent with diabetes in hospitals at any one time?

Prof. ELLIS - Yes, with much longer lengths of stay.

Mr WILKINSON - And cardiovascular?

Prof. ELLIS - There are 30 per cent of people who have a cardiac event who don't get to hospital and die.

Prof. SKINNER - It depends what you are classing as cardiovascular disease. You'd have probably even more in hospital who have cardiovascular disease because it is secondary to and the cause of a vast majority of health-related issues. The other issue rurally is the loss of autonomy and independence that comes from any progression with diabetes complications. There are other models, like managing heart attacks in South Australia, where the State cardiologist has an iPad with him at all times and anyone from anywhere within the State can send him an EG report and blood results and he can initiate

treatment from anywhere. The patient doesn't need to go anywhere to get the leading-edge expert in the State initiating treatment for them.

Mr WILKINSON - I know it seems ridiculous to say, but some say in the good times what should be happening is that these programs should be enforced because there is money to set them up and monitor them. Then you can see what is happening and people realise there is a saving of money.

Prof. ELLIS - In the good times we spend money on buildings, setting up all kinds of fancy things and buying MRI scanners but and we don't spend money on primary care and prevention because it is just small bickies compared to all the big fancy things we buy in the good times.

CHAIR - You can't put your sign on a program, you can only put a sign on a building.

Prof. ELLIS - That's right. That is why we really need a long-term approach to health. We are going to live for a long time. Everyone who is alive now has a very high chance of reaching 100 -

Mr WILKINSON - That's comforting.

Laughter.

Prof. ELLIS - which is unprecedented in human history. That is a terrific thing but the reality is we have to think about health care in a different way.

Mr WILKINSON - So when we're looking at saving money and endeavouring to do what we can with the money we have to spend in the Health area, as I understand your evidence you would be saying there should be much more of a focus on primary health. If there is a focus on primary health there is going to be a long-term gain.

CHAIR - Investment in primary health.

Prof. ELLIS - Yes, and prevention, but it is not just in the primary health setting, every single encounter with the patient and their family should have a primary health approach. There should be a little bit of time in every encounter for health promotion. We also have to be thinking about the whole of health; for example, if you are an anaesthetist you should be giving quitting smoking information to the patient before you anaesthetise them. There are lots of training things that can help with reduction of all these high-risk activities that can be done at every encounter. What they with smoking cessation is that if you are told by your anaesthetist or surgeon to give up smoking, you are much more likely to do so than if anyone else tells you to. Just doing that training and making people aware of those sorts of things that they can do at every encounter will improve health outcomes.

Mr WILKINSON - Let's say I have to speak about this tomorrow. Where do I go to get information on, say, diabetes, primary care, cardiovascular -

Prof. SKINNER - I can e-mail you plenty of references, application documents et cetera. The smoking cessation thing is huge. I was horrified at the figures for smoking rates in Tasmania; it is almost twice the national average.

Prof. ELLIS - And no reduction.

Mr WILKINSON - There is a reduction in males, but not so much a reduction in females.

Prof. ELLIS - It is hideous.

Prof. SKINNER - The costs, short and long term, on that are huge.

Prof. ELLIS - There are plenty of things that can be done to impact, but your issue is what you are doing to do today.

CHAIR - One of the CEOs said that was has been required of them is a 'mad dash for cash' and they had to cut out cash as quickly as they could to make the bottom line look better by the end of the financial year. It's going to look a bit better but not as good as the Government wanted it to, by the sound of it. But that doesn't fix any structural problems here.

Prof. ELLIS - No.

CHAIR - You're saying we need to look at the structure and have that whole-of-State approach and whole-of-health approach.

Prof. ELLIS - Yes, absolutely. You have all your specialists concentrated in two towns and you have a whole population to service. So instead of thinking about how do you get your - it might be a wound care nurse consultant; it might be a burns specialist - how do they provide services to the whole State? At the moment they drive around everywhere.

Prof. SKINNER - Or fly to King Island.

Prof. ELLIS - Or fly everywhere instead of using the technology that is available, but there's no time for anyone to set up those systems in a sustainable way, so they just keep doing the same old thing because they are so damned busy.

CHAIR - You would need less cardiologists if there was one on call all the time with the use of their iPad.

Prof. SKINNER - You can service the whole State.

Prof. ELLIS - Yes. You need a proper system set up to allow your rural hospitals, your GPs to call in. Have a standard time so they can go, 'Look, we'll just give these guys a call today because we're not having success with the current treatment and we need a specialist eye on this'. But people in the tertiary sector - like the Royal Hobart Hospital - are so busy that there's really no time for thinking and planning at how to do a whole-of-statewide service delivery with the skills you have in the State. You have great skills in the State.

CHAIR - Maybe the common chair can focus on this with the THOs.

Prof. ELLIS - It really is an important thing for them to think about because it is a huge investment. It's a small State and we're doing an enormous amount of training, both undergraduate and postgraduate, so we have a very well trained workforce but not meeting the needs of the community.

Prof. SKINNER - It is the whole-of-State approach because the hospitals should be cohesive in the way they work and they are not. There are some things that the Mersey excels at; there are other things that -

CHAIR - But there are some statewide services, like neurosurgery. NIC at the top level is only provided in Hobart.

Prof. ELLIS - And you need to think about the micro specialties and a whole range of other areas. For example, how many vascular surgeons do you have in the State? Not very many, so they need to have a statewide brief that allows that sort of thing. Burns - you don't have many burns specialists.

CHAIR - There is very little waiting list for endoscopies at the North West Regional Hospital; they are mostly done at the Mersey. But when you are referring patients to the Hobart clinicians, it's like, 'Go where?', when there is a huge waiting list down here and people's cancers aren't being picked up early enough.

Prof. ELLIS - That's just crazy, but they'd go to Melbourne in a blink.

CHAIR - Yes, but there's capacity at the Mersey.

Prof. ELLIS - And they can fly to Devonport. It's crazy not to use the services. People would happily go to Melbourne from Hobart but not into Devonport. That's about selling to the community that you have very good services.

CHAIR - Not only the community but also the clinicians who can refer them.

Prof. ELLIS - Yes.

Prof. SKINNER - It is the same for minor orthopaedic surgery as well. They have their own wait list the last time I spoke to them.

CHAIR - Yes, up there at the Mersey, with the arthroscopies and stuff.

Prof. SKINNER - I suggested to the CEO that they could be selling places to Melbourne. Bring them over on the boat, do surgery and send them back on the next boat so you could make money out of it.

Prof. ELLIS - It's called medical tourism in other parts of the world.

Prof. SKINNER - It does link, though. There's some excellent work being done out of Harvard Business School and Harvard Medical School and how health services across the world have to innovate to save money, to become more efficient but also become

better quality in care because the costs of problems with poor quality care is probably greater than the efficiencies that could be gained. One of the things they talk about is the need to have places that do one thing. They do it very well, very efficiently, very quickly and very high quality so you really get the costs of efficiency, the cost savings in quality because you save on complications. There's no reason why hospitals like the Mersey can't become like that. The Mayo Clinic in the US is a classic example of how you take something from nothing to being the world leader and people travel from all over the world, yet it's stuck in the middle of nowhere.

Mr WILKINSON - Is that the one Lance Armstrong went to?

Prof. SKINNER - Yes.

CHAIR - One of the issues with the three THOs and the activity-based funding is that we are going to see them competing for their bucket of money. Rather than saying there is capacity at the Mersey for endoscopies and arthroscopies, they will have to charge the other region. I am not sure how it is going to work but somewhere along the line it is going to create some problems.

Prof. ELLIS - Perverse incentives really.

CHAIR - Yes, so you will end up with no waiting list in the north-west and a growing waiting list down here.

Prof. SKINNER - The problem with that is if you do get to that point where the surgeons are twiddling their thumbs, you lose the surgeons.

CHAIR - And they lose their skills if they are not being kept busy.

Prof. SKINNER - And potentially the knock-on effects from that for wider rural health care when you start losing those specialities.

Mr WILKINSON - I know that Graeme Lynch with the Heart Foundation is doing some terrific stuff in endeavouring to get this prevention up and running, but I question whether other areas within Tasmania are doing the same type of work, which is obviously needed.

Prof. ELLIS - It is a mindset. One of the things I have heard in talking to people is, 'We need to have this you-beaut facility', and I am thinking, 'It has nothing to do with the facility; you have good facilities'. Compared to other parts of the country we have outrageously good facilities but you have to think what do we in our community need to meet our service requirements.

CHAIR - The current and future and not what we did in the past.

Prof. ELLIS - Yes. If we are now a booming place with loads of babies being born then actually it is child health services we need. If we have lots of old people then it is elder care and interesting stuff for people to do in the community.

CHAIR - Perhaps we can turn some schools into aged-care facilities, a diabetes centre or something.

Prof. ELLIS - Actually that's not a bad idea and many communities are doing exactly that.

Prof. SKINNER - Sheffield had the old school closed down so the GPs moved into what was the old school, built a rehab facility into that school. They are a short walk from the aged care facility and they have GPs in there trying to do innovative care. They have a rehab facility on site and they are struggling to find out how do you actually not fund the building but fund the service. We have Diabetes Australia, the Heart Foundation, Alzheimer's Australia and when you look at what they are all trying to achieve in terms of their engagement it is the same things but they are doing it in very different ways. They are all slightly different so they contradict one another. A lot of the activity that is done is not evidence-based activity. Lots of money gets put into different things and it sounds great but actually when you look at where the evidence is behind some of these things it is actually that in the health promotion area lots of money is wasted. Diabetes Australia is targeting the same people as the Heart Foundation and the Alzheimer's and everyone else who is at high risk. That is a phenomenal waste whereas if they were all working together to develop a coherent, consistent program -

Prof. ELLIS - They can't possibly because the money comes in little buckets that they each have to apply for, so it is very difficult.

Prof. SKINNER - I am not saying it is easy but it contributes to that issue.

Prof. ELLIS - Yes, and that is where the THOs have the opportunity to start bringing people together, but it is going to take really strong initiative to do that.

Prof. SKINNER - The Diabetes Australia grant application that they put in for the statewide diabetes prevention program is a very good summary of costings, the benefits and all that put together, so that is a very good document.

CHAIR - The Heart Foundation on 20 April are doing a forum looking at preventive health and trying to coordinate some approach there.

Prof. SKINNER - We are working with the Heart Foundation in Victoria and they are working with the diabetes prevention program.

CHAIR - Thank you very much.

THE WITNESSES WITHDREW.