PUBLIC

THE PARLIAMENTARY JOINT SELECT COMMITTEE ON PREVENTATIVE HEALTH CARE MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART, ON WEDNESDAY 13 MAY 2015.

PREVENTATIVE HEALTH CARE INQUIRY

Mr MICHAEL PERVAN, ACTING SECRETARY, DHHS; AND **Ms SIOBHAN HARPUR**, DIRECTOR, PUBLIC HEALTH SERVICES, TASMANIAN GOVERNMENT, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Ms Forrest) - Welcome. I think you have both given evidence to committees before and understand parliamentary privilege and how it works. Thank you for coming along. I know the minister was intending to come but is unable to, so we will invite him back at another time. We have the submission the Government provided - a whole-of-government submission - so we will invite you to speak to it.

Mr PERVAN - I do not have a copy of the submission with me. My understanding is the reason for its brevity reflects the moment in time we are in with the health system reforms and a number of other things that are happening. We are remodeling and transitioning the department into more of what was envisaged under the National Health Reform agenda of four years ago, so more of a system manager as opposed to a provider and deliverer of services and to make sure those services are delivered through purchasing arrangements, strategic plans such as statements of purchaser intent which detail what it is we are going to fund and why we are going to fund it, and support mechanisms such as that.

While that largely applies to acute hospitals and even down to community health centres, the area of population health and health prevention in particular wasn't captured by the original system manager reforms. As a consequence, we have embarked on this process which is principally to do two things. One, is to take the discussion around where investment and prevention should go to a much wider base, a wider stakeholder group, through the Preventative Health Committee of the Health Council of Tasmania as a reference point to provide recommendations to the minister and government about where the best buyers were. I think that is one of those expressions that is used.

Ms WHITE - The Preventative Health committee - is that the Healthy Tasmania committee?

Mr PERVAN - Yes, sorry, I put the wrong title on. Healthy Tasmania committee.

Mr JAENSCH - Chaired by Tim Greenaway, is that the one?

Mr PERVAN - That is chaired by Dr Tim Greenaway.

The other part is to engage, primarily as a way of starting that discussion, through UTAS to look at the international evidence, the national evidence, and to give us something to start the debate that goes to is there a strong evidence base behind what we are doing? What priorities should we be setting and if not the ones we already have, what should

they look like? That process is well underway as Siobhan, who sits on the Healthy Tasmania committee, can tell you about and Tim will be joining us, I believe, shortly.

Ms WHITE - Can I check that University report is different to the one I have here?

Mr PERVAN - No, that is the University report.

Ms WHITE - The contemporary population health care in Tasmania.

Mr PERVAN - That was the report prepared by UTAS School of Medicine. It has been provided to the Healthy Tasmania committee along with other documents that came from DHHS and that is where their discussions starts. It is the beginning of a process, not the end of one. We are not implementing the UTAS report so much as considering what it says and moving from there through a deliberative process with a wide stakeholder group which is the committee.

CHAIR - Siobhan, did you want to add anything at this stage? Make an opening comment?

Ms HARPUR - To refer to Michael's comments, that committee has been charged with looking at what might be done towards a five-year strategic plan - to table that back to the minister to provide to Tasmanians, along with the white paper, in July. That is what they are looking at and, on the minister's consideration, are looking at that probably in a two-staged way because in the tight time frame there will be an initial plan, that will come from the committee, of priorities and areas where further work will need to flow on in terms of detailing implementation, particularly working to consult on those five areas in greater detail. That will be stage two. Initially our priority is July.

CHAIR - This may be a question for the minister. In terms of your five-year strategy why only five years? It is a very short-term strategy.

Ms HARPUR - I might answer that but Michael may have other things to say. One of the things is that is based on the state public health report in a time cycle for how we can see changes in preventative health, in improvements in health occurring. So a five-year time cycle is a good time cycle for that as far as the evidence is concerned. It is not to say that the work is not much longer term in seeing significant health improvement across the whole of our population but it is to say that a five-year time frame for being able to see specific change is a very good time frame.

CHAIR - Are you looking to see some outcomes from the decisions made?

Ms HARPUR - Yes.

CHAIR - And strategies put in place as opposed to -

Ms HARPUR - Yes.

CHAIR - One of the criticisms from a number of witnesses has been that we are subject to the election cycle, pork barrelling that goes, on and that sort of thing focussing on the buildings that the service is delivered in rather than the services themselves. That requires a much longer term vision and a multi-party support. Where does that fit with

all of this - that need? If you agree there is a need for that. There is a strong view from other witnesses that there is a need.

Mr PERVAN - There is need for long term commitment. There are more complex issues around social determinants of health which you will not see profound change within five years. One of the difficulties for any government and even the bureaucracy is that you may not see change for 15 to 20 years. It is purely an act of faith that you embark on some these strategies and hope, based on the evidence you have, that it is going to have a positive effect downstream.

With some of the more specific interventions that go to nutrition in school age children and things like that, you can measure change in a shorter period. You can confirm you are on the right direction and continue or adjust it, as the evidence tells you, and do something different. You are able to measure some elements of change in a shorter time frame.

We have to try to navigate between the two, which is a long-term commitment to prevention and the structures that are provided to support that. As well we must make sure we are measuring as we go so these things are having a positive impact and demonstrable improvement in health outcomes.

CHAIR - Are you talking about a rolling five year strategy as opposed to a development strategy to be reviewed in five year's time?

Mr PERVAN - That is the way I see it.

Mr VALENTINE - Is it important to have a framework to work within for those strategies.

Mr PERVAN - Yes. I will let Siobhan correct me, but that is where the committee is going in respect to what gets added into the White Paper.

Mr VALENTINE - That could be a 20-year framework, couldn't it?

Mr PERVAN - It could be.

Ms O'CONNOR - We are talking about 2025, so it would make sense.

Mr PERVAN - One of the more interesting things we have observed internationally was a very brave Scottish government that undertook a review of all their health promotion activity, particularly around Glasgow, and shut it all down on the basis their health outcomes were deteriorating even though they had spent billions of pounds on health promotion that was missing the mark. They have restructured and gone back and they are doing things differently. They had the courage to say they should stop what they were doing because it had no measurable benefit and go to a different approach. Apart from a great deal of courage, it shows there is a need to structure these things so they can be regularly measured and evaluated as opposed to just hoping that down the track you are going to get to the objective.

Mr VALENTINE - The objective does not change.

Mr PERVAN - No. The objective is still a healthy population by, in this case, 2025.

Ms HARPUR - The other point worth noting is that this Government is building on the work that was already started by the previous government. Already we have seen cross party support and that would be the hopeful intention building towards a healthiest population by 2025. The extent to which we can become that by 2025 will continue through whatever government has power.

Ms O'CONNOR - A concern has been expressed to us by other stakeholders about the work this committee is doing. We are talking to a lot of very serious stakeholders in the health prevention and social determinants space. There is a lot of expert testimony that is coming before this committee and, arguably, the work we do should feed into whatever the Government's response on preventative health is. I asked the minister about this not long ago and I was not reassured by his answer. I don't want to put you on the spot but this committee will present a thorough report with a series of recommendations. It would be good to know they will be not only be considered by government but acted on. Will they be?

Mr PERVAN - I am not an elected member of the Government. Can I answer as the acting secretary?

Ms O'CONNOR - Yes, please. Is there an awareness this committee's report should feed into whatever response there is on preventative health?

Mr PERVAN - You have given everything you said introducing the question around the fact that you have gathered evidence and you have heard from a wide range of stakeholders. The department would look at it very seriously and consider it and implement what we can implement. The entire purpose behind the journey that we are on is to reinforce the evidence based approach that has been commenced to take the discussion out as wide as possible. No-one, however brilliant they may be, can know as much as an entire community to make sure that what we are doing is relevant to the community and to see that it is measured and it is delivering. It is exactly what you are looking to do, so I cannot see any reason why we would not take the report very seriously and try and integrate the two.

The essence of the Bangkok declaration on health promotion goes to a community empowerment model and that is where real health promotion occurs. It does not occur in the population health or public health branch of the DHHS or the Secretary's office or wherever. It happens out there and anything that contributes to that happening is worthwhile and incredibly valuable.

Ms O'CONNOR - Siobhan, if I could ask you as the new director of the public health division, will the state of public health report continue to be published? Will it be as comprehensive and have the same level of measures, if not more, than the one that was produced by the previous population health division.

Ms HARPUR - I cannot speak to what the next report will look like. That statement tabled in parliament is drawn from the Health Indicators Tasmania. The Health Indicators Tasmania is all of the data that sits behind it and you would know that is drawn from a whole range of different sources including the Tasmanian Population Health survey, the

Australian Population Health survey and then a whole lot of other ABS and other data. Then it is the director of Public Health's position, which is the statutory position which still exists. Mark Beech is the acting director of Public Health at the moment. He may or may not be the next director of Public Health when the next report is due. If that person, that statutory office holder, will look to how they frame their response to the evidence in terms of making that statement. With this next development of the five year strategic plan, and this was partly the intention of the work that was done under the previous government towards building a healthy Tasmania, was to align that statement with specific aims and targets. What me might see in the next state of public health report is one which has not only this is the state of the health of Tasmanians, but also says these are the priorities for improvement that we want to see occurring in the next five years. In the subsequent five year report we will be able to see how we are measuring up against the objectives we have set. That is some of the cyclical thinking that we are sitting with in public health. It is some of the advice we are also providing to the Healthy Tasmania Committee.

Ms O'CONNOR - There was a concern expressed this morning by representative of the Social Determinants of Health Network that the loss of funding for population health and therefore the loss of resources and capacity and its morphing into public health will lessen Government's focus on whole-of-population health outcomes. Can you explain what the difference is between population health as it was when Roscoe Taylor was there for many years and the public health part of DHHS as it is now? Maybe when you do that you could also talk about the number of FTEs who are in population health and the number of FTEs who are now in public health.

Ms HARPUR - The change that has occurred in the last year in public health services is that at the start of the year we faced the cessation of the national Preventive Health Partnership Agreement. We also faced, like all of our colleagues across government, needing to meet the state budget commitments.

We started on the basis of both of those savings we needed to achieve to look at, in particular, where is the discretionary opportunity. Where can we make any savings, bearing in mind a lot of our work is driven by statutory requirement and by federal funds in other areas - the state immunisation programme, for example, or some of our other protected health work. So our only opportunity for discretion is in broadly the area that Michael has talked about as being health promotion. That area within our structure was called Health and Wellbeing.

Essentially, without necessarily giving you all of the detail, which obviously we have, is that we have halved that area which was previously called Health and Wellbeing to now be called Health Improvement. That is where we have had to meet most of our savings. Where we have four teams under what was Health and Wellbeing previously, we now have two.

CHAIR - Are they particular roles?

Ms HARPUR - They are roles and functions which were mainly under the National Preventative Health Agreement, so there has been a loss of some of the areas of work. What we were very mindful to do was to look in a very rigorous way about the evidence for what we should retain investment in. One of the things the committee have asked us

to speak about later is the Move Well Eat Well programme. For example, we have prioritised our work with early years in children because of the burden we know we are facing with potential childhood obesity and overweight adults that will occur potentially greater costs on the health care system and other parts of government. That is a critical part for us to retain and retain evidence, to inform programmes and retain programmes that are already mature and work that is already mature. We have re-worked all of that area, so we are prioritising the areas where we know we have the greatest evidence for work. I will not deny that there has been a loss of some of the previous functions we had.

CHAIR - Can you identify those actual functions or the positions that you have lost, or the programmes they ran, so we can see what you have had to prioritise. You have said you prioritised the early years and Move Well Eat Well and the reasons for that. What have you had to give up?

Ms HARPUR - Some areas which were really informing policy and practice. Some of them would have been around very individual population groups, so we would previously have had individual policy positions around particular population areas - men's health, women's health, refugee migrant health. We have no longer got those positions, so now we work with our central intergovernmental relation policy positions to still ensure that where that advice is still required in terms of our relationship with the Commonwealth Government or across other parts of government, we still have some capability, but what we don't have is that knowledge and dedicated expertise within Population Health Services.

CHAIR - Is that proving to create additional challenges, because the needs of refugees, for example, are quite different from the needs of other groups, perhaps. Then you have got the needs for refugee children and other migrants, and women's health issues. How are you managing to ensure that the advice you are getting is really robust and well informed.

Ms HARPUR - What we have to remember is that the operational service work is not done by what was population health services. In the case of refugee health, for example, the actual work with migrants and refugees is done in our health services or by the TML or by other organisations outside of government. We had a single dedicated position within Population Health Services and in an ideal world with more resources you may still be able to sustain that. We've had to make a very tough call in terms of prioritising what we can afford to maintain and that will be one that we think there isn't a significant loss overall if we make that choice.

CHAIR - I hear what you're saying, but you said it was about policy and advice. Let's just say migrant refugees is a sector you have identified, without that dedicated policy advice and expertise how do you really know what you're putting in place is being effective. I hear that service delivery goes on in a variety of forms, but in terms of knowing and measuring outcomes and things like that, how is that happening, or isn't it happening now and we're just delivering and hoping that it is hitting the mark?

Mr PERVAN - Just to step back a bit, the challenge that we've risen to isn't one that is unfamiliar. That additional capacity in Pop Health only came along with that NPA three years ago. With the exception of a few FTEs we have gone back to where the division was at in terms of its strength and its size pre the generosity of Kevin Rudd. It wasn't a

long-term resource. It was only really just hitting its stride when the Federal Government decided to cease funding.

CHAIR - The vagaries of election cycles.

Mr PERVAN - Yes. What we're doing is doing what we used to do, which was go to the field, get the best advice we can and liaise with the field. The people that we have left, both intergovernmental relations area and in public health, are brokers liaising between the various stakeholders to do that measurement, to get that information to make sure that what is going on out there is relevant and, indeed, maintained. While there are people out there who are directly providing refugee and migrant health, it is a good and needful thing to monitor that to make sure it is still hitting the mark and that it is still what is required out there, and when it is not to either adjust it or move those resources elsewhere.

The resources we had in Pop Health were only there comparatively for a very short time. We managed to deliver a good service before then and we are just having to re-educate ourselves to deliver the same quality of service if not a bit better now that we are able to take the discussion out a bit wider than we have traditionally.

Ms HARPUR - Population Health was a name that was unfamiliar to me, coming from the UK, where the discipline has always been known as 'public health'. The name Population Health as I understand is a name that Australian jurisdictions gave to the work in broadening the work to include the health promotion area.

Ms O'CONNOR - Also to look at a whole-of-population set out outcomes.

Ms HARPUR - Yes. In the UK that is part of the discipline anyway but is called public health. I've been very mindful in asking other colleagues interjurisdictionally in the last year or two because this has been a conversation, which Dr Taylor and I also had before he left. In New South Wales, for example, they're called Population and Public Health Services, which many public health colleagues would say is nonsense, a tautology. In fact we believe that using the name Public Health Services takes us back to the core broad discipline. Contemporary public health thinking absolutely embraces wellbeing and the broader aspects of health promotion. What we have worked very hard to do, and Roscoe was involved in this discussion prior to his retirement, was to look at how best to use, especially in this transition that we've been going through, the resources as effectively as we can. In fact with the Director of Public Health role no longer having managerial responsibility it frees up that role and the role of other public health physicians in public health services to be involved with making sure we are working to the very best of our capability to meet the health and well being, and health protection needs for our citizenry which is really important. I am responsible for how we manage the staff, how we make the best use of the resources, how we set policy, how we drive things strategically with the factoring in of the department. That has been working quite well since we started.

Ms O'CONNOR - I am sorry to interrupt you but this is the last question. I want to know what the change in staffing levels was between population health and what exists now?

Ms HARPUR - It is that change that is the health improvement change where we have halved the number of staff.

Mr PERVAN - I do not have the FTE numbers off the top of my head but we can provide them.

Ms WHITE - I have a quick question to follow up on an earlier one. The next data public health report, when is that due?

Ms HARPUR - That was tabled in 2013 so the next one will be 2018, it is a five year cycle.

Ms WHITE - I thought it was every two years. I wanted to go to another area of health. We talked about some of the functions of population health or public health services now no longer providing policy advice about migrant policy. Are the service deliveries still available in the community? This is probably a question more for you as acting secretary but we have had a lot of witnesses provide evidence about changes to staffing for allied health professionals across the state. This is making it very difficult for them to meet in a timely manner with a lot of different patients who are referred to them.

Our understanding is that if those patients could see allied health professionals, the dietician, the podiatry specialist, who could address their health problem earlier rather than them presenting as an acute patient to the hospital setting. Could you comment on how we might address this deficiency in staffing as a result of budget savings requirements because if we don't invest in these frontline services in the allied health area, patients will present to the acute system where it is more expensive to treat them and they are presenting with more complex chronic conditions.

As the Preventative Health Committee we want to prevent people getting to that stage so what is the department doing to understand the impact of these challenges. What advice have you for us as a committee and how we might frame recommendations to Government to help support those allied health professionals?

Mr PERVAN - I am unaware of any specific examples so my answer is more or less conceptual in its response. The challenge we have with Allied Health Services particularly in the community health area isn't so much one of capacity because there has been very little reduction over the last five years. Even if you don't count the last 12 months there has been very little change in that capacity in the community over the last five years.

What we don't have is an effective referral and contact system. If someone in the community, or a general practitioner who wants a patient to access those particular services like podiatrist and physio, the referral pathways are very disorganised at the moment and very scattered. It is one of the reasons we were so supportive of the health pathways that Tasmanian Medicare local is doing. Until such time as you have the data, it sounds really cold, I know, but until you know what the demand is you cannot design a service to meet it.

There are some areas where we have allied health workers and I know this from personal experience, who complain they do not have any patients and there are others where the demand is so great in the same area or discipline that they can't keep up. It is a matter of

getting a better understanding of the demand so that the delivery system can be organised to meet that demand, and we don't have that connection yet. I am hoping now that we have the confirmation of who the primary health network is, we can build that through the health pathways work and get a better idea of what we are dealing with.

Ms WHITE - The committee has heard evidence from TML today about health pathways. I will give you two examples of allied health professions who have given us evidence. We have heard from Podiatry Services that in THO South, as we currently know, has gone from 12.9 FTEs to 8.6 FTEs, which has meant they are now performing fewer clinics in the community. They might have done a weekly service in New Norfolk and it is now fortnightly. They might have done a weekly service in Sorell and it is now monthly. There is no service to Nubeena.

Senior dietitians have said they have had a 25 per cent cut to their overall budget and paediatric dietitians have suffered a 50 per cent cut in services for the 2-18 year old group and the wait for an appointment is now six months. We have heard from allied health professionals in the south and the north about the impact the reduction in FTEs is having on service delivery, which means people are waiting longer for appointments and getting sicker. They are just two examples for you to consider. I don't expect you to respond but now you have specific examples of what is happening, you might want to.

Mr PERVAN - I wish I could. I don't know the clinical impact of the difference between a one-week clinic and a two-week clinic because I'm not a podiatrist or an endocrinologist. It is an issue of concern and I would have to investigate that. What I would assume is that the clinical impact of those changes would have been discussed with the head of Allied Health Services before those decisions were made, if not having been made by the head of Allied Health Services herself.

Ms WHITE - Can I ask a very broad question now that goes to the pathways answer you gave previously? In an ideal health system, if you had an integrated health system where people could move up and back and through different channels of acuity, where would allied health professionals play a role in that? Do you see them playing the role they currently play or a bigger role? Do you think Community Health could do more in the Tasmanian health system than it currently does, in an ideal health system?

Mr PERVAN - One of the things I really like about the Tasmanian Health Pathways Project is that the two people who are driving it are both allied health professionals. Paul and Caroline are both from the Royal. One is a pharmacist and one is a physiotherapist. They understand how the system can be glued together and how it isn't in various places.

One of the nifty things about allied health workers is that they are not tied to a ward or a particular clinical service. They move in between the spaces and that knowledge and skill set is what makes them so good at driving the pathways work. In the wider sense, allied health has a critical role to play. Not just in the specific profession and the discipline they have, but in driving that kind of service integration we know we need, particularly in demand management. It is unkind of me to say and I say it too often, but once a patient is admitted into the acute system they are basically in a sausage machine. Susan Price from the Royal always used to tell me that you admit someone to hospital to put something into them or take something out, and that is about where the health journey ends as far as the hospital stay goes.

As to the health of the individuals, that is something that happens out in the community, at home or wherever they reside. Managing that nexus, that journey and connection between services is what Allied Health is uniquely placed to do. They are critical to the way forward. Integrated care is that thing we have all talked about forever and is very hard, but let us be happy with collaborative care. We are even aspiring to do that at the moment and the one thing that bridges that through outpatient clinics, through the community and even through a hospital stay, is allied health.

Ms HARPUR - More than 30 per cent of the population have new public health service staff for allied health professionals.

CHAIR - Who is the head of Allied Health at the moment?

Mr PERVAN - At THO South, I believe it is Wendy Rowell

CHAIR - Do you have one in each area?

Mr PERVAN - Yes.

CHAIR - With the new Tasmanian Health Service there will be one?

Mr PERVAN - I will leave that decision to the Tasmanian Health Service CEO. There will need to be some kind of statewide management at Allied Health. Whether they do that by a collaborative approach or by appointing someone at the top of the pyramid, that will be up to them.

CHAIR - Going back to the point you made earlier, Michael, I would like some evidence to back-up your comment. You said that some allied health workers have no patients and others have so many they can't see them all. Who?

Mr PERVAN - No, that was a personal anecdote going back three years. I thought I said, based on personal experience. There was a time when I was approached by someone who worked in the community rehab service in THO South who said they were not getting any referrals of rehab patients from the Royal Hobart Hospital. The rehab service within the Royal Hobart Hospital was bed-locked. It turned out that the then CEO was unaware she had access to a community rehab service.

CHAIR - It came down to communication?

Mr PERVAN - Yes. That is why we don't have the system joined up to make sure that where there is capacity it is being fully utilised. It is done on personal knowledge. I know that person is available to do community physio in that location, so I refer all my patients there without realising there might be a whole physio service.

CHAIR - Would a statewide approach to that be a benefit in identifying all the services that are out there and who can access?

Mr PERVAN - Very much.

CHAIR - Particularly if people are travelling for surgery, they are going for a hip replacement and they end up going to Launceston and they live here or the north-west and then go back to their community.

Mr PERVAN - In connecting services and patients, there is a surprising number that return to our emergency departments for plaster checks and dressing changes. A statewide wound management service, which many other states have, would stop them presenting and enable people to stay at home and it is a really cost effective investment. One of the advantages of having one Tasmanian Health Service, and not three very robust individuals to negotiate with, is that we can have that conversation and get that service organised.

CHAIR - Like I said a couple of years ago.

Mr JAENSCH - I want to return to a topic raised by Ms O'Connor at the beginning. The question she raised the witness was not able to answer fully. It is important for the record of that conversation for completeness to note that in terms of the two processes, this joint committee process and the Healthy Tasmania Committee process, that this committee was formalised last year and convened for the first time this year and has no formal reporting date. It is an open ended process. In the meantime, the Government and minister has moved on commitments that were given regarding preventative health planning and he has also made available to this committee the terms of reference and the work plan and time line and some background information for the Healthy Tasmania Committee's process so this committee can choose to time release of information or interim reports or submissions from one process to the other. There is an opportunity to organise our work to contribute to the process that is under way under the Healthy Tasmania Committee.

CHAIR - It was a deliberate decision not to put a reporting date in for a range of reasons that we don't need to go into now.

Mr JAENSCH - It is not unreasonable that the minister has proceeded with a program of work on his contribution because we would be waiting indefinitely for the outcomes of this process if he was going to do it in sequence. They are running in parallel but there are opportunities for one to feed the other and this committee can take advantage of those if we choose.

CHAIR - It was appropriate that we didn't have a reporting date because we had to grant two extensions to the Government for their submission. If anyone was holding the process up it was not this committee.

Mr JAENSCH - I am just saying we can feed from one to the other for anyone who is reading this.

CHAIR - Yes.

Mr BARNETT - With the Healthy Tasmania 2025 objective there is broad support for that target and objective. Do you feel adequately prepared to do it as a department, are you read to do that and is that happening?

Mr PERVAN - Yes, yes and yes. It is a very interesting question. There was a very robust discussion at the Health Council of Tasmania around those exact issues. Is it a fanciful target? Is it achievable? Do we have the skills? Do we have the capacity in the department, in the community across Tasmania, to achieve that?

I am so glad that Dr Greenaway has arrived in the Chamber because he was in that discussion with us.

CHAIR - He just needs to take the oath before he says anything. If you would not mind sitting down. Do you want to finish what you were saying, Michael, and then we will come to Tim Greenaway.

Mr PERVAN - The discussion went to and fro for a while and the consensus was, and I subscribe to that consensus, you have to have a goal and it has to be that goal. It has to be something that is going to be very hard to achieve. We have sent the signal that it is what we want to achieve, we are serious about achieving it and it focuses everyone's energy and attention on going as far as we can to getting there. We may not get to the healthiest population by 2025 but we are not going to say that anything short of that is good enough. We are not going to sit back and say we have improved our morbidity data by two points so therefore that is enough. Or we have reduced the number of people taking up cigarette smoking by a particular number and that is enough. We will get as far as we can go and we will put every effort and every action that we can do towards getting there through whatever processes we develop across Government.

Mr BARNETT - Thanks for your response and it is very encouraging.

We have had a number of submission talking about the health-in-all-policies approach, a whole-of-Government approach, a whole-of-community approach. I am interested if you support that approach and, secondly and probably more importantly, if so how do you communicate and integrate your thoughts with other parts of Government because this is a really important issue for this committee. Governance arrangements and how we communicate, how we collaborate as a whole-of-Government approach. So it is a two part question.

Ms O'CONNOR - Guy, are you asking how the structure might work too?

Mr BARNETT - I had not quite nailed it there. I just want Mike to give us feedback on those two and then we can go to details.

Mr PERVAN - I would be delighted.

CHAIR - Can I just get Dr Greenaway to swear in in case he wants to say something.

Dr TIMOTHY GREENAWAY, CHAIR, HEALTHY TASMANIA COMMITTEE, TASMANIAN GOVERNMENT, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - I know you are a seasoned campaigner and understand how committees work so we won't go into all that. Michael, or anyone else who wants to take the question.

Mr PERVAN - I will defer to Siobhan because I can feel her eagerness.

Ms HARPUR - Health-in-all policies is a World Health Organisation term and it builds on health promotion and some of the other policy thinking about how do we work across sectors to improve health populations. To see that work progressing will still need strong leadership from the health sector and health portfolio. That is critical and we also need the active engagement of other parts of Government and other sectors to really make an impact over time. So how that might look like we cannot pre-empt but certainly we have already some very good, strong evidence in Tasmania of work that has been done across government. One example currently would be the Premier's Physical Activity Council, led by DPAC but some extra leadership has come out of Public Health Services in the Health portfolio. A former one would have been the food security strategy which was a sub-part of the health and nutrition policy. Tasmania is unusual in having a whole-of-government nutrition policy that it first started in 1994 and it has been revisited, built and grown. No other jurisdiction has such a thing and it is across the whole of government. Its last iteration was the food security strategy, and that had a joint chair in the former commissioner for social inclusion with the former chief health officer. We already have some evidence of those sorts of things in place, either historically or currently, and obviously under Tim's chair of the Healthy Tasmania Committee we are tasked with how do we make that work now.

Dr GREENAWAY - The point about communication across government portfolios is well taken, and certainly the Healthy Tasmania Committee is considering currently exactly the sorts of recommendations we are going to make to government to do coordinate an approach across all sectors of government because we are very mindful that it is not just health. It includes all of the social determinates of health - education, housing, all of these things. Your point is well made with respect to the community healthy spaces program. We are considering all of these things and an overarching mechanism whereby that could be prosecuted across all of the portfolios and across all ministries.

I came in on the end of Michael's comments regarding the aspirational goal of 2025 for Tasmania being the healthiest state. I think we would have about as much chance as the Wallabies have of beating the All Blacks, but it does not mean that we should not try. An aspirational goal is not a bad thing. We will give it our best shot and see. I think one of the things we are very mindful of is setting all of us targets with respect to measures of health and then assessing how we perform. There is no point in trying to do something if you do not actually measure it along the way, and we are mindful of that also.

Mr BARNETT - I am wondering if you are aware of the National Diabetes Prevention Plan and the Life program in Victoria and now in other states? Has it been considered?

Dr GREENAWAY - Yes. In fact I was at the initial discussions when Paul Zimmet and that meeting was convened. In fact we had tabled the document that has come out of that for the Healthy Task Force to incorporate some of the ideas along with a lot of the other documents that have been prepared from the Health and Wellbeing Council, the Heart Foundation work et cetera.

CHAIR - Michael, you were talking about the work that you were doing and the aspirational goals and programs that are already in place, how are you going to measure the outcomes?

Mr PERVAN - That is the work that is being developed.

Dr GREENAWAY - The Healthy Tasmania Committee has only been meeting for a couple of weeks. We've been meeting a lot weekly, including one face-to-face meeting at Ross and others are planned, to sort this out. The intent that we have because of the tasks that we've been given is to provide strategic advice for a five-year plan. That is what we've been asked to do. Then in the second stage actually set concrete goals that can be measured so you can see whether we are working.

CHAIR - So outcome measures?

Dr GREENAWAY - Outcome measures.

CHAIR - That's a work in progress.

Dr GREENAWAY - The committee has only been formed for three or four weeks or something.

Mr PERVAN - It is an incredible challenge, though.

CHAIR - It is because some things take longer to measure.

Mr PERVAN - I'm not aware of any jurisdiction that has managed to nail outcome measurement for population health. We can do inputs and we can do outputs; that is easy. Some of the broader outcomes we already measure, and that is in the state of public health report. In terms of improvement, they are going to be quite challenging because there are so many variables around what leads to an improvement in health status. Getting that focus and that definition down is really hard.

CHAIR - The Canterbury health system in New Zealand have a reasonably mature model, I would suggest. Is that somewhere you could look to to look at some of those outcome measures?

Ms HARPUR - This is the sort of the thing that the committee would be looking at. It is referred to in the state's public health report. It speaks to the framework for health promotion, which the department already uses and for Health Indicators Tasmania. Those are all the sorts of measures that give an indication of the health of the population - the number of serves of vegetables and fruit eaten per day, levels of physical activity, and those sorts of measures. Some of those measures are measurable annually. Some of

them don't change that frequently, but those might be some of the things, as well as the more obvious morbidity.

CHAIR - I will just pick out one: promoting sexual health and wellbeing - chlamydia notifications. The measure is in terms of per hundred thousand population: 349.5 in Tasmania, 361.6 for Australia. I say that is because we are not screening enough and that is why it is lower. It is okay to say there have been 350 or thereabouts notifications, but how many of those were treated and how many were screened again and found to be clear? These are the outcomes you need. You go on to teenage fertility rates. That is great, but what about the women who cannot get pregnant because of chlamydia a couple of years down the track?

Ms HARPUR - What I haven't given you is outcome measures and outcome priorities. What I have given you are some of the things that we already count that we can count and see whether there is a difference. That will have to sit with priorities and targets in terms of outcomes, so they are different.

Dr GREENAWAY - I agree with that. I have to address the AMA National Conference in two weeks on this, but Tasmania has higher levels of chronic disease coupled with poorer socio-economic status, poorer health literacy and all of these sorts of issues. I'm not for one moment suggesting that the granular detail that you are talking about there is not important, but in terms of obesity rates, smoking rates and these kinds of things, we know that they are linked to cancer, cardiovascular disease and diabetes, which are our biggest killers. We know that smoking rates are higher, we know that life expectancy is lower and all of these things. I don't want to reinvent the wheel, none of us have that time and there are some things that will work. Stopping people smoking will work. Trying to get people to lose weight; you do not have to lose a lot of weight to make a huge difference to your health. Drug companies are assuming that weight loss by pharmacological or bariatric surgical measures will equate to the same benefits from lifestyle interventions, but there is no doubt at all that with lifestyle interventions, and some modest weight reduction, five per cent, you get enormous benefits in terms of cardiovascular, diabetes risks, et cetera.

We are going to be looking at big picture things, but also trying to have outcome measures at a big enough level that we can measure something.

CHAIR - I agree with that Tim. The reason I did not look at the figures for tobacco use or smokers, is it is easier to count the number of people who smoke and that is an easy figure, but a number of people, women and men, who have chlamydia is a figure which means nothing unless it is treated.

You smoke or your don't. It is important that we get these right outcome measures. That is the point I am making. I know you are aware of it. It is just we have struggled for a long time to get proper outcome measures and key performance indicators that are outcome based.

Mr PERVAN - That was the entire desire with taking the committee out to a very broad membership, to get exactly that perspective. We have very clever statisticians and data people and a couple of epidemiologists and we can come up with things that you can measure and a whole list of them that we can fill out lots of numbers on a page, but they

are not meaningful. They must be meaningful. The same goes for much of the stuff we report. It says we are really busy and there are a lot of people waiting for stuff, but in terms of what that means for -

CHAIR - That means that your preventative health has failed. That is what that means.

Dr GREENAWAY - Sure. That is one of the things I will be talking about in Brisbane. We need to be focussing on preventative care. We need to be focussing on primary care. Hospitals - and I work in one so I can say it - are not very efficient places and if you are not sick before you go to hospital, you are likely to get sick when you are there. The idea is to keep people our of hospitals.

CHAIR - They are a very dangerous place. In tabling this, did you say you had something else you were happy to provide further advice on?

Ms HARPUR - There is further information on a couple of pages that sit behind of where the numbers are drawn from.

CHAIR - Okay, if you could provide that to Jenny and we will table that as a complete document. Thank you Siobhan.

Mr VALENTINE - I have been listening to the conversation you have just had and I have heard Dr Greenway mention issues going across housing and education and all of those things. This whole briefing of areas that need attention in order to able to get the outcomes we need.

Mention was made of Professor David Adams and that took me back to the social inclusions strategy that was put together in 2009. Some very good strategies that were addressed in there, access to the basics, making ends meet, accessible goods and services in our reach, learning for life, diversity in skills and training, et cetera.

How much are we using of this very well based work in trying to cope with the future? Are we drawing on this? We don't want to re-invent the wheel as you said Tim, so how much of that is being used and is Professor Adams being consulted in this on a way forward?

Ms HARPUR - No, not Professor Adams specifically, but we have drawn on historical work including the work of the social inclusion unit and that strategy. It informed the work of the previous committee.

Dr GREENAWAY - Four members of a consortium, including TasCOSS, so we are very mindful and I was at pains initially to reassure people that although I am - I don't know what I am, a clinical academic I suppose - I do not think of a medicalised model of health. It is very important that people get that message, that just because I happen to be chairing it, does not mean that it is going to be prescriptive, a very narrow focus on health as such.

We are trying to draw from a broad cross-section, including the sort of work you are referring to.

Mr VALENTINE - Does that strategy still exist or not? The social inclusion strategy.

Ms HARPUR - It is still a living document in the same way things such as the chronic conditions strategy nationally is. It has been implemented as much as it has and then been absorbed into DPAC's work.

Mr PERVAN - There is no shortage of good resources in the principles that should drive the work, it is how you order them, prioritise them, set your priorities and then measure what you do going forward. It is the actions. I am a national councillor for the AHHA - the Australian Health and Hospitals Association - and someone challenged each of the national councillors to come up with three specific actions that target a social determinant of health, or more than one determinant, that was evidence based and proven to be effective in addressing the social determinants of health, and people struggled to come up with more than two - beyond what we already have, which is universal access to education and things such as that. As to how you change the trajectory for someone who comes from a background of multigenerational welfare dependency and things such as that, there are lots of actions and programs but there are none for which there are an established evidence base that says, 'This absolutely will fix the problem. This is the silver bullet'. While we know what should be driving out thinking, the specific actions to apply that thinking are still things we are working on.

Mr VALENTINE - The thing that concerns me is that work like this strategy was important at the time it was put together and was accepted as a great document and had some very valid observations made in it and good strategies going forward and yet here we are again looking at forming another set of strategies. We are not getting that long-term framework. Aren't we in danger of not addressing the objectives far enough ahead if we keep doing strategies here and there?

Mr PERVAN - This is what came out of the Scottish work. I agree but the risk is you end up with so many objectives, as good and noble as they may be, but you don't achieve much in any one objective.

Mr VALENTINE - So you need a framework that everybody signs off on?

Mr PERVAN - That prioritises them and gives you sufficient to make positive impact but enough that you can service them with the resources you have. It is striking that balance.

Dr GREENAWAY - It is a very good question but a very difficult one to answer. If I can use an analogy in diabetes, we know how to prevent diabetes. If you take people with pre-diabetes, impaired glucose tolerance, within three years with lifestyle modification you reduce their relative risk - and a number of studies have shown this - of getting diabetes by 60 per cent. The problem is that nobody anywhere in the world outside a clinical trial, which has enormous resources to put into people with education and support, has been able to reproduce that in a community-based approach. This is the sort of thing we're talking about. It's very difficult. We know what to do but the question is how best do we do it and then how do we measure how we are performing? It is not just little old Tasmania that has this problem, everywhere has it, and no-one has done it properly. There was a recent editorial bemoaning the fact we cannot prevent type 2 diabetes, which is increasing at about double the rate the population is increasing

around the world. The prevalence is extraordinary and getting worse. This is the sort of problem we are faced with.

Ms O'CONNOR - I am wondering how broad the scope of the committee will be. We had testimony this morning from Asthma Tasmania and they talked about air quality and environmental contributors to ill-health. You would be aware of the work of Dr Alison Bleaney, who is convinced that chemical contamination of waterways has created a chronic disease cluster around St Helens and particularly some cancers. Is the committee going to broaden its work beyond looking at some of those health promotion measures and have a look at the whole-of-population work and contributors to ill health and make some recommendations around that?

Dr GREENAWAY - That is good and a very tough question. In terms of the scope, we certainly are looking a population health. In terms of the specific issues which you are alluding to, the environmental determinants of health, we have members within the committee from public health services who can provide information and input.

We haven't yet discussed the specific issues that Dr Bleaney, for example, is referring to because we have been focusing more on the problems that are really most of an issue to us. They are smoking rates, poor health literacy, obesity, cardiovascular disease, cancer, the big ticket kind of items in a population setting. The idea is to come up with some sort of strategic advice and then in the second phase try to measure outcome. Siobhan may perhaps be better to comment with respect to the environmental health impacts. We have not considered that specifically as we have only been meeting for a few weeks.

Ms O'CONNOR - Before you answer, Siobhan, because of the budget cuts that DPIPWE no longer conducts the same level of water quality monitoring that it used to and we are back in a situation that we were in around 2004. Monitoring of catchments for pesticide contamination is nowhere near what it was two years ago. Is that something that public health should be aware of and looking at because Roscoe Taylor, from time to time, would insert himself into the discussion about water quality issues? Is there a concern that the monitoring is not happening now and there may be impacts on public health that are not monitored, not known and therefore not addressed?

Ms HARPUT - With regard to that last question, I am not aware that water testing quality has gone down at all.

Ms O'CONNOR - It has.

Ms HARPUR - The responsibility under the statutory officer of the Director of Public Health is about drinking water quality and drinking water regulations. We work very closely with TasWater, local government and DPIPWE colleagues when the reports cross that boundary into possible contaminants for drinking water quality.

With regard to the broader environmental health concerns I might take you back to the data table that I tabled. In the middle of that page the working in health promoting ways framework, which has been a long standing framework and is built on that international evidence for health promotion over many years. We are just updating at the moment and finalising the evidence base that sits behinds that. There is a document that is currently in the public domain that is referred to as the background document to working health

promoting ways, which has chapters on each of those circles with what is the evidence base for each of them. We have particularly updated the environmental health chapter because it is an area where we are seeing a lot of change. It is from evidence, not just jurisdictionally in Tasmania, but also nationally and internationally.

That is in its final draft form and will be out shortly. That gives a broad what are the responsibilities, what should we be looking for, where is the evidence base, what can we be doing to improve the opportunities for health improvement in the environmental health space.

Ms O'CONNOR - The issue is if you do not have the baseline data and you got a health-in-all-policies approach and there are potential contaminants in the water supply then you have a public health issue so I will leave that one there for now. I have a last question for Mike. Mr Pervan, we had the dieticians in to give evidence the other day and I asked them about the food at the Royal Hobart Hospital and I listened with interest to what Chevaun said about the whole-of-government nutrition policy.

Is the Royal Hobart Hospital exempt because I have been at the Royal and I have visited friends at the Royal and they are fed red cups full of jelly, green cups full of jelly, custard, white bread with amalgams of something in the middle of them that is unidentifiable. There is a frustration from the dieticians who are there who do not believe that food services in the hospital are taking their concerns seriously. Is there a way that we can make sure people who do end up in hospital, at least from a nutritional point of view, live a bit healthier instead of being filled full of very ordinary low nutritional processed food. It has been described to me as, and I will say it, crap.

Dr GREENAWAY - I didn't say that to you did I?

Laughter.

Dr GREENAWAY - I could have.

Ms HARPUR - We had an active hospital vending machine program across the state for mild dieticians and population health but we haven't impacted on the feed other than in the north.

Dr GREENAWAY - The dieticians work extremely hard but their work tends to be focused on people with major nutritional issues. They are involved with people who need parental nutrition, people who have celiac disease, cystic fibrosis and need very high calorie diets. It is like niche work that they do because of the pressure on their time and budgetary pressure and numbers of dieticians not being what they would be in an ideal world.

For example, in diabetes we use dieticians when we can get them for very specific purposes such as for Our Daphne program, which is an accredited program for type 1 diabetics that works very well and we run it through the diabetes centre.

Ms O'CONNOR - Do you think the food that is being served at all is healthy.

Dr GREENAWAY - No. I don't eat it if I can avoid it.

Ms O'CONNOR - Is there a way to address that?

Dr GREENAWAY - If you are now asking me what is the healthiest diet, the only diet for which there is outcome data is the Mediterranean diet.

Ms HARPUR - It does fit with the Australian dietary guidelines.

Ms O'CONNOR - A high fibre diet which does not include white bread.

Dr GRENAWAY - The only diet for which there is cardiovascular outcome benefit is the Mediterranean diet.

Mr PERVAN - Which part of the Mediterranean?

Dr GREENAWAY - The Predimed study was sponsored by the Spanish Government but you just need olive oil, nuts, wholegrain, it works, it really does work. Could it be better? Yes, it certainly could be better. I know exactly what you are talking about. The cost?

CHAIR - What is the cost of not giving good food?

Dr GREENAWAY - That is a very good question.

Mr PERVAN - You would hope that they are not in hospital long enough to be affected by the nutritional standards but it is an issue that we should take up. Dare I say, it is also a health promotion opportunity.

Dr GREENAWAY - Yes it is.

CHAIR - They might not be in hospital that long but they can be influenced while they are there.

Ms O'CONNOR - Is there a way, within the funding envelope that you have for food, to make sure that the purchasing decisions you are making are as healthy as possible? It should be possible.

Mr PERVAN - Yesterday I was on a ward round where we went to a patient newly diagnosed for diabetes. They were very crook and that is why they were in hospital. We try and keep people out for the reasons I have said before. The family brought in food because the hospital food is ordinary.

Ms O'CONNOR - People order McDonald's from hospital because the food there is so bad.

Dr GREENAWAY - Yes. They brought in cheezels; it was high fat, high salt, high calorie. That is the thing we face day in and day out.

Ms O'CONNOR - If the food was better at the Royal Hobart Hospital it may not be happening.

CHAIR - It depends what you think is better as the patient.

Dr GREENAWAY - They were eating worse food than was on offer.

Ms O'CONNOR - At least they could recognise what they were eating.

Dr GREENAWAY - Yes.

Ms WHITE - We talked earlier about the National Partnership Agreement on Preventive Health being cut in the last year's budget. Having not thoroughly read the budget, as I am sure someone in the Health department has, is there anything new in this year's Federal Budget for preventive health?

Mr PERVAN - Not a thing. There is nothing new in it; despite the promise of other things, nothing has been reinstated. It is the carry-forward of last year's budget.

Ms WHITE - There is no continuation of funding for rehab beds, for example?

Mr PERVAN - Not that we can see.

Ms WHITE - That is pretty sad. There is no continuation of funding for anything, no new money for anything? You are not surprised by what the budget provides?

Dr GREENAWAY - There is some money for the vaccination program.

Ms HARPUR - It is not looking good, though. What has been asked on the one hand is potentially good in that it is about us doing more by way of surveillance of the catch-up program for children and adolescents, developing and establishing an adult record of vaccination. All of that is very good and will be excellent. We are a little concerned that there will be social marketing media awareness campaigns. There will be an under-vaccinated population, the no jab no pay, and our concern goes back to the social demographic profile of Tasmanians where we probably have, we were estimating this morning, maybe 2 per cent of the people who choose not to vaccinate but maybe another 6 per cent of people who don't vaccinate, probably more likely because of access. That would be of concern that it could have a negative flow-on impact on the under-vaccinated population. There is a consequent loss of Centrelink payments for those people. Part of our thinking is how can we best use the resources we have to get to those people who are not vaccinating because they might not be able to access.

Ms WHITE - The Federal Government's policy of no jab no pay does not provide additional funding to states to help with accessing those clients who might not be able to get to vaccinations.

Ms HARPUR - Not that we can see.

CHAIR - Is it geographic access or is it other access issues?

Ms HARPUR - It is a combination of things.

Ms WHITE - There is a burden on their state health system to fund that activity to try to prevent those people losing income potentially and having other further complications as a result of that.

Ms HARPUR - Yes.

Ms WHITE - The Move Well Eat Well program that sits within your division, Siobhan, you said had been secured in the medium term because of the reduction from four teams to two. Are you confident that Move Well Eat Well in a school canteen program will continue to operate in the foreseeable future? What time frame are they funded to continue operating for?

Ms HARPUR - There is a mix of programs here. I am not sure how much the committee is aware of that. There are three interrelated programs. There is the Move Well Eat Well, which is part funded by the Education department, part funded by the Department of Health and Human Services, through Population Health, Public Health Services. That program was augmented under the National Partnership Agreement for Preventive Health. There are two other interrelated parts of the work with early childhood and primary school, one of which is the school canteens program, which is accrediting school canteens, and the other is the Family Food Patch program which is the Child Health Association and which works to establish peer leadership. It is really training parents in a voluntary way to engage them, their friends and neighbours, parents and playgroups and other informal meeting places about healthy eating and getting those habits starting very early on in the child's life. That program and the school canteen accreditation program were both funded under the National Partnership Agreement for Preventive Health. At the moment they're both funded under the grants funding program through to the end of June 2016. At this point of time are not funded beyond.

Ms O'CONNOR - The Move Well Eat Well and the school canteen program?

Ms HARPUR - No, the school canteens program and the Family Food Patch specifically are funded through to June 2016. Move Well Eat Well we have already modified. Under the National Partnership Agreement for Preventive Health it was expanded in two ways. One, it was expanded into working to develop ideas to take healthy eating and physical activity ideas into the adolescent age, into high schools. That work has now been embedded into the Education department and the school curriculum. Fortunately it came up as part of the National Curriculum in discussion. That was very fortunate timing. The Education department had been delighted with all the formative work that had been done under the Preventive Health Partnership program. That work is no longer being updated by Population Health and it has been discontinued in the adolescent space.

Ms WHITE - This is the Education department?

Ms HARPUR - Because the Education curriculum has picked it up. There is still youth health work that is driven out of Population Health Services, supported, but not as an accredited program in the way that Move Well Eat Well was. The other bit that the Preventive Health Partnership Agreement enabled us to develop and establish was an early years accredited program. That is where in our revisiting how we can prioritise we decided that that is so important we should prioritise that over other things. The early years program, even though it was previously funded under the Preventive Health

Partnership Agreement, we have now absorbed into state-funded activity in a slightly modified way. That is for long-stay day childcare. We have trained 80 per cent of that workforce and at the moment in the early childhood program we've trained 1 800 early childhood educators, and the early childhood program has reached about 45 per cent of the sector. There is still more to go with that, but that is work we continue to do.

In the primary school area, the Move Well Eat Well program is part funded by Education and part funded by us. We had additional funding through the Preventive Health Primary School program, which we cannot provide any longer. They have become tighter, but they are both sustainable to take forward, both the early years and the primary school programs. That is led from ourselves and Education. The reason we've done that is because those are very solidly mature programs. It will be good and it will be part of the prioritisation of all of the grants funding that is going on now across the whole department, and the Healthy Tasmania Committee will also look at whether we can prioritise continuing to fund the Family Food Patch program and the school canteens program.

Ms O'CONNOR - Is the Pulse Youth Health Centre going to continue to be funded?

Ms HARPUR - That comes under the THO South.

Ms O'CONNOR - Will it continue to be funded?

Mr PERVAN - It's not been raised with me that they intend to do anything other than continue to fund it, but I cannot answer that.

Mr JAENSCH - Dr Greenaway, in our hearings we have come across this issue of the difficulties of accessing populations and getting services getting through to them. We have talked about opportunities that exist to intercept people at points where they are coming through some sort of gate, whether it is school or a prison or a GP or a pregnancy. I notice that the Government has recently announced a whooping cough vaccine that will start in June, an excellent initiative. Is the Healthy Tasmania Committee thinking about those points at which we have people captive and we can do other things to them in terms of screening and referral - where we are not just sending out a message and hoping it is being gathered?

Dr GREENAWAY - That is a very good question and it is also a very sophisticated question, particularly if you are starting to talk about the developmental origins of chronic disease. There is a concept called developmental plasticity. If you come to my lecture to Med 3 on Monday you will hear more about it.

Mr JAENSCH - I will endeavour to be there.

Dr GREENAWAY - We know that many chronic diseases are influenced by the intrauterine environment and getting a mum with healthy behaviour, not excessive weight gain, good diet, good blood sugar control et cetera in the intrauterine environment is very important for chronic disease in later life. That is a specific area being looked at more broadly in the medical community. In terms of the work of this committee our approach, although it has not yet been finalised, would be to try and get the health-in-all-government approach, the messages in terms of the strategic plan for the government to prosecute

with a healthy agenda that goes across all communities. I take your point about schools, as we have just been hearing, I take your point about the prison population although they have their own specific issues. Certainly it is true in antenatal care. Our role must be to promote the primary care as the gatekeeper for the health system. At the stage at which the relationship general practitioners have with their patients over many years, hopefully they are the ones who can really drive this.

I take the point that was made by Rebecca that the AMA has already commented on the disappointing feature, if you like, of the Federal Budget last night. There was no specific focus on primary care when that is fundamentally important. It is a very difficult question to answer for a committee that has been tasked with coming up with an overall strategic plan. We have not yet focussed on targeting pregnant women but that is something, for example, we do in practice in terms of antenatal clinics.

Mr JAENSCH - I think the former Health and Wellbeing Advisory Board took a significant volume of evidence around the unborn child and the time of pregnancy as an important intervention point.

On GPs and the primary care gatekeeper, in other activities I have been involved with I have found that sometimes GPs are very reluctant to be referring to service providers who are not doctors.

CHAIR - Not attract a Medicare rebate, is that what you're saying?

Mr JAENSCH - Yes. Things that are available in communities about nutrition and physical activity, there doesn't seem to be a ready acceptance to refer to things that aren't codified and approved.

Dr GREENAWAY - I take that point but we are mindful of trying to come up with some whole-of-community advice and programs - Healthy Spaces initiative, et cetera. That point is well made. I did not mean to imply it was only the general practitioner who had a role after having said I am not medicalising this. We have to include all of community, all of government, across all sectors and be inclusive and not prescriptive.

CHAIR - There are many points where a person may intersect with a health professional of some kind but for a lot of them it's only when they get sick. It may be a self-limiting condition such as the flu. I went for years and years and didn't go to the doctor for anything other than a pap smear. Dr Google gets a fair workout from the general public, which is a bit of a risk in itself. In terms of serious prevention and early detection in picking up a pre-diabetic person, putting in place a framework that would say, 'Everyone every two years should have a well person check'. It doesn't need to be a GP, it could be a nurse-led clinic that does something like that. There is nothing too onerous about a well person check. Do you think there is room for that in this debate? Is that something you guys will be looking at?

Dr GREENAWAY - We haven't got down to that level of granularity that I referred to earlier. We are still in the phase of formulating the big picture strategic approach we're going to take with them. The second stage of the committee would be to look at specific outcome measures. I take your point about nurse-led clinics. The point that was made earlier about some doctors being unwilling to refer outside of a medical model is

anathema to me because I have been working in diabetes where it is a multidisciplinarian team approach. I have done that all my working life so I don't know any other way and would not countenance any other way to approach an issue such as diabetes. What we do with the specific recommendations is yet to be determined. That might be a bit too specific. Whilst it should be done -

CHAIR - So you think there would be value in that sort of approach?

Dr GREENAWAY - Absolutely, but one of the problems we have is the point you have made already. A number of members of the community don't attend for regular checks. How do we get them to go to have those specific checks, particularly males and certain demographics?

CHAIR - In our more regional communities up and down the west coast they may well go and have a well person check. If they need some additional advice or see a podiatrist or physio and get access to those allied health professionals it is very difficult and the whole access issue comes into play. It is all well and good to offer a well person check, but the next step is getting that care they need in terms of prevention.

Dr GREENAWAY - I take your point. Exactly how we are going to address that I have no idea because we are talking equity which is fundamentally important and is critical.

The committee is a work in progress. We do not have any fixed ideas apart from wanting to give something that can be measured, or some specific advice about the importance of health in all of government and then some specific objectives that we can measure to see how we are performing as a society.

I have said this, the AMA have said this many times, that this issue is too important and for us, politics should be kept out of health. I know I am naive, it is an ideal world that we all try and aim for one thing, which is to improve the health of the community and how we go about doing it -

CHAIR - If we had a health in all policies approach so that every department, when working out a policy position of the government of the day, has to consider how will this impact on an individual or community's health. That alone raises it up into a broader range of people and potentially you will have that flow-on effect of greater awareness.

Mr PERVAN - Yes, apart from agreeing. For many years, one of the mandatory processes for cabinet submissions has been the health impact statement. It sits there along with eleven other impact statements.

Ms O'CONNOR - Tick, tick

Mr PERVAN - It has degenerated to that and part of the discussion that has been going on about the Healthy Tasmania committee is, it is there anyway, what can we do to revitalise that and make it a deliverable process.

Rather than being a form, a secretary, or acting secretary just goes [tapping table] or copies and pastes from the last 15 Cabinet minutes and drops the standard spiel about we have assessed all of this and there are no opportunities for doing anything in that.

What if before that Cabinet meeting goes up, there has to be a discussion with the director of Public Health or with the secretary or whoever in Health, to take them through a series of questions about the opportunities to include some health issues in that, or if they really have considered what the health impact of that road or that national park development or whatever it happens to be is.

CHAIR - Is that road wide enough to have a bike pathway as well.

Mr PERVAN - Yes, and it has come out with a process that makes it deliverable, that makes it something that requires people to talk about the health impact assessment or the health impact of policy and decisions without making an already fairly elaborate and onerous process take even longer.

That is the balance. Without giving too much away, the discussions I have had with some of the other secretaries who say, as you would expect, it is hard enough getting something to Cabinet now. I do not want to add another meeting to get us there.

There is an interesting perspective that everyone likes to note how much health costs and people like to talk about how those costs are escalating and that it is unsustainable and all that sort of thing. I will leave the validity of that comment to one side. No-one has taken the next step to say, okay, well as secretary of Education, Emergency Services, Justice, whatever, what capacity do I have to reduce those costs. Until such time as we have reduced that cost growth, I am not going to get my bit of that pie.

Everyone likes to criticise Health but they do not realise they all have an opportunity to reduce the demand we put on the public purse by taking a little bit of responsibility for the health impact of what happens in their patch. They are the discussions we are having. Once you take people through that thinking, they are a lot more engaged with what they are putting up with in terms of the opportunities for prevention or maintenance of preventing what will happen next. Maintaining the health of the people we have, or slowing their deterioration down, will satisfy me for my career. Once we get there we are making progress. That is where we're going with that discussion.

CHAIR - It is also keeping it at the forefront of everybody's minds and that should flow through to the broader community. Siobhan wanted to say something and then Cassy.

Ms HARPUR - That is one of the reasons why the committee has already given some consideration to this in terms of life course, which very much draws on the work the previous committee did. That consideration of giving priority to early childhood and childhood is very important. That is the point in the life course when we can make a significant investment, whole of community, whole of government, different sectors. We know now that for every 10 children two of them are already facing being overweight or obese adults, but we are predicting now another five will be.

Ms O'CONNOR - By what time frame?

Ms HARPUR - By the time they are adults, by the time they reach the age of 18. That is an incredible burden that we know now and we have to work to reduce that if we put greater emphasis on some of these Move Well, Eat Well programs again. It is a mature program

and it has been copied by other jurisdictions, but there are things like planting food and veg in your lunchbox, move, play and go, turn off switch to play, turning off your TVs and your devices and playing, stride and ride, tap into water every day. They are simple messages, but we now have 80 per cent of Tasmanian primary schools and the maturity when we survey the primary school communities, the parents and teachers, and the school community themselves, are saying, 'It's the way we do things around here.' They do not know that this is funded from the Education department or public health services and that is irrelevant. What they know is this is part of the way we do business in our school.

Mr BARNETT - Is that public schools or all schools?

Ms HARPUR - It's all schools. There is a signed collaborative agreement with the Catholic schools and the independent schools in Tasmania. It is a mature program and it is an important program, which doesn't cost a huge amount of money, but it does reap potentially a great saving in health care costs by not having to invest in the reducing weight and healthy eating once we're adults, by getting those habits strongly embedded in childhood.

Mr BARNETT - Do we have that program?

Ms HARPUR - I have information to table for all of you.

Mr BARNETT - Do we have it? I would like to get a copy if possible.

CHAIR - Yes, we will.

Mr BARNETT - Do you have it now?

Ms O'CONNOR - This is a question for either Mr Pervan or Dr Greenaway. There is a proposal put forward by the Health In All Policies coalition, and by Graeme Lynch in particular, when he gave evidence the other day that perhaps one way to ensure that departmental secretaries of all agencies have health at front of mind, is to insert a KPI into their performance agreement. For example, when I was minister we made sure that energy efficiency was in Matthew Daly's performance agreement, but as a result the department acted on it and there was a level of measurement about it. I know it is a decision for the Government ultimately and for ministers, but to put KPIs around health improvement into departmental secretary's performance agreements. How would you feel about that, Mr Pervan?

Mr PERVAN - I don't really think about much else. I think it would be an excellent idea.

Dr GREENAWAY - Graeme is the deputy chair of the committee and he was not at the last meeting, but will be at the next. This is the sort of level of advice and thinking that we need to come up with this overall plan in the next four weeks in time to get it ready by the end of June.

Ms O'CONNOR - Good luck with that.

Dr GREENAWAY - Thank you. That is exactly the sort of thing that we will be discussing and I have no doubt that Graeme will raise it because we have had the preliminary discussions along that line as Siobhan said.

Mr JAENSCH - There is a related thing. There is the Health in All Policies and the various approaches to it. I pick up on comments that people made about mandatory reporting against all policies as they are put up and I have seen processes like that become burdensome. I have also experienced, in a former life, the early stages of the partnership agreement process that was run. When it was fresh and new and strongly led, when a partnership agreement was landed on an organisation or place, that place would get bombarded by government departments ringing up to say we have to write down some things that are important that we do in your area or that we could be doing more of, so what are they? There was a huge energy for it at that stage but ultimately that energy evaporated later in the process. Was I correct in hearing that perhaps your thoughts were directed less towards what the health implications are of your policies that you are going to do anyway and more to rather what can your portfolio, your department, contribute to our health challenge?

Mr PERVAN - It is both. That is what I meant by a deliberative process. Rather than asking a blunt question - what are the health impacts of this proposal? - to take them through a discussion and ask them a series of questions that go to where does this connect to other things and have you thought about the opportunities this policy presents.

Mr JAENSCH - For every single policy?

Mr PERVAN - This is just for Cabinet submissions at this stage and there are not that many Cabinet submissions. At the moment they are required to do it anyway and it is not giving health the value we need out of the process. The idea of having a health impact assessment or an environmental impact assessment was that someone would put some thinking behind the proposals that came forward in terms of those specific issues. I will not say they are being paid lip service to but it has become rather a mechanical process.

The challenge is coming up with something which requires more effort and more thought without making it onerous, because then people will avoid putting up submissions and try to come up with a workaround. Bureaucrats are very good at that. I am trying to strike that balance between something that is meaningful and something that is not giving us value.

CHAIR - One of the questions may need to be - how will this policy positively impact on the health budget? So you would have more money for your department.

Mr PERVAN - It would certainly get some attention.

Ms WHITE - Tim, I wanted to talk about the committee. You have had a couple of meetings but the time frames are pretty tight. You have a report for the July release of the final white paper. There is quite a lot of work you need to do. How are you receiving the submissions? There is already stuff that has been provided to you but is there going to be a call for public submissions at all?

Dr GREENAWAY - That is a very good question. No, because of the time frame involved. We are mindful that it is extremely tight. We are also mindful of the work that has been done previously and I have already made the comment about not re-inventing the wheel. One of the things that was asked initially of the committee was to consider auditing preventive health programs to see what worked and what didn't. That would be an excellent approach if time and money were available to do that. We have agreed that is not practicable and so what we are going to be doing is coming up with overarching principles. We have written to the minister asking for a two-stage approach, to which he has agreed, principles that we can annunciate that would be timed for the release of the final white paper, but then a second-stage approach where we have specific objectives we are trying to measure.

We have discussions about inviting submissions from various people. We have asked for a member from TasCOSS to sit on the committee in terms of broadening its representation. I have had discussions with Adrian Reynolds from Drug and Alcohol Services. For the sorts of things you are talking about, we have directed approaches to people to appear before the committee to try to help us formulate these ideas. What we do in the second stage, assuming we get to a second stage, is fluid.

Ms WHITE - The audit that was supposed to happen of those programs, will that still occur? Are you aware that will happen over a longer period?

Dr GREENAWAY - That would be very difficult. That is a hell of a piece of work.

Ms HARPUR - One of the bits of evidence the committee had is the mapping report that was done. I don't know whether this committee has seen that. It was auspiced under the previous health minister. It is in the public domain and I can point people to it. It is mapping the preventive health activities across the state, not just done by government but done by communities and organisations, commonwealth funded -

Mr JAENSCH - Would it be an appendix to the [inaudible] report?

Ms HARPUR - It is an appendix. I can table it for you. The committee has a bit of a chance to have a look at that and, more importantly, what wasn't so much in the public domain. Roger, as a former member of the committee, you would recall there was an analysis based on that. Some of that will be taken into consideration but, as Tim has suggested, that is not complete. No audit is ever a complete process. This committee, once it has made its proposal and priorities, will also need to consider therefore what that work might need to be, bearing in mind one of the other pieces of work that is underway is looking at all the grants funding to community sector organisations and bringing them into an outcomes framework. That is a Department of Health and Human Services process, so I would suggest this will also be aligning with that.

Ms WHITE - What is the status of the Kids Come First data? Is that information still being collected?

Mr PERVAN - It is still being collected.

Ms WHITE - How regularly is that reported?

Ms O'CONNOR - Is it still on the website?

Mr PERVAN - I haven't said it should be taken down, so I will check.

Ms WHITE - The link was dead when I last checked. It is good early years information to help form policy.

Ms HARPUR - One of the things we have been working on with evidence and data behind the scene is with colleagues in HealthConnect, which the state government has an agreement with, and looking at how we ensure from the spatial perspective as well that we put every different aspect of data that is already collected and available into the public domain. That is some work that is going on in the background and will include all the data that was in the Kids Come First report, but into that geospatial mapping. We have started also working with communities and organisations that have been developing Find Help Tasmania, which is similarly drawn from the community sector, helping access to services that are available in the state.

Ms WHITE - Is that a website?

Ms HARPUR - It is, but it is not in the public domain yet. This is work that is going on behind the scenes and that we are very keen on. I am sure when Tim and the committee are ably briefed they will also be keen for us to build that interface to the general public. We need to build more in the public domain in available information and evidence and build the interface so it is accessible and people can make active use of it in their planning and service delivery.

Ms O'CONNOR - So there is no public access at the moment to the Kids Come First data set. I have been denied access. The Squiz Matrix has asked for a username and password. I have never been denied access to that data set before.

Mr PERVAN - The acting secretary has been denied access to it as well so I would say it is more a glitch.

Ms O'CONNOR - The acting secretary might take that up before Budget Estimates.

Mr HARPUR - I suddenly feel unwell.

Laughter.

CHAIR - Any other questions? Some of them probably need to be addressed to the minister. There are a few that we have held back on.

Ms O'CONNOR - Some have been really good.

CHAIR - It has been really helpful so thank you. You were not here at the beginning Tim to make any opening comments. Do you want to make a closing comment perhaps?

Dr GREENAWAY - I thought about the opportunities presented by this committee in terms of agreeing to Chair it but its aims are laudable and whether we achieve anything only time will tell. It fits with what we all want, which is trying to look at improving health of

all Tasmanians and being mindful of the challenges that we face with respect to demographic chronic disease and health literacy problems et cetera.

I would hope that by 2025 we will be a healthier population. If that is the case then we will have achieved something.

Ms WHITE - Can I ask one final question because it goes to the global health budget. The change from funding activity to funding based on CPI, what impact will that have on Tasmania.

Mr PERVAN - That is my talk in two weeks. We don't know it depends on how the original policy commitment by the Commonwealth Government was to move from the ABF system to one that is calculated on population on a per capita basis and then grown by CPI. That is the extent of the detail so it depends on what your base unit is for your per capita allocation to start off with and then which CPI you pick. There is a health CPI, a Commonwealth one and there is a state one and it is all over the place.

Ms O'CONNOR - It doesn't usually account for Tasmania's specific socio-economic circumstances, which we are accommodated for in GST cover.

CHAIR - Not necessarily but it could and this is the point.

Mr PERVAN - It could and if they follow the Grant's Commission model then it would be good. I am a great advocate of ABF for procedural things, for elective surgery it is a really lifting system. If you have a complex or chronic condition it is almost useless so moving to a block funding arrangement or, if we can influence a policy, a blend of the two. You would have an intelligent block funding arrangement for Tim's patients but for outpatients for elective surgery, for procedural work you keep ABF. From a bureaucrat's point of view, from a health funding point of view, you have the best of both worlds.

Ms O'CONNOR - Is that possible?

Mr PERVAN - That is possible, it has been done in other places in the world.

Ms O'CONNOR - Is it possible within the current policy medical climate?

Mr PERVAN - I don't think they have landed on exactly how it is going to move from here. There is the odd suggestion that they will move to an allocation which is population based but they will keep all the reporting and accountability requirements of ABF. It does not take us anywhere and what everyone is embracing around the world is, it doesn't matter whether the NHS or Canada or any of the systems I have had contact with, everyone is confronting the difficulty of trying to intelligently and equitably fund services to people with complex and chronic conditions of which internationally we are having more and more of. Funding to a health outcome, or getting value out of funding, is something that is a real challenge. It is a challenge that everyone is striving to achieve.

CHAIR - Where do they have that balance? You said there are some jurisdictions that have that balance - activity funding for the term and then the block funding for the chronic?

Mr PERVAN - One of them I really hate to put on record but one of them is Kaiser Permanente. It is managed care. That is why I don't want to put it on the record. Managed care is evil.

CHAIR - Is there any where else?

Mr PERVAN - There are some examples in Canada that I am looking at.

Dr GREENWAY - Not all managed care is the same in the States and Kaiser Permanente is quoted because it is the best of the models in terms of the outcomes they get.

Mr PERVAN - They have used a phrase that we use often, which is that patients need to get the right care at the right time at the right place. When that is said from a managed care organisation, it means the cheapest. The only positive thing you can take out of that is that even managed care organisations, or insurers like Kaiser, recognise that they have to get in there early before you cost a lot of money. So they have made that decision for early intervention on purely financial grounds.

CHAIR - It's not all bad.

Mr PERVAN - Exactly, there are some good bits, and there's the rest.

Ms HARPUR - In terms of conquering the world with this structured target of the healthiest population by 2025 and being mindful that for those of us who have been interested in these sorts of issues all our career, in framing a five-year plan it is probably going to be very important to be focused and targeted on one or two things that are doable. That way we cover a greater opportunity of everyone getting behind them, rather than trying to do absolutely everything. This goes to the point that Roger made, that there are so many messages, so many people trying to do so much to enable us to have better health. Your consideration as a committee, as for our Healthy Tasmania Committee, is important for us to really get behind a couple of things which we can focus on. Then we can measure whether we are making progress and that will give us impetus for doing more and continuing to make progress.

Ms WHITE - What is the timeframe for transitioning to a CPI funding model?

Dr GREENWAY - 2017-18.

Mr PERVAN - What my learned friend just said. It is 2017-18 but that is co-terminus with a political date. Whether we actually get to transition on that date, or they fudge it, I can't say. There has been no discussion that I am involved in, or any type of analysis that has being undertaken, to see what they can do and talk about how we transition from this system to another. There is a big impediment for the Federal Government in that the architecture of the current system was put in place through Federal legislation. The National Health Reform Act 2011 -

CHAIR - More probably the Senate, perhaps.

Mr PERVAN - Yes. The current Federal Government's record of getting legislation through isn't really great so any change to the current structure will be problematic.

CHAIR - Thank you very much, we appreciate your time and expertise in the field. It has been a very useful couple of hours.

THE WITNESSES WITHDREW.