Monday 27 June 2011 - Estimates Committee A (Michelle O'Byrne) - Part 1

LEGISLATIVE COUNCIL

ESTIMATES COMMITTEE A

Monday 27 June 2011

MEMBERS

Mrs Armitage
Ms Forrest
Mr Hall (Chair)
Mr Harriss
Mr Mulder
MrWilkinson

SUBSTITUTE MEMBERS

IN ATTENDANCE

Hon. Michelle O'Byrne MP, Minister for Health, Minister for Children, Minister for Sport and Recreation

Hon. Michelle O'Byrne MP, Minister for Health, Minister for Children, Minister for Sport and Recreation

Department of Health and Human Services

Ms Alice Burchill, Secretary, Department of Health and Human Services
Ms Penny Egan, Chief Financial Officer/CEO Business Services Network
Mr Des Graham, Executive Director Policy, Information and Commissioning/Deputy Secretary, Children
Mr Craig White, Chief Health Officer
Ms Fiona Stoker, Chief Nursing Officer
Mr John Kirwan, CEO, Northern Area Health Service
Ms Jane Holden, Assistant CEO, Southern Tasmania Area Health Service
Mr John Crawshaw, CEO, Statewide and Mental Health Services
Mr Roscoe Taylor, Director Population Health
Mr Mark Byrne, Chief Executive Officer, Child and Youth Services
Mr Gavin Austin, Assistant CEO, North West Area Health Service

Mr Dominic Morgan, CEO, Ambulance Tasmania
Dr George Cerchez, Medical Director, General Practice and Primary Care
Mr Nick Goddard, Manager Coordination and Innovation, SMHS
Mr Des Graham, Deputy Secretary, Children

Ministerial Office

Sean Terry, Head of Office
Peter Robinson, Senior Adviser
Ken Campbell, Senior Adviser
David Clements, Senior Adviser
Claire Cunningham, Adviser
Lesley French, Senior Adviser

The committee met at 9 a.m.

CHAIR (Mr Hall) - I call order. Welcome, Minister, to today's estimates hearings. Just first of all, Michelle, if I could ask you to introduce your staff members at the table for the purposes of Hansard.

Ms O'BYRNE - Okay. For the purposes of *Hansard*, we have the Secretary for Education, Colin Pettit, who will be joining us for this section, particularly as the elements of the Early Years and the Child and Family Centres fall into his area; Alice Burchill, who is the Secretary for the Department of Health and Human Services and, therefore, for the first section picks up the other parts of Children in the child protection space and some Early Years work; and my Head of Office, Sean Terry.

CHAIR - Thank you very much. Just to reiterate, the order of business today is nine o'clock to 10.30, Minister for Children; and 10.45 to one o'clock, Minister for Health. Then we have a lunchbreak. From two o'clock to 3.30, the Minister for Health again and then from 3.45 onwards we have the Minister for Sport and Recreation, of which you are a Minister for all.

Ms O'BYRNE - Indeed.

CHAIR - Minister, what I might ask you to do first up is to provide a short overview, if you would like, and then we can start with Children.

Ms O'BYRNE - Thank you. I will be brief, Mr Chair. I appreciate the opportunity to make some opening comments, particularly in the light of the DHHS challenges that we have before us. The 2011-12 budget for Health across both the acute and the community health sectors is absolutely going to be a challenging one for us. We will be required to deliver some $100 million of savings in 2011-12, and the reality is that most of these savings will need to come in the Health output groups, which by far consume the greater proportion of the overall Budget.

Whilst there is no doubt that we will have to make some very difficult decisions, our focus will be on building an efficient and sustainable health future. That pressure, of course, is upon us as we move to the health reform process, anyway, because the way that we provide health and fund health will be changing. It does mean that we have to also include improving the way that we deliver services, but we will always ensure that safety and quality are the top priority.

As part of the Budget, we are undertaking a major reform of all of our areas within DHHS, including the health and hospital services. That means that we will be establishing a business control team to ensure that there is an appropriate governance framework put in place to guide those savings and make sure that those savings are done in a framework of safe, quality care; establishing a business process redesign team, which will be systematically re-evaluating the way we do business - our efficiency, our productivity - and looking for opportunities where we might improve that; and changing the culture in the system to focus all employees on savings requirements.

That is why you will see a lot of noise in the system, because we are trying to encourage ideas to come from every area of our operations. I do not want to put filters on that at this point. Obviously, with what comes through I will then take a selection of those that are sustainable through to the Budget subcommittee, but we do not want to create a culture where ideas are not put forward. Obviously, we are pursuing the health and hospitals reforms besides some organisational change commissioning - so preparing the system, obviously, for activity based funding - and reducing our costs in line with the national efficiency benchmarks.

We will be achieving benefits and efficiencies through the implementation of the new systems, such as rostering in radiology, reviewing the grant allocation that is managed by the department and reviewing the delivery of services across the organisation to reduce duplication. Duplication itself is not always bad. There are often very good reasons that you have services run in different areas, but we need to make sure that a filter about how appropriate it is is applied over all the work that we do. We will also be reviewing the level and collection of our service charges and using some tools to reduce the number of employees without ever impacting on service delivery and quality of care - that is, including things such as the employee renewal program and some incentivised separation payments.

We have outlined already some specific savings initiatives: the continuation of our vacancy control measures within the system; ensuring the optimal recovery of revenue post the implementation of the RIS/PAC system - that is, the new Radiology Information System/Picture Archive Communication system; the introduction of some competitive purchasing; and some further opportunities for additional state-wide procurement contracts, such as prosthetics. We do have instances where we might have a locum in for a short period of time and they use a particular type of prosthetic and insist on using it.

Mr HARRISS - Mr Chairman, can I intervene for a moment? Aren't you going across the whole health service?

Ms O'BYRNE - This way I do not need to do it again.

Mr HARRISS - I thought we were focusing on -

CHAIR - Children services first.

Ms O'BYRNE - I have a few things to go. What I am saying is that most of our savings we will attempt to find within the health hospital outcome. We do want to protect children services.

CHAIR - I take Mr Harriss's point. I thought we were just doing an overview on children services.

Ms O'BYRNE - I am happy to do an overview for each one. I thought you would be happy if I just got it out of the way, though. It is entirely up to you; I am in your hands.

CHAIR - Are you almost done? Are there matters on children specifically in the overview that you would like to ask about?

Ms O'BYRNE - I am happy to stop and do this again when we get to hospitals as well, if you want. I just thought we would do one overview and not have to do it again in an hour and a half. I am entirely in your hands, Chair.

CHAIR - So how much longer have you got to go, Minister?

Ms O'BYRNE - About that much.

CHAIR - We may as well finish it off now.

Ms O'BYRNE - So generally we have already talked about reducing some of the costs that we have. I will finish the hospitals bit, if that is okay. That way I will not need to do it again, or would you rather I just talk about children now?

CHAIR - No. Perhaps we ought to leave it.

Ms O'BYRNE - I am happy to come back to it.

CHAIR - Come back to it.

Ms O'BYRNE - In terms of children in particular -

CHAIR - Yes, children in particular.

Ms O'BYRNE - What we have seen for children is real recurrent expenditure on child protection and out-of-home care rising by 47 per cent over the five years from 2005-06 to 2009-10. We have a further 10 Child and Family Centres that we will be rolling out this financial year - Queenstown, East Devonport, Ravenswood, Clarence Plains, Chigwell, George Town, St Helens, Derwent Valley, Burnie and Risdon Cove. We will be spending an additional $1.4 million in 2011-12 to manage and operate the State's Child and Family Centres, bringing the total funding to $2.4 million. That will complement the $25.4 million in capital funding which is allocated for the construction of those centres.

We have some significant funding for out-of-home care, with $25.3 million allocated to deliver services for children and young people in therapeutic residential care, foster care and kinship care. We have payments for grandparents which are continuing, and we are going to be releasing shortly the agenda for children and young people which will go to cabinet hopefully very soon. That will ensure that we do provide a high-quality, integrated structure, investing in some dedicated staff development and reviewing the model of care that we have across all of our programs, including child protection, youth justice, children's health and parenting services, adoptions and family violence support services. That is probably all I need to say as an overview.

In terms of finding some efficiencies, in the south we will be merging into one the two Disability, Child, Youth and Family Services areas. The savings will be $50 000 in 2011-12

which will increase to $188 000 in 2013-14. We are asking some of our community, justice and child protection services to share responsibilities for clients where appropriate to create a more efficient child focused process. That should save us around $255 000 in savings per annum. But what we will see is that for individual children they may then have only one contact person rather than changing repeatedly the people that they might engage with if they have moved from child protection into the youth justice sphere. And we are going to increase the fees for intercountry adoptions from $2 500 to $8 000. That brings us in line with other States.

Mr WILKINSON - How much will the savings in that be?

Ms O'BYRNE - For which bit?

Mr WILKINSON - You are saying you are going to increase the fees in relation to childhood adoptions.

Ms O'BYRNE - We hope to get around $150 000 in savings around that. That is what it costs in other States to do the adoptions. We tend to underwrite the costs of it in Tasmania and that is not sustainable. But at the same time we will also be changing the focus. We really do want to get more of a focus on adopting Tasmanian children where we can and working with families around that.

Mr WILKINSON - How many children over the last 12 months have been adopted?

Ms O'BYRNE - I am assuming I have stopped my overview at this point.

Mr WILKINSON - No, it is still in the overview, but it is just a point that you mention there in relation to adoptions.

Ms O'BYRNE - Not many. We facilitated 11 intercountry adoptions, but we are working obviously with local adoptions in really trying to grow that. One of the areas that we would like to be exploring is rather than necessarily adopting a child - because we do have families that are not comfortable to completely relinquish care of their children, even though we know that some of these are going to be in the out-of-home care system for some time - we are looking at a permanent-care status where parents do not want to give up their child.

Mr WILKINSON - Can I stop you there, please. In relation to the numbers I was looking at, so numbers last year were 10 and 11?

Ms O'BYRNE - Overseas adoptions, yes.

Mr WILKINSON - And Tasmanian adoptions?

Ms O'BYRNE - Two local adoptions.

Mr WILKINSON - So we are looking at 13 last year. The year before: are we able to say, both overseas and local?

Ms O'BYRNE - I can probably get that for you. I do not have it in front of me at the moment. It was five, six and two the year before, yes.

Mr WILKINSON - Thank you. It seems to me that, with the figures that you say you are going to make, on the past history that is not going to be -

Ms O'BYRNE - No. The change to the adoptions unit will also be changing the focus very much into working on local adoptions as well and changing the way that we do our business around that. It is an expensive process for overseas adoptions, but it is also becoming a declining market as other countries are making different decisions about whether or not they allow intercountry adoptions. There are 20 countries with which Australia has a binding agreement in relation to the capacity for overseas adoption, but what we are seeing are significant changes. We do have people who want to adopt children. We are truly trying to focus on opportunities for them to work and have relationships with Tasmanian children. There are more people putting their hands up for overseas adoptions than there are children identified in other countries for adoption that we can access. A lot of countries are now reviewing, in some cases, how they feel about the appropriateness of the engagement with other countries in sending children away. That is a challenge that individual countries are dealing with differently. So the costing is about reshaping the entire way that we do our adoptions unit really into a local focus.

CHAIR - All right. If we can get back on track, we will get to questions about the overview on children before we move to Ruth. Are there any questions from members on the overview of the children's segment at this stage?

Mr WILKINSON - Just in relation to the savings, with the itemised savings that you have, how much do you believe that you are going to save with the new strategies that you have?

Ms O'BYRNE - Overall for children?

Mr WILKINSON - Yes.

Ms O'BYRNE - I have to make sure that I have actually added them all up; we do have them here. Individually again - and I shall add them up as we go through - in the first year there is $50 000 for the collapsing of those two units within the south: the child, youth and family services and disability areas in the south. We are hoping to save $255 000 in the realigning of the youth justice worker and the child protection officers in terms of individual children so that we are not flicking them into two systems. We hope to save $150 000 through the change of our adoption programs and half a million through the change to the child health checks. There are also savings to be made by deferring the additional Child and Family Centres to the third tranche. Somebody will magically bring me that figure any moment because it is not on the piece of paper in front of me, so there is a reduction of 41.5 for the Child and Family Centres.

[9.15 a.m.]

With Child and Family Centres we are not opening as many, but what we are doing is investing in staff for each of those. So there will be staff - a coordinator and a community liaison officer or a community youth liaison officer, CYLO.

Mr WILKINSON - How many staff will be lost as a result of these new arrangements? Are you able to say that?

Ms O'BYRNE - In terms of those decisions?

Mr WILKINSON - All of the decisions that you have spoken about which are going to be

a cost saving.

Ms O'BYRNE - We are not necessarily anticipating, particularly in the children's area, significant staff losses, because it is about the way we do business more than that. What we have at the same time as we have some financial challenges is of course what we are seeing nationally, which is a growth in the amount of children coming into the care system, and we are trying to be as efficient as possible around that. Having the two southern facilities is more of an historical thing. It aligned, I think, with what would have been the police areas at the time they were first established. But children and people who work in the south do not necessarily divvy themselves up into the two southern regions and we could find children moving between.

Mr WILKINSON - So you cannot see at this stage any staff losses? You can see that remaining as it is now?

Ms O'BYRNE - In terms of direct care for kids, I cannot see us necessarily having staff losses in that area at all. But in terms of some of the costs behind that that might have been more administrative focused, there may be some opportunities for savings there as we move through the collapsing of the two systems.

Mr WILKINSON - And the savings will not be the loss of staff?

Ms O'BYRNE - Well, they may be within administrative areas if there are efficiencies within that. But what we are attempting particularly to do in children's areas is to ring-fence those people who deal directly with children as much as possible because we do have growing demand in our child protection areas. Of course, at the same time, that is why we are doing the investment in the Child and Family Centres - because we actually do want to stop the cycle of people ending up in the Child Protection Services, and that early identification, prevention and promotion focus has to be key.

Mr WILKINSON - That has been there for a while now, though, has it not? I can remember Lin Thorp speaking about the same thing.

Ms O'BYRNE - A lot of the Child and Family Centres are still being built now, so I think what we will see is changes within that focus. We are already seeing some changes in demand, particularly since the early intervention. Whilst we are still seeing the pressures nationally continue to grow, what we are seeing is probably a reduction in the amount of times that children might re-enter the system. So we are looking at the figures for having contact with Child Protection three or more times. We are seeing those numbers starting to decline. So we are seeing an impact, but remembering of course that we are dealing with extremely high-needs, vulnerable families and we are working with them to try and manage the realignment with families. For instance, in 2008-09, for the three-plus placements, there was a peak of some 25 per cent of our kids coming back into the system within 12 months. We are seeing that number drop to around 22 per cent. So we are starting to see a change in the amount of times children might re-engage with the system and families might re-engage with the system. That, I think, is a lot of the work that is being done in that early intervention, gateway process and the work that we are starting to see with child and family services. For instance, even where we do not physically have Child and Family Centres, a lot of those organisational things are happening. George Town, for instance, ran a lot of its programs during school holidays as a bit of a taster for what they will do when they have their Child and Family Centre. So we are starting to see an integration of services.

Mr HARRISS - I would like to understand, in not too much detail but a bit more flesh on the bones, the programs you have mentioned - the collapsing of those programs into one and the saving of $50 000. Can you address that first of all? It is okay to say that we are going to be collapsing a number of components into one and will save $50 000. What do you mean by 'collapsing' that number of components? What is going to happen to deliver a better service?

Ms O'BYRNE - What we have around the state are four effectively regional offices that provide those services. Now, in the south of the state we have historically run two components within the south. There are two southern areas of this facility. That means that there is a duplication of administration in both. It also means that sometimes kids are transferring between the two if they move to other areas. It seems to have been an historical program and aligned with what were the police areas at the time they were established. They seem to have had a fair bit of synergy with them at that time. So what we are actually saying is that we will have one office that deals with the entire south, in the same way as we have one for the north-west and one for the north. So that is one component: it is the physical moving to just one area, one office.

The other component is that with some of the young people, if they move through child protection and youth justice we will assign them a child protection officer and a youth justice officer. What we are hoping to be able to do for those staff for whom that is appropriate, with their skills mix, is actually have the one person dealing with the one child rather than a duplication of people working with the children. So that is the focus, and we estimate $255 000 savings in that so that you have one case manager dealing with issues across both of the areas and also with the administrative changes in having one area rather than two.

Mr HARRISS - You were just talking about the collapsing of the Disability, Child, Youth and Family Services.

Ms O'BYRNE - Yes.

Mr HARRISS - Can we then have a little bit of padding around the matter of youth justice and child protection with the shared responsibility?

Ms O'BYRNE - Yes.

Mr HARRISS - First of all the time frame for putting that into place, if would you not mind, please?

Ms O'BYRNE - We anticipate that that can be brought into place over the next six months. In terms of the individuals who may be dealing with child protection and youth justice, it would be easy for those for whom the qualifications already exist. Some of our people are actually trained in both of those areas already. Others might need some training and it might be a longer journey for them.

Mr HARRISS - Okay. On the matter of the cessation, if you like, of the number of child health checks with the expectation to save half a million, my concern would be, Minister, how many children will affected by that move and how many, in fact, will miss out on health checks.

Ms O'BYRNE - It is not anticipated that any child would miss out on health checks at all. Health checks are available for all children. At this stage we have already increased the universal child health platform by increasing the number of contacts with child and family health nurses

from six to 10 contacts, and they are offered from birth through to generally the prep level of primary. They include a universal home visit that is made available for every family now.

What we are saying is that we did have a target that we would exponentially increase those numbers. What we find is that people do not tend to use them beyond the sort of six to 10 checks. I know that certainly I used all the ones that my little blue book told me I needed to have with my child and the family health nurse, and most people tend to stick with those ones. It tapers off a bit after the first few months. You see a fair engagement very quickly but then as we get closer - we find our biggest challenge is getting the three-year-old hearing test. The three-year-old hearing test is the one where we probably start to see a reduction in people's engagement.

What we do want to work on, as part of the CHAPS program - the home nursing program that does go and visit you at home - and the child and family health centres is those families who choose not to engage at all. By having that home visit and that immediate engagement with them earlier on, we are hoping that we keep them engaged in the system a little bit longer. But we do find there is a tapering off, anyway, in terms of people's engagement as the children get older and they manage some of the challenges better themselves.

Mr HARRISS - I am relying on your media release, Minister, which indicated that the increase in the number of child health checks would not proceed. You have just indicated that your more recent assessment of all of that indicates that there is not the demand, if you like, post some of the checks that you have mentioned. Can I just suggest -

Ms O'BYRNE - We are hoping -

Mr HARRISS - Can I just ask, then, whether your original assessment that an increase was desirable was not an accurate assessment?

Ms O'BYRNE - I think there was a desire to move to 12. I think what we are seeing is that some families use more than 10 already and some use substantially less. So the figures that we are looking at now are probably more realistic in terms of people's engagement with the system.

Having said that, if you are visiting your child and family health nurse and you want to come in again, they do not actually ever say, 'No, you can't come in anymore,' but we do find that most people tend to use only those that they are engaged for. The real focus is changing, particularly around that CHAPS program, which is our nurses actually having that initial engagement - the Child Health and Parenting Service - so that we see an increase in engagement there. So we actually give the universal home visit and then you have access to nine health and development assessments. What we are seeing, even though we have said one to 12, is that numbers have remained reasonably consistent in terms of how many times people engage.

Ms FORREST - On that particular point, is it not a fair comment that the families who are most disengaged are the ones you are still not going to get and therefore we are not increasing the number? What are you actually doing to engage those families, because they are the ones at risk?

Ms O'BYRNE - Absolutely, and the real focus of the Child and Family Centres in a lot of our communities is to target those families who do not engage at all. What we do have is that initial check and that initial home visit with the Child Health and Parenting Service.

Ms FORREST - For every baby that goes home?

Ms O'BYRNE - Yes.

Ms FORREST - Every baby gets a home visit?

Ms O'BYRNE - We offer it to every family. We are getting at this stage 97 per cent, so we still have that last gap that we really need to work on.

Ms FORREST - For the three per cent that do not take up that option, in what sector do they come? Are they more affluent and think they just do not need it or are they the lower socioeconomic group? Where are they coming from?

Ms O'BYRNE - I will just double-check, because we will probably see a little bit of a mixture of those who do not engage and those who probably have a fair few kids and feel comfortable. The three per cent is a mixture of two. It can be reasonably affluent families who choose to use their GP or their medical practitioner to provide that service. We also have those who are in the lower socioeconomic demographic whom we struggle to engage with on almost every level, and that is where we really want to focus the work of the Child and Family Centres so we are engaging directly with those people.

You have to bear in mind that we have some extremely difficult client bases to deal with as well, and we do try and engage with them on a number of levels. If you could pick the one thing that is the least threatening thing to engage with, your Child and Family Health Nurse is probably the safest and least threatening opportunity, so I think they are the mechanism that we really want to grow an access with. The person who helps you breastfeed and the person who helps you get your child to sleep at night is possibly a lot more trusted than other Government agencies might necessarily be, so we really do want to grow that focus. But reducing the overall number is not targeting those because that is dealing with the 97 per cent of people who actually access the system and access it well. Our focus really has to be on those three per cent.

Mr MULDER - I think the point, though, that Ruth might have been getting at is the fact that it sounds like it is still optional for them to be -

Ms FORREST - They can still refuse a home visit.

Mr MULDER - They can still refuse even if it is from the child nurse. We were wondering whether that is an appropriate policy for children at such risk.

Ms O'BYRNE - I am sure that if you wish to draft some legislation the House will consider it. Unless we think the child is at risk then I think wandering into people's homes indiscriminately is not something that we have the capacity to do. What we are really trying to do is change cultures and engagement and behaviours, and part of the work with the Child and Family Centres is to give people access to less threatening information and support. That is the reason we are trying to focus on that end, because we are dealing with people who quite often have a great fear of Government, as you would be aware. So the Child and Family Centres being in their community and local and engaging and providing things that are not judgemental or are not seen as if they are failing we are hoping will make a difference. I think most of us are extremely proud that we are getting 97 per cent of families getting home visits. That is a very high rate.

CHAIR - Still on the overview, Minister, with the midyear financial report savings, there

were a number of savings measures announced at that time. Can you provide any details as to what savings have actually been achieved in this area since the midyear financial report? I suppose a follow-up question to that is: have all of those savings been met?

[9.30 a.m.]

Ms O'BYRNE - In terms of direct things that we asked this area of the department to do, there was nothing specific that we asked them to actually do at that point other than to identify savings. We are working with staff at the moment around that and some of the decisions that you saw announced in the budget are the result of those conversations. But as to actual savings, I think we are very early into the process yet but I am happy to update the Council when we start to get some data around that.

CHAIR - They were announced at the time.

Ms O'BYRNE - Savings targets and challenges were announced. We have, as I said, attended very much to -

CHAIR - So have there actually been any budget savings met at this stage?

Ms O'BYRNE - We have in that we have made some decisions within the budget that are based on conversations and work that has been done since that challenge, particularly around the Child and Family Centres and the other areas that we have talked about this morning. But, particularly when you are dealing with children, we are very conscious that you do not just turn the tap off on anything. Every change that we make has to be sustainable, particularly when you engage with vulnerable families and vulnerable children. You cannot just stop something and then find out that you have to start it again a few months later. So we have been particularly careful about the way we are doing things. And they are the Budget initiatives that we have outlined - the things that we think we can sustainably do straightaway, bearing in mind that we need to become more efficient in what we do over time. But we are hoping that that investment in our early years is going to start shifting the balance a little bit, too. We have tried very much across DHHS to protect the children's area from significant pain.

CHAIR - I understand all that. Perhaps it might have been better if those measures had not been announced in the midyear Budget.

Ms O'BYRNE - But they are broad savings measures across the entire department. As I mentioned in my opening statement, there are other areas in which it is probably more appropriate to find savings than in the children's area. The things that we have announced in this Budget - such as the collapsing of the two regions, the adoptions units, the home visiting - are all a result of the savings that we are attempting to make in this area that we think we can do without negatively impacting on kids.

CHAIR - Are there any more questions on the overview before we head to output group 1, which is pre-compulsory and compulsory education?

Ms ARMITAGE - I have a couple of questions on this.

CHAIR - On the overview of children?

Ms ARMITAGE - Yes, on children. You will have to excuse me, being new, if I do

something that I should not.

Ms O'BYRNE - I spend too long on my answers as well.

Ms ARMITAGE - No, that is quite all right. You mentioned that we should not just turn the tap off in relation to children's care and that it is very important that we do not do that. I believe that the voluntary community visiting service that we have for children in care is being ceased.

Ms O'BYRNE - The pilot program?

Ms ARMITAGE - Yes.

Ms O'BYRNE - I do not know whether you want to deal with this in the -

Ms ARMITAGE - It is about children.

Ms O'BYRNE - There is quite a lengthy bit of data that we probably do need to discuss around that. I am happy to deal with it now, if you like.

Ms ARMITAGE - I guess where I am coming from is that you were talking about stopping things and you also mentioned in the overview previously that in youth justice you were trying to have one case manager who stayed with the children.

CHAIR - That will come a little bit later.

Ms O'BYRNE - If I can give a general comment before going into the detail, one of the challenges is that I am uncomfortable about pilot programs that deal with vulnerable children. The reality of a pilot program is that there are three outcomes at the end of the pilot. One is to say, 'Wow, that is fantastic. It has worked absolutely as we expected it to, and we will continue doing it.' The second is to say, 'Okay. We have made some learnings out of this and we will adjust it and we will run a slightly different program.' The third is to say, 'The pilot didn't work.' That is always one of the concerns that I have with pilot programs with vulnerable children. You need to make sure that everyone's expectation about a pilot is that it is a pilot and that we do not create an expectation of an ongoing service.

Ms ARMITAGE - It is very hard for children to realise that expectation.

Ms O'BYRNE - And it is very hard also to explain that expectation to people. So we have made a decision in the light of the pilot, which I am happy to talk about further. There has been an independent review into the program. We are now working with the children's commissioner and the carers involved in that program about how we redefine that program. I am happy to talk about the elements of that. But I have also asked the department to find some additional money because, whilst it should never have occurred, the children currently in that program were given an expectation of it being an ongoing program and we will maintain a relationship for those children. I think pilot programs for children are extremely concerning things to engage in. But I know that there will be other questions on this. If that is enough of an answer for now -

Ms ARMITAGE - Thank you. I will be guided by the Chair.

Ms O'BYRNE - We can progress it further in the outcome around it.

DIVISION 3
(Department of Education)

Output group 1
Pre-compulsory and compulsory education

1.4 Early years -

CHAIR - We will move to output group 1 and 1.4, early years.

Ms FORREST - Minister, this output, according to the Budget papers, provides assistance and advice to child-care services and funds are provided to non-government organisations as a contribution towards operating expenses and capital upgrades through the Child Care Grants Program. Licensing and monitoring all child-care services under the Child Care Act 2001 is managed through the Child Care Unit. The output also includes operational expenditure for Child and Family Centres. I am just curious as to why the operational expenditure for Child and Family Centres is not part of the Health and Human Services output group? Why are the operational costs in this area under this Budget item?

Ms O'BYRNE - I think this is historical information from the structure of the previous minister's portfolios. It sat very neatly under education in order to get that cross-agency buy-in there. So it is more of a historical process rather than a determination that we have made to shift them out.

Ms FORREST - If you are looking at a proper and detailed review of how we do things in this State - we have huge ministerial areas now and all of those responsibilities - surely this is something that needs to be looked at in terms of efficiencies and budgetary matters?

Ms O'BYRNE - I am absolutely prepared to take on board anything that will find us savings that do not impact on care. This does seem to be historically where that has sat. One of the things that we are trying to promote as well through the office of children is that we actually do want that massive integration and buy-in, particularly from the three key portfolios - health, education and police - because we are dealing quite often with the same group of people. In one way, yes, there are some efficiencies to put everything together into one portfolio. On the other side, we want that continuing buy-in and that integration, the breaking down of the silos. I guess there is an argument and a discussion to be had about how well placed they are.

Ms FORREST - Just in terms of efficiencies, it could appear to be quite inefficient to have operational funding for Child and Family Centres under an education outcome.

Ms O'BYRNE - I think the cost of running them would be the same regardless of which output you put them in, but they have been historically there. I think that is something we can work on. I do not know whether Mr Pettit has anything he would like to add.

Mr PETTIT - Part of it is due to the COAG agenda. COAG is sitting child care under education. So we are doing most of the work through interagency.

Ms O'BYRNE - The ministerial council, for instance, is education and children. That is

pretty much where the focus sits. In a sense, for us it almost does not matter.

Ms FORREST - They are not managing our Budget, though.

Ms O'BYRNE - True, but the cost of doing it would be the same regardless of which departmental area it is in. It would still have a cost around the service provision. I am happy to look at it.

Ms FORREST - The Treasurer's Budget speech says that the operating costs of the new centres will be $2.4 million and that is half of the $4.5 million budget for this area. This relates to new staff costs that you mentioned. I assume that is correct - that the $2.4 million is for that purpose?

Ms O'BYRNE - Yes.

Ms FORREST - How do you expect this to improve service and outcomes for families accessing these centres?

Ms O'BYRNE - There will be a community liaison officer. So we will have somebody whose actual job it is to make those connections and meet those targets. The other thing is the coordination of the overall integration services. We are bringing a lot of service provision and a lot of programs together under one roof, and we want to make sure that there is proper integration, understanding and engagement across those areas.

Ms FORREST - Are you talking about administrative positions here? You are talking about overseeing the coordination and integration of the service.

Ms O'BYRNE - It is similar to the sort of role you see in neighbourhood houses, where you have your coordinator role. Neighbourhood houses are quite different in every environment that you have, in the same way that Child and Family Centres will be different in every environment depending on what the community needs are.

Ms FORREST - If we are putting on administrative staff, we need to be sure that we are actually getting better outcomes for children.

Ms O'BYRNE - This is about coordination of care, absolutely.

Ms FORREST - How are you going to measure the outcomes?

Ms O'BYRNE - In terms of those individual staff positions or the tracking for the CFCs in general?

Ms FORREST - Basically, yes. How it all comes together, the staff -

Ms O'BYRNE - One of the things that we have to accept is that we are probably going to see outcome changes in various forms. There will be some immediate figures in terms of the engagement they are having with particular families. It may take some time to see the different educational and child protection outcomes that we are hoping to get from this engagement as well. So we will be measuring that over time with those communities that we are working with. But the reality is that we are dealing with changing behaviours and attitudes and engagements, and some

of those things will take some time.

Ms FORREST - In my view, it is fairly important to ensure that outcomes you measure are meaningful.

Ms O'BYRNE - Yes.

Ms FORREST - That was the question. How are you going to measure? I know it will be over time because children take a little while to show -

Ms O'BYRNE - And families.

Ms FORREST - The families and the children themselves. Is there going to be some sort of tracking process? I want to know what we are going to see reported, basically, in terms of outcomes.

Mr PETTIT - We will take it on notice.

Ms O'BYRNE - What we do have are local enabling groups. So they are determining very much what the needs of the community will be. The local enabling group, as I understand it, will be engaged from then on to ensure that we are starting to see differences and different outcomes. One thing that we are also trying to do with our Health and Wellbeing Strategy state-wide is to start putting some rigorous data around behavioural and engagement change. It is difficult, because a lot of the work we know now is anecdotal. It is what we believe to be best practice. You are right in terms of the need to put some decent data around it. The question is: how much of the budget do you want to spend on getting that data as opposed to engaging directly with families?

Mr PETTIT - We do have an evaluation program running alongside this. It is part of the project through each one of these Child and Family Centres. We can get you some more detail if you would like that.

Ms FORREST - I am not sure whether this is the correct area to ask this, so I will see how we go. Is this the right spot to ask about the additional funding of $259 000 per annum to assist grandparents caring for their grandchildren? If it is, I am just wondering how these funds are going to be allocated. We have a lot of grandparents out there caring for grandchildren.

Ms O'BYRNE - We do. There is an assessment done, predominantly around the child's age. I understand that if a grandchild is under a care and protection order and placed with a grandparent then the grandparent receives the same support as a foster carer, and that includes the same payments that foster carers receive in case management. In 2010 we reviewed circumstances of grandparents and other relatives - so it is not necessarily a grandparent; it can be an aunt or an uncle or another close relative - who are not receiving standard foster care payments and that resulted in the approval of foster care payments for 215 children who are not under care and protection orders, and 213 of those children from the 215 on 30 April continued to be supported through foster care payments.

If the grandchild is not under a care and protection order and the 2010 review found that there was not a case for child protection intervention, grandparents are eligible for financial assistance of $1 696 per child per year. We have the relative carers of 102 children currently receiving that payment. A number of those grandparents also receive some support through

Centrelink and that will be dependent on their particular circumstances.

Ms FORREST - That is regardless of the age and need of the child?

Ms O'BYRNE - There are three levels of payment for those who are under a care and protection order. For those who are not, it is the flat rate of $1 696.

Ms FORREST - Even if they have specific things? They do not have to be under a care and protection order to have significant challenges.

Ms O'BYRNE - No.

Ms FORREST - Even if grandparents are caring for them.

Ms O'BYRNE - No, but they also get to access some support through the Australian government in those areas. But as a state, our primary responsibility is for those families for whom the normal family structure and support is not working. It is an interesting thing for states. I do not think states should ever become parents, but there is a point where we do engage and that is for those children who are under child care and protection orders. With other family structures, we do encourage and support families to manage through some of those normal circumstances as well in the same way that you might be with your parents and still have significant needs. That is where other services come into play there.

Ms FORREST - Can you provide a list of details of the child and family service centres that are being completed, those which are under construction currently and those that have been bumped off the list as stage 3?

[9.45 a.m.]

Ms O'BYRNE - Yes, we do have the list. Beaconsfield is up and running and looking very, very good for those who would like to go and visit it. The ones that are not going ahead at this stage - that is not to say that they will not go ahead in years to come but they are not budgeted for at the moment - are Warrane/Mornington; Risdon Vale, which is the Risdon prison area; Glenorchy/Goodwood; Invermay/Mowbray; and Latrobe. They are the next identified places that we would like to move when the financial circumstances allow us to do so. But they are not budgeted for now.

For the others, the Ravenswood one in the north should be hopefully in the next four to six weeks. George Town is awaiting a DA - and those who are familiar with that know that there have been some conversations with the community about its integrated role with the LINC, which has meant slower progress than we had hoped. Beaconsfield, as I said, has been up and running since January.

I had a look at St Helens a couple of weeks ago when I was there and they were almost complete, so we are hoping the end of July, early August for them as well. With the East Devonport Primary School site in the north-west, we are hoping to be finished pretty soon. We are almost done on East Devonport, I think. Yes. Queenstown, we are hoping as well by the end of July, early August - probably a bit later with that one. That is a co-location with LINC services Tasmania.

With Burnie in the north-west, the location is Acton Primary School and tenders are going

to be called following the design process. South-west is Chigwell and we are hoping around February next year - for building to commence hopefully next month. Derwent Valley - the Norfolk one - they are still in the process of design discussions on that one. Clarence Plains, at the Clarendon Vale Primary School next to the neighbourhood house, we are hoping later this year - sort of October-November. Risdon Cove is the one being managed with the Tasmanian Aboriginal Centre through an agreement with the Department of Education and building has commenced on that - possibly October. We have Bridgewater, hopefully by the end of the year. We have a completion date there and there is a contract being managed around the Geeveston one. So we are hoping to get to work on that pretty soon. So that is a bit of an update on those. As I said, currently we have Beaconsfield up and running.

Ms FORREST - So can you provide some details of the savings over the forward estimates from the ones that have been deferred?

Ms O'BYRNE - Yes. $41.567 million is the capital saving that we will make. In terms of the operation of those positions, that is less the fact that we have managed to get some of that money in order to have recurrent funding for the positions. I think one of the - and I think reasonable - criticisms about the CFC program originally was that there would not be anybody to pull it all together on site and that we would be relying on those people employed by different programs getting together and working together.

Ms FORREST - So some of that $4 million will be used?

Ms O'BYRNE - No, $41 million is after the saved sum, as I understand, for the recurrent funding.

Mr PETTIT - No, some of it will be used. There is some $12 million put aside for recurrent costs over the next four years to ensure that all 11 centres can operate effectively, with two officers running each of the centres. They are in the process of being employed at the moment. In the first year that is -

Ms FORREST - That comes out of your $41 million saving?

Mr PETTIT - That is correct. So the net saving is $34.7 million.

Ms FORREST - Thank you. I have just one further question on this area. What is the future of programs - or is there a future for programs - such as Reading Together, which is a program that was often run in libraries with preschool-age children?

Mr PETTIT - That is still operating in our libraries at the moment.

Ms FORREST - There are some that it has been withdrawn from.

Mr PETTIT - Not at the moment, but we are looking at it, obviously, case by case.

Ms FORREST - At Smithton?

Mr PETTIT - I have not got that exact detail here.

Ms O'BYRNE - Ms Forrest, if you have any particular concerns then we are happy to

follow up with any particular one that you might be aware of. So we will certainly be seeking advice on Smithton.

Ms FORREST - Right.

Mr PETTIT - Because that is run through the Minister for Education. So we can have that clarified later on, if you like.

Ms FORREST - So this is the odd thing -

Ms O'BYRNE - I appreciate that there are some concerns, which is why we are trying as much as possible to be flexible in the provision of answers, but we will seek that answer for you.

Ms FORREST - Because this really is with preschool children and their parents.

Ms O'BYRNE - The other thing is the Launching into Learning program, for instance, which is run by the Minister for Education, because that is primarily driven out of schools.

Ms FORREST - Yes, but this one is not.

Ms O'BYRNE - Yes. I am just trying to give some clarity as to where some of these might sit.

Ms FORREST - This is where the inefficiencies fall, I think.

Ms O'BYRNE - I guess it is a question about whether it is an inefficiency. I think it is a bit of a confusion for some of these discussions, but there would still be a cost in running the service. One of the things that we are attempting to do through the office for children is actually have staff from police, staff from education and staff from health so that we start to get that integration. I am hoping that we will actually see a far better efficiency.

Ms FORREST - But my point is: would there not be greater efficiencies if one area was responsible for this area - preschool children's education?

Ms O'BYRNE - The libraries are also run by Education, so for instance the early reading program would be run by libraries and education anyway. I think across agencies there are always those areas that have some level of crossover and we do try to manage that.

Mr PETTIT - Libraries are working within the CFCs to make sure that that program occurs right through.

Ms O'BYRNE - As we have just been advised, libraries are working directly with CFCs as well. For those that are co-located with links, there are obviously library services within the link. We are changing the culture in terms of the engagement across agencies and there will be some progression through that.

Ms FORREST - Thanks, Mr Chairman.

CHAIR - Are there any further questions on output 1.4? If not, we will move then to CIP, which is on table 3.9, and we have Bridgewater, Campbell Town and the Child and Family

Centres.

Ms FORREST - We basically talked about those, Mr Chairman, in one of those questions I asked.

CHAIR - So you covered some of those?

Ms FORREST - I did, yes.

CHAIR - Okay. Are there any further questions on any of those? If not, we will move then to division 5, which is table 5.2 and output group 3.

DIVISION 5
(Department of Health and Human Services)

Ms O'BYRNE - Since Mr Pettit and other officers are leaving, I thank you all very much for coming. Do enjoy the rest of your day in committee B. Mr Chairman, we are still doing children but the children in Human Services as I understand. I invite Des Graham to the table, who is the Deputy Secretary, Children. You did mention which table you were moving to next, Chair.

CHAIR - Yes. We are on table 5.2.

Ms O'BYRNE - Thank you.

CHAIR - It is output group 3 and 3.1.

Ms ARMITAGE - A lot of the issues that I was going to raise have actually been dealt with in the overview, but I have a few other questions that I will ask.

Ms O'BYRNE - No, that is fine.

Ms ARMITAGE - With regard to the completion of the family services review and reform, there is no more funding because that has been completed. So the strategy and the outcomes -

Ms O'BYRNE - Sorry, but the family services review and reform is a five-year process. We are three years into a five-year process, if that provides some information.

Ms ARMITAGE - Reading here, the decrease in children and family services in 2012-13 reflects the completion of the family services review and reform.

Ms O'BYRNE - What page are we on?

Ms ARMITAGE - I am looking at page 5.9 at No. 11.

Ms O'BYRNE - Thank you. I am just trying to make sure that I am looking at the same page that you are.

Ms ARMITAGE - I was just wondering about the strategies that are in place and the outcomes that were achieved.

Ms O'BYRNE - It is a five-year reform process. We have done three years of that reform process now. The reduction of funding which is -

Ms ARMITAGE - I want the achievements to date to see how it is tracking.

Ms O'BYRNE - The funding has not ended.

Ms ARMITAGE - No, but it is going to end. But how is it tracking and what are the achievements to date?

Ms O'BYRNE - Okay; sure.

Ms ARMITAGE - Obviously you need to have positive outcomes if it is still -

Ms O'BYRNE - Yes, this is where we are up to with the five-year review and the outcomes we have so far. With the establishment of Gateway - just to confuse people further, the Gateway programs are actually in Ms O'Connor's portfolio - we have seen a transfer of a number of people into the Gateway program to allow for more coordinated care for their services. We did at that stage see a tapering down in the number of cases coming to Child Protection. What we have had and what we are seeing nationally as well is that those numbers are continuing to grow. We are beginning to see a bit of a move out the other side of the Gateway program now so that we are getting a lesser level of complexity or a management of some of those complexities.

We are seeing a reduction in the number of times people might re-present to interaction with child protection. We will be starting a review process soon to give us a current picture of where we are. It is a difficult one because it was always going to be one that took a little while for us to see the outcomes. But what we are seeing is that children are now being assessed - the notifications are being assessed faster in the way that they should be.

What we have seen since we started the entire review process is an increase in the level of notifications and that is because it is about engaging with people differently in terms of particularly mandatory notifications. So we are seeing more notifications come through. From there, we have a far more appropriate and quicker process of identifying which of those notifications require investigation, bearing in mind that you might get multiple notifications for the same child. So we are seeing a much quicker and faster process moving through there.

What we are still seeing at the same time though - and this is the challenge - is that nationally more children are coming into contact with child protection, and Tasmania is not immune to that. Our focus is on one side with our CFCs and our work there to impact on the number of children we do come into contact with. We want families to manage their challenges in the home earlier on, so we are looking for that early identification. What we are seeing with the Gateway is people starting to not come back into line with us. So we are creating that support, but we are three years into a five-year reform process.

Ms ARMITAGE - At the bottom of page 5.21, it states -

The proportion of children in care with three or more placements within a 12 month period has been more than twice the target of 10.0 per cent since July 2007. During 2009-10, 19.9 per cent of children in care had three or more placements in the previous 12 months. Carer availability has

been identified as a critical factor in improving stability for children in care. While it is anticipated that strategies to enhance the carer pool in all regions will deliver some improvement, a considerable increase in numbers will be required to achieve the target.

Are we putting a lot more money into that to provide for all of those carers?

Ms O'BYRNE - Yes. We have just run our second carer recruitment campaign.

Ms ARMITAGE - Are we increasing the numbers?

Ms O'BYRNE - We increased the numbers in the first campaign. We got 50 additional carers in the first campaign. We have 46 families now that we are working with to become carers - not all of them will. We need to make sure that their expectations are exactly what being a carer will be. We did have a couple of people who rang up after the carer campaign saying that they would like the little blond boy. So sometimes you do get a slightly unrealistic expectation of what being a carer might be.

Ms ARMITAGE - It is more the funding I am concerned with so that we will be providing additional carers.

Ms O'BYRNE - We are attempting to get more carers, yes, and funding those carers. With the 'Real Carers' campaign, 47 households have returned expressions of interest to be a carer and they are currently being visited. We want them to meet with existing foster carers as well so they understand some of the changes that there might be. We do have the payment changes in relation to that - it is $351 per fortnight for children aged four years and younger and $460 per fortnight for children aged 12 and over. So that was the 'Real Carers Really Needed' campaign that we have just had. But, as I said, we got an additional 50 from our last carers call.

[10.00 a.m.]

There is also some work being done between the office for children, the commission for children and also Housing to look at the other kinds of supports that we can offer families to allow them to remain and continue being engaged in the carers program. We do have some carers at the moment who do not take children. There is a strategy around that - and that is that, if they have had a particularly complex group of kids to deal with, we often like to give them a rest. We also have some older carers who have moved from having full-time placements to having that on-call placement. So we do have some carers without children at the moment, but that is very much about managing the pressure and demand we have on our carers.

Ms ARMITAGE - So funding really is not the issue with carers?

Ms O'BYRNE - At the moment if we can find carers then we will be extremely happy.

Ms ARMITAGE - So it is more finding the carers than funding the carers?

Ms O'BYRNE - Yes, absolutely. We absolutely need more people to put their hand up to be carers in Tasmania. If there is anybody at this table who feels that they would be able to do so, please, we will welcome any engagement.

Ms ARMITAGE - So the funding will be there?

Ms O'BYRNE - Yes. It is the best way of dealing with our kids; otherwise, we have to put them into other more expensive care models. It is also about replicating, as close as you can, a stable family environment. That is what we want for these children while we work with their families. Not in every case it is true but in many cases we are looking within the first three months or the first 12 months to support their families enough so that their kids can go back to their families with that additional support. What we are seeing through Gateway and the different types of engagement is that, instead of kids going home and then coming back to us at quite the frequency they were - and you mentioned the three plus placements - we are now starting to see that that is starting to drop off a little. It is early days but we certainly have hope that that is going to continue, that that additional support for families empowers and supports them to stay together. We assume that every family has all of those parenting skills and all of those capacities, and a lot of them do not and a lot of that is generational. So we are, particularly through the CFCs and the Gateways, trying to work with families to make sure that they have the skills to remain together.

Ms ARMITAGE - Divert them away from places such as Ashley by getting them into a better home life?

Ms O'BYRNE - Absolutely. If you look at Ashley - and I am sure the Chair is going to ask me about that later; I am sure he wants to ask me about the numbers at Ashley; no? - we are seeing a reduction in the number of children going to Ashley now. Part of that is the different programs that we are working with through the courts in terms of different support mechanisms.

Ms ARMITAGE - It is about getting the foundation right for the children.

Ms O'BYRNE - Yes, but it is often about being able to manage their family environments a lot better as well. I am sure we will get into a conversation about the cost of Ashley later.

Mr WILKINSON - As I understand it, there is no anticipated reduction of staff in relation to children and family services?

Ms O'BYRNE - In terms of those who deal directly with children, no. But there may very well be. We anticipate there will be some in senior management and administration, particularly with the collapsing of those two units.

Mr WILKINSON - Are you able to estimate approximately how many?

Ms O'BYRNE - We are still working through the numbers, so we cannot give you anything definitive. There will probably only be a handful in the first stage but over time we anticipate further savings. But I am happy to update Council when we can.

Mr WILKINSON - I take it, though, that when you look at your Budget you would be saying, 'Jim Wilkinson, Greg Hall, Tony Mulder -

Ms O'BYRNE - I would like to name any of you at this point.

Mr WILKINSON - aren't going to be employed there next year. Therefore, as a result of them not being employed, we are going to save X.' There would have to be some of those figures done.

Ms O'BYRNE - They are only very rough at the moment as we also need to look at the

skills mix and the way that that will process. Also, there may be staff who wish to make their own nominations about whether they would like to take another option or another opportunity within the agency or outside the agency. Whatever the skill mix that leaves will determine the skill mix that we then need.

Mr WILKINSON - So, if it is outside the agency, they would be moving to another agency but that would still be a saving within your agency?

Ms O'BYRNE - Yes. But it may be that they fill a vacancy somewhere else.

Mr WILKINSON - There is no argument with that. But what I am looking at is how many people within this agency under this -

Ms O'BYRNE - The question will be the skill mix of people we have there, because we have such a wide range. But we would anticipate a handful.

Mr WILKINSON - What I cannot understand -

Ms O'BYRNE - No, and I am not trying to be vague either.

Mr WILKINSON - I like to be as indifferent as I can, but what I cannot understand is this: if you do not know approximately how many people are leaving the agency, you are unable to say what the savings will be.

Ms O'BYRNE - That is why the savings we have identified are approximate savings. But a lot of the savings come from not duplicating the carers who are dealing directly with children.

Mr WILKINSON - Therefore, in relation to all of this output, they are only approximate savings. Therefore, we do not know what the actual savings are going to be which could really affect the Budget at some later stage.

Ms O'BYRNE - We have given conservative estimates in that case. We anticipate that there are potential more savings in that area. It comes back to my opening statement. We are very much attempting to protect the children's area from anything that is seen as a cut. We want efficiencies, but we do not want a cut in services in the children's area at all.

Mr WILKINSON - Sure, and that being the case, if these people are not going to be employed - how ever many that may be, how ever much money we save - is it going to at all reflect upon output?

Ms O'BYRNE - Our focus is very much the quality of care for the children, but there are, as we have identified, savings still to be made in terms of the way we do business. We have made those conservatively. In terms of which staff go, it may be that there are more savings to be made as a result of that particular mix. But I could not at this point give you an exact number of staff and their positions that will go, but I am happy to update Council when we have those figures.

Mr WILKINSON - All right. If you had a budget as you had a few years ago when GST was the golden stream that was overflowing, what would you do differently to what you are doing now?

Ms O'BYRNE - It is an extremely hypothetical thing. I look forward to the days when the GST runs free again.

Mr WILKINSON - Well, it has been there you see.

Ms O'BYRNE - I think what we did see over that period was that investment in the reform agenda. In terms of the process at the end of that reform agenda, I guess we will have a better picture of how we want to move forward from there. If we had more money then I would do the rest of the CFCs. I think we would focus very much on the early intervention area. Rather than necessarily change where we are with child protection in its real sense, I think if we got additional money we would put that into early identification and promotion prevention. That would be my call at this stage bearing in mind that that is very much a hypothetical because we are dealing with the numbers that we are dealing with now.

Mr WILKINSON - Sure. In relation to the process that you have been going through at the moment, I take it that the reduction in figures that you can see in the forward estimates involve some savings but you do not know how much because it is a bit furry and also savings as a result of the reform being completed.

Ms O'BYRNE - Yes. The bulk of the savings are a little over $5 million and they are at the end of the reform process. We will be doing a review prior to that to determine what then needs to happen into the future, but the shift to Gateway is probably the thing that will give us those ongoing savings.

Mr WILKINSON - Can you provide a breakdown of what the expenditure items were for the family services reviews and reforms, as this does seem to be quite a significant expenditure?

Ms O'BYRNE - I am not sure if I can give that to you right now, but otherwise we will take on notice what I cannot find, Jim. I am hoping this answers the question, and I am not trying to not answer it.

Mr WILKINSON - That is all right.

Ms O'BYRNE - The programs under the child and family services output include the families for Gateway and Integrated Family Support Services and the total for that is $6 million, early years parenting support at $1.2 million and targeted youth support at $700 000. As we said, we are three years into that process. We have done a strategic out-of-home care framework and a full electronic child protection information system - since I had a look at that just on Friday, that does allow immediate access to all records held by Child Protection - and we have a principal practice consultant to lead some practice development and to monitor those case work decisions employed there. That is pretty much all I can give at this stage. Is there anything else that you specifically want? I am not trying to be vague.

Mr WILKINSON - No, I understand that. Page 5.1 at footnote 2 notes that the decrease in children and family services in 2012-13 primarily reflects the completion of the family services reviews and reforms.

Ms O'BYRNE - Yes, and that is that reform process which we will evaluate before the end to determine what our next phase forward is.

Mr WILKINSON - This is nearly a $4 million cut which is followed by a further around $2.5 million in 2013-14.

Ms O'BYRNE - It is not a cut in that it was always funding for that five-year period.

Mr WILKINSON - What I am looking at is how much specifically relates to the family services reviews and reforms, because then we can find out exactly in some ways whether there is going to be a continual -

Ms O'BYRNE - The $4 million will still be there, so that is not a cut. What we have had are changed processes and changed engagements. Part of the cost of that was setting those up and engaging the new partnerships. They will be in place by the end of the five years, so we do not necessarily have an ongoing commitment. I am not sure if Des wants to give any further information.

Mr GRAHAM - Yes, the Minister is right. It is not unusual for Governments in the forward estimates, as you would be aware, to recognise where the reform dollars stop, but there is a commitment to continue to fund those and, in fact, the department has identified funds to continue those services.

Mr WILKINSON - So that money, if I might, is going to stay, is it - that $4 million? Once the reform process is finished, that money is going to move into another field for probably the implementation of the reforms?

Mr GRAHAM - That is right, so that will become on a recurrent basis. What we want to flag, though, is that there is a review underway and, depending on that review, we might need to make some adjustments to the way we deliver those services. There is a review underway across all of the programs within Children and Youth Services. So Gateway will be part of that because, as the Minister mentioned earlier, we want to make sure that we are efficient and that we are using the dollars in the most appropriate way.

Mr WILKINSON - In relation to the last four years - just picking an example - how have you been in relation to your Budget in this field? Have you been on Budget, below Budget, above Budget, a complete blow-out? Are you able to assist with that?

Ms O'BYRNE - The agency overall has been on Budget. There have been variables within that. Certainly, as we went to this particular Budget round, you would be aware of the supplementary appropriations bill that passed both Houses of Parliament. Part of that was a recognition that, with increasing demand on all of our services across DHHS, there were targets and challenges that we needed to deal with. That is the reason we got the additional money. So, overall, by the end of the year everything is on Budget but certainly we have had an increased demand and a cost around that increased demand, which is now catered for in the forward estimates.

Mr WILKINSON - I speak with a number of child protection workers and child workers and they all say that they are overworked. They are drastically overworked, it would seem, on the evidence that I have and as a result they either burn out or alternatively people say, 'Look, I don't want to go into this job because of the problems that we face.' The person I know who is an expert -

Ms O'BYRNE - And we give that commitment to provide good training and support to assist people through that process.

Mr WILKINSON - With regard to that person I know who is an expert in this area without doubt, you say to them, 'What's the problem?' and they say, 'We need more money.' That is the only way really around it to do the job that they would like to do.

Ms O'BYRNE - The Budget is what the Budget is and we have to manage against that. We are all required to live within our circumstances. However, our focus has been that where we can find efficiencies and savings and there is not the direct relationship with the child that is where we are finding them, which is one of the reasons we are collapsing, in a sense, those two areas in the south, because we believe that we can make savings there. But also one of the reasons is that we are looking at having the one case worker deal with one child through the process rather than duplicating, and we get a lot of duplicating because, unfortunately, a number of our kids in child protection are also known to Youth Justice Services. Having two separate staff having to provide a whole gamut of things, which can be very confusing for the child, is an awful lot of pressure. Having said that, that will not be possible for every one of our child protection staff. It does very much depend on the skills that they might have and the appropriateness of doing that with the child.

Mr WILKINSON - With the child protection worker out there doing the work - the legwork - are those workers going to be decreased at all or are they going to remain the same, or be increased?

Ms O'BYRNE - No, we are not anticipating any reduction in the amount of direct care but we are as an agency - not only child protection - looking at all of that early intervention work. What we need to stop is the flow in the number of people who are hitting the system and that is where the engagement needs to be at the same time, providing that programs service those children where care and protection is required. So there is money that we have that could go into child protection, but I think it is appropriate that we invest that in that early intervention so that we stop the number of children presenting to child protection or being found to be known to child protection. Part of that will be better information sharing across all agencies so that we can get those earlier identification points.

[10.15 a.m.]

Mr WILKINSON - I have heard that for 15 years, 16 years.

Ms O'BYRNE - True; I know. I was not there over the period of 15 years but one of the roles of the office of children, one of the elements of the agenda for children and young people will be that we are actually requiring that sharing of information, because I think there are a lot of indicators in other agencies that would give us that notification earlier. We are going to have the Child and Family Centres - we have got one already coming on line - which will start to give us that integration as well. There is no easy fix to this. If there was an easy fix, we would have done it. There are pressures on families all across the country and Tasmania is not immune to them.

Mr WILKINSON - Right.

CHAIR - Are there any more questions on 3.1? If not, Minister, we will move to 3.2, Youth Justice Services.

3.2 Youth Justice Services -

CHAIR - I think you have just quickly ruled out any closure of Ashley at this stage?

Ms O'BYRNE - There is no closure of Ashley outlined. I understand your particular interest in it. However, I think it is important to note that it costs $10 million to run Ashley. We have had around 100 children in there over the past 12 months. The numbers are declining. That is a good thing. There is probably somewhere between 20 and 30 young persons involved in Ashley at any given point and I think we do need to at every opportunity explore alternative methods, and we are doing that with collaboration with Justice at the moment around some of the decisions that have been made at court level in terms of our engagement and support for children there. I think there is some really good evidence around diversionary work - and particularly in Canada there was some stuff that we looked at and in the UK - that is an alternative. There are some children or young people involved in Ashley for whom there is a significant risk to community and we do need to manage that, but where we can provide a better pathway for young people than Ashley then we will certainly look to do that.

CHAIR - So I will take that on board.

Ms O'BYRNE - But having said that, clearly Ashley is required at the moment.

CHAIR - At the moment? So down the track it could be closed?

Ms O'BYRNE - Ideally, you would want a system that meant that you had very few young people entering that level of complexity. The reality is that there are always going to be some and we do need an appropriate mechanism in which to, hopefully, support and provide different pathways for them. But for many of them there may be alternative sentencing opportunities, alternative engagements, that they might be able to do that have more to do with curfews and monitors for where people are allowed to be. So there are opportunities for that, but I do want to say that, having visited Ashley just recently, I am really impressed with the school out there at the moment and the engagements they are having. I guess the challenge in the future is how you make sure that the learnings and the changed behaviours that they get there carry through beyond their incarceration.

CHAIR - The previous minister, Lin Thorp, talked about moving some of the worst offenders to the mainland. Is that still an option?

Ms O'BYRNE - I do not know that it is necessarily an option. Actually, I do not think it is an option at the moment. I do not think that is something we could necessarily do, but I think it is important to recognise that we run an incredibly expensive model for a small number of young people and we need to look at ways of making that more efficient in terms of the cost to our system. But I think the focus of that really has to be on whether or not we actually make the decision to send children to Ashley or whether we are actually able to provide alternative sentencing opportunities. That is really where the focus has to be, I think.

CHAIR - Given that there will always be, unfortunately, some -

Ms O'BYRNE - There will always be an element from whom the community needs protection.

CHAIR - Of the more violent, if I could say, older offenders who still fit under the Youth Justice Act.

Ms O'BYRNE - Unfortunately, I do not anticipate a time when we will not need to have some level of secure facility for young offenders, yes. I cannot anticipate that that would be the case.

CHAIR - Okay.

Ms O'BYRNE - I think there will always need to be a secure facility for some offenders. What I would like to see is what we are already seeing, and that is a reduction in numbers of people actually getting there and I think it would be good to grow that. Where we can provide better environments for children that change their behaviours, that deal with recidivism, that support them to become valuable, integrated members of the community then we should do that. But as you are aware, given some of the cases that require children to enter Ashley, I should imagine that we will unfortunately always have some element of secure facility requirement.

CHAIR - And I understand that. You will recall that we had the Legislative Council select committee into youth justice and we recommended a lot of those programs take place.

Ms OBYRNE - And we are already starting to see a change.

CHAIR - So are there any of those recommendations from that report that are still left that the government has not taken up at this stage? Security cameras - the whole lot? Are they all -

Ms O'BYRNE - We have all of those. We have implemented all of those.

CHAIR - You have implemented all of that?

Ms O'BYRNE - All of those. There are CCTV cameras now.

CHAIR - As you say, it is a very expensive system.

Ms O'BYRNE - It is an expensive model, yes.

CHAIR - But if we get down to a small quantum of young offenders, is it still possible, then, that the centre at Deloraine will close and you will move them somewhere else?

Ms O'BYRNE - I do not think I could make that sort of call at the moment. The demands at the moment are still quite high. We have 100 children who the courts are determining need to go to Ashley. I would like to see that number reduced. I think we all would. I am not quite sure at what point you would then decide that you did not need Ashley. I think what you might end up with is less of Ashley being used in the first instance.

CHAIR - What is the current -

Ms O'BYRNE - But what is really important is that investment in the schools - the education services at Ashley - and we have had some really good community groups going out there and running services as well.

CHAIR - Yes, I appreciate that. I have been there and seen that.

Ms O'BYRNE - It is a tough environment that people do well in.

CHAIR - It is. Is the quantum of people - clients if you like - in there right at the moment?

Ms O'BYRNE - The average daily number has gone down to 26. As I said, we have roughly between 20 and 30 in there at any given point. At the moment the average is 26. The number of young people admitted to Ashley between 1 July 2010 and 30 April 2011 was 85. For the same period last year it was 120. But that is not a full year, as you can recognise. It is a couple of months short of that. So we are seeing a reduction in the admission figures, and the average daily number is 26, which is a little lower than 28, which it was the time before. Of those individuals held on remand, as at 30 April, seven had been held on remand for longer than 30 days, 10 had been held on remand for less than 30 days, and the longest an individual had been held on remand was 87 days. As I said, the differences in those are the sentencing by the courts.

CHAIR - The expectation of numbers decreasing is built upon those programs and other -

Ms O'BYRNE - We would like to see the numbers continue to trend down, but it would not be to the point at this stage where we could not say there would not be a role for Ashley. I think we would be some way from ever being able to make that statement. There are a number of views around youth detention, and I hold some of them. But I think we do need to look at alternative sentencing arrangements wherever that is appropriate.

CHAIR - Could you provide any details on saving strategies in the youth justice area?

Ms O'BYRNE - In terms of our area, we do think that as the numbers continue to decrease we can reduce the bed stock which would have an impact on staff.

CHAIR - Would there be an anticipated reduction in staff in this whole area of youth justice, not just at AYDC but in total?

Ms O'BYRNE - Whilst not able to give you a concrete number here, as the bed requirements reduce then the demand on shifts will change. So via natural attrition we will probably allow those numbers to decrease so long as we have the right number of staff for the bed stock that we have. Obviously the number of staff you need is dependent on the number of children and young people that you have, and any reduction in young people of course will result in a change in the shifts. But you would probably need to lose a bed before you could make an impact. We anticipate at this stage probably the loss of a bed.

CHAIR - That is just within the facility, but what about in the youth justice area per se - the whole shooting match? Will there be any reductions there?

Ms O'BYRNE - We are not looking to reduce the number of staff in youth justice. We are looking for better collaboration and, once again, the collapsing of those two areas will allow us to reduce some of the administrative costs. Also, we are attempting to remove the duplication of a youth justice worker and a child protection officer dealing with the same child. That then frees up time for those staff to deal with other children as opposed to duplicating the service. So we are not looking at a reduction directly in justice staff. But, as I mentioned before, we are looking for savings in the administrative model around the two divisions.

CHAIR - I am conscious of the time. Unless there are any other questions on youth justice, we will move on to 4.1, Office of the Commission for Children.

4.1 Office of the Commissioner for Children -

Mr HARRISS - Minister, in the public arena there has been some dispute about recent reports of the Commissioner for Children, as well as the former Commissioner for Children, Mr Mason, with regard to the number of visits paid to children at risk. I just want to get a handle, first of all, on where you see all of that in terms of particularly the most recent report from the current commissioner.

Ms O'BYRNE - I will take you through the process generally and then you may wish to ask further questions, if that is okay. There is an annual audit of child protection case files undertaken by the commissioner, and that is a really important mechanism for ensuring that quality of service. The 2009-10 audit undertaken by the Office of the Commissioner for Children did raise some issues of concern. The previous audits, however, concentrate on a small cohort of child protection cases and probably did not reflect the status of the children in the child protection system. There were certainly some questions around methodology that there were some differences about.

What Mr Harriss is possibly asking about - and I am not quite sure - is that there was some concern that the visits had not taken place and there was some disagreement between us and one of the reports about whether visits had taken place. Is that the information that you are particularly seeking?

Mr HARRISS - You have read the mood, Minister.

Ms O'BYRNE - I do actually have some data on that somewhere. But what it is is that there was a difference of opinion as to how the information was gathered. We are absolutely of the view that those visits took place.

Mr HARRISS - A difference of opinion between whom?

Ms O'BYRNE - This is an historical one, but there was a problem with the collection of data and the information that was available as a result of moving to a new system. We contend - and I believe the commissioner accepts - that those visits did take place. There was a collection of data issue in terms of the report. When we reassessed the information and provided that information, there was agreement that those visits took place.

Ms FORREST - Did that come down to the definition of what a visit was?

Ms O'BYRNE - There is a question around what constitutes a visit. We do have a disagreement - I am not sure if it is with this commissioner or with the previous commissioner - but we do have a difference of opinion with the Office of the Commissioner for Children which is to do with the nature -

Mr HARRISS - Who is 'we'?

Ms O'BYRNE - We as the department.

Mr HARRISS - A difference of opinion between the department and the commissioner?

Ms O'BYRNE - There is a difference of opinion between the department and the commissioner in terms of the definition of an informal visit and the value of an informal visit. The department is of the view that those informal visits should be calculated because quite often you do actually get different and sometimes more valid information from a child in a less formal setting.

[10.30 a.m.]

So, when you have a conversation with a child in the company of their siblings or on a drive somewhere, we think the information that is gained in that is actually quite good, because in a less formal setting children are often more open to having those conversations. I am happy to invite Mr Byrne to the table to explain that, if you would like. That is simply where the numbers differ. We count those as visits, because we think we actually get value out of them.

Mr HARRISS - Because there is a differing opinion, then, why can't we have a shared opinion, an agreed position?

Ms O'BYRNE - I am hoping that we will. We are working towards a shared opinion. Part of what we are developing with the commissioner is a new audit tool that we can all agree with so that there is an understanding of the values that we all put on those visits. So we are working on that with the commissioner at the moment.

Mr HARRISS - In terms of putting a cap on that, what correspondence have you had with the commissioner, and the commissioner with you, in terms of settling the issue?

Ms O'BYRNE - I might invite Mark Byrne from Child and Youth Services to the table to talk us through the audit process.

Mr BYRNE - When the new Commissioner for Children came into office, a discussion started between the department about the way forward because often the audit was a snapshot in time rather than actually a reflection of the child protection process. So we are working with the Commissioner for Children, who has been in correspondence with the New South Wales Guardian, who has run a similar audit process of the whole child protection process in the space where we are looking to develop that tool. It will probably be delivered in the next calendar year. It will cover the domains of health and education rather than just the visits that got picked up in our last audit.

Mr HARRISS - So that is into the future. My question to the minister was: what communication/correspondence has there been between the minister and the commissioner to try to settle this difference of opinion?

Ms O'BYRNE - I think there has been certainly discussions at a departmental level. I have had informal discussions with the commissioner myself in meetings around this. The previous minister did write to the commissioner asking that she and the department enter a process of determining an agreed set of audit data. That is the work that has been undertaken as a result of an attempt to get to one point and an agreed understanding on those processes.

Mr HARRISS - Has the commissioner expressed concern to the effect that you as the minister and the department are disputing the commissioner's figures as to what constitutes a

visit?

Ms O'BYRNE - In discussions with me, the commissioner has not raised that. I would have to seek information as to whether that was raised with the previous minister. No. I think we have had a change of commissioner and a change of minister. So there are a number of changes in terms of those discussions. I am certainly aware that we are attempting to get some agreed principles in a number of areas so that we can support the Office of the Commissioner for Children as much as possible.

CHAIR - Are there any further questions?

Ms FORREST - I just want to go down the path you talked about earlier with the children's visitors program.

Ms O'BYRNE - Yes.

Ms FORREST - It is my understanding that the current commissioner has informed the people working in this area that the program is to be axed and that the minister, yourself, has said that no decision had been made - you are waiting on this review.

Ms O'BYRNE - Which has finished. It has come in now, so I am happy to take you through where we are at.

Ms FORREST - The review allegedly did not talk to a broad range of people. So it will be interesting to hear your comments about the review and what the outcome of the program will be.

Ms O'BYRNE - This is the second review that has taken place. There was an earlier review as well which probably gave rise to a number of questions that you will want to have answered as well. It comes back to my original point. I think we do need to be extremely careful when you have a pilot program dealing with children, particularly vulnerable children. There was possibly not clarity for either the visitors or the children that this was a pilot program, and I think expectations were grown. I also think that those children's visitors had created some very strong relationships with the children who were in the pilot program. These are vulnerable kids whom we do not want to send another negative message to about people's engagement. We do not want to walk away from them again.

That leads us on two separate pathways. There is one pathway around the view of the children's visitor system and the learnings that we had from that. Some suggestions have been made about a review for change and where it might go in the future. The other is this particular cohort of children who have been engaged. I have a view that it is unfair to those children to suddenly take away their visitors and the commitments that they have had. So we are sourcing within the department money to ensure that those children can maintain their relationship with the visitors.

Ms FORREST - How much will that cost?

Ms O'BYRNE - I think we need to identify $20 000 for that, and we will do so.

Ms FORREST - So what does that cost incorporate, because these people are volunteers?

Ms O'BYRNE - This is the cost of petrol and their reimbursements. Most of these children are over the age of 13, so we will eventually see a number of these children no longer part of this system and that will flow through. The other side then is the evaluation of the project. A number of concerns have been raised about what people expected to get out of the program and what rigour was placed around the program itself. It is a program that is run by the commissioner's office and as such we wish to work with her on that.

3p Consulting did a report which came out around a week ago. That report has since been the subject of a meeting with representatives of the children's visitors and the Commissioner for Children, and they are working on a new model there. As I understand, there is a fair amount of agreement around some of the things that possibly were not taken into consideration and needed to be done better, and we will be looking at designing a new program based on those discussions. We will be identifying the costs around that as we develop the program. From what I can understand, there is a view that we really should be focusing on children in therapeutic residential care, particularly being able to get some better benefits out of that program. But, at the moment, the Commissioner for Children, the visitors and 3p Consulting are having conversations about stepping that report through in terms of what it might look like.

Ms FORREST - There is no funding factored into the Budget for an expanded or different version at this stage.

Ms O'BYRNE - This is actually in the Commissioner for Children's budget, not ours. It is not a departmental program; it is a program run by the Commissioner for Children. We are happy to work with them in terms of what they come up with, but at this stage they have not come up with a model for us to look at. But I imagine that they will in the coming months as they go through the learnings. I think that should take place. This is the reality of pilot programs. You quite often end up with a completely different picture from your learnings, but I do not think there was enough clarity for those children involved that this was a pilot program.

The Commissioner for Children did write and say, 'The pilot program is ending and therefore you should disengage with children.' I think what she was trying to avoid - and I do not want to put words in her mouth because she is an independent statutory officer - was the reality of people suddenly not turning up anymore, and she wanted to make sure that the children understood that the pilot was ending. Having said that, I do not think that was a message that those children would have taken extremely well, because I do not think that was part of the ongoing engagement. So we will fund that.

CHAIR - We will move to the last one - children abused in care.

Mr MULDER - The budget papers reveal that last year you spent nearly $700 000 on the Commissioner for Children. That is increasing this year. Given the history, particularly the relationship with the former children's commissioner, can you give me a breakdown of how much of that money goes into salary and how much of it goes into travel and consultancies and that sort of thing?

Ms O'BYRNE - I might take that on notice and provide it for you today.

Mr MULDER - Could you provide perhaps just an overview, because I would like to go into that. The Budget also notes that that funding will continue to grow into the future. Given the fact that you have a very competent, I imagine, deputy secretary for children and a Commissioner

for Children playing in this particular space, I am wondering whether you think that continuing to grow this budget is good value. I would be particularly interested to know whether or not that money could be better spent on actually delivering the services rather than quibbling about what defines a visit? Perhaps we could have a few more visits and worry about the definitions later. I will ask you about your views on the role of the Office of the Commissioner for Children and whether we are getting value for money out of that.

Ms O'BYRNE - It is an independent statutory role. As a result of that, the commissioner is responsible for her own internal budget and the processes around that. So she is responsible for the make-up of her budget within that. I am actually looking forward to a really positive relationship with the Commissioner for Children, because I do think we need that independent voice outside of Government. Particularly her focus is very much on the impact on children. I am trying to get a feel for where you wish to head with this. We will get to the budgetary information presumably by the end of the day - in fact only a minute away. It is an ambitious one minute, I think.

Mr MULDER - I did not think it would be that difficult.

Ms O'BYRNE - In terms of the role of the Commissioner for Children and the office for children, I see what you mean. The idea of the office for children is not to duplicate the things that are done with the Commissioner for Children. What they are trying to do is ensure that across Government when we are working we are working in the same space. That is very much the focus there. The office for children is not about growing our budgetary responsibilities; it is about taking existing people across agencies and effectively putting them together.

Mr MULDER - What I am getting at is the value for money - in a State as small as ours and with a Government and departments as small as we are - of having these independent bodies basically conducting reviews across policy areas across other agencies. Don't we provide the deputy secretary with a telephone?

Ms O'BYRNE - I think it is a broader argument about the role of statutory officers and those things independent in government and I should imagine that we have all had very lengthy conversations about the value of those. But I think when we are dealing with vulnerable children I do not think that it is inappropriate to have that other voice in the environment that is not locked into a government policy at any given time which can provide that frank and fearless independent advice. We might not always like what the Commissioner for Children has to say, but they certainly have the right to say it and I do support the continuation of that role for that reason. Of the $697 000 funding for this output group, $580 000 is salaries, but that also includes people who are involved in visitor programs.

Mr BYRNE - At-risk advocate nationally, program advisers and policy advisers.

Mr MULDER - So the rest of the table is travel?

Ms O'BYRNE - There are five full-time staff: the Commissioner for Children; the coordinator, promotions and projects; the senior policy consultant; two policy officers, one of whom works part time; the Ashley Youth Detention Centre residents' advocate, who works part time; and the executive officer. But it also includes programs such as the children's visitor program. So the cost of the children's visitor program is run out of the overall Budget of the Commissioner for Children.

Mr MULDER - And the travel component?

Ms O'BYRNE - I would have to seek some advice on the travel component for you. Did you want that just for this year or did you want an historical -

Mr MULDER - I would like a bit of a trend.

CHAIR - You could take it on notice if you would like.

Ms O'BYRNE - If we take it on notice to give you, would three years be enough for you? If you wish for further information we could provide it, but that could give you the trend.

CHAIR - With regard to children abuse in care, are there any questions on that?

Ms FORREST - I have one quick question. Is this the end of the road for this - again I say? How many applications are on foot?

Ms O'BYRNE - That is what I wanted to give you - that information. I am looking for a particular document at the moment. I have my latest update from the abuse in care area. I met with Mr Arnold Shott in relation to this program. There has been a lot of information at the moment out from the media suggesting that a number of claims had been assessed and simply were not being paid, that we were sitting on the payments and that the program was not going to continue. We are now into the fourth round. We have completed three rounds since 2003. The third round of claims was not completed until December 2010 and there were about 1 000 applications processed in that. What we did do was open up round 4 prior to the conclusion of round 3, and that is because there is a challenge getting people to come forward. Some people want to do it at different stages in their life. There is also the fact that some of the people for whom a payment may be appropriate are older or unwell and we wanted to provide an opportunity so that, if somebody did have a life expectancy issue, we were able to deal with that in the round that we are paying. We are currently doing round 3.

Ms FORREST - But the question is is this $4.8 million all that is left and how many are on foot at the moment?

Ms O'BYRNE - No, it is not the end of the line at all.

Ms FORREST - There is nothing in the forward estimates.

Ms O'BYRNE - No, because we draw down from Treasury.

Ms FORREST - So we have drawn down every year?

Ms O'BYRNE - Yes, at each point where a payment is to be made, we draw that down from Treasury. So under round 4, for instance, we have so far received 391 claims. They are averaging at the moment of one to two per fortnight coming in. So they are still coming in. Of those, 179 eligibilities have been completed. So we have done an assessment of 179 of those. The total ineligible claims - those for whom a claim cannot be made - is 41. That leaves us with total eligible claims of 138. Of those total claims that are completed at the trust fund office, there are 99. Within our system to be paid out, there are 34 that have just gone - that have left the commissioner's office to be paid. We have finalised claims of 63. There are 16 that have actually

been payments that have been made and there are three offers that have been made that are waiting acceptance from the individuals.

So this is an ongoing process and I need to point out that it takes some time in order to assess whether or not the claim is valid, because we do take that extremely seriously. That means an interview with the person, which may not be able to take place in Tasmania. They may not be in Tasmania anymore. We then interview others who are named within that claim so we get that broader understanding. We obviously do records checks as well to substantiate that information based against other information that we have. So the actual assessment of each individual might take seven months in terms of being able to have all of those conversations. But once the assessment is done, it then goes to Mr Arnold Shott in his role as the independent assessor. From the independent assessor it then comes back to the department and comes to me and I refer it to the Premier and then the Premier authorises an offer to be made. Some people go and seek legal advice about their offer. That can slow it down a little bit. Generally, most people do not. People can ask for a review, again, if they are so inclined. But 16 have been paid of the 63 finalised claims. Three we are waiting to hear back from and there are 34 that have just left Arnold and they are on the way to an offer being made through that process. So we are getting through them.

I think there is going to be a point when we do not need to have it - I am hoping that there will be a point where we do not need to have it - because we are dealing with a finite number of people as we go through the process. But this is round 4, and my discussions with Arnold were very much about identifying some information from him as to what he thought might have been left in the system, what might still be there in order to be uncovered, and we will make some determinations around that.

Mr WILKINSON - You might have just a quick answer on this. Have you worked out a percentage of those people in care who may well have been abused and who already have been classed as being abused?

Ms O'BYRNE - No, I do not think there is -

CHAIR - Do you want to take that on notice?

Ms O'BYRNE - I do not think there necessarily is a percentage.

Mr BYRNE - It is hard, because past records are not very good. So it is hard to actually get a quantum of how many kids were in care during that time period.

Mr WILKINSON - So in total, in relation to your tranches, so to speak, how many have been indemnified?

Ms O'BYRNE - Overall - I am looking at the total figures here - of the applications -

Mr WILKINSON - Yes, that have been successful.

Ms O'BYRNE - At this particular break, there were 790 eligible claims assessed for ex gratia payment at a quantum of $25.3 million by the end of the third round. As I said, of the 391 that we have received - and that was at the end of the last fortnight and they are still coming in - 179 of those eligibilities have been done and 41 were deemed ineligible. But in speaking with the independent assessor, there are variations in that as well. So it is not a really clear percentage

track you can find. You might have a couple of weeks where they are all found to be ineligible and then a couple of weeks where they are all found to be eligible. It really just depends on when they are being assessed. The only thing that we are making sure is that, if we do have somebody who is unwell or who is aged, we are dealing with them in the time that they can appreciate the benefit from it.

Mr WILKINSON - Thank you.

CHAIR - We will adjourn for 10 minutes and then we will finish off the Minister for Children and Minister for Health.

Ms O'BYRNE - Thank you.

The committee suspended from 10.50 a.m. to 11.03 a.m.

Ms O'BRYNE - Chair, if I may, I undertook to put one bit of data on the record as a result of the last question. This was to do with the division in the Office of the Commissioner for Children in terms of salaries and travel. In 2008-09 salaries were 450, travel was 43. In 2009-10 salaries were 523 and travel was 33. In 2010-11 to date, salaries were 501 and travel was 40. As I understand what is budgeted for 2011-12, travel is 27. So it is a reduction in the cost of travel in the future.

CHAIR - Thank you. The Minister has given us her overview on health per se before we started.

Ms O'BRYNE - I had almost finished. I guess the only thing that I would like to put on the record is that we will actually have DHHS overall as a balanced Budget but we did, as you are all aware, seek additional funding through the supplementary Budget appropriations process on the basis that the expectations of the costs were very clearly under what we could deliver given increased demand on our services. As a result of that, each of our particular area health services, for instance, certainly spent more than we had asked them to on 1 July, but that was an understanding we always had. So none of them are actually having to carry over any debt into the next year as a result of that. But then it is all covered through the supplementary Budget. Obviously we do ask them to find cost savings around that. I am sure we will go into that. I just wanted to put that on the record.

CHAIR - We will go into questions of overview. Just bear in mind that we are basically 30 minutes over time on our first segment.

Ms O'BRYNE - I apologise.

CHAIR - Some members had important questions to ask. So I just want to ask everybody to be succinct from all sides of the table.

Ms O'BRYNE - I will attempt, Sir.

CHAIR - I know the minister will ratify and deliver it.

Ms O'BRYNE - I get in an awful lot in a short time.

CHAIR - However, could you be succinct please? I appreciate that. Ruth, over to you for questions on health.

Ms FORREST - I wanted to pick up on what the Minister was just mentioning. You say that you are on Budget. The estimated outcomes in Budget Paper No. 1 -

Ms O'BRYNE - Can you refer me to the page you are looking at?

Ms FORREST - Page A3.5, right at the back of the Budget papers.

Ms O'BRYNE - Sorry, it is just easier if I am looking at the same document that you are.

Ms FORREST - It is right at the back, three or four pages from the back.

Ms O'BRYNE - Do you just mean the totals?

Ms FORREST - Looking at the variation there, the $126.3 million, which is an eight per cent increase.

Ms O'BRYNE - Yes, which is the money we achieved through the supplementary -

Ms FORREST - That accounts for all of that?

Ms O'BRYNE - It also would include some Commonwealth money as well I am assuming. I am looking at Penny at this point.

Ms FORREST - This is over Budget.

Ms O'BRYNE - So that 126 in 2010-11 is the additional money that we got with the variations around it based on when Commonwealth moneys are drawn down for particular projects. I have not cleared it up at all for you, have I?

Ms FORREST - The comment we hear every year -

Ms O'BRYNE - When I came in as minister 12 months ago one of the things that we had inherited in terms of the Budget targets was the money that was identified as part of the GFC that we needed to save, and everyone accepted we needed to find those savings. The reality is that making savings at a time when demand was increasing was reasonably challenging for our services. I think most of them internally have found savings. In fact, when we get to those individual line items they can talk you through some of the things they have done in each area. However, it was very clear that some of the things that we were asking of them they did not have the money to do. That is why the Budgets for the hospital areas actually all came out rather late; we did not get them out till November. We immediately engaged with Treasury to see whether or not there was a capacity to seek that additional funding to allow us to manage the commitments that we had made and the commitments that we wanted them to make in terms of targeting. So we got that additional money in the appropriations bill that would have passed the Upper House earlier this year, but we were able to assign that money from November because we knew it was coming.

Ms FORREST - The Auditor-General recorded in his report in 2010 - effectively what he was saying when you wrap it up is that in 2010 wages were up nearly $74 million, which is 8.9 per cent above last year's estimate, and it was $38 million above what was compared to Budget.

Ms O'BYRNE - And that was what we were seeking in that additional money. There is a number of reasons for that. Some of them also include things like opening up the ninth theatre at the Royal Hobart Hospital and some increasing acuity as well. We also entered the nurses' EBA. We were hoping that that would be cost neutral but what did not occur was the move to six-hour shifts until just recently. So there are savings that we will now notice trending down in our hospitals as a result of that - the weekend six-hour shifts, for instance, that did not come in at the same time as the EBA because they took some time to structure where to get in. I am seeking confirmation. Yes. So there are those sorts of things that I think we will now start to see the savings from.

Ms FORREST - The Auditor-General suggests that of the increase - the $74 million - approximately $47.5 million related to new staff.

Ms O'BYRNE - Staffing costs, yes, additional doctors.

Ms FORREST - And only $26.5 million was award increases.

Ms O'BYRNE - There are also additional doctors and staffing. For instance, the rehab unit in Launceston required us to have additional staffing for that. The Royal - and I will double-check the figure when the CEO is here - actually employed an additional 58 doctors over the last 12 months as well in order to provide those services.

Ms FORREST - The Auditor-General gave figures of 225 nurses, 13 ambulance officers, 75 medical practitioners and 38 allied health professionals, which leaves 152 positions. So I would be interested to know what those other 152 positions are because they would appear not to be front-line staff.

Ms O'BYRNE - We have got that for you now. Ambulance Tasmania got an additional 24 staff. Six of those are ambulance people - ambulance award is the award grouping. There are six in ambulance, 19 under the human services award bands 1 to 9 and 1 to 5 - HSO and the normal one - and no senior executive service increases. The Business Services Network - so if I can give you these it will give you a bit of a picture.

Ms FORREST - The ambulance officers want to know -

Ms O'BYRNE - In Business Services Network we dropped 19 staff.

Ms FORREST - Are you in the ambulance service?

Ms O'BYRNE - So back to Ambulance, yes.

Ms FORREST - The Auditor-General said 13 and you are saying 24.

Ms O'BYRNE - Our data would be more recent than the Auditor-General's.

Ms FORREST - So are these all ambulance officers, or are we talking about administrative staff as well?

Ms O'BYRNE - Six ambulance staff. Some admin/clerical, some technical. So they can actually be the people answering the phones, I am assuming. Do we have Dominic around?

Ms FORREST - We can do that when we get to Ambulance if you want.

Ms O'BYRNE - Can I just clarify one thing?

CHAIR - Are we talking about the same years here?

Ms O'BYRNE - Can I clarify the Auditor-General report date that you are looking at?

CHAIR - For what year?

Ms FORREST - 2010.

CHAIR - 2010-11.

Ms O'BYRNE - 2010. These are where we are to now. These are the 2010-11 numbers.

Ms FORREST - What I am interested in -

Ms O'BYRNE - It is a jump in staffing.

Ms FORREST - There has obviously been a significant increase in staff numbers and significant increase in staff costs.

Ms O'BYRNE - As a result of increasing demand.

Ms FORREST - I want to know who these staff are, the extras who have been put on. You have talked about Ambulance -

Ms O'BYRNE - We have appointed additional paramedics. We have opened the team paramedic -

Mr MORGAN - Actually, I think four since this sustainable ambulance service funding came on. That was Queenstown, Scottsdale, Triabunna and Nubeena.

Ms O'BYRNE - For the purposes of Hansard, Mr Dominic Morgan has joined the table. He is the CEO of Ambulance Tasmania. I do apologise, Mr Harriss. I was actually intending to answer on his behalf, but it is probably quicker if he answers it.

Mr MORGAN - And in addition to that, we put on an additional six new positions for a late shift within Hobart itself and we have been continuously recruiting against those positions. The sustainable ambulance service funding was a combination of all of those front-line positions. It was also about establishing and sustaining. So that has also ambulance paramedic educators who have been employed into each of the regions. I am just not quite sure how far you want me to

go into that.

Ms O'BYRNE - We have more up-to-date figures in terms of staff changes that you might like to have. Perhaps I can give you those -

Ms FORREST - Is there a document you can table?

Ms O'BYRNE - I will take advice. I am assuming that I can. We might be able to find you a copy so that you have got one in front of you as well. If I can just give you an indication, for the pay period at the end of May we have 21 additional people at Primary Health North and one in Primary Health North West. These are cumulative totals. For instance, North West lost some administrative positions but engaged some more nurses. Primary Health South have an additional three. The Royal Hobart Hospital has an additional 187 people, and that includes 10 allied health professionals, 30 on the Health and Human Services award, 20 on the Health and Human Services award HSO, 69 nurses, two radiation therapists and 58 salaried medical practitioners, but we actually dropped five visiting medical practitioners. It is part of that transition to not having that expense there. In state-wide mental health services, which we will get to later, there is an additional 11. So it is an additional 163. Ambulance Tasmania was 24. In our Business Services Network, which is the overarching stuff, we have dropped 19 staff. In care reform there is an additional 17 - 13 of those under the Health and Human Services award band 1 to 9. In the Office of the Chief Health Officer we have got an additional 13 people.

[11.15 a.m.]

Ms FORREST - Is that administrative staff?

Ms O'BYRNE - Fourteen are within the Health and Human Services award and Health and Human Resources HSO. That is the political framework.

Ms FORREST - These are the staff that are the bureaucracy that is driving these changes for the local hospital network?

Ms O'BYRNE - Yes.

Ms FORREST - So how many was that again - 14?

Ms O'BYRNE - Some of those 14 will be that, yes. For the chief nurse and allied health, there has been no change. The Commissioner for Children - I am not really sure about those ones, sorry. They are not mine; they are the other Ministers. The LGH is up 47. Nineteen of those are Health and Human Services band 1 to 9, but they lost 13 on the Health and Human Services HSO 1 to 5. They have got an additional 12 nurses and an additional five radiation therapists, which would be the bringing on line of the new MINA placings. There are an additional 23 salaried medical practitioners there as well. Mersey has an additional 24, of which the bulk of those are the 13 nursing staff. North West Regional Hospital has 26 overall.

Ms FORREST - Thirteen out of 24 is not the bulk.

Ms O'BYRNE - Sorry; the others are five on the Health and Human Services award band 1 to 9 and six on Health and Human Services 1 to 5. When we get to having the CEO here he might be the one to ask. I am giving you these figures so that you then have a base for when the CEO is here. It is probably more for that particular question. North West Regional Hospital did drop 12 in

Health and Human Services 1 to 5 but picked up eight allied health professionals and eight Health and Human Services award people and dropped a visiting medical practitioner. We have lost staff in the Office of the Secretary. There are three additional overall in policy information commissioning, but that is a mix in there of care staff and administrative staff, I think, or those with a care focus. That is the national health reform team as well.

Ms FORREST - There is another three there, did you say, for that?

Ms O'BYRNE - Yes. These are overall figures. There have been some gains and some losses in each of the areas within it.

Ms FORREST - Do you have a figure on the number across the state that are purely employed to deliver a rollout plan for -

Ms O'BYRNE - State-wide services and that sort of thing?

Ms FORREST - No, the national health reform.

Ms O'BYRNE - Some 4.8 people are engaged in the national health reform process.

Ms FORREST - Across the state?

Ms O'BYRNE - In terms of additional, yes.

Ms FORREST - In all departments?

Ms O'BYRNE - Whose specific job is working on that particular transition, bearing in mind that we have 12 months to go before we roll out the new services.

Ms FORREST - So the 14 you talked about earlier -

Ms O'BYRNE - No, four. This is policy information commissioning. So the total of staff in policy information commissioning across the state is 72 people.

Ms FORREST - So they are all administrative staff?

Ms O'BYRNE - Some of them may have been medical. There are some nursing staff and some allied health staff in there as well, but predominantly they would be administrative in terms of policy.

Ms FORREST - The predominant role of that area at the moment is rolling out the National Health Reform?

Ms O'BYRNE - Is identifying what is going to be needed and certainly providing the information that we need in terms of the National Health Reform. There are a number of things in the National Health Reform that are not bedded down, that we are in negotiation around, so it is the work that we need to do in order to provide what we need to the Commonwealth for the rollout to start. So that is the progress charts, the national performance agreements, the new information management to advance on how we actually do the tracking - that is, the coding - activity based funding and the policy discussions we are having with the Australian Government

and the intergovernmental liaison.

Ms FORREST - This is 72 FTEs in this area?

Ms O'BYRNE - Yes. These are not necessarily people we went and got in addition. These are people who were predominantly already within the department - most of them. In fact, there are 30 fewer people in this area than there were 18 months ago. So these are existing people whose tasks have been reassigned to focus on the national reform agenda.

When we do move to the local hospital network model we are not allowed to increase the cost of administration, so the people that we have on a state-wide basis will be the people or the positions that move into the hospital networks - other than those that are required for the maintenance of Tasmania's Health Plan, which is about ensuring those clinical overrides are taken care of. What we do not want under any circumstances is each of these LANs competing with each other and attempting to do things that are unsustainable. We learned a lot from previous years, and the reason that we have the Health Plan is to ensure that we have across the state agreed understandings of what should be done where. The question will be in the LANs how they will do it.

Ms FORREST - Chair, do you want me to continue with the other overview questions?

CHAIR - We will continue with the overview, yes.

Ms FORREST - Of the $100.2 million savings for this year, $520 million over the next four years, can you give us some more details within Health exactly where those cuts are going to be made and how many staff you are looking at and from what areas? And where there are redundancies, if there are, have the redundancies been factored into the forward estimates?

Ms O'BYRNE - Some of these things I can't give you yet because they are a work in progress, but I can give you what we have at the moment. Of the $100.2 million this year we have identified some $27 million savings already; for instance, the implementation of RIS/PAC - Radiology Information System/Picture Archive Communication - which we anticipate will provide increased revenues and therefore savings that we can make elsewhere in excess of $870 000. We have identified opportunities for savings by competitive purchasing through state-wide procurement contracts including prosthetics, which I mentioned before, which will save $900 000 in 2011-12. There are some other options that we can explore through some State and Commonwealth initiatives to get savings around 1.5 per annum when they are fully implemented. So by 2013-14 we are expecting to save $4.46 million there. The co-generation plant at the LGH should save us around half a million a year.

We are reviewing the operational task currently performed within DHHS that might be able to be provided more appropriately through external providers, such as the provision of subacute beds. We anticipate savings of $1.4 million a year. There will be the consolidation of motor vehicle fleets and the suspension of non-essential travel and consultancies and savings. So we are budgeting to save $2.3 million in 2011-12 and $2.95 million from 2012-13. We will be reducing the cost and usage of locums to deliver savings of $1.5 million in 2011-12, increasing to $2.3 million a year. The focus we have now is on the establishment of a business control team to ensure that an appropriate governance framework is in place. We will be establishing a business process redesign team to evaluate the efficiencies of all the things that we do and identify some opportunities for improvement.

We are wanting to change the culture so that savings are put forward. There is a document that has been circulated to 10 000-plus staff at the moment that indicates a lot of opportunities for savings. Not all of those will end up going to the budget subcommittee, but we are trying to get staff focused on bringing up ideas. The ANF, for instance, provided an extensive paper on suggestions that they had - many of which we can do; some I think are possibly more challenging. We will also be pursuing the health and hospitals reform, particularly preparing for activity based funding, which I will need to touch on because that is the other imperative that we have in the Budget.

We will be achieving benefits and efficiencies from the implementation of new systems, such as radiology, which I mentioned, and rostering. We will be reviewing the grant allocation that we manage through the department and reviewing the delivery of services to reduce duplication. I hasten to add that all duplication is not by its very nature bad, but we do need to look at where things are duplicated to make sure that there is a justifiable reason for it. Obviously we are looking at the employee renewal program and incentivising separation from the service. The ANF, for instance, have requested - and we have agreed - that we look at early retirement rollover for older nurses who may wish to move out of the workforce.

The other reason that we have to get this right - even if we did not have to find $100.2 million this year - is that in 12 months we move to activity based funding. We will be funded not in the way we are now. At the moment we are given a global budget. We hand it over to our area health services and they manage as well as they possibly can with the demands that they have in order to live within their means. Sometimes it is a challenge, but we work through it. Under activity based funding in health reform, we will now be paid per activity that is undertaken in a hospital. That is not just a case of 'We will give you *X* for a hip.' Every component that goes into the service that is being provided needs to be identified and allocated.

So we actually need to not reduce our services, because we are going to be paid per service, but we need to reduce the back costs for all of those services because there will be a national efficient price set by the national pricing authority and that will be what we will be paid against. We have said to the Commonwealth - and they have agreed - that they need to take into consideration the fact that there are additional costs for providing services in regions. So we would expect that there will be an efficient based price for a capital city and an efficient based price for regions because there will be an acceptance that those things will be included. We need to be able to meet that. There will also be some things that you simply cannot have an efficient based price around. For instance, activity based funding on a small regional hospital is not going to work because they are never going to have the kind of throughput. We are anticipating that the Commonwealth will be advising us on their block funding.

Ms FORREST - We will get to that more in a moment.

Ms O'BYRNE - I will just finish my last sentence. If we are not at or below the efficient based price, then that will be a significant problem for us because we will only get from the Commonwealth the efficient based price. So we have two imperatives to find savings at the moment. One is that we have the budget challenge. But at the same time we were going to have to find those savings anyway because we have to become more efficient in the services we provide.

Ms FORREST - So the question I asked at the beginning was: have the proposed redundancies been factored into the Budget?

Ms O'BYRNE - We have not identified the number of staff. There is no identified hit list of staff that need to go other than in particular areas. You would be aware that I made the announcement of the LGH laundry and the anticipated closure of that service. We are obviously doing the numbers at the moment of the nurses who may wish to take an early redundancy/retirement.

Ms FORREST - There will be some redundancies. Obviously the laundry is one. There may well be others. Is there a figure in the Budget to account for redundancies?

Ms O'BYRNE - No, not at this stage because we are attempting to just get the numbers. One of problems is that we cannot drop the number of services that we provide. So the staff that we have who provide services still need to be there. The savings for us have to be the background behind that. There are others other than nurses and doctors. And should there be redundancies I anticipate that they will be centrally funded, and we have to subsume that within our overall budget.

Ms FORREST - The Premier suggested recently that this is your Budget. You have to work within it. If you cannot make savings in one area, you have to start making them in another. That tells me that if there are redundancies in health they have to be funded in health.

Ms O'BYRNE - Yes. There is a cost to redundancies. It is not the first option you go to.

Ms FORREST - Let me go to the question. The decisions are made by the department heads. Last time that was a decision that was made by the former Treasurer for the department heads to make these cuts and savings measures. The Premier came out recently and said that they failed to do that. They did not take it seriously. What confidence do you have that this will change this time?

Ms O'BYRNE - That is why we are establishing a business control mechanism in order to have that oversight.

Ms FORREST - So it is not the department heads who will make the decisions then or it is?

Ms O'BYRNE - At the moment, as soon as we give our agencies a budget that they need to operate within they attempt very much to do so. That means that I do not on any one day have a list of any savings that they may have made because they have to operate within their global budget. The business control team will have a process whereby we can assess against that and we are now required to report to the Budget Subcommittee quarterly to identify those savings.

Ms FORREST - So there will be quarterly reporting. Is that how you are going to measure and monitor the cuts?

Ms O'BYRNE - Yes.

Ms FORREST - So what sort of expectations will you have? What sort of reporting mechanism are you expecting in that quarterly reporting?

Ms O'BYRNE - That is what the business control team is doing. They are working with all of the agencies and that is an ongoing process. Then we have to take that on a quarterly basis to

the Budget Subcommittee to establish that we are making progress against the targets that we have.

[11.30 a.m.]

Ms FORREST - So is there a plan to report any of that to the Parliament so that the Parliament can be assured -

Ms O'BYRNE - Under the Budget there is. I think there were questions asked of the Premier in question time last week, and there is the midyear economic report -

Ms FORREST - Which we do not get until February.

Ms O'BYRNE - and the Budget. Yes. We can spend all of our time working on trying to have a sustainable Budget or we can spend all our time reporting against it. So that is a matter for the Premier.

Ms FORREST - The departments are reporting quarterly you said?

Ms O'BYRNE - It is a matter for the Premier. We are required to report to the Budget Subcommittee at this stage. That is a matter you can ask the Premier tomorrow.

Mr HARRISS - It seems from what the minister said in her answer to Ruth's question that this business control team is going to be somewhat central to your direction. Who is going to constitute the business control team?

Ms O'BYRNE - I might just ask Alice to give you the list of people now, before you move to the next part of the question, Mr Harriss.

Ms BURCHILL - The business control team will be chaired by myself with the Chief Financial Officer, Penny Egan. A representative from the Department of Treasury and Finance is on the team, as well as the Department of the Premier and Cabinet.

Mr HARRISS - Minister, you have said - let me frame it this way. We are in a different situation this Budget round because we would normally spend a fair bit of time going to the outputs and just examining the outputs. Your agency saving strategies are fundamental to the direction which we have been visiting with you. So I suspect we are going to spend a fair amount of time today on these agency saving strategies to convince ourselves, as the House of Parliament, that these strategies can, first of all, be met and that savings can be made.

As Ruth has just put to you, you have not achieved any in the past. The Auditor-General has reported that. Do not worry about the year; the Auditor-General has reported it time and time again. We only have to look at the Budget papers to see that there is constantly across the whole of Government a blow-out in wages alone to the extent of six or seven or eight per cent year on year. How can you convince this committee that, with the establishment of your business control team and setting up a business process redesign team - good phrases, good aspirations - savings will be made? And what are you going to do as the Minister to ensure that the savings are made?

Ms O'BYRNE - I accept that it has been challenging for Health in particular to live within the means that it has been historically granted. Part of that is because of the increasing demand that we have. We have an increasing level of acuity in our community and an increasingly ageing

community, and the inflation costs of Health run somewhere around eight per cent regularly. That is very challenging, and I commend all of our services for how well they manage those demands.

You are right if you just said, 'We have to go find $100 million. Off you pop and see how you go.' I accept that there may be some concern that we do not have the capacity to do that because we do have those demands. But, at the same time, Mr Harriss, we have a shift to activity based funding, and there is not an employee who should not understand that unless we bring down the cost of the services that we provide we will not get a growth in Commonwealth funding, because we will be funded per service at an efficient base price.

So we have no choice other than to find savings at the back of our system costs. We have no choice. I understand that that does not give you an answer based on my absolute understanding of how it will occur, but that is why we have to look at every single thing that we do, because we are going to be funded not globally but per instance of care, and that is an absolutely significant change to the way the public hospitals have been funded.

As we have gone through this last 12 months I know that there have been increasing demands on hospitals, but savings have been made as well. We have in a sense been getting a shadow picture of what that activity based funding might mean and that is what we are working towards. But that is the thing that will ensure that we find these savings, because, frankly, if we do not, health reform is a significant challenge for us.

Mr HARRISS - Okay. Savings strategies, as your Budget paper suggests, will focus on, one, improving productivity and, two, performance.

Ms O'BYRNE - Yes.

Mr HARRISS - Give us a snapshot as the Minister of some key areas in improving productivity and improving performance which you would expect.

Ms O'BYRNE - In terms of some things that we can do to show that we are actually making significant productivity and outcome increases in terms of the work that we do, separations at the Royal Hobart Hospital between 2005 to 2010 have grown 14.51 per cent for instance. The weight of separations - and I will just randomly pick these - at the North West Regional Hospital have grown 15.54 per cent. So we are seeing more throughput. We have had a 20 per cent increase in emergency department presentations at the Royal Hobart and a 34 per cent increase in presentations at the LGH, a 12.36 per cent increase at the North West Regional and a 17.17 per cent increase at the Mersey Community Hospital. What we are seeing is, yes, there are growing costs on the health system and we are managing those, but we have significant demand increases as well. So whilst there are budget increases, I think that they possibly do not give the same message of the savings that are obviously being made in order for us to be able to live within the budgets that we have had. Elective surgery admission rates have grown. With regard to ambulance responses, for instance, we have had a 21.66 per cent increase from 2005 to 2010.

Mr HARRISS - I will just interrupt you. That is a snapshot.

Ms O'BYRNE - What I am attempting to give is a snapshot that, yes, costs have grown in health but I think costs have not grown as exponentially as demand has grown. I think our hospitals are working very hard and all of our services are working very hard to live within their means. The further focus on that is that now we are moving to efficiency based pricing. We have

to continue to find that.

Mr HARRISS - I understand all of that. Let us go to your key targets as Minister to improve productivity and performance. What are you expecting? What do you expect? You are the one who has the hand on the wheel. Ruth indicated earlier that the Premier, the day after the Budget, was blaming public servants for not delivering and for not believing that there was a global financial crisis - or any crisis. So they backed off. We have known about the GST shortfall since 2008-09 of $302 million and it has got worse than that. That is the shortfall. We knew that back in 2008-09, yet we did not make efficiency dividends.

Ms O'BYRNE - I disagree. I think all of our areas have found ways of doing better. The problem with health - and it is an ongoing challenge - is the increasing demand, which we continue to need to manage.

Mr HARRISS - You have just told us from your table there that we are going to have a continuing increase in demand.

Ms O'BYRNE - That was the demand increase that we have had.

Mr HARRISS - Yes.

Ms O'BYRNE - That we have managed extremely well.

Mr HARRISS - That being the case, what are we going to do about productivity and performance?

Ms O'BYRNE - Take the staff from the beginning with the health reform as well, they are also going to be paid based on productivity and performance. That is the new structure. This is the structure that will change the way that we conduct our health service.

Mr HARRISS - We understand that, but no matter what you get paid you have got to use it productively.

Ms O'BYRNE - Yes.

Mr HARRISS - And improve performance.

Ms O'BYRNE - Yes.

Mr HARRISS - Or you will be going to the Treasury and asking for more of their consolidated fund dough.

Ms O'BYRNE - Except there will not be an opportunity to do that, because we are going to be funded per instance per care now as opposed to that sort of global picture

Mr HARRISS - That is across the system?

Ms O'BYRNE - Yes.

Mr HARRISS - In medical services, surgical services and the like?

Ms O'BYRNE - Yes.

Mr HARRISS - But there has to be some cost savings in the administration.

Ms O'BYRNE - Yes, there certainly is. We have certainly had savings within that area already and somebody any moment now is going to give me a little piece of paper that says that. Whilst I wait for it, we are doing things within the agency already. So we are having a focus now on filling vacancies internally wherever possible, and that has been because quite often a position comes up and we will just advertise the vacant position without first checking whether or not there is someone already within the agency who can fill it. So there is that sort of focus. We are assessing all of the vacancies prior to advertising to ensure they are properly addressed, such as opportunities for redeployment.

One of the things in nursing that is a prime area is that if we have a nurse who is sick we have a significant cost in terms of replacing that nurse. Now, in order of costs, it would be cheaper to have a casual nurse employed by the department filling that shift. The next cheapest would be an agency nurse. The most expensive model would be overtime for an existing staff person. So we are changing the focus to ensure that we are actually assessing all of those things at that point rather than just going for whatever might be easier on a given day.

We are reviewing the current staffing structures in establishments so that we have the appropriate skills mix for the work that needs to be done. We are moving to six-hour shifts of nursing on weekends so we have not got the complex handover time, which nurses have agreed within the EBA that they do not need. We are looking at the abolition of vacancies that have been there for a long period of time that do not need to be there, improved rostering of leave and the abolition of multiple employment policy. For instance, you can be employed for two days a week at one of our facilities and three days a week at another one and that has a number of costs around that.

We have saved already across the department $3.4 million in general administration and salaries. Our fuel consumption savings are working out at around $19 000 per month due to the reduction in the fleet. We have reduced rental car costs from $542 357 and reduced motor vehicles by 26, which saves us $350 000. Some of the procurement changes that we have made with new state-wide contracts in negotiations will provide savings. The budgets that we work with for everyone will actually have that increase to focus on retaining savings.

In the last month we have had a reduction of 89 staff, and that has not been with an expensive redundancy program. That has been about managing the positions that we have and ensuring that they are replaced internally or assessed at each point. So I think we are on the pathway. I accept that it has been a difficult place in Health to find savings over years, but I think that everyone is focused very much on not only the savings target that we have to achieve but also recognising that we have to reduce the back end of each of our costs before we go into activity based funding.

So we are doing things. I understand the view of the committee that it is hard to see outcomes in Health in terms of savings, but savings are being made. The investment in RIS/PAC, for instance, will save us some $870 000 this year building up to over a million in forward years. So sometimes the saving is an investment to save as well.

Mr HARRISS - Okay. You have relied on some figures there to indicate some of the savings in recent times.

Ms O'BYRNE - A snapshot, yes.

Mr HARRISS - You are establishing the business process redesign team, as the paper says, to undertake systematic re-evaluation of business efficiency and productivity and identifying opportunities for improvement.

Ms O'BYRNE - Yes, and they are the sort of things -

Mr HARRISS - Is that not an admission that in the past those evaluations have not been appropriately made? If it is not such an admission, why do you now need a dedicated team to identify those savings?

Ms O'BYRNE - I understand where you are coming from and the point that you are trying to make, but I think it is also important to recognise that Health changes all the time, and the change that we are about to go through is a much more fundamental change than we have ever had before. So it does require a different level of attention, because we are moving to a completely different system as well. It is often difficult to find savings in Health, but we want to work with all of our staff to find those savings. I accept the point that you are making, but I think we are well placed now and we are putting in place the structures that we need to assist our CEOs and directors of those areas.

Mr WILKINSON - I hear what you say. It was said - and I know the answer to this back in the GST - 'We are going to find savings. We will find savings. These are going to be the savings. We are going to save "X" amount of millions of dollars.' This just seems to me to be fast forward two, three years. Here we are again saying exactly the same.

Ms O'BYRNE - Well, 20 years for me.

Mr WILKINSON - Yes, I know. I understand that. Are there going to be penalties applied if people do not meet budgets?

Ms O'BYRNE - There certainly will be if we do not get activity based funding right, because we simply will not get Commonwealth funding.

Mr WILKINSON - Because it would seem that these measures have to be put in place -

Ms O'BYRNE - You mean put into people's KPIs perhaps?

Mr WILKINSON - Yes.

Ms O'BYRNE - I can seek some advice on that. Under the shift to the local hospital networks, those governing councils will be accountable for their budgets. So there certainly is that shift there. I understand we are moving towards - and the secretaries are employed by the Premier, so that happens outside of my area - being able to meet our budget challenges into KPIs and the CEOs of the local governing councils. So, yes, we are now putting in mechanisms that talk about 'That is one of your things to do.'

[11.45 a.m.]

Mr WILKINSON - When I look at the Budget - and I have not been in your position - it would seem to me that the only way that proper savings are going to be made is if some really tough decisions are made. We can beat around the bush, put a bandaid on here and a bandaid on there and there is a trickle but we might not create any activity at all as far as savings are concerned. You look at the Mersey Hospital. You have to ask yourself the question: do we continue to allow that to do the jobs that it is doing? You look at other hospitals as well. Should we look at specialities in certain hospitals? I know it has been spoken about, but the only way I believe - and you may comment on it, please - that we can make savings and proper savings in health are if we make tough decisions, and I do not believe that those tough decisions are being made at the moment.

Ms O'BYRNE - I will cover a couple of things, if I can. I will just make sure that I have them all. We moved to the state-wide health plan in order to ensure that what was happening across the state was sustainable across the state. For instance, the cost of running cardiac surgery in Tasmania is a lot. It is an expensive thing to run and it would be much cheaper to send it away - to send those people to Adelaide or Melbourne where there are specialities. But we do not do that because of the distance and the impact on people. So there are things that we do in Tasmania that are not necessarily the cheapest thing that we can do but we do them because of isolation, and that is what the Tasmanian health plan then reviewed - that is, where we do them and making sure that we do them in the best way.

We have now the state-wide clinical networks and within each clinical area you will eventually want to get to a point where there is an agreement across all of our service delivery points about where things occur. For instance, we have a state-wide pharmacy service now that I think is doing really well. It is still early days - I think it is fair to say - but with state-wide pharmacy we have more pharmacy services being offered but we are doing it more efficiently and we are not getting the sort of re-presentations at general practice or re-presentations back into the hospital as a result. We have a state-wide cancer plan, which determines where things are done and where those things are more effectively done. The only unknown part of that, of course, is that we are waiting for the expert panel in the north-west to tell us when they believe we should be bringing on the linear accelerator services. We have the state-wide renal plan, which has meant that we have the out-clinic - the clinic in Kings Meadows - now for renal services. It is about deciding where things need to be best done.

Regional hospitals always come up immediately under fire. If you are going to save money, why would you not get rid of regional hospitals? But the ones that we have there are actually doing really important community work. If you look particularly at Rosebery and Ouse - and there was a lot of community disquiet about the changes there - I was up in Ouse recently for the opening of the facility and they are overwhelmingly happy with the change in the services, because it is about keeping people healthy now. So the services have changed. So I do not see that in terms of our budget challenges there is a need to say, 'We are simply not going to have these regional facilities.' I think it is about how we use them, and one thing that we are going to have to get better at is using the beds in our regional facilities in a more strategic way so that we can move people out of our acute hospitals into regional communities.

Mr WILKINSON - But if I might, with those types of - I am not being disrespectful - answers, there are not these decisions which I believe are going to save the amount of money that is here.

Ms O'BYRNE - No, and if I can get to that -

Mr WILKINSON - I will cut your lawns with a pair of nail scissors if we come in next year and say, 'Yes, I came in on budget,' because I just cannot -

Ms O'BYRNE - I have lots of lawn!

Mr WILKINSON - Yes, and I will get a new pair of scissors. But what I am saying is that I just cannot see how these savings are going to be made.

Ms O'BYRNE - Yes, and I understand the committee's concern about that, because it is a challenge within health. The other two things is that if we use our regional hospitals more effectively we do save money in our acute service, because the cost of a bed in an acute hospital is far more expensive than in a regional hospital, far more expensive than using beds such as, I think, all of our areas do now - and I look for a nod - and that is actually using beds in the aged care sector as well. I do not have the North West nodding at me. But that is North West as well? So all of our areas are now looking at purchasing beds within the aged care sector for those people for whom it is appropriate. So we are moving people out of the acute sector, which saves us cost.

Your other issue that you raised was the Mersey. Certainly, the Tasmanian health plan had a different plan for the Mersey than the one that we now have to live under. It is the only place where the Commonwealth has a hospital and we run it for them. I have a contract, I believe, hopefully waiting for me by the end of today to sign for the continuation of the Mersey agreement. Yes, having two hospitals in the north-west is a challenging environment, but one thing that the Mersey has allowed us to do is to increase particularly those easier services - the endoscopy and those sorts of easier services - and we are getting through some numbers as a result of that. But the Commonwealth owns the fourth hospital - the Mersey - so that is very much a decision for them and I do not think any of the political parties nationally are of a temperament to change that. They have certainly agreed to sign for another three years now, so I appreciate that. Certainly, the Tasmanian health plan had a different future plan for the Mersey than that which we now experience.

But there are savings that can be made in terms of the way that we use community facilities and getting people back out in our communities but also on the preventative health side, because a lot of our community facilities have doctors surgeries attached now and they have dental surgeries attached now. Dental health, as we know, is crucial in terms of a number of other health determinants. So we are making changes in those regional areas, which we hope will have an impact.

Mr WILKINSON - Just finally if I might, in relation to the changing of the culture, I know government is different from private enterprise because we have to look at a lot of other things, but it would seem with what you are saying in relation to duplication and in relation to non-essential travel and things like that that those are areas which could have been looked at and perhaps should have been looked at ages ago as opposed to waiting until now.

Ms O'BYRNE - And certainly were, but I think in some cases it has taken a while to recoup the costs from that, but I will take that on board.

CHAIR - So how would you describe, Minister, the present culture - just following on from Mr Wilkinson's question?

Ms O'BYRNE - I think there was a document circulated to all staff late last week, which I believe the *Examiner* thought was leaked. We gave it to over 10 000 people, so it was a big leak if it was. That and the retargeting of work groups in each area is about finding savings. The key to that is being able to show that when people come up with ideas we actually respond. So it is us changing the culture of our engagement with staff. So staff actually put up suggestions. We are responding to those - whether we are or not going to do them - and the ANF document, I think, is a case in point in that a number of the initiatives identified by the ANF we have incorporated into our budget strategies. So part of it is getting people to come up with ideas of savings as well in what is an incredibly difficult environment, because demand is increasing and the cost of health increases. Health inflation runs very high.

CHAIR - So you are confident enough that you can focus the attention of the employees in doing that?

Ms O'BYRNE - I think we are getting staff on board in those sorts of conversations now. I actually feel quite positive about that. I think the first year in one way is possibly the easiest of the four years, because the next three years are really going to be as a result of engaging with clinicians about state-wide services again. They are tougher conversations because they are about where we provide services, but they have to be led from a care perspective and not from the budgetary-political perspective. So we need to work with clinicians state-wide in their areas to determine what they think should be different.

To be fair, that is a tough thing to ask, because we asked clinicians to back us on the Tasmanian Health Plan and that included changes for the Mersey and then they were politically overruled. The clinicians stood very firm about the Mersey and there was a political fix on that nationally. We also need to work with our clinicians so that if they do make determinations we back them. If we ask our clinicians to go out and say, 'This is the way we are going to provide a service,' then we had better be ready to back them, and that is all of us.

CHAIR - You may have already answered the question. You talk about such things as motor vehicles, travel, conferences and all those issues. How are you going to manage some of those matters and what proposed savings can you make?

Ms O'BYRNE - I have put on the record for Mr Harriss - I think you may have been out of the room at the time - some of these suggestions already.

CHAIR - That is good enough. Thank you.

Ms FORREST - I take you to your cash flow statement on page 5.39.

Ms O'BYRNE - Yes.

Ms FORREST - I am wondering why the cash at the end of the year for 2010-11 is $40 988 000 and the cash at the beginning of the year for this year is $55 239 000.

Ms O'BYRNE - I am going to ask Penny Egan, the Chief Financial Officer, to join us at the table now.

Ms EGAN - There is actually an easy response to that one.

Ms O'BYRNE - It is not an easy one, so I will let Penny do it.

Ms EGAN - The $40 988 000 is actually what the budget was back in May 2010. So it does not reflect the actual year-end projection for 2010-11. So you will not find the continuity figures.

Ms FORREST - I just wanted to know what it was.

CHAIR - Are there any more questions on the overview before we head into the outputs?

Mr WILKINSON - Where can I ask questions about the Royal Hobart Hospital?

CHAIR - You can ask them in the overview.

Ms O'BYRNE - Or we can do it when we get to the line item.

CHAIR - Yes, we can do it when we get to the line item. We will have the CEO here then.

Output group 1
Acute health services

1.1 Clinical Support Services -

Mr WILKINSON - Can you provide some details on the impact of the savings strategy in this area? Where is it going to impact upon? What is going to occur in relation to savings that you have earmarked?

Ms O'BYRNE - As you can see, there is additional funding over the year for the clinical services output. It is skewed a little bit because of Australian Government funding that comes in that area. The conversation that I just had previously was about the things that we were hoping to achieve in the first year and what we were hoping to achieve in the second year. In the clinical services delivery area, those things will probably take a little bit longer because we need to do those things with the clinicians who work in those areas.

In a lot of these areas it is difficult for us to have a defined budget savings strategy yet, because that is the work that we are doing now with our CEOs. Those meetings are taking place over the next month in terms of identifying specific things that hospitals might do and their services in terms of finding savings. It is possible that some of that conversation will be teased out when we have the individual hospitals at the table. But some of the things that do provide savings overall are things like the RIS/PAC system, because that brings down the cost of radiology services for those medical services. They are things that really go to the way that we provide those services. I am seeking some additional advice here.

Mr WILKINSON - Are you putting any physios or occupational therapists off?

Ms O'BYRNE - That is not a decision that is being made by me. What we want to do is work with each of those clinical areas about their service provisions. So that is that assessment of where we do things, how we do things and how we fund the way that we do them. They are going to be done very much on a case-by-case basis around service delivery. I am trying to give an example that might work at the moment. For example, I still desperately need a physio for St

Helens and, even though we have budget challenges, if a physio who wants to work in St Helens walked through the door right now we would employ them. We need them in order to reduce costs in other areas of Health because not having a physio impacts on us in other ways. It is difficult because we are working with all the areas about service provision.

The difficulty with Health is that you cannot just turn the tap off. We talked a bit about that with children. You cannot stop something tomorrow with any of the services that we offer that are clinical. They are about patient care. So we are working with our staff to identify where they might do things differently. That is not about saying, 'We are going to get rid of *x* positions in this area' and reducing the service. We actually need to have the service outputs because that is what we are going to be funded on into the future. So it is a difficult one that we are working through with our area health services and our clinical areas at the moment.

I am afraid that under all of these output groups we are going to be giving you the process that we are going to go through. Health is different. Health is not something where you say, 'We are simply not going to do X today,' because that is just not the way it works. The cost of reimplementing a system can be greater than the saving that is made from stopping it.

[12.00 p.m.]

Mr WILKINSON - I understand that, but what I am saying is this: the midyear financial review talked about savings and talked about savings in Health. Health of course had quite an input into it to get it to where you believed it should be. I would have thought that the talk would have occurred from then or even beforehand and we would have started to get this plan into place.

Ms O'BYRNE - The things that we have identified in the Budget around procurement instruments and services that are in the Budget are the result of that work. There is a whole lot more work that needs to be done in Health to continue doing that. So the $27 million of the $100 million that we found are things that we have identified over that period. It was not that we just said, 'Oh dear, let's put it on the shelf and deal with it come Budget time.' The things that we have said we would do in this Budget we all know to be achievable because that is what we have worked on for the last period of time. We are continuing to work. This is an ongoing process around work that we are doing.

Ms BURCHILL - Our plan over the next couple of weeks is to set our budget with the chief executives, so we will be looking at the budget for the year and within that they will identify savings that they will have to find in the next 12 months. Those budgets will be agreed with the chief executives by the end of July. So they will find those savings that they need to make within their patch.

Ms O'BYRNE - That is in addition to the $27 million that we are already hoping to find.

Mr WILKINSON - Has there been any more added pressure on the heads of agencies to come in on budget or under budget if possible but still provide the services that are out there at the moment?

Ms O'BYRNE - As I have mentioned before, we anticipate that achieving budget savings will be part of secretaries' KPIs in the future.

Mr WILKINSON - And for that to occur there obviously have to be firm hands on the wheel by the Minister because the buck stops in the end with you.

Ms O'BYRNE - Which is why we are setting up that business review team. There has been a suggestion that it is a razor gang. It simply cannot be a razor gang in Health. We actually deliver the service provision.

Mr WILKINSON - Has the business review team met yet?

Ms BURCHILL - The business review team has not. The business process redesign team has been established. It is made up of two senior people, two team leaders and five system analysts who will actually be analysing how we deliver our business over the next 12 months and saying where savings can be made.

Mr WILKINSON - Has it met yet?

Ms BURCHILL - The business control team is a team.

Mr WILKINSON - Has the team met yet?

Ms BURCHILL - The team has come together, yes. They work together on it.

Mr WILKINSON - How many times has it met?

Ms BURCHILL - Sorry, it is a team of people who work together on a daily basis.

Ms O'BYRNE - It is not a 'come together once a month and look at a piece of paper' team. It is an ongoing engagement as part of their job.

Mr WILKINSON - So it is an ongoing, day-to-day thing?

Ms O'BYRNE - And we have to report back to the Budget Subcommittee quarterly on how we are working against our targets, and should we not meet them then there will be ramifications for that.

Mr WILKINSON - To the physios, podiatrists, speech therapists, radiologists, et cetera, out there we can say that there is no concern that you are going to lose your jobs, those jobs will remain and it is just a matter of how you carry out your services - is that what we tell them?

Ms O'BYRNE - Whenever we look at statewide services there are changes to the way people do their jobs. The statewide pharmacy plan, for instance, actually resulted in more pharmacists in hospitals and I am looking for a nod from Mr Kirwan at this point. The statewide pharmacy plan actually involved more people on the ground providing the services but we saved money because it was more efficient.

Mr WILKINSON - Yes, but the question is, Michelle, for those people out there - the podiatrists, radiologists, speech therapists, physios, you cannot guarantee that?

Ms O'BYRNE - I cannot agree that there will not be a point where a position is not refilled or a position is changed but it will only be made on the determination that we can provide the service that we are committed to providing. I cannot rule it out absolutely, and neither should I, because there is always going to be a point when the systems change, but when we are asking

people to look at the systems and services that they provide we are asking them to look at the most efficient way and if that results in staff reduction then it results in staff reduction - but the key has to be the maintenance of service.

Mr WILKINSON - In relation to output, obviously the people who go through these services, the people who require treatment for injuries, assistance for speech problems or whatever it might be, are you able to say over the last year whether more people have been assisted or the same number of people assisted or fewer people assisted in the whole of the clinical support services output group?

Ms O'BYRNE - What we do have is of broader outcomes but I do not think we would necessarily have a by a clinical output group available for you today.

Mr WILKINSON - In short, would you be able to get us, say, from last year to the year before, how many people went through your physiotherapy services and your podiatry services

Ms O'BYRNE - We wouldn't by the end of today. That would take us quite some time to do because we would need each of the area health services to do that work.

CHAIR - Can you take that on notice?

Ms O'BYRNE - To find that information is a huge piece of work, at a time when we are trying to focus on making savings. If the committee really wants it, can I ask them to consider how much depth they want because if you are about to ask for that across every single little output group, that is a heap of staff I am going to tie up who are not doing what I am asking them do right now. If that is what the committee wants, that is fine, but we do need to understand the implications.

Mr WILKINSON - Let us have a look at it for physiotherapy and occupational therapy.

Ms O'BYRNE - Am I about to get this question on all these output groups?

Mr WILKINSON - I don't know. At the moment we will let the jury remain and at the end of the meeting we might ask the question again. In relation to physiotherapy and occupational therapy, I would take it that it would be fairly easy to find out how many people have gone through your services.

Ms O'BYRNE - I would need to go to each of the area health services to do that. I am just going to seek a nod from the CEOs whether that is easy. The CEOs are all indicating that they can provide that.

Mr WILKINSON - It would be on a computer, would it not, as to the people who go through it? My wife is a private physiotherapist and she knows how many people she sees.

Ms O'BYRNE - Ours are a little bit more complex than that.

Mr WILKINSON - I realise that, but it is all on computer.

Ms O'BYRNE - I am just conscious that we are asking everyone to focus on savings at the moment. It is fine if you want to get a couple of snapshots, but if the committee as a whole is about to ask for an itemisation of everything, I am not sure that would be an effective use of time.

CHAIR - I don't think we are going down that path.

Mr WILKINSON - A snapshot of physiotherapy and occupational therapy over the last three years would be fine.

Ms O'BYRNE - That is okay. For instance, if we are looking at dental prosthetics over the last five years, we have grown something like 193 per cent in terms of cases of prosthetics provision. As long as we are looking at snapshots, and if you are comfortable we can probably look across a few different snapshots for you.

1.2 Medical services -

Mr MULDER - I have three areas but I guess I will be lucky to get more than two of them out. The first one relates to the renal services plan. I think it cost more than $200 000 to produce and it is going to cost us about $11.2 million over three years to implement, but according to the papers I think it would save around $16.2 million. Will the recommendations be implemented, Minister, and what money has been set aside for the implementation of this plan? What money was spent in 2010-11?

Ms O'BYRNE - As you know, we have invested already in the two major facilities. In Launceston, the Kings Meadows facility allows us to decamp particularly the chronic, stable haemodialysis patients. In the south we have the Area Health Service home therapies education and training facility. I believe we have a nurse at the moment who is dealing with home dialysis. It is a new appointment to grow the number of home dialysis, bearing in mind that that is very much an individual choice about whether or not people should have that. Home dialysis is a cheaper mechanism and for some people it is the right mechanism but it does require people to feel safe to be able to perform that service at home.

The strategic plan for in-services - we have other things that we want to roll out but we are not able to do so at the moment; we do not have the money to take the next steps.

Mr MULDER - Can we get a breakdown of that money - it doesn't have to be instantly - the money spent and the projected expenditure going forward?

Ms O'BYRNE - I will try to get it by the end of the day.

Mr MULDER - It just seems to me if we are looking for savings - and I will pick up your own words earlier - sometimes you have to invest a bit. I was very impressed with that because I thought, 'I have the perfect project for you'.

Ms O'BYRNE - It is one of those things where, if we are able to invest it is whether or not we have the cash to draw upon in this year to allow us to do so. I am not averse to counter-intuitive savings, which are about investing to save, and I accept that we want to do a lot more work in the renal services area but it is extremely costly at a time when we are trying to manage things.

Mr MULDER - Could we get those figures at some stage - what has been spent and what is going to be spent - that would be much appreciated.

Ms O'BYRNE - Yes.

Mr MULDER - My second area relates to the GP Super Clinic, which is not in my electorate either.

Ms O'BYRNE - Which is also an Australian Government thing.

Mr MULDER - It is an Australian Government thing, but it was to be opened May this year. Your budget says 2012.

Ms O'BYRNE - It is on track for 1 July.

Mr MULDER - Open in 2012 was the latest announcement in the Budget.

Ms O'BYRNE - Which one are you talking about?

Mr MULDER - The Clarence super clinic.

Ms O'BYRNE - There is a super clinic.

Mr MULDER - When are you opening is the question. I thought it was fairly straight.

Ms O'BYRNE - The super clinic is on track but there is an integrated care centre.

Mr MULDER - On track to open in?

Ms O'BYRNE - On 1 July as I understand it. The Australian Government are opening it on 1 July. What is on track for us, Mr Mulder, is that that is part of the integrated care centre and that is a few-staged development.

Sorry, 4 July is the latest data that I have from the Commonwealth on the opening date for that, but the entire integrated facility, obviously we have built the first bit and the second stage is being done now.

Mr MULDER - It is the clinic that I am particularly interested in at this stage.

Ms O'BYRNE - I can give you some information but bear in mind that the Australian Government is managing it.

Mr MULDER - That is fine, but a number of patients who have spoken to me have said that from 30 June this year they have been told that the clinic will close. What are they to do in the meantime.

Ms O'BYRNE - There is no point where services are not being provided. There is an issue with the fact that some staff who were employed are not being re-employed. There is a level of disenchantment and disenfranchising as a result of that, so some of the messaging has been

confusing for people. I am not saying that that is deliberate. I think there has been a number of elements around that. I am just seeing who I have got who could give us some information.

Mr MULDER - That is fine. I am happy to say the dilemma was confusion around the problem.

Ms O'BYRNE - The actual opening date of the GP super clinic will be 2 July. They will be taking patients from 4 July. There will be three doctors employed immediately and there are three doctors on track to come on board for that, but there is no point where there is no service.

Mr MULDER - Are you taking 2012?

Ms O'BYRNE - No. This is now. 2012 is the final integrated care centre which is the other elements that are State-funded as well.

Mr MULDER - Given the fact that it is a Commonwealth government project but that it is having an effect and one of the outcomes is deemed to be to take the pressure off.

Ms O'BYRNE - With the whole integrated service, yes.

Mr MULDER - Yes, that is the whole integrated service. In the end, what budget contribution in a recurrent format is going to be required from the Tasmanian Government to service this particular one.

Ms O'BYRNE - For just the Clarence one?

Mr MULDER - Yes, and is that overall a saving or an additional cost to the health budget going forward.

Ms O'BYRNE - Is that the Clarence integrated care centre or just the super clinic?

Mr MULDER - The whole centre.

Ms O'BYRNE - Well the super clinic is funded by the Australian Government because they are responsible for primary health which is GPs. The integrated care centre is the existing funding that we provide. For the service that we currently run. It will be a transfer of the budget that we currently have for the Clarence clinic. It is a more effective way of delivering services within a defined budget.

Mr MULDER - So there is no overall increase required going forward in relation to this Commonwealth Government project inside the State health budget.

Ms O'BYRNE - No, we are not anticipating an increase in costings from us. The only thing is that over time we may choose to put additional services in there that are determined as needs by community, but all of the integrated care centres will have some flexibility around the services that we provide based on an 'as needs' thing. So you might see changes over time, but we are not anticipating a budgetary cost increase for us.

Mr MULDER - I am happy to leave the other issue for others.

Ms FORREST - Minister, in relation to the area health services are you able to provide the amount spent on locums, like medical staff and agency persons who are actually area health services, each of their operating units?

Ms O'BYRNE - Yes, I can. We will start with the locums - it does not necessarily give us the break up.

Ms FORREST - I want a break up of each area.

Ms O'BYRNE - I will give you what I have here while we try to find the other information as well. What I can tell you is that as of April 2011 the cost of agency workers for the health portfolio was $22 504 878 and the cost for the same period last year was $22 651 304, so a slightly less than 1 per cent decrease in the costs.

The positions that are currently filled by locum doctors and nurses - Mental Health Services South specialists has a position, North West Area Health Services has two residents, two registrars and 9.5 specialists and the use of locum nurses FTE as of June is three for the Mersey, five for primary health and none for the North West Regional Hospital.

For the Southern Tasmania Area Health Service we have one specialist and for the nurses, FTE are seven at the Royal Hobart Hospital and one at Oatlands. For Northern Area Health Services, which incorporates the medical retrieval service - the doctors that we employ to go on the air ambulance - there are four registrars and specialists, which includes 50 for DEM and 53 for a head count of people, the use of locum nurses for Campbell Town is 2.29, Flinders Island is .61, Georgetown is 0.11, St Helens is 0.89, St Marys is 0.32 and none at the Launceston General Hospital.

Ms FORREST - So there are no locum staff at the North-West Regional Hospital in Burnie?

Ms O'BYRNE - According to this we have the two residents and the two registrars and 9.5 specialists. That is for the North-West Area Health Service. We include Mersey as part of the north-west area.

Ms FORREST - I want a breakdown for each within the area, like the Mersey and Burnie.

Ms O'BYRNE - I am sure that we can get that for you. I do not have it with me right now but we will put it on the record as soon as we get it.

Ms FORREST - Obviously locum cost has been identified as a significant cost and the Treasurer noted in her speech that she will be cutting spending on locums, so how do you intend to achieve that particularly when the Mersey relies very significantly on locum medical staff.

Ms O'BYRNE - Part of that has been re-evaluating that those locum positions are truly locum positions. There have been instances -

Ms FORREST - So it will not be a saving then, it will be a reallocation?

Ms O'BYRNE - No.

Ms FORREST - Are they dropping their salary?

Ms O'BYRNE - There have been instances where people have remained as a locum for an extended period of time, I think it is fair to say.

Mr AUSTIN - For the Mersey we are actively recruiting. We have been to the UK expo and to the Irish expo recruiting for permanent staff, and taking every measure we can to attract and retain permanent staff.

Ms FORREST - As we have for the last so many years. How is it going to be different?

Ms HOLDEN - The issue with the savings is how we are recruiting, how we are engaging locums and looking at more innovative ways of engaging locums by narrowing the market so that we are not just at the whim of every agency that is looking to provide a locum, so those savings are around the process of locums as well as the ongoing focus on recruiting permanent staff where we can.

Mr AUSTIN - We have also taken quite a few steps to make the Mersey more attractive in terms of its new DEM and the UTas development which will make it a centre of excellence for learning.

Ms FORREST - So you believe that will mean you will get permanent staff, not locums. Is that what you are suggesting?

Mr AUSTIN - It will make it more attractive for permanent staff as a working environment.

Ms FORREST - Obviously that is almost a cultural change and a shift in the way of thinking for medical staff to come and work at the Mersey because of the various issues that surround working there. The Mersey is a big user of locums, we all know. Have these savings been factored into the budget and if you do not manage to achieve that, is that going to create a problem with meeting the budget?

Ms O'BYRNE - Within the identified savings that we have already put up we factored in a target for a savings for locum employment, but that also includes nurses, and we are already starting to see, I think, a change in the nursing numbers.

Ms FORREST - So you do not have a particular target for the movement of locum medical staff?

Ms O'BYRNE - I gave it to you before. We are hoping to save 1.5 in the first year, growing to 2.3.

Ms FORREST - Million dollars?

Ms O'BYRNE - The other issue for the Mersey, of course, is that we are paid to run the Mersey so that whilst we run it as part of the North-West Area Health Service, it is a cost construct all of its own that is paid by the Commonwealth.

Ms FORREST - In other areas locums feature quite heavily too. The issue of getting specialist medical staff to any of our Tasmanian hospitals is a challenge because of the marketplace conditions, there is a lot of competition out there, so if you do not meet these savings

that you have identified there, does that mean that you have to meet them in the other areas of the budget because are they factored in?

Ms O'BYRNE - Well, as I understand it, these are savings that we think we can make.

Ms FORREST - So they are not factored into the budget?

Ms O'BYRNE - We have identified these as savings that we believe are achievable.

Ms FORREST - So they are factored into the budget?

Ms O'BYRNE - If we make more savings then that would be great, but yes.

Ms FORREST - So they are factored into the budget, though, those ones?

Ms O'BYRNE - Of the 100 million that we have to find, they are part of the 27 we have already identified, yes.

Ms FORREST - They are in that 27 then?

Ms O'BYRNE - Because of the work that we have done, that is the number that we believe we can achieve.

CHAIR - Obviously the heat is right on because of the budget situation and you will not want to be seeing any budget overruns from your hospitals. Are there any disincentives in place to make that happen?

Ms O'BYRNE - They will not be able to survive under attorney-based funding is probably one of the disincentives. Sorry, that was flippant for *Hansard*'s purposes. I think it is really important to know that whilst it has cost us more to run the hospitals than we had hoped when we had this discussion 12 months ago, we recognise what the additional target would be, and that is the additional money that we have got, and hospitals have lived within that. So they have come in to where we thought they were going to come in as a result of the work that the CEOs have done on site in terms of managing their savings. So yes, there is more money that has been spent than was subject to the conversation that we had 12 months ago. We recognised that very quickly and that was the subject of all of our conversations with Treasury to ensure that Health had enough money to manage what we knew were going to be the targets which were based on the demands we were making of the service and we are not, as an agency, over budget, overrun, this time because we have lived within those means because area health services have managed demand extremely well. So there is not a huge budget blowout this year in a real terms sense because this was what we anticipated, what we recognised was going to be the case and we funded towards it so that additional $120 million that we got is in the forward Estimates to manage that. Having said that, we now have to find the $100 million worth of savings so each of these area health services will be, within their budget discussions, given some money, a target that they need to find because we all have to find money across the department. The reality is that as the largest consumer of money within the agency each of the area health services will have a role to play n that and we will be setting their budgets with them before the end of next month.

Ms FORREST - Just on that point, a question was asked in this place a week or two ago about the LGH budget and you said earlier that everyone was on track and on target but we were told that the Northern Area Health Service at the LGH was $5 million.

Ms O'BYRNE - It is $5 million more than the conversation we had 12 months ago but we recognised that and it was factored in that additional money that we got and it is factored into the forward Estimates. With the LGH we recognised very early that we were going to have that additional demand and they have certainly not blown out from that early recognition. They have stayed within that and I think that is a testament to all of the CEOs that they managed to manage that. It sounds a little confusing because yes, they have spent more money but we recognise that and Treasury has funded that into the forward Estimates.

Ms FORREST - How much more are we looking at between when that answer was provided and the end of the financial year?

Ms O'BYRNE - That $5 million was covered as part of the $120 million additional money that we got in that budget.

Ms FORREST - Yes, but $5 million over budget was the -

Ms O'BYRNE - Oh, no, I think we will probably see a little bit of a reduction in that, and please jump in if I get this wrong, John. One of the things is moving to those six-hour nursing shifts which has only just happened but the cost of the EBA happened some time ago. So with the EBA we were supposed to see a general equilibrium and not see much of an impact but what we did see was a growth in costs and we did not see the corresponding growth in savings that we needed to see. But now that the six-hour shifts are coming in everywhere now I think that we might see some of those staffing figure costs trend down a little bit.

Ms FORREST - The question remains, by the end of the financial year what will that $5 million figure be out of the budget for the LGH?

Ms O'BYRNE - It will be what we anticipated it was, which is why we got the additional money. This is a difficult one because, yes, we have spent more than we were going to spend when we had this conversation 12 months ago but we recognised that particularly because of the things that we were asking them to do and that is why we got the $120 million into the forward Estimates ongoing to cover that, so that the hospitals we able to deliver what we were asking them to do. They have all managed to do that. The challenge comes that we have to find the $100 million now but that has to come from the costs behind the services because we are going to be funded by service in the future. Is everyone comfortable that I have explained that in the right way?

Mr MULDER - This year your department spent $72 000 on a consultant to do a service planning study to 'identify options for development of future emergency and medical services in Tasmania'. There was a Tasmanian firm that put in a bid for this study but it was awarded to a UK firm called Operational Research and Health Limited. I think that is a little bit of a side issue but it is interesting to see that you needed to go to the UK to do this. Can you tell me what the study is about, why it was needed, can this committee have a copy of the terms of reference and will the report finally be made public?

Ms O'BYRNE - I will invite Dominic Morgan to the table. He can provide that information. Dominic Morgan is the CEO of Ambulance Tasmania and he can provide some information around that.

Mr MULDER - I thought it was part of your business process review.

Ms O'BYRNE - Everything is part of the business process review.

Mr MORGAN - The firm that we employed was to develop up a model of what future planning priorities would be for Ambulance Tasmania in terms of staffing and infrastructure over the next four years. We did go to the market under the usual sort of Treasury guidelines for a request to quote. We had a number of firms put in for that. There is a formal valuation report on why the particular firm that gained it did so, but essentially their pedigree is that they have done similar studies and modelling within New South Wales, ACT, both fire and ambulance, rural Victoria, South Australia and now in Tasmania.

Mr MULDER - That was a side issue. I said I was more interested in the terms of reference.

Mr MORGAN - We can certainly table that without any problems.

Ms O'BYRNE - Yes, we can get those for you today.

Mr MULDER - The terms of reference and what your expected outcomes of that report. Has it been completed I guess is the next question.

Mr MORGAN - The report has been completed and our intention is to put it through the department. We have given briefings to the department on that and it is to be considered in light of all the other funding priorities that the department has.

Mr MULDER - Just as a supplementary, if it has already been completed is it talking about substantial funding increases needed? Or is it saying that the way to do what we do today is correct.

Mr MORGAN - At this stage the study is just a study, it does not go into the financial aspects. We need to do all of that entirely and build it up as a business case.

Ms O'BYRNE - At that stage it then comes to me.

Mr MORGAN - Yes.

Mr MULDER - I will be asking more about ambulances in the next, in a few line items' time.

CHAIR - Are there any more questions whilst we have the hospital CEOs here?

Ms FORREST - Yes, the local hospital networks.

CHAIR - Jim, you had one on the Royal. Do you want to just go through?

Mr WILKINSON - With the Royal, I want to talk about the progress on development - how are we tracking; how much money has been expended to date; is it on budget, that type of thing?

Ms O'BYRNE - On budget, on time, all those things. It is a massive redevelopment process. It is the largest health infrastructure project ever undertaken in the State. It has had $586 million, of which the State Government's contribution is $225 million, so 40 per cent of that. It works out 40 per cent of that is State money. Where we are up to is that we have done the enabling works on site, we have commenced those on site that are able to support the whole redevelopment program.

There is a lot of underpinning because we are actually about to add a significant deal of weight to the site. We have also upgraded the electrical and water infrastructure. We have expanded medical imaging and refurbished the kitchen facilities. There is a detailed assessment plan being finalised at the moment at the decanting because one of the things is that we are not stopping services, hopefully.

The aim is not to stop services whilst work is undertaken so we actually need a plan that allows us to move people out while their work is being done and hopefully minimise the amount of moves that they have to make over the next few years as much as possible. We are nearing completion of the PET-CT suite.

We have started the early works for the additional beds for the intensive care units and the creation of the new APUB assessment and planning unit which is going to be just right next to emergency and that should hopefully take some pressure off ED as well. We have commenced some early works to relocate some of the clinical assessment rooms. That is all pretty much I guess, that is phase one stuff. Phase two -

Mr WILKINSON - Can I just ask this question in relation to it. That is in progress now or completed now?

Ms O'BYRNE - Yes.

Mr WILKINSON - Is that on time?

Ms O'BYRNE - Yes.

Mr WILKINSON - It is on time. And on cost?

Ms O'BYRNE - Yes.

Mr WILKINSON - Right.

Ms O'BYRNE - Phase two is going to be the Cancer Centre and the other enabling works we need to do on the north-eastern corner. The tenders have closed for the design and quantity survey. I do not think we have selected anyone yet but tenders have closed for that. The Cancer Centre will have the new linear accelerator, a multi disciplinary outpatient clinic centre and the chemo and consult facilities.

Mr WILKINSON - All right, thank you. I just wanted a whistle stop tour of that, thanks.

Ms O'BYRNE - Okay and women's and children's is going to be the stage three and four stops. I think it is really important to recognise this is going to be a building site for a very long time. If people are interested we do have some visuals of the Royal redevelopment program if anyone is interested in that.

Mr WILKINSON - We will look at it at lunch time.

Ms FORREST - Minister, with regard to the local hospital networks you have confirmed the decision to have three local hospital networks?

Ms O'BYRNE - Yes.

Ms FORREST - How can they be more cost effective than one local hospital network. I have said that you need quite local decision making permissions. It is a vital aspect of any service delivery but we actually have the three area health services so why have we gone back down this path?

Ms O'BYRNE - The reason that we considered it was in light of the budget constraints and the challenges around that. One way that would have saved us a truckload of money would have been to get rid of all of our area health CEOs and have one statewide CEO and local management. That model was considered and certainly there were savings around that. Having said that, I think that the Tasmanian Health Plan that we undertook has not been in place for a very long period of time and I think we have seen great benefits already from the area health services but a lot of that benefit comes from the engagement of the local CEOs. A model that would have saved money would have removed what I think is one of the strengths of the facility.

What is important and will ensure that we do not have a challenge with the LHNs is recognising that they will all be subject to the Tasmanian Health Plan to ensure that we do not see what I think we were all aware of before, and the reason that we went to this type of model - clinical services being duplicated in an unsustainable way around the State.

Ms FORREST - Could you not say the same about three local hospital networks sitting over the top when you already have three well established areas in health services?

Ms O'BYRNE - You could have one with the three area health services but I think a lot of the way that you manage budgets on the ground is by having a CEO on the ground within those regions and I think our CEOs do that extremely well.

Ms FORREST - But you have anyway.

Ms O'BYRNE - Not if you wanted to really save money. The cost difference would be negligible if you were not looking at keeping the CEOs. I think the area health services model has been extremely good and it has worked really well for Tasmania. When the Australian Government and Rudd in particular went to national health reform he was dealing with the fact that in every State things were done quite differently. I think our area health services were somewhat more progressed in terms of the local decision-making than what other States have but it is a national model and therefore, we have to operate within the national model.

Ms FORREST - This is my point, we are a small State, we have well established area health services which are doing a good job and meeting that local input need. The discussion at the time over whether we should have three, one or whatever -

Ms O'BYRNE - At one stage there was a suggestion for 20, which I thought which was a bit rich just for the north-west.

Ms FORREST - Yes, but when we were going along this path, out of your office came a suggestion that it was too expensive to have three in the current budget circumstance so we needed to look at one. If it was too expensive then why is not too expensive now to have three when we have three local area health services that provide that local input and we are trying to reduce duplication?

I would also like you to inform the committee as to how you think three local hospital networks as opposed to one with the three area health services will improve patient outcomes and access.

Ms O'BYRNE - Going back to the first point, one of the things that we are obligated under health reform is to not grow the cost of administration so we have to find a way to manage the three services within the existing administrative budget in the framework we currently have.

Ms FORREST - Isn't one local hospital network a way of doing that?

Ms O'BYRNE - There will not be an increase in administrative costs as a result of having three because there cannot be. We are not allowed to do that. What does give it sustainability, and I think you are absolutely right, if we were starting from scratch in setting up three right now, you could probably have some concerns about how that might work viably but we do have a Tasmanian Health Plan that has statewide clinical responsibilities. In all of the consultations that we had around the State there was a range of views put but what everybody was very clear on, particularly the clinicians, was that they did not want to unpick the statewide clinical models.

Ms FORREST - I am not suggesting you do but my question is: how does having three local hospital networks over the top of three area health services create efficiencies and improve patient access and outcomes?

Ms O'BYRNE - If you are saying you have three area health services with three CEOs plus a statewide body, you are actually creating another level of bureaucracy. What we are attempting to do by the three is to have a statewide clinical model, an underpinning statewide framework that provides for those administrative costs but maintains the engagement of three local decision-making bodies around that.

Ms FORREST - When you talk about this statewide body, what are you talking about there?

Ms O'BYRNE - Sorry?

Ms FORREST - You talked about 'statewide'.

Ms O'BYRNE - The other thing that came through very clearly with consultation is things like IT. Nobody in any of the consultations wanted every LHN to develop its own IT system and its own patient numbers and its own transfers. All of the discussions were about heading for the

entire State, cut picking up those costs that would be a burden and an increased cost for three LHNs to do - the administrative role such as the IT staff or the payroll staff. Human resources is a little bit in between because of the work of human resources you would do statewide but you want the ability to make those employment decisions locally, plus you have your statewide clinical bodies. What we are really doing is enshrining that those local governing councils can make the decision not of what they do - you need to remember that these LHNs will not be deciding what treatment that they offer will be. The way it works is the State is the manager of health services under health and hospital reform. We will purchase from the LHNs the services, based on what the community needs in those areas and they then do those services. How they do those services now is determined by us, but in the future that will be determined by them.

Ms FORREST - You have three area health services. You are talking about a statewide body to do HR, IT and payroll. All sensible stuff. But under that we have to have four bodies. You are having a statewide body to manage the IT, payroll and all that and then you have three local hospital networks which provide some sort of unknown support in some way to the three area health services. You have your three CEOs so we are creating whole layers of duplication here -

Ms O'BYRNE - The area health service will become a local hospital network. So the picture the people have of an area health service is not in the picture any more - I should not do this for *Hansard* - so the governing council, what will occur is that I as the minister will have a commissioning role; whether that is an independent commissioner or an employed commissioner we still have to work that around in terms of the legislation. We will purchase from the governing council the services, we will say for instance you did 100 hip operations last year and we now know, based on trend figures that you probably have to do 105 and we will buy 105 from you. It is then up to that local hospital network to provide that 105. If it provides less, then we will only pay for the ones that we have actually asked them to provide service if they only do 100 we will pay them for 100 if they do 110 then -

Ms FORREST - I understand what you are saying. What I want to know is are we replacing the area health services?

Ms O'BYRNE - The area health services become the local hospital network.

Ms FORREST - So how do the roles change then? What is an area health service doing now -

Ms O'BYRNE - The governing council becomes the management authority for that. I will get one of the CEOs to explain this, but the governing council becomes - the CEO for instance of an area health service now will become, or their role will become, the CEO within a local hospital network. They will be responsible to their board, their governing council, that body but it is not a board in the old days whereby we just handed over the money and said off you go, it is now a governing council to ensure that the services that we purchase are provided.

Ms FORREST - So how is the funding going to be offered?

Ms O'BYRNE - The local decision-making, the effectiveness come with them being able to do things in a way that is efficient within that community, based on their community needs.

Ms FORREST - So how does the funding work then?

Ms O'BYRNE - The commissioner or the State body decides that we need 100 hip operations - this is a very simplistic model, but more simplicity you probably need - say we need 100 hip operations so I will ask the local hospital network to do 100 hip operations, they will do 100 hip operations, they will acquit it, the will send it back to us and then I will advise the Commonwealth that we believe they have done that and the Commonwealth will then fund them the Commonwealth contribution towards that.

Ms FORREST - There have been concerns that if the independent hospital pricing authority's role is confined to setting a price for a narrow range of services delivered only by hospitals, this could create a perverse incentive of encouraging hospital care for patients with better care for the community. What do you say to that?

Ms O'BYRNE - I think it is absolutely one of the challenges with national health reform. I am happy to put on the record in any environment that I actually believe that the eventual end point of this has to be a single deliverer of health services. Rather than having the Commonwealth here and the State here, I think the pathway we need to head on is actually about single cells to stop, exactly, the concern that you have, and that we will be ending up funding hospitals for throughput and then no focus on how we engage in keeping people well and managing community services. What we will have as the State, as our responsibility as the manager of services, we will be determining what we wish to buy from the LHNs but we will also be ensuring within that that there is a focus on things other than just surgery; that is about the other things that we would like and w want to purchase from them, which is the engagement around allied health and community health and those sorts of things. The issue that we still have is that the national pricing authority is still developing what that means.

Ms FORREST - How will the activity based funding model encourage collaboration and integration of acute and primary health services to ensure that patients are treated in the most appropriate location?

Ms O'BYRNE - They are the engagements we need to have with the Medicare locals because the risk is that there could be a cost shift between the primary and acute care sector, but we are looking at those partnerships for an integrated care service.

Ms FORREST - We still have a layer of Medicare over the top of this?

Ms O'BYRNE - Alongside it rather than over the top of it.

Ms FORREST - If it is alongside it how are we going to avoid this cost shifting and the gaps you create when you have two -

Ms O'BYRNE - They are the conversations that we are having at ministerial council level at the moment, to ensure that it does not become a separated system. It is a separated system now, but we want to see that integration work and that throughput work. One of the things for Tasmania that makes it easier is that we have, already, an individual patient record for every patient. So we are in a position to track where their engagement points are, and as we develop the IT programs that we are developing, we should be able to track whether or not there has been an inappropriate shifting in terms of costs around the services that they are offered. But my conversations with the Australian Government are that Tasmania stands absolutely willing to trial for them, in advance of the other States, an integrated health care service whereby we do not have

primary over here and acute over here. We have had some initial conversations around that but it is a big step for the Commonwealth at this point. But we think that Tasmania is ideally placed to trial a proper integrated health care model because that is exactly what it should be. I am not territorial at all. If the Australian Government wants to take over health care or they want to absolve themselves from health care, that is find. But I think you need a single model because, otherwise you always run the risk of that shifting around. But that risk exists now, not just into the future.

Ms FORREST - It has been suggested that the proposed funding model may also exacerbate inequities. For example, if the Commonwealth is only required to grow hospital funding in proportion to the degree to which the State grows them then Tasmania, with its limited opportunities for future growth, might be relatively worse than the other big States.

Ms O'BYRNE - That is a discussion we are having with them about the different costs in regional areas and the block funding. But, also, that is what our commissioning work is about because we want to purchase not only surgery, we want to purchase those other health initiatives as well.

Ms FORREST - How will the activity-based funding model impact on each major hospital in terms of administrative costs, time and impact on the budget, reliability of predictions of activity and how will this impact on allocation of resources?

Ms O'BYRNE - That is the transition work that we are doing at the moment. This is nationally becoming a challenge about how you would code every service that is provided in the hospital. It is not just, I am going pay for the hip. When somebody came in for the hip, they use a bit of pathology, this bit of whatever part of the hospital and we need to be able to code all of those things. That is the work that is going on now.

Ms HOLDEN - We have been doing this work for quite a long time. It is not new work because we could see that we need to be accountable for how much we spend on each output or DRG that we deliver. So it is not new work going on, it is current work and, in fact, we are looking across the whole of the State to build something that is an intelligence that we can all share, so we are not going to duplicate or triplicate that work, we are going to try to do it in one business intelligence unit. So it is not new work, it is work we are already doing and it is based on a discharge code, which is a process we already do now as well.

Mr KIRWAN - In part, what Jane has indicated is right. It is in our best interest to understand what our costs are, how they compare in respect to a statewide average and the national average. We have a potential disadvantage in regional and remote areas because we need to also identify why there is a cost difference and if it is fair, because if it is not, we have to address that. That is part of how we are going to address the $100 million, because if there are costs that are unexplainable, be they through inefficient purchasing or individual, clinical decision-making that is relatively exotic or high-cost, sometimes they are right and sometimes they are not. That allows us to do that.

There is a lot of work being done by the department. The activity-based funding in respect to education of our staff and others. It is not new to staff who have come from other jurisdictions where it is something they are used to do, particularly New Zealand, Victoria, Western Australia and South Australia at various stages. So it is not new for some of those people.

For inpatients it is very good. For other areas, ED, it is yet to be proven but there is a model in place. We are particularly interested from a regional perspective for teaching, training, research and development because we think we could be winner in that exercise because of some of the hidden cross-subsidisations that are in the system which will be become transparent. In respect to going forward in the future, it really does allow that.

It really is not all that different to what we do in some other areas, as Jane has already indicated. We do need to understand the algorithms and what informs the algorithms, but we also need to understand what else we have in the system and that can help inform both future capital works and other areas. It also allows us then to be very clear about what service and service delineation we have rather than it being a responsive-based model, which is what it is now.

Mr AUSTIN - This year we will run a shadow budget of the ABF model so that we can see how it will impact us and what changes we need to make.

Ms FORREST - So that is really an unknown at this stage then?

Mr AUSTIN - It is not an unknown. We have data already but we will feed that into the budget to measure the impact.

Ms O'BYRNE - The other aspect is that the local hospital networks will be governed by legislation that needs to come to both Houses. We are in the final stages of getting that together. That will have to have some community consultation and pass both Houses as well. Just as a bit of a model, most States have modelled theirs on the New South Wales legislation, because the Commonwealth have indicated that New South Wales is the one they like. Everyone probably has some subtle differences based on the way their States operate. We will have the draft legislation out as soon as possible for consultation.

Ms FORREST - How does that then sit with your discussion with the Commonwealth to look at a fully integrated primary and acute health care model?

Ms O'BYRNE - They are conversations that we are having with them and would like to progress. But we have to pursue an LHN structure that will sustain any kind of variation into the future because we do not want to be amending the legislation every time we make some kind of progress in health reform. So the legislation needs to be able to be adapted to whatever the circumstance is that we are operating within.

Ms FORREST - New South Wales is a very different State from Tasmania, so it will need looking at very carefully.

Ms O'BYRNE - Every State and Territory is doing it slightly differently based on the variations within their own State or Territory, but most of them have based it on the first legislation that was done that the Commonwealth endorsed, which was the New South Wales work. But everything will be slightly tailored to individual States' needs.

Mr WILKINSON - Just quickly looking at medical services in the forward Estimates, we have a $34 million increase; then $2 million the following year; then $16 million; and then a $2 million increase. Under medical services in the forward Estimates, this year it is $381 million, next year $383 million, the following year $399 and a bit, and the following year nearly $402 million. Are you able to give me some idea as to how that is arrived at?

Ms O'BYRNE - Part of it is salary and non-salary indexation, but also it is to do with the money around the national health reform and some of it also will be things such as the work in getting LGH's new acute medical unit and emergency area. We have changed the way the business is done as well.

Mr WILKINSON - I understand that is the $34 million increase for this year. But then you go down for an increase of only $2 million, then you go to an increase of $16 million and then back to 2 million. It seems a bit like a roller coaster.

Ms O'BYRNE - A lot of those projections are based on the draft projections for demand that we have got from the Australian Government, the ones that are up for review at the moment, is that correct? Yes.

Mr WILKINSON - Good.

Ms FORREST - I have a couple of other questions under medical services. You mentioned earlier about the Mersey Hospital arrangements being signed off. The budget papers note an additional $5 million from the Commonwealth to fund the Mersey. How much is the total amount now allocated for that?

Ms O'BYRNE - We are about to sign the contract for the Mersey. I can publish those figures once we have actually signed with the Commonwealth. We have to do an agreed announcement with them. That is where I am with that. I might be able to sign it at lunchtime and then I can come back and tell you; otherwise I will probably get it by the end of the day. Then there will be a joint announcement with the Commonwealth about the randomness of it, but I can safely say there is no reduction in funding.

Ms FORREST - So you will be able to identify the total amount on an annual basis?

Ms O'BYRNE - Yes. One of the things that we were pushing very heavily for was indexation as well.

Ms FORREST - So far as north-west cancer services go, when are you expecting that report from the expert panel?

Ms O'BYRNE - I think I will get it in July – no, at the end of June, so any day now I shall have that report. And then from there we are also providing it to the Australian Government. It will then determine the Health and Hospitals Fund.

Ms FORREST - So that funding is safe in there?

Ms O'BYRNE - We have quarantined our part of it in the infrastructure fund within Treasury. So our part of it is fine. The Commonwealth's money sits within the Health and Hospitals Fund. But certainly I have not had any indication from the Commonwealth of their backing away from the commitment to fund the service. The question has simply been that we have put this panel in, because there was a concern in the community that our timelines were not necessarily what the community thought they should be and we agreed to an independent process to identify those.

Ms FORREST - The member for Braddon would be lynched if any funding was lost.

Ms O'BYRNE - I do not think there is any intention of removing funding. I would be very surprised if the committee came back and said not to do it. I think they are accepting that there is certainly a need to do it. But all of the other work - the chemo chairs and the other cancer facilities - I understand are all on track.

Ms FORREST - Minister, of the $11 million allocated over three years to provide access to emergency departments, how much and on what were last year's allocations actually spent; and how and where will the allocation be spent this year?

Ms O'BYRNE - It is implemented from 1 July and will be given to the area health services in their budgets that we will finalise before the end of July.

Ms FORREST - I thought this was announced last year. This is not the same money; this is different money from last year, is it?

Ms O'BYRNE - This does not come in until 1 July, does it? If I can invite Alice to respond.

Ms BURCHILL - We received $16.6 million for the emergency department and that was for the last three years, and that comes to the end at the end of June. There is another $11 million that comes in this year for the next three years and it has been allocated to the area health services from 1 July.

Ms O'BYRNE - Did you want a breakdown of the 16?

Ms FORREST - Yes, I am interested in what has been spent so far and what we are going to spend now to improve productivity and improve access. That is the whole purpose of spending this money, I understand.

Ms O'BYRNE - There is a whole list of projects that we have been doing and in particular managing throughput and getting people out of the patient discharge units and all those sorts of things. We can get all that for you.

Ms FORREST - In each area?

Ms O'BYRNE - Yes, we can provide that. I am just checking whether we can get that today? I am conscious never to give the committee the indication we will have something by the end of the day if it is going to take us a bit longer.

Ms FORREST - With regard to the funding for the subacute beds, the $37.3 million, when it was first announced it was $37.3 million and this is another lot of funding - I might be confused here. But now in the budget papers and in the Premier's speech, she mentioned $35 million being allocated to subacute beds. So I am wanting the same information about this aspect.

Ms BURCHILL - We have been allocated money to open 30 extra subacute beds across the State.

Ms FORREST - Where will they be?

Ms BURCHILL - We have not decided that yet. We are hoping it is 10 north, 10 north-west and 10 south -

Ms O'BYRNE – That is generally. There will be some variations.

Ms FORREST – Thanks, Chair.

CHAIR - Minister, it might be an appropriate time to adjourn for lunch, unless you have something else pressing to tell us.

Ms O'BYRNE - That is fine. There is some additional information, but I can provide it when we come back.

CHAIR - We will resume on 1.3 surgical services when we come back at 2 o'clock.

Mr WILKINSON - Can I ask a question now and people can think about it over lunch. It might be easier and then you can come back with an answer. How many unfilled doctor positions are there across the hospitals at present?

Ms O'BYRNE - Do you mean unfilled entirely or staffed with locums?

Mr WILKINSON - Just unfilled entirely.

Ms O'BYRNE - Senior or junior doctors?

Mr WILKINSON - Both. And second, what is the latest in terms of the incidence of infections in our hospitals? Do you keep any statistics on these and how does it compare with previous years?

Ms O'BYRNE - I am really happy to talk about that one.

Mr WILKINSON - Can I put you on notice for after lunch?

Ms O'BYRNE - They will be the questions that we answer when we come back and we will all be ready for them.

CHAIR - Thank you. The Committee will now adjourn for lunch.

The Committee suspended from 12.59 p.m. to 2.00 p.m.

CHAIR - Thank you, Minister, we will start the next session. I think you have some information.

Ms O'BYRNE - If I can add some answers to questions that were asked previously about the doctors' vacancies that we are apparently recruiting for. At the Southern Tasmania Area Health Service we have one specialist; at the Northern Area Health Service we are looking for five, one registrar and four specialists; and at the North West Area Health Service, 24 - one intern, five residents, two registrars and 16 specialists.

The other issue was to do with the local costs for actual units: Launceston General Hospital at the end of 2010 was $4 920 050 and in 2011 was $3 411 122; North West Regional was $2 828 541 and in 2011 was $3 156 726; Royal Hobart Hospital was $3 109 336 to $3 394 380; and the Mersey, which of course is a Commonwealth Hospital, from $5 846 523 to $6 913 592; which, overall, is a variance of just over $1.2 million year to date.

I have some information on ED funding allocations.

CHAIR - If you could table those.

Ms O'BYRNE - On the infection control rate, I will invite Dr Taylor to the table for this. What I want to tell people is that we have actually led the nation in collecting data on infection control and management. This is not an attempt to name and shame hospitals or parts of hospitals, it is about engaging people in a broader understanding of the risk of infections. We have data now that we have historically not been able to produce. If I can hand over to Dr Roscoe Taylor, the Director of Public Health.

Dr TAYLOR - Thank you, Minister. The Tasmanian Infection Prevention and Control Unit now publishes on the web the quarterly hospital or health care-associated infection data and I can table that document which contains significant information. As the Minister mentioned, we now identify the Royal, the Launceston Hospital, the North West Hospital and the Mersey in that data.

The Tasmanian rate of health care-associated staphylococcus aureus bacteraemia is 1.51 cases per 10 000 patient care days. We talk about the rate per number of patient care days. This rate of 1.51 is comparable to other Australian States. That is significant because that particular infection is associated with roughly one-third mortality. The rate has declined significantly from several years ago when a hand hygiene initiative was introduced across the hospitals.

Ms O'BYRNE - It was a good idea that came from the hospital floor. There is a gentleman in one of the hospitals whose idea it was.

Mr WILKINSON - Was that to wash your hands?

CHAIR - It did not come from the floor, surely!

Ms O'BYRNE - No, using the hand pumps, having the hand pumps distributed widely around the hospital, rather than just in nurses' rooms and doctors' areas.

Dr TAYLOR - Another measure of health care-associated infections is clostridium difficile infection, which is a particular type of bacterium. The rate of that is 3.56 per 10 000 patient care days. It is hard for us to compare that rate with interstate hospitals because of different ways of measuring but in general it has been lower than or comparable with the published rates from the rest of Australia or internationally.

Hand hygiene compliance has improved from as low as only 35.5 per cent of hospital staff washing their hands at all five moments of care, before seeing a patient and during and after and so on, and now it is up to 64.1 per cent of occasions that they are witnessed to have hand washing at the right five moments.

Ms O'BYRNE - We have some really good posters in hospitals that advise the patients it is okay to ask if your doctor has washed his hands, to give patients the implied authority that it is okay to check on those kinds of things. It is about changing cultures and behaviours.

Dr TAYLOR - Very much. There is still room for improvement with the hand hygiene data but it is also the case, I am afraid to say, that the medical profession is lagging behind their nursing colleagues and others in the frequency with which they wash their hands.

Ms FORREST - They do not like being asked, either, do they?

Dr TAYLOR - The final measure was the vancomycin resistant enterococci infection. We count that in numbers rather than rates here. There were only four reported in Tasmania during 2010.

CHAIR - Thank you.

Ms O'BYRNE - Can I table as well the consultancy terms of reference for the Service Development Planning Specifications Study Requirements - Fact Finding Emergency and Medical Services.

CHAIR - Thank you very much.

Ms O'BYRNE - I formally table as well the Tasmanian Acute Public Hospitals and Health Care Associated Infection Surveillance Report and the Tasmanian Health Care - Associated Infections - Common Questions and Answers for Health Care Professionals.

Mr WILKINSON - Minister, can I ask you two very quick questions. First, the Launceston general car park, we talked about construction continuing on the $15 million car park at LGH and also the redevelopment of the hospital car park at the North West General at a cost of $4 million for an expansion of the car park. So we have $19 million stretched over those two for car parks. One could argue: should the money be spent elsewhere, if it is spent at all?

Ms FORREST - Have you tried to park there?

Mr WILKINSON - No.

Ms O'BYRNE - There are slightly differing stories for each. If you are familiar with the Launceston parking area, we have a substantial problem with getting people access to the hospital there. John Kirwan may wish to talk to that particular project. I think we have opened up the first

area for staff, staff are accessing the first area now.

Mr KIRWAN - That is correct.

Ms O'BYRNE - It has been a significant problem.

Mr WILKINSON - For staff?

Ms O'BYRNE - For staff and particularly for people visiting, because staff tend to take every available park in the surrounding streets, which of course impacts on residents.

Ms ARMITAGE - An on-street problem for the residents, as you say.

Ms O'BYRNE - Yes, it is a challenge for the residents. Also, if you are coming to visit, there is very little term parking that people have been able to access. John might be able to talk about where we are with that. We can explore some of the conversations we have had about the North West which might be might be of interest.

Mr KIRWAN - Thank you, Minister. The LGH is an inner city hospital site and also the largest employer on the north of the island, so parking is at a premium. It is an area of complaints from the local residents, from the council, from staff, from visitors and from patients. Often we have patients who are delayed, who then get parking fines, so it is a really significant issue. The government agreed to invest $15 million in two stages. The first stage, which is just over an extra 100 car park bays, is now complete and is open and is being used by patients of the Holman Clinic and staff. The second stage, the tender is about to be announced by the Minister; I have been told it will be tomorrow. That will give us an additional net 400 bays, once that is completed.

We are also in the process of preparing tender documents for the management of the car parking. It will include us charging staff for parking for the first time. All we can say is that at an inner city hospital site, parking is an issue. We have explored the public transport options, but that is not particularly popular.

Ms O'BYRNE - We have trialled a number of different park and ride opportunities because of the nature of the engagement.

Mr KIRWAN - This should give us capacity into the future.

Ms O'BYRNE - The discussion we need to have in the light of the Budget, which is one we are having at the moment, is what will happen in terms of the car park: do we look at a private person managing it or managing it ourselves, and the ramifications around that, in order to minimise cost but also to ensure that the service can be sustainably provided.

Mr WILKINSON - Some might argue that it is a significant amount of money to pay in these times, $19 million, for car parks.

Mr MULDER - Can I suggest that the question to be asked is not the need, which is the answer we keep getting, but the timing of it. Is this a time where perhaps we need to delay ratification, if you like, because of the circumstances in which we find ourselves?

Ms O'BYRNE - This is why we had the conversation that Gavin and I might be able to have with you now about the North West. The reality with Launceston is that that pathway had already been established and there are additional costs to stopping and restarting the program now, which would mean we would end up paying a lot more over the time.

Mr KIRWAN - Through you, Minister, the approval process was a couple of years ago, hence the comment that you might take a slightly different perspective in the current economic climate. However, it should be made unequivocally clear, without putting the new member for Launceston on the spot, that the council indicated that if we wished to go ahead with the other developments on the site without addressing parking, there was every chance our development approvals and others would probably not - and probably rightly so - have been approved. We are a landlocked site and parking did have to be addressed. The council, who has been exemplary in this, both in respect of the speed of approving our development approvals and putting up with ongoing issues, has been excellent.

Ms O'BYRNE - The North West is a different case in point. We have had some preliminary conversations around this. It is a two-stage development and there may be merit to doing the first stage but then delaying the second stage until such time as it is required. We certainly need to do the first stage in relation to access to the cab facilities and those areas. Gavin can speak to that. I hasten to add, no decision has been made. But exactly on your point, Mr Wilkinson, we are re-evaluating every one of these and that conversation is taking place.

Mr MORGAN - Anyone who has tried to get a car park at the North West Regional Hospital would be aware of the issues that there are; people are triple parking. As you have highlighted, the need is certainly established. The council has banned parking on one side of the adjacent streets from the hospital, so that there is a thoroughfare for the public, from a safety point of view. The North West Regional is looking at phasing the car park over two stages, so that we can get the savings you are talking about.

Ms O'BYRNE - Certainly, with ongoing management of them, it may be there is a management option that will recoup our investment cost, and we are exploring all of those opportunities right now.

Ms FORREST - Through you, Mr Chairman, one would suspect that part of the problem which is compounded at the North West Regional was the fact that the North West Private Hospital is charging.

Ms O'BYRNE - They have free car parking.

Ms FORREST - They are charging.

Ms O'BYRNE - Sorry, they charge, and people who are employed by them or who are visiting do tend to come over and use our facilities.

Ms FORREST - They come across the road.

Ms O'BYRNE - Yes.

Ms FORREST - That is part of the plan, is it, to consider charging for parking?

Mr MORGAN - We are considering it.

Ms O'BYRNE - One thing we have always talked about is that there would be options for charging.

Mr WILKINSON - That is consistent interstate, is it not? I have visited people over there myself in recent times, and if you park within their own car park you have to pay for the car park.

Ms O'BYRNE - Yes. There are things we can do for staff around how they manage, such as quantifying the cost of how much they might spend on parking, for their own taxation issues. There are different things we can look at in that space.

We have committed to these projects. There is some capacity to possibly slow down the second stage of the North West, but the first stage is crucial. We are prepared to countenance any other option that might recoup to us the value of the costs. We need to ensure that we can have a sustainable pricing mechanism as well, because we do not want a private operator taking over and charging so much that absolutely nobody uses it, and then we would be back in exactly the same trouble that we were before. We have put those on the table for discussion as well.

CHAIR - We are done with car parks and will move on to 1.3, surgical services.

1.3 Surgical services -

Ms ARMITAGE - Obviously, with surgery, we have waiting lists and the fact that Tasmania has some of the worst outcomes in the country is nothing against the north, it is Tasmania-wide.

The output provides emergency and elective surgical services, including services contracted to the private sector and surgical outpatient clinics. Minister, can you advise which services are outsourced and what is the cost of the surgery that is outsourced to private hospitals?

Ms O'BYRNE - We have partnerships with private hospitals, and have had for some time, especially in relation to cataract surgery, and long waiting minor surgical cases. I think we had 652 patients admitted to private hospitals for surgery between 1 July 2010 and 30 April 2011. At the Launceston General Hospital almost all of the cataract work is done by the private facility that is down the road.

Mr KIRWAN - Yes.

Ms O'BYRNE - In a way, this is one of the challenges for smaller jurisdictions under health reform, that the national health reform agenda does not necessarily reflect for jurisdictions like Tasmania the codependency we have with the private sector. There are spaces that, if we were in the space, we would deliver an inexpensive service, which would mean the private service would no longer be viable in its own sense. I do not know if you want to add to that, John, in terms of the Launceston experience, while I get the data.

[2.15 p.m.]

Mr KIRWAN - Through you, Minister, the only private surgical work we have done is at the Launceston Eye Hospital, which is a range of ophthalmic work. We have a contract with them which is coming up for renewal next year or later this year. That has been a longstanding model and they provide a good service to us. They provide also the surgeons to work with us on our eye emergency department and areas like that.

In other areas we do not contract out any surgical work to Calvary, which is the only private hospital in Launceston, however we contract out some pre and postoperative care on occasions, either under the care of the surgeon or under physicians, particularly when the hospital is full. We will redirect work from the emergency department if people are privately insured, again if we are full, for them to have the work done. But at that stage they are private patients with a private doctor, so it is not actually public work.

Ms O'BYRNE - It is important to recognise that if you present at a public hospital, we ask if you have private insurance and if you would like to use it, but we cannot under the legislation compel people to use their private insurance. That is an issue that is raised regularly as a cost saving mechanism but it is something that is not in our hands.

Ms ARMITAGE - That is a bit unfortunate, is it not?

Ms O'BYRNE - Yes and no. I guess it would be great to get paid for it all but in Australia we have a universal health care system so we also commit to people that they will get the service.

Ms ARMITAGE - Through the Tasmanian elective surgery improvement plan, I notice that in 2009-10, if you look at page 5.11, the percentage of improvement from 2009-10 did not hugely improve, so the improvement is short-lived. Going back to the target for 2011-12, it will be lower than it was for 2008-09. It got up to 77 per cent in 2009-10, 80 per cent in 2010-11 - category 1 is the only one we are mentioning - but in 2011-12 it will go back to 71.7 per cent. Would you consider that the initial $8.4 million to improve elective surgery access in 2009-10 has delivered outcomes, when you consider that they are not ongoing outcomes, they are going back?

Ms O'BYRNE - I am sorry, I was having a conversation as well. We are looking at the jump to 80 per cent and then down to 71.7 per cent?

Ms ARMITAGE - Yes.

Ms O'BYRNE - This is a conversation that took up a little bit of time in terms of those sorts of targets. They were determined to be targets, and I guess the question was whether or not they were sustainable or achievable targets, given the throughput. We believe the new 2011-12 target is probably more appropriate to where we believe they are going to be, where the demand is going to be.

Ms ARMITAGE - It was more because on page 5.12, in the second paragraph it refers to the amount of money that has been spent to improve - sorry, it is elective surgery.

Ms O'BYRNE - Yes.

Ms ARMITAGE - Do you consider that money has been well spent? Also, further down, it says that Tasmania is achieving all but one performance target. What was the performance target that was not achieved?

Ms O'BYRNE - The one we did not achieve was to do with the volume or the number of patients waiting.

Ms ARMITAGE - The question would be, in the public hospital system, with the amount of

surgery in categories 1, 2 and 3 and the people coming through, is there much room for elective surgery in a public hospital?

Ms O'BYRNE - There is. There has to be.

Ms ARMITAGE - Is there going to be time for elective surgery to be done? The question is, with the amount of work coming in, with accidents coming through A&E, filling up the theatres and the recovery rooms, how does elective surgery put itself into place when you have urgent cases that are coming in, in categories 1, 2, and 3, particularly in categories 1 and 2?

Ms O'BYRNE - Categories 1 and 2 can be elective surgery as well; they are not necessarily category 3.

Ms ARMITAGE - How often do they occur? You would have so many category 1s, I would assume.

Ms O'BYRNE - I'm sorry, I am struggling a little bit with what you need me to answer. I am not trying to be obtuse.

Ms ARMITAGE - That is all right. We will go back to the second paragraph, to do with elective surgery and the money that has been spent on it.

Ms O'BYRNE - We are making improvements to our elective surgery work because of a number of programs we have put in place. We recently completed an elective surgery waiting list reduction plan, where we achieved and exceeded the median number of days within which 50 per cent of patients were admitted, and the 90th percentile represents the number of days within which 90 per cent of patients were admitted. That was a target set by the Commonwealth.

We are certainly making ground against the elective surgery and it has been through some of the work that is different. For instance, in Launceston - I am sure John is about to tell you this - the day surgery unit that we have implemented has allowed us to increase the level of throughput. So it is about changing the way we have done business around it. I think we can get through 50 patients a day now at the LGH. We do not use bed numbers any more, because the bed might be used several times - cleanly, obviously, Mr Wilkinson. We are getting through 50 in a day, of that area.

In Hobart, the opening up of the additional theatre has allowed us to make some progress in elective surgery.

Ms HOLDEN - We have dedicated acute bed space so that the elective surgery can go through without bumping patients off the list.

Ms O'BYRNE - We have dedicated some of the theatres to be predominantly for that acute space.

Ms FORREST - Without bumping anyone off.

Ms O'BYRNE - That allows us to have that channelling through of the elective list. Bearing in mind one of the challenges of elective surgery is that there will be occasions whereby the demand coming through emergency through any kind of accident will throw out the list, and that

does happen.

Ms FORREST - Or an elective surgery case becomes much more complicated than anticipated.

Ms O'BYRNE - That is true.

Ms FORREST - That can bump others off end.

Ms O'BYRNE - Yes, that can happen as well. The other thing is we are always cognisant that a lower level elective surgery case may be on its journey to becoming an acute case if we do not take action, so there is that competing demand there.

Ms ARMITAGE - The other questions I have are regarding the department of surgery particularly - and I am sure this is across the board, not just at the LGH. It was mentioned to us, Minister, on Friday by Professor Onoda, regarding mental health and dentistry taking surgery time or filling up recovery rooms.

Ms O'BYRNE - Professor Onoda has a particular view about dental surgery.

Ms ARMITAGE - The view was there was no funding coming in for dentistry through the surgery and also for the ECTs that were being done. While they may not be taking up a theatre with the ECTs, they are taking up a recovery room and also the anaesthetist, whereby surgery cannot be going on because there is a recovery room full of patients from an ECT, so the other theatres cannot be used. Is there any thought to extra funding for those areas that would be coming into the department of surgery?

Ms O'BYRNE - At the moment we are very much trying to manage the costs around the services we are currently providing. We have had some changes around the adult occasions of use of the dental service. I guess it is important to point out that this is an area where I have to disagree with Professor Onoda; Professor Onoda and I have some differences. The oral maxillofacial service is provided by a surgeon. The person doing it in Launceston, Daniel Player, is a dentist and a surgeon, so it is a surgical treatment process that is undertaken in the hospital. It is undertaken because there is a dental need. That can be, for instance, a cancer patient who is about to have radiation therapy who might need significant work to ensure that they are able to sustain the radiation treatment as a result of the impact, particularly on jawbones - and there is a technical term for that - or they might, as a result of having cancer treatment, require surgery to manage what may be a crumbling bone infrastructure.

Whilst it is easy to say that dental services should be funded separately, it is part of an acute patient care model as well because it is acute care.

Ms ARMITAGE - Do we have any figures as to how many dental patients we have going through and how many mental patients we have going through the department of surgery, as opposed to pure surgical, as in ECTs?

Ms O'BYRNE - Did you say mental patients as well?

Ms ARMITAGE - Yes, as in the ECTs. Remember, that was brought up as well, that the ECTs are preventing surgery time because they are filling up the recovery room.

Ms O'BYRNE - In terms of the mental health patients, we are providing in each of the area health services additional support around EDs, which is being done differently in each region, to manage their particular challenges, whether it be a staff member involved.

One of the big things that comes back, particularly an emergency around mental health presentations, is that there is a difficulty and a difference of opinion often or a different understanding of the way the treatment might be being offered. For instance, a person might regularly present in emergency with a mental health issue and the care plan that has been crafted for that person in consultation with their psychiatrist and the people who work with them is not to admit them, because often it is to do with a particular behavioural or attention seeking challenge around that. So they can present and not be admitted, and that can be confusing for emergency staff, but it is often to do with the individual care plan.

Ms ARMITAGE - I have some questions to ask you later about mental, but this is to do with ECTs and surgery. It was the fact that ECTs are being done in surgery, which takes up an anaesthetist but also takes up a recovery room, which prevents the theatre being used until the recovery room is empty for the patients to come through.

Ms O'BYRNE - It is still a treatment that requires an anaesthetist, therefore it is still a surgical procedure in that sense.

Ms ARMITAGE - I am talking about the funding for it.

Ms O'BYRNE - In the same way that there is broadly funding for surgical procedures. We do not at this stage - and we certainly will under activity-based funding - have different streams. At this stage we do not have a line item for each particular treatment.

Ms ARMITAGE - You do not provide a stream of funding for it.

Ms O'BYRNE - I think we fall into the realm between surgeons as to what is surgery and what is not. Certainly we fund it out of the broad surgery budget. I am getting nods from all three about that. We consider that to be part of the general surgical throughput.

Ms ARMITAGE - The other question I want to ask you is with regard to the efficient base price that we were talking about with the LHNs.

Ms O'BYRNE - Yes.

Ms ARMITAGE - There was an issue that the price base might be based on an area somewhere on the mainland where they are doing procedures and, as we mentioned previously, they can do them a lot cheaper because that might be all they are doing.

Ms O'BYRNE - Because of certain numbers, yes.

Ms ARMITAGE - What will we do, if that's the case? We used hips before.

Ms O'BYRNE - We have already sought assurances from the Commonwealth that the national pricing authority will also take into consideration a regional variation, that there may be increased costs in regions, by the nature of distance, in terms of getting goods or services to the area but also it could be in terms of the low numbers that might be being done.

The other one that comes into that is possibly neurosurgery. I am not sure how you would ever get an efficient base price - maybe you can and a doctor will find a way to do this - for neurosurgery in a regional community, because it will always be expensive, based on the sorts of things you have coming around. We have asked the Commonwealth to consider not only the regional loading that will need to be applied but also whether some smaller hospitals should be block funded and actual treatment in regional communities might need to be block funded in order to make them sustainable.

Ms ARMITAGE - If the efficient base price came back, for example, at $15,000 for a hip replacement, when we know we can only do them for $20,000 in Tasmania, what would we do?

Ms O'BYRNE - We would need to look at two things. One, is $20,000 what it actually should be costing us? Is there a reason that is justifiable that it costs us $20,000; and, if so, one would imagine there would be a regional overloading on that. We also need to look at it to see whether it is costing us more because we are using more expensive equipment or because we are not doing things smart enough. That is what we need to assess, and we need to assess that across the health services.

Ms ARMITAGE - That would be assessed by the local health network or by the overarching body?

Ms O'BYRNE - The national pricing authority will be setting the prices and we will be having input into that. We need to look at all of the things. If we are the only place in Australia where it costs $20,000, and it is $15,000 everywhere else, we would need to look very carefully at what we do because we are not the only regional facility or regional centre. The national pricing authority is not being set to price us out of the market, it is being set to make sure we are efficient. Obviously we have the challenge of being a regional environment that we anticipate there will be regional costs and we have got a commitment from the Commonwealth that there will be a regional loading around that.

Ms ARMITAGE - It is not anticipated that frontline service staff will be cut with the funding you are looking to save, obviously, with the high waiting times?

Ms O'BYRNE - I am very careful never to rule out any job cuts because I cannot make that blanket decision. But the focus we have is on delivering the instances of patient care that we currently have and having the right amount of staff and the right placement of staff to do that. One of the focuses we are looking at is the right treatment in the right place at the right time. Part of that is ensuring that when a patient comes in we are dealing with them in the best possible way and also at the right place. Do they need to be in an ED ward or should we look at ways that we might support people coming into community facilities or a regional hospital? It is about making sure we give the level of care at the most appropriate place, so we are not seeing escalations and everything fronting up at the most expensive high end need. Part of that is the way we deal with some of the presentations, which are clearly GP presentations, which come to our hospitals. Every hospital has structures now where they are trying to manage those, streaming those people off into other service provision, so that we manage that.

The other challenge we have is a society that is possibly becoming a little more intense in its expectation that everything will be resolved immediately, and we are getting a lot of presentations at hospitals which should not be there. Some of them are because of challenges to get to a GP,

and we accept those, which is why we provide the fast track services for them. Some of them are because people jump from "I have a headache" to "I will go to emergency" without any steps in between. It is also one of the reasons we ran our ambulance campaign, which we will talk about later, which is making sure that people are making the demands on the system at the right level and at the right place so that we are dealing with them cost effectively.

It is compounded, obviously, by a shortage of doctors and an ageing doctors environment, but that is controlled nationally as to where doctors are placed and how many people they can take on in terms of their provider numbers.

[2.30 p.m.]

We are trying to deal with that. We have people who come into an emergency department with a hangover and want to get fixed because they are they are used to getting immediate responses. Generally, they tend to be younger presentations, because we have created a culture of "I have a problem, it must be fixed immediately." Most of us would know from our own constituencies, from our older population that we represent, that the majority of them would not turn up anywhere unless they absolutely needed to.

CHAIR - They are more stoic.

Ms O'BYRNE - They will not ring the hospital or run to the emergency unless they desperately need to.

Ms FORREST - They will take some Panadol first.

Ms O'BYRNE - Yes.

Ms ARMITAGE - They suffer in silence.

Ms O'BYRNE - Yes, they look at all those other mechanisms. But we do have a younger group of population, possibly not with the same kind of family support, who maybe do not know who to ring and ask, who are fronting at emergency, upping the cost, and frankly should not be there. Having said that, I always point out if you have small children and you are nervous, you should always feel safe to go to emergency because children's issues do escalate quickly.

Ms ARMITAGE - Thank you, that is fine. I hope we can make savings in health without impeding the health service patient care.

Ms O'BYRNE - That is absolutely the reason, that is the exact reason we do not have $100 million worth of savings identified already, because I could not make those decisions and we could not make them at a bureaucratic level and guarantee those outcomes. We need that to be in consultation with clinicians and service providers and our community and area hospitals, to ensure that the decisions we make are sustainable. Because if you turn off something in health, you have to be damn sure it was the right thing to do, because it is extremely expensive to turn it back on again.

Ms ARMITAGE - Thank you.

Ms FORREST - I would like some data, Minister, on the figure related to the amount of overtime and the number of hours overtime across all areas and the cost of overtime. On the

waiting times for surgery, can you provide data showing the waiting times for the various categories of surgery? In the past we have had it broken down into orthopaedic, gynaecological and so on, and how many over-boundary cases do you have in each hospital and each category of surgery?

Ms O'BYRNE - On overtime levels, one thing we are doing is reviewing, as part of the broader program, rosters and attendance, to make sure we have the best mechanism around that, which we hope will have a positive impact on overtime usage. Overtime levels were marginally lower for the final pay period of April 2011 compared to the final pay period of April 2010. Medical practitioners have the greatest percentage of overtime, per FTE of 19.07 per cent at April 2011. In comparison for the same period, ambulance officers were at 12.66 per cent, nurses at 1.63 per cent, those on the Health and Human Services Award at 0.97 per cent and allied health professionals at 0.44 per cent.

Ms FORREST - Can you explain what the Health and Human Services Award category is? Who are the people on the Health and Human Services Award category?

Ms O'BYRNE - They can be everything from cleaners through to orderlies, clerical staff, ward clerks. It is a very broad award.

Ms FORREST - They include some clinical or patient care? Cleaners I consider to be patient care.

Ms O'BYRNE - And ward clerks I would consider to be patient care as well. In fact, to a certain extent almost everyone is.

Ms FORREST - There are some administrative staff who do not have any patient contact or care role in that figure?

Ms O'BYRNE - Who may have overtime, possibly, yes.

Ms FORREST - Thank you.

Ms O'BYRNE - The second issue?

Ms FORREST - The quantum of overtime, how much it has cost?

Ms O'BYRNE - This is the overtime paid per FTE. What I have are percentages and per FTE, which is not the actual cost. We can get that for you by the end of today. Mine is given in a different format, but we can give you the dollar figure.

Ms FORREST - The waiting times for surgery in each category?

Ms O'BYRNE - The number of patients waiting for elective surgery by category at each hospital, which is those who have waited longer than 30 days as at 30 April 2011: the LGH has 13 category 1, 1,343 category 2, 1,335 category 3; the Mersey has four category 1, 55 category 2 and 376 category 3; the North West Regional has two category 1, 105 category 2 and 283 category 3; the Royal Hobart has 467 category 1, 2,475 category 2 and 670 category 3.

Mr WILKINSON - Waiting lists have jumped by 1,400 over the last year. Is there any

reason for that increase of 1,400 approximately and how much, if any, can be put down to budget savings?

Ms O'BYRNE - There is an increase in elective surgery waiting lists. At the Royal Hobart, over the past five years it has been 15.85 per cent; at the LGH 25.82 per cent; North West Regional has dropped 31.95 per cent; and the Mersey has dropped 10.18 per cent. What we are seeing is a change in the median waiting time. Whilst there are more people going on the list, which is primarily due to the ageing population and the comorbidities we are seeing, we are seeing a reduction in the time that they are on the list but the numbers on the list are continuing to grow, yes.

Ms FORREST - That goes back to my question. I was asking about the numbers in orthopaedic surgery and gynaecological surgery, where they sit in that.

Ms O'BYRNE - We have provided that information to you previously, I am sure we can provide it again today.

Ms FORREST - If you have it in a table that you could table, that would be good.

Ms O'BYRNE - You want how many people are on the list right now. The number of patients on the waiting list by specialty, I am reminded we have a reduction in the median waiting time but more people coming on to the lists. Orthopaedics is 2,090, general is 2,039, ophthalmology is 1,506, urology is 699, plastics is 551, ENT is 518, gynaecology is 374, neurosurgery is 223, faciomaxillary is 62, cardiothoracic is 45, vascular is 33, paeds is 21, gynaecology/oncology is 17, anaesthetics is 2 and other is 97. We will get that into a table that is appropriate.

Ms FORREST - Is it possible to break it down into the regions, to see where the biggest net throughput is?

Ms O'BYRNE - We can get that. It will take some time but we can provide that, yes.

Ms FORREST - Yes, especially per region.

Ms O'BYRNE - Yes.

Ms FORREST - The other question is how many out-of-boundary cases do you have in each of categories 1, 2 and 3?

Ms O'BYRNE - We can get that for you at the same time as we get the other one.

Mr WILKINSON - I have a couple of questions on waiting lists. Are you able to say how many people were removed from the waiting lists in the past year, ignoring those who have been operated on?

Ms O'BYRNE - Ignoring those who have been treated, we re-evaluate the lists regularly to ensure that they are up to date. I can get those figures for you.

Mr WILKINSON - All right.

Ms O'BYRNE - Some people move interstate, and there is a whole variation of reasons why people do not follow through.

Mr WILKINSON - Yes. That was going to be the next question. First, how many people were removed from the waiting lists in the past year?

Ms O'BYRNE - Yes, and for what reason.

Mr WILKINSON - Second, can you provide a breakdown of the reasons why people were removed?

Ms O'BYRNE - Yes.

Mr WILKINSON - Third, of those removed, how many were due to death?

Ms O'BYRNE - We can provide that. As part of our management of the elective surgery challenges, we are regularly re-evaluating the lists and ensuring that people are where they are supposed to be on the list. That involves some people staying exactly where they are, some people being removed from the list and some people jumping up the list as a result of conversations they have had with their clinicians. The ones who were removed for the reason of death, surgery provided elsewhere or could not be contacted - 107 people were removed from the waiting list prior to admission because of death.

Mr WILKINSON - Because of death, 107?

Ms O'BYRNE - Yes. Having said that, their death may not necessarily be related to the condition they have, because these are, of course, elective surgery lists. Some 378 have been treated elsewhere, not necessarily as a patient at the hospital that we were advised about, and 12 could not be contacted.

Mr WILKINSON - Are you able to break it down even further to say how many died as a result of waiting for their operation where the symptom caused the death?

Ms O'BYRNE - I am not sure that is necessarily possible but I will see what we can do.

Mr WILKINSON - Thank you. Are you able to provide any details as to whether any operating theatres have been closed in the past year and, if so, why?

Mr KIRWAN - In respect to the LGH, I can answer that. We closed one theatre to create the acute medical unit. That work was moved up on to the fifth floor, so that the net change has not been any reduction. We are currently operating six theatres. In respect to the building works, there was a period of time when it was closed because we simply had to do that. We are currently in the process of rebuilding the fifth floor, which will expand those areas, but that is 18 months away.

Ms O'BYRNE - For the Royal, we have not had any closures; in fact, we have partially opened the ninth theatre and we are beginning to utilise that. The North West have not closed any.

Mr MORGAN - We have not closed any.

Ms O'BYRNE - Has there been any need to with the Mersey redevelopment work at all?

Mr MORGAN - Definitely not.

Mr WILKINSON - The only other quick question in relation to surgery is, are you able to give me the latest figures for surgery cancellations in the past year, and how does it compare with previous years?

Ms O'BYRNE - Yes. From 1 July 2010 to 30 April 2011 there were a total of 2 608 hospital-initiated elective surgery cancellations and 92.2 per cent of those were before the patient got there. The main reasons are to do with running out of operation time at theatre, which is those cases we underestimated the time they would require, and overriding emergencies were 21 per cent.

The other point to make from a public health basis is that we will receive funding under the reform agreement under the national partnership agreement on improving public hospital services as a result of implementing improvements in our elective surgery access, so we are looking at whatever mechanisms we can to improve that access.

Mr WILKINSON - Are we able to have a breakdown of that, if not now, perhaps at a later stage, in relation to surgery cancellations, in which hospitals and why?

Ms O'BYRNE - Royal Hobart was 1,424, LGH 836, North West Regional 253, Mersey Community Hospital 95. That can include advising them, "Yes, we thought you were going to be on the 3rd but now you will be on the 4th or the 5th," so it is not a cancellation but a postponement. Generally, the cancellations are in fact postponements to another date.

Mr WILKINSON - I have been spoken to by a person who was prepped and ready to go and -

Ms O'BYRNE - There are unfortunately those circumstances, yes.

Mr WILKINSON - At about 4.50 they were told, 'Sorry, you have to go home again,' after the husband took the week off work.

Ms O'BYRNE - I know. As much as possible we try to manage those before anybody gets there but the reality of running an acute care system is that there are times when the acute care system takes precedence and that does happen. We try to manage it as much as possible.

Mr WILKINSON - Are you able to say how many of those there were of that type of example, when people are there in hospital, ready for the operation?

Ms O'BYRNE - It was 7.8 per cent of the numbers that were admitted to hospital. I do not have a breakdown of whether they were day surgeries or shorter surgeries.

Ms HOLDEN - That is about right, 7 per cent of patients admitted and about to go to surgery, for some reason have their surgery deferred from that admission to another one.

Ms O'BYRNE - The average delay from the date you might have been given to the date you

actually get is about 33 days. On average we get through it extremely quickly.

Mr WILKINSON - I understand that.

Ms O'BYRNE - It is always a challenge for those families who make arrangements and we try as much as possible for that not to occur. But it is impossible, unless you are only running easy elective surgery all of the time, you are always going to run the risk that a complication occurs, and that impacts on time.

Mr WILKINSON - Am I right in saying on occasions that is because of cost initiatives as well, if they run over time?

Ms HOLDEN - No.

Mr WILKINSON - Are you sure of that?

Ms HOLDEN - I would think that would be a rarity that we would cancel.

Mr WILKINSON - Have you spoken to doctors about that?

Ms HOLDEN - Yes.

Mr WILKINSON - Are you really saying that has not occurred at any stage?

Ms HOLDEN - No, I am not saying that.

Ms O'BYRNE - The only thing might be that anaesthetists have a lot of time constrictions around the hours they are allowed to work and that can be a matter for surgeons but it depends on the individual college. That is more to do with safe work practice rather than a timing issue.

Mr WILKINSON - In other words, if somebody went to a doctor and the doctor said, "This operation is going to take me 15 minutes," and there was going to be an overrun from 5.00 to 5.10, or whatever it was, and the person was prepped and ready to go but was told, "Sorry, cannot do it because it is going to be overtime."

Ms HOLDEN - No, that would not happen. It would be a rarity.

Ms O'BYRNE - There would be another reason for it.

Ms HOLDEN - It could possibly happen if it were going to be until 6.30.

Mr WILKINSON - I am just mentioning a time.

Ms HOLDEN - Yes. We might not want to run an hour or two over, because that means we may have to start people being back on call, and they do not get a 9-hour break.

Ms O'BYRNE - That is a rarity.

Ms HOLDEN - Then the whole of the next day would be cancelled. So that would be more of a reason than someone saying, "I want to save money now," and stop an operation. That would

be very rare.

[2.45 p.m.]

Ms O'BYRNE - If you have a particular instance, we are happy to look at that instance and check for you.

Mr WILKINSON - Okay. The final question is how many people have had their surgery cancelled on more than one occasion?

Ms O'BYRNE - From the first cancellation to completion of procedures is an average of 33 days for it to be dealt with. The number of times cancellations occur, for each patient?

Mr WILKINSON - In other words, one patient has been cancelled on one occasion, advised again and prepared again and cancelled again?

Ms O'BYRNE - Of those 2 608, 1 735 would only be moved once, 609 were moved twice, 195 were moved three times, 60 were removed four times, five were moved six times, four were moved eight times. As I said, on average they are all dealt with within the 33 days, but it might be a shuffling around of, 'We were supposed to do it Monday, we will try to get it done Friday or the next Monday,' and that would count as two dates that you had been given, even if neither of them were used.

Ms FORREST - Some of those could have been because they did the wrong thing, like they ate before they came to hospital, had a Big Mac on the way.

Mr WILKINSON - Or they had the flu.

Ms O'BYRNE - Some of it is because of patient behaviour as well. You can have non-presentations as well, because people have got confused and mucked up their date; I guess that comes within that as well. There is a broad range of reasons.

CHAIR - Minister, how many resignations of doctors or surgeons have there been at hospitals in the past year?

Ms O'BYRNE - We will have to get that information for you.

CHAIR - And a breakdown of the reasons for those resignations, can we have that as well?

Ms O'BYRNE - You do not mean students?

Mr KIRWAN - Can I ask for some clarification, when you talk about doctors and surgeons, given we are all teaching hospitals, by definition our registrars and RMOs and others are on rotation.

Ms O'BYRNE - You mean people who have actually broken contract, is that what you mean?

CHAIR - For whatever reason.

Mr KIRWAN - Are you looking for specialists?

Ms O'BYRNE - Specialists who have moved on, if we can get that.

CHAIR - Yes.

Mr KIRWAN - By definition, we turn people over.

Ms O'BYRNE - There are areas that they all go through pretty quickly.

Ms HOLDEN - One hundred per cent of the juniors are likely to - that is not right, some stay on for periods, but most of the junior doctors in training move every year. You want the senior ones?

CHAIR - Yes.

Mr KIRWAN - That would be staff specialists and MOs, the consultants?

CHAIR - Yes.

Ms FORREST - On the issue of adverse outcomes, patients who have been -

Ms O'BYRNE - Readmissions.

Ms FORREST - Readmissions, unexpected deaths and outcomes that were not anticipated, do you have figures on that?

Ms O'BYRNE - We would have to get that for you. Do you mean directly related to surgery?

Ms FORREST - Yes.

Ms O'BYRNE - As opposed to those who turn up at emergency?

Ms FORREST - No, I was interested in the ones who come into surgery who have adverse outcomes and end up staying longer or being readmitted.

Ms O'BYRNE - Yes, we will get those.

Ms FORREST - Or the wrong procedure?

Ms O'BYRNE - One of the things that will change in the data collections we are doing is to start identifying whether we have a larger weighting of hospital-related infections or adverse outcomes in a particular area. That has been hard to collate historically. That will give us a picture about where we might need to intervene in our practices or procedures or supports around those areas.

Ms FORREST - Are the infection rates in the document that was tabled?

Ms O'BYRNE - Yes.

Ms FORREST - If the wrong procedure was carried out or someone left with an instrument left inside or a swab or whatever, those are outcomes that -

Ms O'BYRNE - We will get those, but we do not think they are massively large numbers.

Mr WILKINSON - Are there many outstanding cases in relation to those mishaps and, if so, how many?

Ms O'BYRNE - One thing that is really interesting to look at, when we were talking about the universal health care system and the single streaming, is that areas that are able to employ not only everyone in the hospitals but all of their primary sector, so they employ GPs as well, are able to manage issues more effectively. For instance, if a particular area had a high preponderance of hypertension that was not dealt with and was ending up as heart attacks, you could go back to the GPs in that area and say, "What do we need to support you with and work with?" So there is really good scope in the integrated health care system for managing a lot of things prior to the emergency sector being involved.

DEPUTY CHAIR (Mr Wilkinson) - Thank you. Any other questions on 1.3?

Mr MULDER - I have one question. It should be fairly short to answer.

Ms O'BYRNE - You say that.

Mr MULDER - It is fairly easy for me to answer, put it that way, but there is a difference between ease and length. In relation to emergency management, from my experience and lots of stories and your own admission, a lot of people are fronting up at emergency management who really should not be there.

Ms O'BYRNE - Emergency departments, or making the phone calls, yes.

Mr MULDER - I am talking about people who are rocking up there and spending Saturday morning there with their kids because their kids have a cold, and things like that.

Ms O'BYRNE - A lot of that is because of access to general practitioners but also we have a community culture that hospital is free.

Mr MULDER - My question is quite specific about the role that paramedics play in triaging, which is basically to separate the cases that need to be there.

Ms O'BYRNE - Yes. We do a triage at the front desk.

Mr MULDER - By whom?

Ms O'BYRNE - There is a nurse triage at the front desk. They are the ones who will determine whether you should head down the pathway to -

Mr MULDER - They will stay sitting around there, even if it is just for a cold.

Ms O'BYRNE - Yes. However, we cannot require people to leave.

Mr MULDER - No. The question becomes, you may not be able to require them to leave, Minister, but you can tell them they are not going to get any attention.

Ms HOLDEN - You cannot tell them that either.

Mr MULDER - You cannot?

Ms O'BYRNE - No, we cannot, but we can make sure they are effectively triaged so those people with greater need are seen first.

Mr MULDER - That is the question I am getting to. There needs to be a capacity to triage at these services.

Ms O'BYRNE - And we do.

Mr MULDER - To turn away those who do not need to be there.

Ms HOLDEN - We cannot do that.

Ms O'BYRNE - We cannot turn anyone away. We run a universal health care system and if someone presents demanding attention then attention they will get. The question will then be when.

Generally, the options are that in all of our hospitals now we have the capacity for fast tracking, which is to send you down a different pathway, so we will not take you into the ED, we will take you to where we have a senior nurse or a practitioner or a doctor or a paramedic in some circumstances who can deal with your area differently. The problem is it is more expensive when people front up to emergency services already, whether it be the ambulance or our EDs.

Part of the conversations we need to start having with the communities is an understanding of the cost of the service. But you need to manage it carefully because we are dealing with quite different client bases. An elderly 87-year-old woman who does not want to be a burden should never feel she should not front because she does not want to be a burden, if she is scared. It is a really careful balancing act. How do you say, "Do not turn up unless you need to," compared to frightening some people who might legitimately need care? It is a balancing act.

When we get to ambulance, a lot of work that is done when the phone calls come into the ambulance service now is about attempting to do that triage first, to explore whether or not there are more appropriate options than dispatching the ambulance. But the end point of ringing the ambulance service is that if you demand an ambulance an ambulance will be dispatched.

DEPUTY CHAIR - We will get on to that with ambulance. Any more on 1.3?

Ms O'BYRNE - We certainly triage at the hospital.

Mr MULDER - I am too frightened to ask any more.

DEPUTY CHAIR - If we can move on to 1.4, women's and children's services.

1.4 Women's and children's services -

Ms FORREST - Minister, how will cost savings be achieved in this area? You have to make savings everywhere, so how are you going to make them in this area?

Ms O'BYRNE - It comes back to our point about how we are working with each of the areas around that.

Ms FORREST - The question is, are there any services that are likely to be discontinued that are currently in place? I am asking two questions.

Ms O'BYRNE - We have not across the state identified a service that we intend to withdraw. They are the conversations we are currently having with all of the agencies and with senior staff, around are we providing the best service and is the cost structure around that service the best that that it can be? It is a little hard to turn away a woman who is giving birth! In most of our areas we are investing in services: Launceston has just increased the neo-natal intensive care area and in Hobart stage 3-4 is the new development of the women's and children's area in order to be able to manage that more effectively. In the north west, I went and looked at the new rooms at the Mersey.

The question is, if we can safely sustain services and from a statewide perspective we are providing them in the right place, that is what we will continue to do. The only place outside of the four big hospitals that we provide maternity services is Scottsdale NESM. I do not know that we provide it at any of the other regions. That is to do with the depth of population, I think.

Ms FORREST - Are you talking about postnatal care and that sort of thing?

Ms O'BYRNE - Yes, we do deliveries at NESM as well.

Ms FORREST - It is a shame that it is not in other parts of the state, but anyway.

Ms O'BYRNE - I have sympathy for that, but it is also to do with the amount of births that would take place and the support that is required around that to get to that level of support.

Ms FORREST - Yes. Smithton people are very good breeders, though.

Ms O'BYRNE - I will not comment on how big your family is.

Ms FORREST - They keep the numbers up from Smithton and the Circular Head area.
On that point, the contract to provide maternity services in Burnie, do you believe it is still value for money, particularly as we are reviewing everything we do? Now that the government owns the Burnie Hospital, and has for a little while now, is there likely to be any review of that, and might we see public maternity services provided by the state?

Ms O'BYRNE - The difficulty is that I have two experts in this field on either side of me now. I will defer to Jane.

Ms HOLDEN - There is a contract for that and that needs to run its course.

Ms FORREST - Is it an ongoing rolling contract?

Ms HOLDEN - Yes, it is, but we are allowed to review.

Ms FORREST - When does it end?

Ms HOLDEN - No, it never ends.

Ms O'BYRNE - There are access points.

Ms HOLDEN - There are periods for us to review and I think the next one is in a couple of years. We are constantly looking at that service and its costs and talking to them all the time about where we see that. You will be aware of the maternity review in the north-west, which is around repatriation, women from east of the Middle River back to the Mersey, to birth safely with low risk. We are looking at making sure that, as it is a fee for service basis, we use it when we need to.

Ms FORREST - As far as the caseload models, where are we at with those around the state?

Ms HOLDEN - In the North West it is a caseload midwifery model at Mersey and it is being considered at the moment at the Royal.

Ms FORREST - No plans for the LGH?

Mr KIRWAN - No.

Ms HOLDEN - It is in place only at the Mersey right now. I know the Royal is looking at it and I am pretty sure you are looking at it as well, but it is only in place at the Mersey Hospital.

Ms FORREST - What level of antenatal service is provided within the community in each region, MSOP and that sort of thing, is that still going?

Ms HOLDEN - Yes, and so is KYM, Know Your Midwife, and the extended midwifery care level.

Ms O'BYRNE - There is also the See You At Home.

Ms HOLDEN - Yes, the See You At Home, so every area has their own model.

Ms FORREST - Every regional area?

Ms HOLDEN - Yes.

Ms FORREST - The west coast?

Ms HOLDEN - No, not the west coast. There is a 50 kilometre boundary but we offer an MSOP service out to Queenstown.

Ms O'BYRNE - And the CHAPS See You At Home program would apply to those as well. We get that fitted in under CHAPS.

Ms FORREST - Yes. The MSOP is just Circular Head, Queenstown?

Ms HOLDEN - Rosebery, they have the service in there as well.

Ms FORREST - And other parts of the state?

Ms HOLDEN - I honestly do not know the answer to that, I am sorry. We can find out for you.

Ms FORREST - If you could find out, to see whether it has been expanded out at all.

Ms O'BYRNE - The CHAPS program is the one that had 97 per cent take-up, and that is the See You At Home program, for everyone when they get home.

Ms HOLDEN - You mean antenatal?

Ms FORREST - Just antenatal, yes.

Ms HOLDEN - Postnatal it is 97 per cent.

Ms FORREST - I have a question on the performance information. Why is the caesarean birth rate no longer recorded in the Budget papers, particularly when we know that caesarean births are quite a bit more expensive than natural birth, vaginal birth?

Ms O'BYRNE - I am not sure. We can probably get the you the data on that. I do not know why it has been changed. I am not aware of any decision that was made to drop that off.

Ms FORREST - At least the perinatal data comes out a bit quicker these days, so you can get to it a bit quicker.

Ms O'BYRNE - I do not think we have had the rates from a number of private hospitals. We have had an increase in caesareans in the public hospital systems in other states. There have been some significant differences.

Ms FORREST - Do you know what the rate is?

Ms HOLDEN - No. We definitely report it but I do not know what it is.

[3.00 p.m.]

Ms O'BYRNE - We will get it for you.

If I can give you the information you asked for, Mr Wilkinson, on the overtime costs. For the Launceston General Hospital it was $5 446 545 for the full year to 2010, the year to date for 2011 is $5 125 128; North West Regional, $1 946 506 to $1 811 690; Royal Hobart Hospital, $9 698 007 to $9 846 936. That is the overtime costs per hospital.

Mr WILKINSON - Thank you.

CHAIR - If there are no more questions on 1.4, we will move to 1.5.

1.5 Diagnostic and pharmacy services -

Mr HARRISS - The increase to the tune of almost 18 per cent or thereabouts is significant in the context of what is happening. The only explanation for it is in footnote 4, that it primarily reflects a reclassification of highly specialised drugs, et cetera.

Ms O'BYRNE - I am sorry, I could not hear you.

Mr HARRISS - The note on page 5.8 of the Budget papers provides what I would suggest is a bit of a sketchy indication as to why there is a fairly significant expansion of the line item in the coming year. Could you give us more details around that?. The note says a reclassification of highly specialised drugs and other acute health services outputs and a bit to do with salary and non-salary indexation. It is a not insignificant increase.

Ms O'BYRNE - Mr Harris, there is a change of accounting practices. We have previously dealt with them in the acute care output groups under medical services and now we are putting them through the pharmacy area. That would account for the bulk of the change. Is there any other information as to the nature of the change?

Ms HOLDEN - No.

Ms O'BYRNE - The primary driver is the volume and the amounts we are using.

Mr KIRWAN - And it would be the impact of the PBS reforms as well.

Ms O'BYRNE - That would not include yet the changes that were announced last week, obviously.

Mr HARRISS - It is a shift in actual reporting?

Ms O'BYRNE - It is just a shift in where we put them, but there is a change that is based on volume and demand for any particular treatment.

One thing is that as we progress our IT and health intelligence we will see a impact on the usage of a number of diagnostic services. Somebody might front at a hospital, whose doctor the week before did a whole series of blood work, then they turn up at emergency and we order the same whole series of blood works. We are hoping, with our change in health intelligence, to reduce the duplication of services for an individual patient. John might want to mention the particular program around that. If you are interested, there is a particular program, but if you are not interested, that is fine too.

Mr HARRISS - I am always interested, but I am conscious of time.

Ms O'BYRNE - If I can do a quick 30-seconder.

Mr KIRWAN - Through you, Minister, there are two things occurring. One is by standardising the assessment processes amongst nursing, medicine, allied health and others, instead of having to redo everything and redo the testing. Some of that is important because it is a teaching hospital and that is how some of the students learn. But where it is not required, particularly when there is a whole range of triages that may well start with the ambulance officer, the GP, a community hospital or a nursing home, we avoid duplicating, and that improves quality

significantly. The new IT systems which we are in the process of rolling out will allow us to encapsulate and self-populate but also to say to the clinician, if there have been tests done recently, "There they are."

Ms O'BYRNE - They may choose to run them again, given the time issue, or they may not.

Mr KIRWAN - Yes, or if they are not appropriate or if sometimes they are not known. Some of this goes to the integrity of who it is. So there are those issues.

Ms O'BYRNE - I am conscious of time, but we believe the systems that are coming online will create some savings in that area.

Mr HARRISS - The only other thing here, Mr Chairman, is there any particular problem with - I presume it comes under this area of pharmacy services - people accessing drugs like morphine on the premise that they are needed for pain management, but maybe not; they are used to address addiction issues?

Ms O'BYRNE - We have in Tasmania an extremely high rate of inappropriate use of schedule 8 drugs. It is a significant challenge for us and one that we have taken on board. A couple of things that we have implemented around that are a program called DORA, which is working with pharmacists. If you, Mr Harriss, went and saw Dr Armitage and then you went and saw Dr Mulder and then you went and saw -

CHAIR - Professor Hall.

Ms O'BYRNE - - all on the same day and got prescriptions filled from each, but Dr Armitage was your regular treating doctor and you went to a pharmacist, the pharmacist under the DORA program can call up your file and say, "That is very interesting, but we notice you have already filled two prescriptions," or, "Is there a reason you did not go to your normal treating doctor?" They can refer back to start managing that.

We have two elements. One is that they are being prescribed inappropriately, and that is a management area we can work with in terms of treatment and support doctors around that. The other is people who are addicted themselves and are managing their own addiction, and there are others who are clearly using it to sell on the common market, in a sense. The DORA program is allowing us to start picking that up now. The problem we had is we have waited for the Australian Government to give us the figures from pharmacies, so it has been three months sometimes before we have realised that Mr Harris has claimed his prescription three times in a week.

There has been an issue of people going from State to State, taking their prescriptions to other states to get them filled, because they know they cannot get them filled at home. We are not allowing that. That is something all States are working on. If you have a prescription from a doctor in Victoria and you come to Tasmania, you need to see a Tasmanian doctor in order to get a prescription.

Mr HARRISS - Do you suspect there may be a significant level of what I would term trafficking by people accessing such drugs?

Ms O'BYRNE - I think that is a safe assumption. It is certainly one of the assumptions we

have been managing our work around, in terms of trying to capture some of the schedule 8 overuse, absolutely. It is the reason we have initiated the DORA program.

Mr HARRISS - How long has the DORA program been in place?

Ms O'BYRNE - Late last year. I will ask Dr Craig White, Chief Health Officer, to come to the table. We are looking at recruiting addiction medicine specialists as well. When we identify a person, it is not enough to say we have identified an addiction, we need to work with that person to try to manage the addiction. I will hand over to Dr White at this point. I think I have covered everything I need to.

Dr WHITE - The information system we call DORA is in part a rewrite of an old system that was used to support the administration of the Poisons Act, which includes opioids. The part we have added as part of the recent work is to get real-time reporting from pharmacies, so that as it is dispensed that information comes back to the database. Over time we will be able to make that information available at the point of prescribing. That is one of the initiatives, to promote the best and most effective use of opioids.

It is a multifaceted problem, of course, with all sorts of issues, right along the clinical and patient chain of use. We are quite a way through an opioid review being conducted for us by the National Drug and Alcohol Research Centre, based in Sydney, to help us look at how we can better manage the use of opioids in Tasmania to reduce the harm, at the same time as making sure that the people who need them for their pain management, for example, are able to get them in a timely way.

Mr HARRISS - When did the DORA program start?

Dr WHITE - It was earlier this year. I could not tell you the month. We are about to go live with the program update, which will speed it up. It was recently launched and it is still not completely finished.

Mr HARRISS - Thank you, Mr Chairman.

1.6 Ambulance services -

Ms O'BYRNE - I now welcome to the table Dominic Morgan, the CEO of Ambulance Tasmania and a recent recipient of a Queen's Birthday award.

Mr MULDER - Congratulations to a fellow recipient of a Queen's Birthday honour. My first question in relation to the ambulance - which I was not going to ask because I did not think I needed to but I think the media over the weekend has suggested I do - are you ruling out the potential of an ambulance levy?

Ms O'BYRNE - There is no paper before Budget committee or on my desk that indicates an ambulance levy opportunity for Tasmania. Certainly it is one that has come up from other sources as a suggestion, and as such I have said that every suggestion will be considered, but we are not at this point indicating a levy for ambulance services.

Mr MULDER - Thank you very much.

Mr HARRISS - You say there is no paper on your desk, but what is your position?

Ms O'BYRNE - No, I am not considering an ambulance levy. No.

Mr MULDER - Her position was she was not considering an ambulance levy.

Ms O'BYRNE - Bearing in mind that I am trying to encourage a culture where everybody feels safe to put up ideas, I do not think I could be convinced of an ambulance levy at this point. Certainly the previous debate we all went through recently indicates that.

Mr MULDER - Minister, I am fairly conscious that, should we have this discussion for another three days, your position would not change.

Ms O'BYRNE - No.

Mr MULDER - So I think we have to take the position as safe.

Ms O'BYRNE - I am conscious that I am asking people to come up with lots of ideas and I do not want to be seen to be killing them off before people suggest them, but that is not one that I think we could sustainably manage; and, if so, it would be of such significance we would have had to have included it in the Budget papers if we were going to do it.

Mr WILKINSON - Which state do you believe has the best ambulance system in Australia? Which state would you look at to suggest that it may well be worthwhile following in Tasmania?

Ms O'BYRNE - I do not know that there is necessarily huge differences between states that would make me say we would unpick everything we did in order to copy something else. I think there are learnings from lots of other states. I have an interest in - but this is not a policy position at this stage - the rapid response, the early response unit work that New South Wales, Victoria, Queensland and South Australia are doing. That is the process whereby, instead of dispatching an ambulance straight away, we might dispatch staff in a different way. I am also quite interested in terms of ambulance location areas - and this is done in some states but not all - whereby they almost have roving teams. They do not have everybody necessarily back at ambulance headquarters but for particular shifts they might place somebody strategically, to manage traffic buildups in peak hour times as well. We know the centre of Hobart is really difficult between 4.00 p.m. and 6.00 p.m., so we might have a couple of ambulances just on standby outside, in order to get them through a little bit faster. I am interested in those kinds of models and they are done differently from state to state.

Mr WILKINSON - It would seem that the model you spoke about, the rapid response, is in four other states.

Ms O'BYRNE - Is it everywhere?

Mr MORGAN - Not everywhere. Internationally it is referred to as the front-loaded model. There is a lot of merit in exploring this. Predominantly the reason is that, just by the very nature of having ambulance crews on a station, physically located away from the vehicle, it takes a number of minutes to get the crew to the vehicle and rolling. Having these rapid response teams - they are known by many different names in different states - effectively mobile when the information comes in, you kill all of that time that it takes a crew to move to the vehicle. You can

back them up with a full crew, if and when it is proven that a crew is needed.

[3.15 p.m.]

Ms O'BYRNE - That also comes back to the triaging issue that Mr Mulder mentioned before.

Mr MORGAN - It is a direct hit on our response performance. It is one of the things that I suspect the Minister will be talking about later, in terms of what we are doing to improve ambulance response performance.

Ms O'BYRNE - These are the sort of things we need to look at now.

Mr MULDER - One of the things I have a particular interest in is the helicopter. Last year there was a $30 million promise in relation to providing a helicopter medical retrieval service, which most of us would know as medivac. You abandoned the promise in the mid-year financial report.

Ms O'BYRNE - Yes.

Mr MULDER - Can you say, for example, how much money was spent before the promise was abandoned, what did we get out of it, and what are we doing going forward, to use a favourite phrase, in regard to dealing with this inevitable problem with helicopters and their costs? The fact is that it does not matter what you have, they are going to be used and have a major impact upon budgets.

Ms O'BYRNE - Certainly that decision on HEMS was a difficult one for the government and it is something that particularly the Premier is very supportive of. It was a difficult decision to make. But in terms of the challenges that we had, not investing in this system was seen as a more prudent mechanism than doing that and then finding we could not necessarily resource the other parts across the service. I am looking for the details of what we expended, because we did an air optimisation study.

Mr MORGAN - It was all under the aeronautical funding and sustainable access. To cut a long story short, the answer to your question is that it is my understanding it was in the order of about $500 000. It included recruitment of some positions that had been redeployed and absorbed into Ambulance Tasmania in our nominal recurrent budget.

Ms O'BYRNE - The work we did in optimisation is still work that we find valid across the service anyway.

Mr MORGAN - And it can be carried forward.

Ms O'BYRNE - It can be used later on.

Mr MULDER - What is it recommending?

Mr MORGAN - The optimal system for Tasmania recommended as a future model was a combination of one fixed wing aircraft and one dedicated helicopter emergency medical service. Predominantly it comes down to the balance of doing our interhospital transfers and medical retrieval work, which generally can be scheduled. Additionally, it opened up a whole area of

latent impact, where we could assist rural and remote areas with primary emergency medical response and getting doctors and paramedics directly to them.

Ms O'BYRNE - We still have access to the police rescue helicopter.

Mr MULDER - You do. I guess that is where the issue comes from. Having been responsible for the police side of the budget at different times in the past, I am wondering what we are doing in relation to arranging for the costs of such a program to be attributed to the agency which has responsibility for activating the helicopter and servicing it?

Ms O'BYRNE - Do you mean do we pay the police?

Mr MULDER - Where do we find the costs of the medivac system being applied to Ambulance Tasmania in the Budget paper, how much was it and what are we doing about doing that?

Ms O'BYRNE - At this stage it is just part of the police contract. When we use it, I do not think we are necessarily increasing the cost because it is a fixed contract.

Mr MORGAN - My understanding is it is a historical arrangement which dates back to when ambulance was part of the Department of Police and Emergency Services at that time. There was a small ambulance service budget that went from health to police. When ambulance left, that budget did not go back with ambulance. I would qualify that by saying -

Mr MULDER - A medical transfer of an interesting and longer lasting aspect than usual.

Mr MORGAN - I will concede the point that I suspect it was nowhere near enough to actually do it.

Mr MULDER - Yes. My other question relates more or less to the issue that became fairly public this year in relation to the private ambulance, and even the St John Ambulance Service. I note in an era where you are battling to try to manage increasing demands upon the emergency aspects of it, here it seems to be that the ambulance service is basically engaged in activity that is driving a private sector person out of the market by taking over some of the roles that they perform.

Ms O'BYRNE - No. If I can clarify that - and I understand there has been a lot of community debate around this - we have our emergency ambulance service and we also have patient transport, which is moving patients between hospitals, the trip home from Launceston to the north-west, those sorts of areas.

Mr MULDER - To finetune your argument, I am not interested in emergency.

Ms O'BYRNE - Yes. I am about to go to the Banscott review.

Mr MULDER - I am interested in patient transfer.

Ms O'BYRNE - I know, but I need to make one point, that there is no point that this impacts on our emergency patient transfer at all.

Mr MULDER - Yes. That was not my question.

Ms O'BYRNE - We initiated the Banscott review which looked at the ways that we might do things more efficiently across ambulance services. It is beholden upon us to spend taxpayers' dollars as appropriately as possible. Some $11 million was made available for a patient transport review by Australian Government and Tasmanian Government money.

One of the things we did through that was to look at the way we dispatch ambulances for interhospital transfers and patient movement. We changed from just somebody ringing up from the hospital saying, "I have got somebody who is ready to go," and us outsourcing it, to having it on one computer system so we could see whether we had somebody who was at the LGH in Launceston and had to go back to Burnie. What happened previously was we would do that as a separate transfer. What we were able to do is say, "We have got somebody from Burnie who will arrive about 20 minutes after your pick-up time, do you mind holding on to that person and we will send them back?" We anticipated some flexibilities from that review, some better outcomes in terms of the usage of the dollars. What we did not anticipate is how large that would be. Whilst Banscott was a very widely publicised review and there was a lot of opportunity for people to be engaged in it, I do not think we anticipated how much work we could do more efficiently. That impacted upon one private provider in terms of the profitability of their program. Having said that, whilst we are mindful of the profitability of their program, we are also mindful of running the most efficient service we can run using taxpayers' dollars.

Mr MULDER - That leads me on to the point that in ordinary nonemergency patient transport, first of all, are you using the same assets, in other words the same ambulances, to do the private as well as the emergency? If not, have you thought about outsourcing nonemergency patient transport, to leave the emergency services to focus on emergencies?

Mr MORGAN - There is a lot of confusion around which bits are which, Mr Mulder.

Mr MULDER - Some of which no doubt you are about to clarify?

Mr MORGAN - Hopefully. One of the key findings of Banscott was that nonemergency patient transport had to be managed as a completely separate business unit within Ambulance Tasmania, so we did that. The second part of it was that the nonemergency patient transport that was managed by the area health services in the north and the north-west should be amalgamated under - it was not called Ambulance Tasmania then - Ambulance Tasmania and it would be dispatched from a single statewide communications centre. The single statewide communications centre was predominantly funded out of Commonwealth funding to improve patient transport services.

n July last year, North West Patient Transport came over. We took on coordination for them in October and the same three crews that we had had there since pre-2009 suddenly took on a substantial amount of the departmental work.

Ms O'BYRNE - But we have not increased the crews.

Mr MORGAN - No, there are still three crews in each region, in Hobart, Launceston and the north-west, as there have been since 2009. There are different modes of transport, like cars and things like that, but the number of crews available to do it are the same. When we took it over and they became centrally coordinated, it had a profound impact. As the Minister said, literally we said, "Can you wait from 10.00 until 11.00, when we are dropping someone off." That had a

significant impact on one of the private providers.

Ms O'BYRNE - There are two private providers we have arrangements with.

Mr MORGAN - Yes. However, I might add that the money that was saved by us doing the departmental patients went straight back into patient care in the north-west.

Mr MULDER - My position is that here you have a nonemergency service and here you have a mixture of departmental and private sector providers of that particular service and you have chosen to set up a model that basically freezes out the private sector.

Ms O'BYRNE - No, we did not choose to set up a model that did so, Mr Mulder. This is the existing model, just running more efficiently. This was always the case.

Mr MULDER - Okay. There was an opportunity maybe to move to a different model rather than this particular model.

Ms O'BYRNE - The independent report suggested we get better at doing it ourselves because that was the most cost effective way of doing so.

Mr MULDER - All right. What I am saying is that maybe we need to challenge that and simply say that where you have a service like yours, which ought to be focused on the emergency stuff, perhaps we need to think about the prospects of outsourcing the nonemergency patient transfer stuff. I know where that happens. I had an occasion when my mother was down here, to discover, when I thought I was running her home one weekend, that I had four people in the car in addition to my mother as we headed up north, because of those sorts of things. Sometimes the government starts to get into things that maybe it does not need to. We will leave that point. We will take it on board and have a look at it.

Ms O'BYRNE - We are happy to look at any of those options whereby there are services that we provide that we do not need to be in but I remain unconvinced that we could do it cheaper externally.

Mr MULDER - It was something being provided by the private sector that was being squeezed out by the fact that you were expanding your services, even if it was more efficient for you.

Ms O'BYRNE - I think it is more efficient for taxpayers' dollars to spend the money more wisely. Effectively we are able to do it a lot more efficiently and I would think that is the sort of thing that normally we should be quite proud of the fact that we are running a better service and therefore not having to have an increased cost on the ambulance budget overall.

CHAIR - Any more questions on the ambulance service?

Mr HARRISS - Mr Chair, I have questions on the very same issues Tony has been addressing. I was scribbling down, as best I could, when Dominic was providing an answer, as to what happened in the north-west. He said, as I recall, 'When we took over the non-urgent patient transfer service last year.' That is the greater ambulance service, if you like, because I presume it was sitting outside the department.

Ms O'BYRNE - It was but it was still a government service.

Mr HARRISS - Indeed it was. You said the same crews took on a substantial number of cases at that point in time.

Ms O'BYRNE - Yes, more so than we thought they would. We got more efficient at it than we thought we would.

Mr HARRISS - Why did this they take on this substantial number of cases? How did that occur?

Mr MORGAN - Essentially, as I understand the previous arrangements within the north-west, if two requests for nonemergency patient transport came in at the same time, they would offer one to the private provider. Obviously, we have been able to reschedule this; the very nature of the work being nonemergency. We have been doing exactly as we said; when they would ring up and ask for a patient at 10.30, we would say, 'We are bringing someone in at 11.00, would it be okay to pick up your patient at 11.30?' By doing that, we realised significantly greater efficiencies out of the departmental nonemergency patient transport staff. The feedback we have to date is, generally speaking, they are much happier to be more active.

Mr HARRISS - You indicated also, Minister, that there was an $11 million joint funding from the feds and the state?

Ms O'BYRNE - We got $9.9 million from the feds over four years for the Tasmania patient transport initiative and we had $11 million allocated to patient transport and accommodation. That gave us the completion of the Ambulance Tasmania communications centre in the state headquarters, which was jointly funded by us; the augmentation of the patient transport service, including that we gave two new vehicles to Cancer Council's transport to treatment service, which was particularly to deal with those north-west patients coming into Launceston for treatment; and the construction of the new patient accommodation near the North West Regional Hospital.

Mr HARRISS - So am I clear in what you just said that there were two new vehicles purchased?

Ms O'BYRNE - No, this is for the Cancer Council, which is a slightly different arrangement. They provide their service. The question was the type of service they were operating at the time, and it came to light in community conversations around the new accelerator services in the north-west. Cancer Council run those themselves and always have done.

Mr HARRISS - But purchased with the funding provided by the state and federal governments?

Ms O'BYRNE - Yes, there was some federal funding for transport to treatment services, yes.

Mr HARRISS - The Cancer Council runs those services themselves.

Ms O'BYRNE - They run them out of the money they get out of the 24-hour walk-around fundraiser, Relay For Life. That is how they run their operations.

Mr HARRISS - What vehicles did they use in the past?

Ms O'BYRNE - They had the little buses they have been using and it was the upgrade of those, as I understand. They are little eight-person transporters which they have been running historically all the time and they do it all around the state.

Mr HARRISS - They had their own vehicles in the past?

Ms O'BYRNE - Yes, they always do.

Mr HARRISS - What have they done with those? Did they need extra vehicles? You have purchased a couple more.

Ms O'BYRNE - I think it is to do with the timing issues around them. They wanted the capacity to not have people doing the one-hour treatment at 9.00 and having to wait until 4.00 in order to get home again.

Mr MORGAN - Generally it is related to a program that is outside of ambulance but essentially it is within the community transport sphere. My understanding is that the Commonwealth money that came to the state for patient transport services was not limited to the government. As I understand it, Cancer Council made a submission to the department to gain some funding for some vehicles that were seeing the end of their usable life and were successful in that, and that represents those vehicles.

[3.30 p.m.]

Ms O'BYRNE - Yes, but that is separate to Ambulance Tasmania.

Mr MORGAN - Yes.

Mr HARRISS - In the last 12 months how many vehicles have been added to the fleet for the specific purpose of non-urgent PTS?

Ms O'BYRNE - For Ambulance Tasmania?

Mr HARRISS - Yes.

Mr MORGAN - There were three wheelchair vehicles provided by the Commonwealth. It did not change crewing or staffing, I might add. All it does is that these vehicles allow us to better plan the movement of stretcher patients alongside wheelchair patients, et cetera, so that we move them by the most appropriate means.

Ms O'BYRNE - But the staffing has remained the same. It is still a vehicle, it is just that it is the appropriate vehicle.

Mr MORGAN - The staffing has remained the same, with the exception of the west coast. When the ambulance transferred over there was a position in the area of health service 4 gardener/driver and we converted him into a local patient transport officer so that the paramedic does not does not come out of the west coast. That is the only change in staffing.

Mr HARRISS - Were there any other providers capable of providing the service which necessitated the purchase of those vehicles that you mentioned with wheelchair capacity?

Ms O'BYRNE - Do you mean in terms of the Cancer Council ones or the wheelchair ones?

Mr HARRISS - No, the wheelchair ones. The couple of vehicles that you purchased which were wheelchair accessible, was there any other provider capable of providing patient transport services?

Mr MORGAN - It would only be the commercial taxi fleet that would have that capability. Neither St John nor ambulance private, to my knowledge, have any vehicle capable of doing that.

Ms O'BYRNE - I do not think they sought licensing for that, that I am aware of, but they may have.

Mr HARRISS - Sorry, what was that, Minister?

Ms O'BYRNE - I have not noticed any representations from them wanting to be in that space but I can happily check for you.

Mr HARRISS - From the other providers?

Ms O'BYRNE - Yes. I certainly have not seen anything but I am happy to check whether they have ever expressed an interest.

Mr HARRISS - Finally, what are the protocols applying to non-urgent patient transport services with regard to what I would term as staffing in the vehicles? For instance, do you require a suitably qualified medical person in the back of the truck rather than just a driver? What protocols do you operate under and what are the qualifications of the staff assisting or total staff numbers in the truck?

Mr MORGAN - There is a general rule that we use two patient transport officers. But if there was a scenario where there was a walking patient in a sedan, for example, then it is suitable for one. The reason we generally have two is that it is a requirement of the workers compensation to use two officers when using the stretcher in the vehicle. That is one of the requirements that we have, that if we turn out a stretcher ambulance there will be two qualified patient transport officers who will use the stretcher at the same time, for patient safety.

Mr HARRISS - Finally, Tony made the observation that it really does sit with most people in the community as a non-core business for a time critical component of the business. Tony made the suggestion to you, Minister, that because it is non-core business, it is something that you ought to lift the load from the departmental spend and let it sit elsewhere.

Ms O'BYRNE - In the end it comes down to the most cost efficient way of delivering the service and that would certainly drive any decision-making we would have around that.

Mr HARRISS - Cost efficient for whom?

Ms O'BYRNE - In the end, somebody has to pay for the service. It is not that the private service - we still pay the private service to deliver the services they do, that still comes from us. It is beholden on us to do things as efficiently as possible from a costs perspective. If they can do it substantially cheaper than us, I am more than welcome to talk to them about that. But if that is

not the case then moving to the private sector for the sake of moving to the private sector is not enough of a reason; you need to be able to show you can deliver a sustainable service efficiently.

Mr HARRISS - Have you undertaken that analysis?

Mr MORGAN - I think what you are referring to is a full cost attribution study. That was undertaken back in the early 2000s. That process took approximately nine months. We undertook in discussions back in January with the secretary of the department that we would do another full cost attribution study. We are five months into that process. It is towards the end of it that it generally goes to an economic impact statement and at that time we will go to consultation with the affected stakeholders. What I can tell you is that the pricing differentials between what the ambulance service would have charged when we did this work versus what was paid to the private provider in the north-west was substantial.

Mr HARRISS - The difference?

Mr MORGAN - The difference.

Mr HARRISS - Yours is a full cost attribution model?

Mr MORGAN - It was based on the ambulance transport fees. The particular provider had a slightly different view on the currency of the current regulated fees and that is why we agreed to undertake full cost attribution.

CHAIR - Thanks, Paul. I do not think Mr Wilkinson has anything on 1.7.

Mr WILKINSON - That is forensic services. Due to the time limits, we should be moving on.

Ms O'BYRNE - I am happy to give you a briefing on forensic services later, Mr Wilkinson.

Output group 2
Community health services

2.1 Primary health services -

CHAIR - We will resume. Minister, would you introduce your people at the table.

Ms O'BYRNE - I welcome to the table Dr George Cerchez, director general practice and primary care, and Dr Craig White, Chief Health Officer, Tasmania.

CHAIR - We will move straight into 2.1.

Ms FORREST - Minister, could you provide the occupancy rates of the regional hospitals to the committee?

Ms O'BYRNE - Yes, we can get that for you.

Ms FORREST - What is being done to address the issue of the shortage of rural GPs, as

noted on page 5.15?

Ms O'BYRNE - Bearing in mind, of course, GPs are entirely the Australian Government's fault. However, we care a lot so we work wherever we can -

Ms FORREST - We work with companies who are not easy to work with.

Ms O'BYRNE - Indeed we do. There is a challenge in replacing general practitioners in regional communities. Their provider numbers are determined by the Australian Government. We work with GP Workforce, now called Health Recruitment PLUS, in terms of the sort of things we might be able to offer some assistance around. For instance, a recent occurrence is the challenges we have had at the Evandale practice over some years. We own the building and are happy to provide the building at cheap as chips rates. We have worked with a couple of providers to try to entice them to stay but in the end these are commercial decisions being made by individual general practitioners. That has been one challenge.

We are currently working on the challenge in relation to the doctor from Brighton who is relocating to New Norfolk. We offered whatever we could to make it tenable for him to stay but he has signed a new contract and is moving to New Norfolk.

The other area we are in in the GP services is the contracts around the west and east coasts and the islands. Down the process of health reform, the Australian Government, being fully responsible for primary health care, will be taking on some more of those responsibilities. But it is a challenge for us as we are not their actual employers, other than those for whom we have contractual arrangements, where market failure exists, and the west and the east coasts and the islands are one of those.

Mr WILKINSON - Is the Brighton clinic still open? That was Dr Rasamak Armeni who is moving to New Norfolk. Will that close down the Brighton clinic?

Ms O'BYRNE - Green Point Medical Service is taking on a fair bit of the work and the extension at Oatlands means they are taking on quite a bit of the work as well. We are actively working with the GP recruitment group about getting another GP in there. Despite media reports, it has the same rural rating as New Norfolk so that should not be a reason on its own why somebody would choose to move.

Mr WILKINSON - He would rather stay if he had his choice, would he not?

Ms O'BYRNE - We did offer him the choice on the same basis but he signed the contract elsewhere.

Dr CERCHEZ - He would not rather stay. He chose to move to New Norfolk, where his wife works.

Mr WILKINSON - I see.

Ms O'BYRNE - We would like to provide support.

Tasmania's rural hospitals have occupancy rates of 34 to 94 per cent, average occupancy of 68 per cent in 2010-11. One of the ways we are looking at managing some of the pressures on our

acute services is by better utilisation of those beds.

Ms FORREST - Can you provide the breakdown of each unit?

Ms O'BYRNE - Yes, I can certainly do that. Do you want a breakdown of the type of beds they are, inpatient beds or aged care beds, or just occupancies?

Ms FORREST - Some only have one sort, but yes.

Ms O'BYRNE - Beaconsfield is running at 84 per cent, Campbell Town 93 per cent, Deloraine 73 per cent, Flinders 58 per cent, George Town 70 per cent, Scottsdale NESM 75 per cent, St Helen's 52 per cent, Saint Mary's 46 per cent, King Island 72 per cent, Queenstown 55 per cent, Smithton 34 per cent, New Norfolk 40 per cent, Midlands 94 per cent, Toosey 77 per cent, Esperance 64 per cent, Huon 63 per cent, May Shaw 86 per cent and Tasman 57 per cent. Some of those smaller percentage rates are very much about the capacity that might be required seasonally in some of those areas as well.

Ms FORREST - The figure for Smithton was 34 per cent?

Ms O'BYRNE - Smithton is 34 per cent, 16 inpatient beds.

Ms FORREST - What is the occupancy rate of the inpatient beds?

Ms O'BYRNE - They had 516 separations, so it is not a not busy facility.

Ms FORREST - No, I am not saying that. I am just wondering what avenues are being pursued to better utilise those beds.

Ms O'BYRNE - Certainly to send people out of the North West Regional into those services.

Ms FORREST - Yes, on discharge.

Ms O'BYRNE - It is something that the area health service model, the LHN model, will allow us to do. We are getting better at it. I think those numbers that are utilised in those facilities are getting better for us but they are taking a little time. Some of it is to do with the staffing profiles.

Ms FORREST - That does not include aged care beds in Smithton, does it?

Ms O'BYRNE - Those percentages include aged care beds, yes.

Ms FORREST - What is the occupancy rate with the acute beds for Smithton?

Ms O'BYRNE - Smithton is only 16 inpatients beds, not aged care beds.

Ms FORREST - Yes.

Ms O'BYRNE - The ones with aged care beds are Beaconsfield, Campbell Town, Flinders, Scottsdale, King Island, Queenstown, Midlands and Esperance.

Ms FORREST - As far as the Medicare locals go, having to consider a fully functioning health care service so that we can better utilise hospitals like Smithton, where are the discussions and the process at with the national health and hospital reforms as applied to primary health?

Ms O'BYRNE - They have changed a little bit. Originally, under the Rudd reforms, primary health was going to include a number of other services and there was some debate around that time about what allied health services it would include: when they were talking about community health facilities, were they talking in the same way we are about community health facilities? Since the Gillard rework of the Rudd reforms, it seems, from what I can see, that the Australian Government is pretty much staying where it has been in terms of primary health care immediately, which is GPs, but there is the scope, as Medicare local is developed, to grow some of those capacities.

[3.45 p.m.]

Ms FORREST - Do we know where we are headed with it at this stage?

Ms O'BYRNE - At this stage we are operating it under just being GPs, as it always has been, with consultation occurring with Medicare locals about other areas that they may wish to engage in. Certainly we have seen an interest in terms of general conversations around the preventative health and support stage.

Ms FORREST - Have the Medicare locals given any indication of what else, besides GPs, they would like to include or how they intend to expand?

Dr CERCHEZ - The Medicare locals are going to include allied health and all providers of primary health care services. That is quite clear. What exactly they will be doing, the Commonwealth has not completely clarified. Certainly after-hours care is very high on the list and all Medicare locals will be having as part of their remit after-hours care. The Commonwealth has not yet fully, although they have announced Medicare locals -

Ms O'BYRNE - Some Medicare locals.

Dr CERCHEZ - The majority of the first round, they have not yet given the contracts of what they will be covering.

Ms FORREST - Are we looking at one Medicare local that will have the GP north-west, the GP south and the GP north underneath those?

Dr CERCHEZ - That is correct, yes. The GP north, the GP north-south, will no longer be GP north, it will be primary health care north. In the north-west the membership of the local division of general practice last year changed to include allied health workers. They are expanding their remit and they will no longer just be general practice.

Ms O'BYRNE - We have started conversations with them, but I would have to say they are a bit early days yet, about which ones will share.

Ms FORREST - Obviously that has to be finalised at the same time as the local hospital networks?

Ms O'BYRNE - They are now identified and I think they will go through their process as

well.

Dr CERCHEZ - They are waiting for the Commonwealth to give the basis of the contracts, and then they will know what the sharing will be. It is really in the court of the Commonwealth Government.

Ms FORREST - What is the funding model looking like now for the Medicare locals? Will it be 100 per cent Commonwealth?

Ms O'BYRNE - Yes. The question was how far it went, and a lot of that was language because they were talking about community health services. Our community health services are far more encompassing than theirs in terms of language. I think we will get to a reasonable point.

Dr CERCHEZ - There will be an increase in primary health funding to the state.

Ms O'BYRNE - Yes.

Ms FORREST - When you are talking about allied health professionals - let's say physios, for example - if I am trying to fix my knee problem and I had physio beforehand, that will be funded 100 per cent by the Commonwealth. If I then go into hospital to have a knee replacement and I have some physio while I am in hospital, that will be funded by the local hospital.

Dr CERCHEZ - Yes, the local hospital network.

Ms FORREST - Then I will go out and have postoperative physio and that will be funded by the Commonwealth under the Medicare local again?

Dr CERCHEZ - That is right.

Ms O'BYRNE - Once again, this is why we should head to a proper integrated service.

Ms FORREST - My point is, how do we stop this cost shifting nonsense, that we have gone on with for so long now, that creates a heap of inefficiencies?

Ms O'BYRNE - That is the reason we want to have as much integration as possible under the Medicare local model as it exists but also why I think we are perfectly placed to explore a proper integration in Tasmania because our connections are very strong.

Ms FORREST - The Commonwealth cannot see that there is a problem there or that there has been a problem there?

Ms O'BYRNE - I do not like to speak for the Commonwealth but the Commonwealth is attempting to bed down this raft of reforms, and in 10 years they want to be in an integrated service. What we would really like to explore with them is that we are better placed to start that journey and to see how it might work than necessarily in some other States, which are still struggling around some of the earlier commitments. I would really like to see this happen.

Ms FORREST - The cost shifting issues will probably continue?

Ms O'BYRNE - There is always a risk of cost shifting. I think that is always the risk when

you have a number of different services providing care in roughly the same space. I think there is a commitment from the Medicare locals and what will be the LHNs to work together on those areas.

Ms FORREST - Okay.

Ms O'BYRNE - The other option, if it is all activity-based funding, is that you might have everybody struggling to demand that they are the ones giving the service in order to up the incidence of care.

Ms FORREST - This is the worry about forcing things into the hospital arena that are better dealt with out in the primary health setting.

Ms O'BYRNE - And the community health setting is really important for that as well.

Ms FORREST - That is right. That is what the risk is here.

Ms O'BYRNE - Yes, and we have to be very careful about how we progress through this, which is why it is good that we have got the time to step through the legislation. I look forward to engaging with the Upper House on the legislation because it will need to be for the LHNs extremely tight.

CHAIR - If there is nothing else on that output, we will move to 2.2.

2.2 Oral health services -

Ms O'BYRNE - Dr John Crawshaw will be available for dental services questions and also for mental health services questions as they all come under the same area. He will remain at the table for both areas.

Mr WILKINSON - In relation to oral health, will there be any savings made in this area and, if so, where?

Ms O'BYRNE - Once again, we have challenges around the fact that we need to work with oral health services around that area. What is interesting that is happening in oral health services is that we are getting a lot better at what we do. Our waiting lists are still long but our waiting times are shorter. The other thing to remember is that, generally, with a dental treatment it is not one appointment. Once you get to the top of the waiting list you might have two, three, four or five appointments. We are pleased with the median waiting time in dental services. The equivalent figures are that between 2009-10 we did 18 147 occasions of service and by April 2011 we had done 18 716. We are seeing more occasions of service but the lists are still certainly a challenge for us.

We attempt to treat all of those who are assessed as emergency on the same day they are triaged. Some 73 per cent of emergency clients are seen on that day, which we are very pleased about.

Mr WILKINSON - The amount of people you see seems to be increasing markedly. If you look at 2008-09, there were 62 224 occasions of service for children. In 2009-10, there were 9 659 adults on the waiting list, then we see a dramatic leap last year, 2010-11, to 14 735, and next year,

16 700 is the expected target. I know they are very raw figures but you have just about doubled the people you are seeing in the last two years. How have you done that?

Ms O'BYRNE - Part of that is the facilities in our regional hospitals that are allowing us to deal with those.

Mr CRAWSHAW - We have brought on more dentists. You may remember there was additional funding.

Ms O'BYRNE - The better dental care package.

Mr CRAWSHAW - The better dental care package has allowed us to see more people. Paradoxically, that increases our waiting list but not our waiting time because when dentists see them they come back again because they need further care in subsequent years.

The other part is that we are putting in special dental care units in major hospitals so that we address some of the dental care issues of acute patients and patients requiring cancer surgery, cancer therapy and so forth, because they are people who have high dental care needs, including those people who have cardiac surgery and so forth. We have broadened the nature of the service we provide as well as increasing the frequency of service.

Just to give you a sense of some of the dynamics of that, in the last 12 months we had 7 170 added on to the waiting list and 3 200 removed but our waiting time dropped. Really, what we are seeing is that as the population of Tasmania feel they can access care, they are accessing it at a higher rate.

Mr WILKINSON - Dentists are hard to get. If you speak to any private practitioner around southern Tasmania and northern Tasmania - I have not spoken to them in the north-west but in the north I have - they say that dentists are very hard to attract. Do you find the same difficulties in attracting dentists into the public system?

Mr CRAWSHAW - The oral health service went through a very careful recruitment process and recruited from overseas some South African dentists and other dentists and brought them into the state. We have been reviewing how we make the service attractive for them to work in, including improving the clinical governance around dental care. While we cannot guarantee we will keep them there, we do our best to try to maintain the service because we are responsible for providing the service for community care card holders and the like.

Mr WILKINSON - We have seen this jump in people who are being treated. How many extra dentists have been employed since there was the policy to improve oral health?

Ms O'BYRNE - I would need to check but there have also been changes in our dental therapy numbers as well.

Mr WILKINSON - These numbers relate not only to dentists but also to dental therapists?

Mr CRAWSHAW - Yes.

Ms O'BYRNE - The other conversations are about the use of the dental hygienists as well and the work we can do there.

Mr CRAWSHAW - We are changing some of their models of care so that we do not wait until people get holes, we teach children how to brush their teeth and things like that.

Ms O'BYRNE - Can I ask how many of you spend three minutes brushing your teeth?

Mr WILKINSON - You sing "Happy birthday", and by the time you have finished -

Ms O'BYRNE - I have a timer.

Mr MULDER - Is that per time or over a week?

Mr WILKINSON - Depends how many teeth you have got.

Ms O'BYRNE - The three minutes each time you brush your teeth is what you need to do, and it is quite difficult. Timers are my advice to all of you.

Ms FORREST - Electric toothbrush with a timer.

Mr WILKINSON - When you say the amount of people who have gone through the system, it is not just those people who have seen a dentist but also those people who have seen allied dental services?

Ms O'BYRNE - People who have had an occasion of care, whatever that care might need to be.

Mr WILKINSON - Are you able to give us any figures in relation to the people who have seen actual dentists as opposed to others; a breakdown of who people have seen?

Mr CRAWSHAW - I do not have the figures with me but we could provide them.

Ms O'BYRNE - Our dentist head count has increased by six.

Mr WILKINSON - As you say, often a visit would be just telling you how to brush your teeth properly and how to properly care for your teeth and what to eat and what not to eat, et cetera.

Mr CRAWSHAW - That is part of what oral health has been doing, making sure the appropriate practitioner sees the person for the appropriate task.

Ms O'BYRNE - Right time, right place, right care, yes.

Mr WILKINSON - Do you have a system where, prior to going to the dentist himself or herself, you see the dental hygienist first?

Mr CRAWSHAW - It depends upon the instance and the triaging.

Ms O'BYRNE - If you are triaged as an emergency patient you will be treated as an emergency patient. But, for instance, when I ring up my community dental service for my children, I will see a therapist, who may refer to a dentist if necessary. It depends where you are

on the triage. If my child had a difficult emergency filling it would be dealt with that day but if it is just their general check-up generally they would be seen by a therapist and referred on for additional care. It depends on the triaging.

Mr WILKINSON - Interestingly enough, you see an increase in the amount of people going to the dentist and you see a decrease in the amount of people requiring dentures over the next couple of years. What is the situation there?

Mr CRAWSHAW - If we can do preventative dentistry, hopefully people keep their own teeth.

Mr WILKINSON - Is that why the figures are down in relation to the dentures waiting list, which has reduced from 2,272 in 2008-09 down to 1,675, then 1,400 and 1,400 again, or is it just that you got the bulk of them last year to get dentures?

Ms O'BYRNE - I think there are more occasions of prosthetics over the last five years but that has been growing. The difference is that you are getting to that stage at a more appropriate time rather than as a crisis management; you are getting people through the prosthetics process more appropriately.

Mr CRAWSHAW - We did have the initiative over the last 12 to 18 months where we deliberately targeted the prosthetic waiting list to try to reduce it. We had a voucher system operating whereby people were able to go to private prosthesists to get their dentures addressed.

Mr WILKINSON - Those numbers are reflected in here as well, the ones that went to the private prosthesists?

Ms O'BYRNE - Yes. For instance, in 2005-06 for prosthetics there were 3,365 occasions of service and in 2009-10 there were 9,879.

Mr CRAWSHAW - That allowed us to reduce the prosthetic waiting list.

Ms O'BYRNE - One of the challenges we have had with the dental service - and we are trialling some mechanisms around this - is that the Australian Government used to allow private dentists in rural communities to treat public patients. I think that was an excellent scheme because it allowed us to deal with some of our regional communities. We have had to change the way we work with regional communities, now that the Australian Government do not do that.

[4.00 p.m.]

For instance, the dental van on the east coast, we are also using it for St Marys Hospital, to pick up those people who might present, when it is clearly identified that there is a dental health issue. And we have a trial with some private dentists in regional communities as well, so we are looking at every mechanism. Oral health is a huge determinant of overall health.

Mr WILKINSON - That is what I was going to say. A few years ago it was very poor, as we all know. We heard it being stated a few years ago. Has it improved, and to what extent has it improved, or is it still the same problem that it was two to three years ago?

Dr CRAWSHAW - Certainly there has been a marked improvement in the level of dental care being offered. There are measures but I do not actually have them with me at the moment.

Ms O'BYRNE - There are challenges with dental health care with an ageing population as well. I think we are getting better at what we do, but I think our demand is still high.

Mr WILKINSON - And how are we going compared to other States, if we look at figures from other States, which no doubt we probably will?

Ms O'BYRNE - I will have to get that comparison, I do not think I could tell you off the top of my head.

Mrs ARMITAGE - In the public system, is there any after-hours or emergency care?

Ms O'BYRNE - For dental services?

Mrs ARMITAGE - In dental services.

Ms O'BYRNE - We treat 73 per cent of emergencies on the day, and for children we do treatments up to 15 years.

Mrs ARMITAGE - No, after hours. If someone presents on a weekend or after-hours with a dental issue, do we have statewide or in the north, any provision for treatment?

Ms O'BYRNE - If they are emergency triage I think we do, but I would probably need to check.

Mrs ARMITAGE - I do not believe we do.

Dr CRAWSHAW - No, what we do sometimes - and certainly David Butler has come in and seen people within the hospital who are requiring urgent care.

Mrs ARMITAGE - Is there a budget for after hours?

Mr MULDER - You said David Bartlett came in to see them, that is all.

Ms O'BYRNE - No, David Butler.

Mr MULDER - Butler, I thought you said Bartlett. I was going to say well, a man of many colours.

Dr CRAWSHAW - No, David Butler, he is my clinical director for oral -

Ms O'BYRNE - He would probably be more useful in the circumstances.

Mrs ARMITAGE - I have heard on several occasions that if this happens there is no service, there is no budget for the service, and that people then have to try and find even a private dentist, if they can.

Ms O'BYRNE - Well, certainly we have had some flexibility with David for emergency cases in the north.

Mrs ARMITAGE - So David comes in basically as a favour you mean, he is not -

Ms O'BYRNE - No, no, that is part of the arrangements we have.

Mrs ARMITAGE - I realise that, but there is no budget put aside for -

Ms O'BYRNE - It is the broader dental services budget.

Mrs ARMITAGE - I guess what I am asking, if someone presents to DEM and they have an issue, they have an abscess that has all of a sudden started to play up in the middle of the night or on a weekend, of they have knocked a tooth out, and they go in and they see the resident or the registrar who is in there, who can they call, or can they call someone apart from David -

Ms O'BYRNE - Generally they refer the triage to Dental Services for a bed.

Mrs ARMITAGE - But is there someone over the weekend -

Ms O'BYRNE - But that is who they triage to.

Mrs ARMITAGE - Yes, but is there -

Ms O'BYRNE - And then it depends on the nature - as I understand, and I will seek some clarification on that - of the issue; if it is an emergency service, particularly an emergency service with a child for instance, and I will double-check that there is -

Dr CRAWSHAW - I can double-check.

Mrs ARMITAGE - If you would check, because I have been advised there is no one.

CHAIR - Okay, that is something we can take on notice. We will adjourn for 10 minutes or so.

Ms O'BYRNE - We might seek that answer while we are doing it.

Mrs ARMITAGE - Yes, if you would.

The Committee suspended from 4.03 p.m. to 4.22 p.m.

Ms O'BYRNE - As people are sitting down, can I advise particularly in the north if there is a trauma circumstance then we have somebody who is available for that, but in non-trauma circumstances people are referred either to their own private dentist or, if they do not have a private dentist, the on-call roster of ADA.

2.3 Population health services -

CHAIR - Minister, we know that issues such as obesity and heart disease are endemic in the western world and unfortunately here in Tasmania we have some of the worst outcomes. With

preventive measures, do we have any updated figures on what we are doing to try to combat the problem of obesity, for example?

Ms O'BYRNE - Across Tasmania we spend around $15 million in the preventive health space. One of the things that we have identified through that is that there can be a level of duplication or fragmentation around that, which is we are working on a health and wellbeing strategy that I am taking to Cabinet, to allow us to better integrate a lot of those programs to make them place-based initiatives to start dealing with some of the challenges that present to people. There are some specific initiatives that we have done on social marketing around the Find Thirty campaign; obesity; the healthier work program; Move Well, Eat Well, Get Active program; Eat Well Tasmania and the school canteen accreditation program. We are working across government to try to deal with some of those issues.

At a national level, there is work we can do in influencing decision-making about physical activity but also around nutrition and what people are eating. If you ask most people, they know they should have five serves of vegetables and three serves of fruit each day and we need to look at the reasons they do not or the reasons that they might not take healthier options. We are pushing nationally the 'front of packaging' food labelling in as simple a way as you can because if you put too much data on the information then you find that people just do not read it or it is so small that it is impossible to read, so that traffic light warning system is important.

We are looking at restrictions on the advertising and marketing of junk food. We have already started some work with other States on labelling of standard menu items in takeaway food outlets so that people can see the sodium content -

CHAIR - That would have to be a national initiative on advertising.

Ms O'BYRNE - We are looking at what we can do at a State level and there may be some opportunities but the very large space that is occupied in takeaway food is, of course, by international chains that have statewide restrictions around them. So we are working with that.

We are doing some work, particularly with PPAC around the planning and design of the built environment. But we, as you say, do have high rates of obesity and we do have less than optimal rates of physical activity.

CHAIR - In regard to those matters of obesity, how would you measure that up against alcoholism and tobacco? They are three significant components which affect our health system.

Ms O'BYRNE - One of the challenges that you have is co-morbidity. So, somebody who does not take care of their health in one aspect is more likely to be less taking care of themselves in those other areas as well. Alcohol and other drugs consumption, obesity and tobacco are all extreme pressures not only on our health sector but on our economy as well in terms of impact.

CHAIR - They are all part of that package that you are looking at with the strategy?

Ms O'BYRNE - The health and wellbeing strategy is very much about changing behaviours and patterns and it is very much about focusing on children and a lot of it is around denormalising, so it is not okay to drink alcohol in front of children and think that they will not start drinking alcohol. It is not okay to smoke near playgrounds and let them think that is okay to do that and it is not okay to ignore our physical activity.

There are a couple of really good models going around the moment, the food security model that we are doing which is looking at, with Clarence Council and Dorset Council. Particularly in Dorset Council, access to fruit and vegetables is not such a significant challenge. It is one of those areas that has the right amount of produce that one should eat but we are still seeing people not making the decision to do so. So what is the barrier that stops you getting access? For some it does seem to be, with some earlier conversations, the fact that you can get it at the supermarket but you cannot get it at the community shop in a small town or you have to go to farm gate or you have to make that extra effort. So a lot of the focus is going to be on how we make it easier for people to access the right decision-making because it is not that people do not necessarily know what they should be doing, it is that it is not the easiest choice to make. It is the same with tobacco. We need to take away from the normalisation of it.

CHAIR - Just remind me gain, what was that quantum of that, $12 million?

Ms O'BYRNE - Around $15 million is the preventive health. I will refer to Roscoe.

Dr TAYLOR - The $15.3 million is the budget given to population health but that does not include other programs, for example, the breastscreen program or, indeed, what community health services do as part of their role. So it is very difficult to cost out those parts to community health

CHAIR - Minister, you probably would have noticed - I think it was on *7.30* on ABC - the fact that we had the highest teenage pregnancy rate in the nation. This was the other night I noticed that and, in fact, we are right up there with all the other countries in the developing world. Obviously that would have some impacts on the health system as well as other social issues. That data is quite alarming.

Ms O'BYRNE - The Minister for Education and I has some conversations previously about the best way to provide that sort of education within schools. We are encouraging people to make safer choices. But certainly, there is a cost to the system for every underage pregnancy and we do need to work with particularly young women but also young boys in terms of what are safe choices to make.

Ms FORREST - It does take two.

Ms O'BYRNE - Absolutely. So it is about -

CHAIR - Not too much information.

Ms O'BYRNE - Some schools, through the resource budget, have been using a family planning model. We are looking at other models that might integrate it more fully throughout the education system, so it is part of your core learning, delivered on a more consistent basis rather than a one-off program where someone comes into the school, speaks to you for half a day and goes away again. Those decisions have been made at school but the Minister for Education and I have had some discussions about how we might broaden access to those because I think that will make a difference.

CHAIR - A couple of other quick questions on that. One is, what is the risk assessment with Swine Flu, is that still a problem? Also, I get varying comments on whooping cough, as to whether or not that is an issue as well.

[4.30 p.m.]

Ms O'BYRNE - I would be immunised for whooping cough if I were you, Mr Chair.

CHAIR - I have been done.

Ms O'BYRNE - Well done.

Ms FORREST - When he was a child?

Ms O'BYRNE - As a child or as an adult?

CHAIR - I had one when I had my check-up.

Ms O'BYRNE - For an adult I would absolutely suggest people be immunised for whooping cough.

CHAIR - Is there anybody around the table in that age group who you think should have one?

Ms O'BYRNE - Anybody who has not had one since they were a child I would encourage to seek -

Ms FORREST - Or who has had the disease.

Ms O'BYRNE - I do not think that is necessarily right, though, no. But I will hand over to Dr Taylor in terms of some other -

Dr TAYLOR - In relation to swine flu, the surveillance systems around Australia showed an unseasonable increase in the north of Australia in the summer months, in the early part of this year, which did not impact on Tasmania. So far there is some flu activity occurring in Tasmania, including the swine flu strain, but it has been in quite low numbers. I think our statewide vaccination program has protected us still at this point, but it is certainly still worth while everybody having the seasonal flu vaccine now, because it does contain protection against the flu strains.

We are not out of the woods, though, with whooping cough. There has been a significant decline in whooping cough in Tasmania since last year's outbreaks. Fortunately the numbers have started to drop right away, and that is being paralleled in other States now. So it appears to have reached its peak.

Ms O'BYRNE - Having said that, some people might not necessarily identify it as whooping cough because of the language. The doctors have been talking about the hundred-day cough. It is not whooping cough in the same imagery as you had as a child, but it is the hundred-day cough, the cough that does not go away.

CHAIR - Dr Taylor, do you have any concerns about immunisations generally in that some families or some parents choose not to have their children immunised?

Ms O'BYRNE - You are asking about 10 questions there - absolutely.

Dr TAYLOR - Yes, I always have concerns about people who are making what they think is an informed choice that immunisation either does not work or is harmful, when on balance all of the reliable evidence indicates that it is actually very protective. So if we achieve 95 per cent coverage of the population that is a very good outcome for Tasmania, given that about 4 per cent of people do not believe in immunisation in that sense. Our immunisation rates are very high and good in young children, in our one- to two-year-olds. My remaining concern is more the uptake in the adolescent age bracket of vaccines in the school-based programs. The whooping cough booster comes in at that point and so does Gardasil, the cervical cancer protection vaccine. Our coverage rates are not up to scratch there yet.

Ms O'BYRNE - I think the difference with the school age work is that in order to get into a school you have to show that you have done all of your vaccination processes. Of course, once you are in the school it is a bit harder to ensure that you keep up with them. That is possibly one of the elements there, but we do need to continue to encourage people to take vaccinations.

CHAIR - Finally, our ageing population will have a significant impact on our health demands.

Ms O'BYRNE - Yes.

CHAIR - Can you try to budget for that? What other measures apart from preventative health can you look at to try to mitigate -

Ms O'BYRNE - Even with preventative health eventually we all grow old. I guess the incidence of care that you might need within your life journey becomes the factor there. One of the issues that I think we need to spend a lot more effort on - and it falls into John's area as well - is dementia. The anticipated dementia level in Australia is extremely high. For every one person who has dementia now, I think four will have it by 2030 or 2040, something like that. It is a massive growth, and the debate about dementia is changing as well, in that we are starting to recognise that it is an acute illness from which you will die. That changes the way that we offer treatment and engagement around it. With the ageing population we have the frailty issues that occur with age. We also need very much to look at that work, which is why John is doing some work on the statewide dementia care plan. It is the type of care that you might need. Dementia can happen to extremely young people, but historically you are exposed to more risk as you age.

CHAIR - Thank you. That is all I have on that output.

Mr WILKINSON - I was going to ask one on meningococcal. There was talk a couple of years ago about issues with meningococcal -

Ms O'BYRNE - We have had a couple of -

Mr WILKINSON - What has happened?

Dr TAYLOR - We are still seeing the odd sporadic case of meningococcal infection. It is still a threat but it is not coming from the vaccine preventable strain any longer, which was the group C. The vaccine program for that has done a very good job of reducing the outbreaks that we were seeing in 2003, for example. But we still see the odd sporadic case of group B, so parents need to be vigilant still about signs and symptoms in their children.

Mr WILKINSON - What are the signs and symptoms that they should be -

Dr TAYLOR - For example, if an infant had a fever, illness with vomiting and becoming very floppy, you would be starting to wonder and, especially if a rash was starting to appear, you should be seeking medical advice quite quickly.

Ms O'BYRNE - Which is why I keep saying that we do not want people turning up to hospitals for no reason, but when you are dealing with small children, because they can escalate very quickly, it is an appropriate step to take.

CHAIR - Thank you. If there are no further questions, I will move on to 2.4, mental health services.

2.4 Mental health services -

Ms O'BYRNE - In the mental health area we will have remaining at the table Dr John Crawshaw.

Mrs ARMITAGE - Looking at the figures here for the reviews and reforms initiative, I notice that is obviously another five-year -

Ms O'BYRNE - Can I look at the page you are dealing with there, please, Mrs Armitage.

Mrs ARMITAGE - It is 51.13 at the outputs. I am just noting in note number 3 about the reviews and reforms initiative in the area of alcohol, tobacco and drugs that the figures are changing, reflecting the end of that review by 2013-14. Is that a five-year program as well and, if it is, can you tell us the outcomes that we have to date and how that review is tracking?

Dr CRAWSHAW - That was the future directions for alcohol and drug services that was announced, where there was a substantial increase in funding for the operation of the services, so we increased our addiction specialists. We have also increased our funding within the community sector organisations to improve the service delivery components, and that has allowed us to make a substantial shift in terms of the quality of the services delivered. It has also allowed us to move on some of the population health type issues that we were talking about before in terms of the interagency stuff on alcohol and other drugs.

Mrs ARMITAGE - Which Australian Government funded programs have been finalised? I notice here it says that the writs of finalisation will be from 2012-13?

Ms O'BYRNE - I will probably need to get you a list of those. We regularly have different programs that are funded within the State. One of the things that we are working to do and have had some good support from the Commonwealth on is to better integrate where the Federal Government money is going into the State so that we can avoid duplication, and particularly that Safe Keep feature of the suicide prevention strategy. We are getting a lot better, I think, in terms of our relationship in jointly working together on initiatives as opposed to having them standing alone. But we can get you a list of any individual programs that might be ceasing or winding up.

Mrs ARMITAGE - With mental health obviously it is not part, for example, of the public hospital system. What is the reason behind mental health being a separate arm?

Ms O'BYRNE - We have run it as a statewide system. Probably a lot of it is because we see quite a bit of movement in our client base. They do tend to move around more regularly than others, and that is one of the strong reasons for it. Also, it is a smaller pool for a smaller State and, whilst we have regional services in each of the regions, whether or not you would really want to dismantle it into three regions and therefore create some levels of -

Mrs ARMITAGE - For example, in the north coming under the LGH. Many GPs have said to me that, at the first presentation, if they have a patient sitting in their rooms and they want to refer it to Mental Health, they have to send that patient basically up to DEM. Many of their patients do not want to sit in the Department of Emergency Medicine.

Ms O'BYRNE - No, they do not have to do that.

Mrs ARMITAGE - They do not have to do that now?

Ms O'BYRNE - No, with the divisions we are doing quite a bit of work in terms of appropriate referrals.

Mrs ARMITAGE - One of them told me that only last night, that is all.

Dr CRAWSHAW - You can probably find an individual doctor in certain situations in terms of acute care but, among the initiatives we are taking, in the north we are developing an extended crisis assessment team so that we can provide more appropriate care not just within the Emergency Department but within the community. We have had substantial improvement in terms of outcome in psychiatrist -

Mrs ARMITAGE - Is that easy access for a patient? If a patient, for example, presents to a GP, is it easy for that doctor with that patient sitting in their rooms to get treatment straightaway if they are suicidal or they have a problem?

Dr CRAWSHAW - It really does depend upon the circumstance of the patient because as I am sure you are aware there are some patients who need to be seen urgently and some who can be seen on referral. From a referral point of view, yes, they can be seen through the Emergency Department and through the ECAT process, so that is our clinicians doing the assessments, and then through onto a psychiatrist or psych-registrar doing the assessment as is appropriate. One of the initiatives, as the minister is clearly indicating, is that we really want to move more closely to working out some of the improvements in the referral system. We do have the Mental Health Helpline, but we are aware of some issues that we need to resolve with that as well.

Mrs ARMITAGE - As I have said, one of the issues that has been brought to my attention is, for instance you are a GP, someone has come in and says they are suicidal, you need treatment for them now, would they be told to go up to the Department of Emergency Medicine and wait for a referral? Is that the situation at the moment, would they have to go up there?

Dr CRAWSHAW - Again, it really depends upon where that patient is sitting because, yes, they may end up going to the Emergency Department if it is really an emergency.

Mrs ARMITAGE - But they may wait a long time and the issue is -

Dr CRAWSHAW - That is exactly why we are trying to improve our response to the Emergency Department in terms of one of our clinicians.

Mrs ARMITAGE - Apart from that, I am trying to say that the issue that has been brought up is that if they are sent to DEM, they can actually wait for quite a long time. They will not wait and they will then walk out and walk in front of a car, or whatever they are going to do.

Ms O'BYRNE - I think what Mrs Armitage is asking is: what does the GP do in the first instance. In the first instance they should contact Mental Health and quite often these people are known to Mental Health and therefore an appropriate treatment plan may already be in place that you can activate, otherwise it really is dependent on a triage and that occurs at Mental Health Services.

Dr CRAWSHAW - That is right. It really depends upon the urgency that the patient needs to be seen and how we can best provide that service.

Ms O'BYRNE - We are trying to work with what the divisions were about some of those health identification issues, so that an appropriate referral takes place as opposed to what seems the easiest thing. It is information for GPs as well.

Mrs ARMITAGE - I think you have to appreciate, particularly in the north of the State where we have two part-time private psychiatrists as opposed to the south where you certainly have a lot more, then the public sector becomes a lot more important when you do not have anyone up there you can actually reach.

Ms O'BYRNE - Which is why we are doing the work with DEMs.

Mrs ARMITAGE - I notice one of the issues, too, and I do not know how we handle it up there, but I believe that Headspace, which I realise is Federal, no longer has a psychologist at the moment and now they are going to be cutting the funding to the GPs. They are only going to pay them for the time they see the patient, not the time it takes to write up the report and I have been told is it is going to be much harder obviously to get GPs to work for Headspace, which will in effect impact on the public sector.

Ms O'BYRNE - We can certainly take that up. Headspace has not raised that issue directly and I will ask someone to have a look at that.

Mrs ARMITAGE - I think it is important. I will give you some facts and figures later if you like.

Ms O'BYRNE - I will talk to Headspace.

Mrs ARMITAGE - I think it is important that if it is going to be impacting on the public sector it makes it far more difficult.

Ms O'BYRNE - It comes back to what we have been talking about a proper integration and partnering with the Australian Government about where and how the funds are spent, and that is the work that Therese and John will only make half of Estimates tomorrow as they will be meeting with the Australian Government particularly around those sorts of challenges and the work that we want to do in that space.

Mrs ARMITAGE - Lastly, I know that we are running behind time, do we now actually have any forensic mental health services in the north of the State?

Dr CRAWSHAW - Yes.

Mrs ARMITAGE - I knew we lost our private forensic mental health service and I did not know how we were going for public.

Dr CRAWSHAW - For your information, we have a community forensic mental health service which provides services across the State and in the north in particular we have a proper clinic with a psychiatrist and community forensic mental health workers and a forensic court liaison officer.

CHAIR - Any more on mental health?

Ms FORREST - Dr Crawshaw would love to tell me what number draft the Mental Health Amendment Bill is?

Ms O'BYRNE - Can I have a drum roll please, ladies and gentlemen. May I present to you a copy of the draft for consultation, the Mental Health Act for Tasmania, draft five million and twenty-nine.

Laughter.

Mr MULDER - You failed to answer the question, is what number is that draft?

Laughter.

Ms O'BYRNE - It is around about 5 million. What number is it?

Dr CRAWSHAW - Twenty-one.

Ms O'BYRNE - As of today we have done it. I couldn't get the brightest red ribbon for you, but we got you a really good red ribbon.

Ms FORREST - Nice Legislative Council red, I am glad.

Ms O'BYRNE - This has been a huge journey. One of the things in terms of the consultation is that this is probably not going as far as we need to in terms of reform, but to jump from where we are to where we need to be is a massive change. So if we get through this then we will commence. Once we get this done we are happy to commence further consultations about further reform as practices change.

[4.45 p.m.]

Ms FORREST - In spite of the many years and public servants that have gone into this -

Ms O'BYRNE - Yes, their blood, sweat and tears. We have lost many on the way.

Ms FORREST - are we likely to continue to proceed down the path for a capacity-based generic framework for this -

Dr CRAWSHAW - You obviously have not had the chance, but you will see that within this exposure draft we have moved towards capacity testing.

Ms FORREST - We saw a bit of it in the Disability Services Act.

Ms O'BYRNE - Probably not where we would ideally like to be.

Dr CRAWSHAW - There still is an open debate, as you would be aware from some of your committee work, as to whether or not you can completely do away with mental health legislation in the generic capacity basis.

Ms FORREST - And reported knowledge that you can't, if you remember. There are still areas that you need to have there.

Dr CRAWSHAW - There are some components. We are also just about ready to move into the discussion around the Alcohol and Drug Addiction Act to finalise the detail for releasing a discussion paper.

Ms FORREST - On page 5.14 where you talk about the target of 60 per cent of persons with a mental illness whose needs are met- I don't think Rosemary asked this one, did she?

Ms O'BYRNE - That was the target - no. This was an aspirational target and some of these areas are not held with in terms of the services that we provide. The 30.5 is more realistic in terms of the people that we provide the service for as opposed to the non-government or Australian Government sector that might pick up some of those people. I will check with John but that is my understanding of the change.

Dr CRAWSHAW - One of the things that is happening nationally is trying to improve our reporting in the mental health space and particularly being able to report accurately on population percentages. We don't provide all the services, nor does the Commonwealth, and we need to get a common database so that we can get reliable and accurate reporting of mental health data and that is a major piece of work going on nationally.

Ms FORREST - Should the progressing of the health and hospital reforms enable this, if you are going to have a more consistent funding model?

Dr CRAWSHAW - It will help somewhat but probably more importantly some of the work we are doing nationally on the fourth national health plan and the Commonwealth Government's work in looking at a COAG around mental health - so there is a separate process with respect to all that.

Ms FORREST - It just seems odd that the targets are high - I don't think it is even a high target.

Ms O'BYRNE - As you can see, it is quite different from the actuals of the year before. I think we were attempting to include in that a whole raft of engagements that we don't necessarily have.

Ms FORREST - In the private sector.

Ms O'BYRNE - In the private sector or in the Australian Government sector. I think we will get a much better picture in the future.

Ms FORREST - Wouldn't it be a more meaningful figure to have the percentage of services the State provides?

Ms O'BYRNE - It says they are met by the Tasmanian Mental Health Service.

Ms FORREST - The percentage of services they provide and the percentage of people who have their needs met by services because this figure means absolutely nothing.

Ms O'BYRNE - I don't have a problem with looking at providing additional data in the future.

Ms FORREST - I think the reporting of our outcomes is important.

Dr CRAWSHAW - One of the pieces of work we have had going on through this last financial year has been looking at our data collection and data reporting and looking at some more meaningful data targets, being very mindful of what has happened in the national scene. As you would appreciate, at the moment one of the difficulties that we work on was that most of our data is manually collected, which means that we know that they are under-reporting. We have a major information system process which is about to start rolling out over the next year to two years which will allow us to report accurately on what we are doing. Equally, as part of looking at how we best provide services, work is undertaken in terms of looking at more meaningful data.

Ms FORREST - I look forward to some meaningful data in the next budget papers, but that figure means nothing.

Ms O'BYRNE - Absolutely, we would like to see far better pictures drawn around that.

Mr WILKINSON - In relation to alcohol and drug services, here in relation to Corrections, are we able to say how many inmates at the prison are partaking in alcohol and drug assistance?

Dr CRAWSHAW - We provide a clinical nurse-consultant who does work within the prison. We also have work which is undertaken by the prison itself addressing alcohol and drug issues, because that is one of the determinants of offending behaviour.

Mr WILKINSON - One of the major determinants.

Dr CRAWSHAW - As I am sure you are aware. And part of why I repackaged some of my services is to give them an approved focus within the forensic health space so that we can look at some of the work that Justice is doing in terms of *Breaking the Cycle* and work with Justice on that and also in terms of a healthy prison approach to start to look at how we can work effectively across it. The rate limit as always is specialist staff, but there is significant work which we are trying to work through in that space.

Ms O'BYRNE - In terms of absolute quantity you probably need to talk to Prisoners Aid.

Dr CRAWSHAW - In terms of the actual numbers we have some numbers, which I don't think are in the Estimates papers, that we may be able to get for you.

Ms O'BYRNE - We can probably see if we can -

Dr CRAWSHAW - I will see what data is available -

Ms O'BYRNE - It might be a question that is appropriate for Mr McKim who may have some data around that as well.

Dr CRAWSHAW - It may be Justice that need to -

Mr WILKINSON - I can remember a number of years ago I mentioned that I think it was 80 or 85 per cent of people who were in prison were in prison as a result of or partially as a result of an alcohol and drug problem.

Ms O'BYRNE - And Justice has the *Breaking the Cycle* program that they are working on.

Mr WILKINSON - And that being the case at that time there was only one person over there to endeavour to assist those inmates. Is there any increase in the people over there to assist?

Ms O'BYRNE - I think it is really a question for Mr McKim, because we would know the bits that we are engaged in -

Dr CRAWSHAW - We know the bits which we do, but I also know that part of their *Breaking the Cycle* is actually putting programs in that space so I think it's more appropriate -

Ms O'BYRNE - I think Mr McKim will probably have that data.

Mr WILKINSON - So you are unable to answer that question.

Ms O'BYRNE - We only know the bits. We can give you information about what we do, but that won't be the entire amount of work that is done in that space, because we wouldn't have access to that data.

CHAIR - Any more questions on mental health? If not, we will move to CIP, the Capital Investment Program.

Ms O'BYRNE - And I thank Dr Crawshaw.

CHAIR - No questions there.

Ms O'BYRNE - I think we covered some of those in the broader questions already.

CHAIR - Are there any further general questions before we move out of the health portfolio into sport and recreation?

Ms O'BYRNE - Can I thank very much the secretary and all the other staff, and wish them all a lovely evening.

DIVISION 2
(Department of Economic Development, Tourism and the Arts)

Output Group 2
Sport and Recreation -

Ms O'BYRNE - At the table now we have me, Peter Robinson, who amongst his many responsibilities advises in this area, Liz Jack, who is Deputy Secretary for Recreation and Sport, and Craig Martin, who is the Director for Sport and Recreation. Do I get to do an overview? I can do it really fast. What do I want to tell you? We are doing wonderfully.

CHAIR - Are you going to speak slower?

Ms O'BYRNE - No, because you want to go home and I have got to do this again tomorrow.

CHAIR - A very quick overview.

Ms O'BYRNE - I am very pleased to have this portfolio again. We have taken some positive steps in the past decade regarding participation, but clearly we need to continue to grow. Since 2005, the rate of participation of five or more times per week has increased by 2.1 per cent with 27.7 per cent now undertaking this recommended level of physical activity, which is on par with the national rates. But as we have talked about in other areas today, certainly we want to grow that.

We recognise the role that Sport and Recreation plays for the community, continue to provide participation opportunities through our Indigenous Sport Program and the Aboriginal Outdoor Recreation Program and the wilderness therapy opportunities for our at-risk groups which are run by the Wilderness Program. At the other end of the scale, the Institute of Sport continues to play a pivotal role for our elite and developing athletes. We look forward to their continuation there.

The next 12 months will see the continuing implementation of the Premier's Physical Activity Council's new Tasmanian Physical Activity Plan, a 10-year plan, as members would be aware. We have some targets in that including a 10 per cent increase in current physical activity levels. The Disability, Sport and Recreation plan over the next 12 months will provide Sport and Recreation with a very clearly defined direction to address the four priority areas identified in the Sport and Recreation Framework for People with a Disability: capacity building; collaboration; information, awareness and promotion; and accessibility. We will continue with Sport and Recreation to guide and lead the disability sector organisations with those opportunities.

I think it is great to have a Sport and Recreation portfolio. It fits very neatly with the work that I want to do in terms of health and wellbeing space. It is about making those opportunities available. That is probably all I need to say and I will hand over to you, Chair.

CHAIR - You have done well.

Mr WILKINSON - We mentioned obesity in the last output group. Can you tell me what Sport and Recreation are doing in relation to obesity? It seems to me that a lot of the participation in sport, as far as having people and a captive audience, went when sport went from the schools into clubs. I know it has been a debate for some time.

Ms O'BYRNE - I am a big fan of more sport in schools.

Mr WILKINSON - I am a big fan of it. Can I ask what is happening please?

Ms O'BYRNE - There are quite a few things happening. We have seen the emergence of clubs as entities that are supporting physical activity opportunities and we want to work with them to grow those. We are seeing a greater engagement at the education level and we are certainly pushing that from a Sport and Recreation perspective. We were one of the drivers of the initiative to deal with the pilot program around the insurance issues that previously prevented organisations using school facilities outside hours and we think we are seeing a greater engagement with communities for those sport and recreation facilities.

We are working with Education to develop a strategy Australia wide that will see more kids getting involved not only in sport but also in physical education in schools. That fits very well with our policy of trying to get education facilities made more accessible. That was the blanket cover public liability that we used. The key for getting kids involved in sport is we have to make it fun, so it is about how do you encourage that participation without making it the most unpleasant experience that a child might have. We do need to make sport fun and accessible.

We have looked at some of the barriers to kids playing sport. Some of that can be lack of transport, lack of time, the cost of participating, sport might be offered at the wrong time for some families to manage it and the lack of venues. But what is really crucial to a lot children making a decision around sport is whether their friends play it or whether their parents are supporting that engagement.

Mr WILKINSON - In relation to that, what used to be the case - I know sometimes we sound old when we say it - was when there was an afternoon put aside in the primary curriculum at any rate where people played a sport against other schools or was involved in a sport. Is that the situation now where there is a specified time put aside within the school week? That would save a lot of the transport problems that you are talking about, et cetera.

Ms O'BYRNE - Some of these are questions for Education because they make these determinations internally, but we certainly have supported some of those organisations that provide the competitions and some of those are provided during school hours.

Mr WILKINSON - I think Craig is aching to speak.

Ms O'BYRNE - Yes, go on Craig.

Mr MARTIN - Just about everything we do - apart from the TIS, the Tasmanian Institute of Sport, I guess - is aimed at increasing participation through our State grants program, through initiatives such as Play By The Rules which is an interactive website that the Australian Sports Commission runs to make sport more safe, inclusive and fair. That is a website designed to provide welcoming sporting environments, which obviously encourage children and families to participate in sport.

We have also funded in partnership with the Health department the Good Sports program. Good Sports is a program designed to promote responsible selling of alcohol in clubs throughout the State. Again, that is a really important thing as far as creating those safe, welcoming

environments for families. As the minister said, we are having discussions with the Education department at the moment at a very senior level.

Ms O'BYRNE - It is the national Sport and Education policy.

Mr MARTIN - Yes, that is right. So that is happening at a national level. That is the thing that came out of the Crawford review - the independent review into Australian sport. I sit on a national working group to get more sport back into the education system, which, as you quite rightly pointed out, is something I am very passionate about and we think is really important. So that will look at four main things. That will look at us, as a working group, having a strong input into the health and physical education component of the new national curriculum. Phase three of that will kick in in 2014.

It will also involve training of physical education teachers. I think we need to have more physical education teachers trained throughout the country to make sure that they are capable of teaching gross motor skills and coaching as well.

This strategy will also involve tapping into after-hours activities. We have had the Active After-School Communities program that is being run by the Sports Commission. We think there are ways in which we can match schools up with local clubs and some of the activities that the sporting organisations throughout Australia are running to maximise the number of kids participating in sport after hours.

As the minister pointed out, the fourth plank of this strategy will involve increasing community access to Education department facilities. As the minister said, we have partnered with the Education department to put in place a blanket cover public liability insurance policy which means that groups of people can go into the Education department sporting facilities, the gyms and onto the grounds without fear of the public liability issue.

Ms O'BYRNE - The other area of course is to recognise that people are actually getting their sporting and wellbeing opportunities increasingly from non organised sports environments, mountain biking, BMX riding, walking, and that is why we have had some extremely good partnerships with Sport working with Parks, for instance, to ensure that people can appropriately access urban fringe parks for those pursuits as well. So part of it is recognising that people's engagements are changing in terms of the things that they enjoy doing.

Mr WILKINSON - So you can see an increase in participation as a result of what you are getting in place. Is that right?

Mr MARTIN - That is the aim, certainly. One of the issues that we have with participation data in Australia - Exercise and Recreational Sport Survey or ERASS - is that it does not actually measure participation levels of people under the age of 15. That is an issue, but you are absolutely right, the aim of this strategy and the work we are doing with the Education department is aimed at getting more kids in the school environment playing sport and being physically active.

Mr WILKINSON - In relation to participation in sports sometimes it is, I suppose, a bit daunting for some that may not have the abilities of others to play sport and therefore a diverse choice for those children often is of assistance. Is that the case as well? Are you looking for different choices where people can entertain fencing or whatever it might be.

Ms O'BYRNE - And sports go through fads as well. There are times when a sport is really, really popular and then it will wane and decline in terms of people's engagement. We need to be able to manage that.

Mr WILKINSON - In our day it was footy in winter and cricket in summer, that type of thing.

Mr MARTIN - Certainly there is a lot more choice available these days. As the minister said, one of the things that sport and recreation departments around Australia are coming to terms with is that young people are getting a lot of their physical activity these days through unstructured forms of physical activity: through the BMX bikes, rollerblading, skateboarding and things like that. I guess down the track we will need to make sure we are mapping those trends properly and make sure there are proper opportunities for kids in those areas. The other thing too is that the Active After-School Communities program that the Sports Commission runs provides opportunities for children to participate in a wide range of sports. We partnered with them during last year. It was a program that was a bit of an offshoot of that. It was called Play for Life, Join a Club. We think the critical thing with regards to getting kids after school or kids who are playing sport at school is getting them to join a club. It is really important. That makes their participation in sport sustainable and it means they will probably stay in sport hopefully throughout their life.

Mr WILKINSON - I can remember talking about mountain bike riding and whatever a few years ago saying look, it is going to be a new sporting horizon I think for a number of different people. There is an extremely good mountain bike track up on the mountain.

Mr MARTIN - Yes.

Ms O'BYRNE - In a number of places now.

Mr WILKINSON - Yes, sure. Then you have got the Smithton to Hobart bikeway. How is that going?

Ms O'BYRNE - Elements of that extremely well. You would be aware we have had that trails and bikeway program that was established when I was minister last actually, which is $4 million over the three years. The program for that will conclude this year and all those grants would have been allocated, so out of that we have had, I think I have the list of all the places that we have done.

The cycleway development fund, which includes the Queenstown cycleway, the Strahan cycleway, the Rosebery cycleway, the Holbrook one - I have spoken to the mayor and they had been unable to secure their other funding partners for that so that has not been a possibility - and for the Smithton to Hobart one we did the feasibility study which was $150 000.

Where we are with that now is that we have actually done a bit of a re-focus around that in terms of where we think a better bang for the buck is, and that is about identifying Tasmania's great rides, so that there are rides that are within themselves and a process to get really good feedback. One of them is stage one of the north-east rail trail, which is the disused rail line from the north-east out.

Mr MARTIN - When we sat down and had a really good look at the Smithton to Hobart feasibility study we took quite a few lessons from what they had done in New Zealand.

Ms O'BYRNE - Yes, because they were going to have this fantastic ride all around New Zealand but long distance cycling tracks just do not get the kind of numbers.

Mr WILKINSON - Craig, what did you find in New Zealand?

Mr MARTIN - What we found was that economically you are going to get more people participating in great rides in particular regions. That is what they found in New Zealand. They found too that the cost of putting in place a north island to south island bike track would be huge. I have not got the -

Ms O'BYRNE - Which would be okay if they were going to get the usage, but it was clear that they were not going to get a usage for it.

Mr MARTIN - There were going to be a lot more people using or being attracted to these great rides. A lot more people into local communities, a lot more usage so we put a proposal to former Minister Wightman that $150 000 for that Smithton to Hobart bike track be used to develop a series of great rides.

As you just said, there is a number of opportunities around the place for mountain biking. As you quite rightly point out Mount Wellington offers enormous opportunity for mountain biking. It would be one of the few places anywhere in the world where you would have this fantastic mountain biking infrastructure.

Ms O'BYRNE - Are you suggesting it will rival Kate Reed and Trevallyn?

Mr MARTIN - I am just saying I think it is another great opportunity for us.

Ms O'BYRNE - It is.

Mr MARTIN - You are 15, 20 minutes from the capital city. I think the opportunities there are great.

Mr WILKINSON - The mountain is underutilised, I believe, in relation to a lot of recreational activities - climbing, bushwalking et cetera. People know about it who are involved but I do not think they know, as well as they should, the sights that you can see. I have spoken with a number of people who walk there once or twice a week, but unless you know where the walks are, unless you know the history behind it you do not know what to do.

Ms O'BYRNE - I do not disagree, I am just wondering whether or not that is more of the role for the Mount Wellington Management Trust which I think reports to Parks.

Mr WILKINSON - That is part of it.

Ms O'BYRNE - We have Luke here with us and he is an expert on these things. There are challenges that the trust needs to deal with around some of those access opportunities.

Mr MARTIN - At the moment we have a project we are working on with the Wellington Park Management Trust, the Greater Hobart Mountain Bike Plan. We are looking to explore further opportunities to develop mountain biking in the Wellington Park area.

Mr WILKINSON - What about the Tas Trail? How is it going?

Ms O'BYRNE - I think parts of the Tas Trail do quite well but because it is a mixed-usage trail catering for walkers, bike riders and horse riders -

Mr WILKINSON - It was to go right down to Dover, wasn't it, and I understand it is not a connected trail at the moment because of insurance reasons, problems getting through private land?

Ms O'BYRNE - There have historically been land access issues because sometimes it crosses private land, forestry land and crown land. There are people who have done a fair bit of the trail but I think you get specialisations of parts of the trails, so the bit around Latrobe gets quite a good bit of usage and some other parts of it get really good usage but it is rare that you get someone doing the entire journey.

Mr WILKINSON - But the idea was, if it did travel to Dover, to stop in at certain rural areas, stay the night and give them a bit of a spark as you were going through. Is that still the plan?

Mr MARTIN - As the minister said, there are parts of it that are getting pretty well utilised. It is a similar situation with the Smithton to Hobart idea. Whether you are going to get people going all the way from top to bottom is debatable but we understand that parts of it are being utilised.

Ms O'BYRNE - And also for different things. There are sections that are very popular with horse riders, sections that are popular with walkers, and sections that are popular with mountain bikers.

Ms FORREST - It is all downhill from Smithton to Hobart, though.

Laughter.

Mr WILKINSON - Can I talk about elite athletes? How is that going? We seem to do extremely well in rowing. You look at the rowers who are going to the world championships soon.

Ms O'BYRNE - In 2010-11, we had 52 instances of TIS athletes achieving selection in their respective sports national teams. Some highlights of that were Eddie Ockenden with the Kookaburras and the Commonwealth Games and the Champions Trophy. Amy Cure won three gold medals at the World Junior Track Championships. Sam Beltz, Anthony Edwards and Blair Tunevitsch won a silver medal in the men's lightweight four at the World Rowing Championships and Blair Tunevitsch and Alister Foot won a silver medal in the men's lightweight eights. We are providing some really good programs and high-performance services but also what I think is working really well for us is the personal development work we are doing with athletes which is empowering them to maximise their opportunities to the best level.

Mr WILKINSON - Is anything happening with talent identification in cricket? Cricket has been a magnificent flagship for Tasmania over the last few years. Is Sport and Recreation playing any part in identifying those athletes that you can see doing extremely well in cricket?

Ms O'BYRNE - We provide education support through the elite development program for scholarship athletes including cricket, but also including AFL, canoe, wild water, gymnastics, netball, sailing and swimming.

Mr MARTIN - We have a partnership with Cricket Tasmania to do that sort of thing.

Mr WILKINSON - Can you tell me why you think we are doing so well in certain sports? We do extremely well and punch far above our weight.

Ms O'BYRNE - Can I make it extremely clear because I learnt this on day one of being Sports minister, we do not punch above our weight, we are just good. It is impossible to punch above your weight, you can only achieve the best you can achieve for the people you have. That is the first lesson that Liz taught me.

Mr WILKINSON - It is a bit of an in-joke because in boxing parlance you can punch above your weight. Liz, why do we do so well in rowing? The rowers who are born and bred in Tasmania, remain in Tasmania for a great deal of the time and are still representing the State and Australia and doing extremely well on the world stage.

[5.15 p.m.]

Ms JACK - Tasmania has shown over a number of years that we have sports that we are historically very good at. Rowing is one, cycling is another. I think it is a combination of a number of things and if you take diving on the other hand well we have only had a couple of people who have ever left the State and done very well.

Ms O'BYRNE - But we do think you are wonderful.

Ms JACK - Thank you. Diving is an easy one because I know it. I am generalising, but in our population we have rowers who are being developed who have size with them. Tasmanians have, in the past, been seen to be smaller in stature, and our lightweight rowers have done extremely well. We do not do as well in the heavyweight classes or in the big boats. That has been changing but it is a bit about what we breathe down here - the climate, the fantastic level of coaching -

Mr WILKINSON - That is right.

Ms JACK - and expertise we have. Look at cycling and rowing in particular, and hockey is another, but I will stick with rowing and cycling. We have developed a really good power play for our coaches as well as our athletes. Once you breed a stock of those athletes it is much easier to keep those numbers going. When you have one or two talented athletes in any sport, whether it is trampolining or diving or gymnastics, it is very hard unless you have that mass behind you to develop anything that is going to be strong and sustainable.

The institute has purposely focused on the sports where we have historically done well. As a former TIS board member many, many years ago said, you can't continue to spread the jam on the bread too thin or you end up with nothing. So it is about being really focused in that sport.

Mr MARTIN - I think another thing that needs to be said, and Liz will not mind me saying this, I think that the TIS has received outstanding leadership over the years as well. Liz and Paul

are really outstanding leaders and that is reflected in the way that the TIS has performed. It consistently delivers on its benchmarks and KPIs.

Ms JACK - But it is very, very focused in what it does, and I think they have to continue to be.

Mr WILKINSON - You have hit the nail on the head. I think you need to have good coaching from a young age - not when you get to the higher age groups but from a young age - and when you look at rowing especially it seems to me that is the case. The rowing program both at schools and clubs is pretty good - schools especially, I think. Those people seem to go on so if there is a focus on getting good coaches down here do you believe we are going to get better outcomes as far as individuals reaching their full potential?

Ms O'BYRNE - I guess the other challenge to that though is that you are not necessarily going to get coaches to come down to an area where you might only have one or two elite athletes because the demand on them will be elsewhere. In those areas that we are good at we do attract good people, people want to come and work here. But we have one lawn bowls athlete so can we necessarily get the best lawn bowls coaches to come and work when we at this stage only have one? I guess that is the balancing act for the TIS too in terms of ensuring that we are taking care of those athletes in areas where we are well placed but also providing support for those in the less popular sports.

Ms JACK - The TIS recognises that where there are talented athletes without that base it is very difficult to develop the right culture because part of it is that culture. It is not easy to be a high-performing elite athlete and if you do not have athletes around you who are performing at that level working their butts off, training two or three times a day, seven days a week, it is hard to change that culture. So the TIS does recognise that there will be sports where a talented athlete is far better supported by moving to a program where they do have that culture and that environment.

Jim, you talked about rowing and that is a classic example. We have a fantastic rowing culture in this State that is built around the schools and the club system supports the schools and vice versa. I think that if you bring a really good coach into that like Sam Le Compte and others in the past or following him it continues to build on that.

Mr MARTIN - Coaching is absolutely critical from a young age, as you say, but TIS athletes also have access to the latest in sports performance in strength conditioning, nutrition advice, all that modern technology that is critical to giving you an edge and we have access to that here. Obviously we have a strength conditioning facility at the Silverdome. We have recently opened one at the TechnoPark in Glenorchy as well, which means that the southern athletes have easy access to that as well, which is really, really important.

Mr WILKINSON - What does that involve? Is that just like a gym or is it a special gym that can track exactly what your aerobic capacity is, et cetera?

Ms O'BYRNE - We would be happy to give you a tour of the facility if you do have an interest because it is really interesting to see the sports conditioning work that takes place at both the north and south.

Mr MARTIN - It is all that. It athlete, career and education as well, like teaching athletes how to deal with the media and things like that.

Ms O'BYRNE - Also what might happen post-sport and how they make that transition perhaps into a coaching role or a junior development role themselves.

Mr WILKINSON - That was the only other thing I was going to mention because I was told not to talk about football. In relation to after-sport life, a lot of young sportsmen, especially in the elite area really, to some degree, are looked after extremely well.

Ms O'BYRNE - I think the biggest challenge in that probably comes in areas like football and I know you are not talking about it. But the pathway back into regional competition football if you have been drafted, for instance, is probably one of the areas that AFL Tasmania wants to work on. If you have been drafted by a major club and you come back to Tasmania, we want to make sure that you then go back into your local club scene and that transition works well again and that is part of the statewide league initiative.

Mr WILKINSON - But it is not only that, is it? It is assisting in them preparing for not getting the pats on the back and there are a lot of people who suffer in varying degrees after they finish playing football. Are you looking at that as well or is that outside the area of TIS?

Ms O'BYRNE - Certainly those for whom we have a scholarship. We certainly work on those programs. But we work with Sports about how they manage transition for players as well.

Ms JACK - There is a program, through you, Minster, that supports not just the athletes but also the coaches and it is about life after sport and it is about having a career beyond being a rower or a football player or anything else.

Ms O'BYRNE - In the same way that we also want to work out the balance while they are playing sport as well, so they can manage their education or employment opportunities at the same time as competing. Apparently, according to our rowing medallist, you can become a doctor as well, at the same time as winning Olympic Gold and be really lovely, a role model at every level.

CHAIR - I am not going to talk about the war because I know there are three southern members and three northern members here.

Ms O'BYRNE - Also, that is not in our portfolio!

CHAIR - Football?

Ms O'BYRNE - The North Melbourne stuff, if that is where you are going to go.

CHAIR - Okay. I was not going to speak about it anyway.

Ms O'BYRNE - Just so you did not feel bad about dodging the war.

CHAIR - You talked about a Tasmanian team in the AFL, that was something that the Government had promoted at some stage. Where are we at with that?

Ms O'BYRNE - Also, it is not something that Sport and Recreation have as part of our responsibility. I am happy to talk about my views on it. That is part of -

CHAIR - Where does it live then?

Ms O'BYRNE - It has been in many places but generally - and I am sure you will be able cover this later in the week as well - we presented a model to the AFL of a Tasmanian team and they came back with some questions. We responded to those questions. The AFL have said that when an opportunity arrives, that Tasmania is well placed to take that opportunity. They have to move to an 18-team competition by 2012, that is what they have sold to the networks. So they have to deliver on that. That is the Western Sydney and the Gold Coast initiatives. I guess Tasmania is well-placed in two ways. Firstly, beyond what happens to the 18-team comp - and certainly Demetriou has floated a 20-team comp or two-tier comp as well. But the other is that whilst we do not ever wish ill on any existing club, there are some sustainability issues for clubs in Victoria and the AFL have to be able to deliver the 18-team comp. So, should another team merge or cease to operate or relocate, then Tasmania is extremely well-placed to respond in that area. But it is not something that Sport and Recreation do, because we are about participation and engagement. So that is an update of where it is up to, but it is not a Sport and Recreation responsibility.

CHAIR - That is the main code. The other code, of course, being the round ball code. Is there any involvement at all from the State Government to get involved in the national soccer league?

Ms O'BYRNE - We did a lot of work on the potential for A-League. We have a number for that to tell where we are up to. We provided $40 000 for the A-League feasibility study. That was carried out by Stratcorp Consulting, who are now known as Coffey Commercial Advisory. They certainly believe that they found that the stadium economics would support a Tasmanian A-League side. I must confess, I looked at some of that early data and thought their numbers for the gates were probably ambitious. But they certainly found that.

In January of last year, 2010, the A-League commissioned a survey by Enterprise Marketing and Research Services to ascertain community views and found that there was a strong awareness of the A-League bid. I think some 75 per cent of respondents were saying that they would go and become members of an A-League team.

When I was still minister, back in those days you contributed $80 000 toward the production of a full business case. The findings of that were released just because I became minister again, which was that a successful bid would need: $8 million to $10 million in start-up funding in cash reserves; that they would be seeking Tasmanian Government support for Bellerive and Aurora; that there was some support in both business and that based on market research, they anticipated to attract 13 460 average attendants. But there was an understanding that they would operate at a loss. That business case exists. It does suggest that there would be a very large government investment required but also, once again, we need to recognise where the A-League competition is sitting. In particular, we have just seen them withdraw the North Queensland Fury licence and give that twelfth licence to the Sydney Rovers. I think, at the moment the A-League nationally is probably more in a space of consolidation of where they want to be into the future. We are seeing growing interest and it is something that we can respond to but I guess we cannot respond to an opportunity that is clearly not there for us at the moment while the A-League works out where it is going to be.

Clubs around Australia are losing money - hand over fist is probably one way of saying it. The stadium economics for Tasmania are good; they always are good because of the nature of the stadia that we provide, but it would be very dependant on having good crowds and if you could not sustain a good crowd then you would be in a rather difficult place. At this stage we are waiting to see where the consortiums who are supporting this end up in their conversations with A-League nationally, but the A-League is not giving any indication of an opportunity at this stage. We have certainly done the work that we need to do in preparation for an opportunity.

Mr MARTIN - As the minister quite rightly pointed out, is there are certainly some issues at the moment with the A-League and I think they will be looking to consolidate what they have got at the moment rather than expanding in the short to medium term.

Ms O'BYRNE - I think I misspoke - when they took away the Fury, they also took away the Rovers licence. So they are coming back in rather than expanding.

Mr MARTIN - And the Rovers licence was taken away simply because they could not stump up the money to make it happen.

Mr WILKINSON - Talking about taking it away, if you look at the Budget for this year, the last Budget $18.554 million reducing to 2014-15 by approximately $4 million. What is that going to mean to your outputs and to the work that you would like to do and may have to cut?

Ms O'BYRNE - Most of that is the ending of some infrastructure programs that we had engaged in. That is trials and bikeways, the funding for surf lifesaving and the infrastructure for Southern Tasmania, which is are the lights at North Hobart and KGV. All of those provide a benefit into the future but they were particular commitments that we auspiced through Sport and Recreation and are winding up. There are some changes. Obviously we are going to need to manage the amount of money that we get in grants and redistribute to communities.

Mr MARTIN - Yes. Like all areas of government, we have had to make some savings. That is what we have done to a total of around about $1.6 million over the next three years. They involve, as the minister pointed out earlier, the Holbrook Street cycleway development fund project; the main reason for that project not going ahead was because the Launceston City Council indicated to us they had trouble finding matching funding. There will be $85 000 less available for the State grants program from 2013.

Ms O'BYRNE - But there will still be over $1 million available for all those.

Mr MARTIN - So that is still a lot of support for the State sporting organisations as far as growing their capacity.

Ms O'BYRNE - The others are probably smaller things. We host a fantastic sports award every year but I do not think we can necessarily afford to do that in the face of some of the challenges that we have. We will still recognise those athletes but probably not in the same gala flash dinner that we have been able to. We are working with PPAC.

Mr WILKINSON - Is Sport and DHHS working together, because obviously with the obesity problem, with the active lifestyle, I would have thought there is going to be a saving as far

as the health budget is concerned in years to come, so is there any coming together of those two agencies?

Ms O'BYRNE - The health and wellbeing strategy I am taking to Cabinet is whole-of-government so it is trying to pick up on the work that is being done in PPAC, in Sport and Recreation and in Parks because there is a whole lot of really good stuff happening. Let us face it, it gets that broader engagement agenda in terms of wellbeing, and physical activity is a huge way to increase wellbeing.

[5.30 p.m.]

Mr WILKINSON - How is that going to happen? It seems to be a very hard thing to make happen to say okay you get your people active, get your people healthy, it is going to be a gross saving it would seem to me on the Health budget in later years. How are you able to marry the two together?

Ms O'BYRNE - Sport and Recreation has always been funded on an increasing participation. The things that we fund are funded on the basis that we increase participation - an increased participation from my other portfolios of course keeping people active and healthy so that is always where they have been working. I think what we will try to see is some more alliances across some of the targets so that we are spending money in the same space. For instance, the work that PPAC did on the Healthy By Design, and this department is just picking up with planning around that that will help as well.

Mr WILKINSON - In years to come are we going to be able to see figures - we put some money in here, and these are the benefits we have got from it? Are we able to track that?

Ms O'BYRNE - Well we have seen an increase in participation to five times a week.

Ms JACK - Through you, Minister, I sat and had a conversation with Roscoe Taylor after he left and we were talking about exactly that, what you were raising. It is not going to be easy. I don't think anyone can sit on this side of the table and say yes, we have solutions, but certainly there has been good dialogue between Sport and Recreation and Health for many years. Previously some five or six years ago, Health and Wellbeing Groups were established that involved largely Health and Sport and Recreation but also the Premier's Physical Activity Council and other members of the State Government that were interested in health and wellbeing much more broadly, so it was not just about obesity but also about smoking, drug use, and physical activity. I think in the last 12 months there have been discussions about the fact that we need to be more strategic in the way we are doing it now. We cannot sit here and say we have solutions today but I think you will see that that engagement will increase and hopefully in another 12 months we will have at least some solutions.

Special capital investment funds -

Ms FORREST - Minister, I know the AFL football deal has given another million dollars a year to the Hawks. I do not have a problem with funding the Hawks but that is a 25 per cent increase effectively from $3 million a year to $4 million a year. How can you demonstrate a significant growth in economic growth in the State based on the increasing amounts that the Hawks are getting? Every other area has to take cuts.

Ms O'BYRNE - I am not sure that I would agree with that figure, I'm sorry. Can you refer me to the page you are dealing with?

Ms FORREST - It is budget paper 1, page A.2.8, right near the back.

Ms O'BYRNE - There has been an increase but it is certainly not at that level. There has been a CPI increase, obviously, that has gone through.

Ms FORREST - The question is how much is the AFL football deal worth now; the Hawks? Start with that.

The policy and parameter statement tells me they are going to get $3.1 million this year and then $4 million in 2012-13, $4.2 million in 2013-14, $4.4 million in 2014-15 and I would expect $4.5 million or $4.6 for the next year over a five-year arrangement. It is $20.7 million over five years.

Ms O'BYRNE - Part of that is money that goes to AFL Tasmania and it has been logged here. That is $500 000 that we give to AFL Tasmania. What we have had in terms of the contract to an increase of 3.1, and the total of the contract is now worth $18.5 million.

Ms FORREST - How much are the Hawks now getting?

Ms O'BYRNE - The contract with the Hawks is about $18.5 million over the life of the contract.

Ms FORREST - It was $15 million, so we have $3.5 million more then over the five years.

Ms O'BYRNE - Yes.

Ms FORREST - So when everyone else is taking a cut, why are we seeing this sort of increase to the Hawks?

Ms O'BYRNE - This is a contractual arrangement that we had already entered into. It is done on the basis of the return that we get. We do not fund it, it sits with me because I had it through a number of portfolios, but it is very much an Events focus. It is about the marketing opportunities as a result of the investment and we get some $15 million annually as a return from our investment.

Ms FORREST - We are going to get the $15 million return annually every year, regardless of whether we give them an extra, whatever it is -

Ms O'BYRNE - This was the cost of the new contract, which builds into the fact that with the increased roster there will probably be an additional game.

Ms FORREST - Where everyone else has to take a cut, why are we giving more?

Ms O'BYRNE - You cannot really unpick a contract that we have entered into.

Ms FORREST - This was a new contract in the height of the global financial crisis when we knew -

Ms O'BYRNE - Because we believe the investment in this actually returns an economic value to the State.

Ms FORREST - How hard did you fight not to have an increase for this at the moment?

Ms O'BYRNE - We certainly worked pretty hard in terms of our contract arrangements, we did not just sit back and say give us money, and certainly that was not helped by some of the comments that were going around in the media in terms of weakening our bargaining position, but we argued very strongly for the position we had. There are obviously ambit claims put in, or I hope they were ambit claims put in by the club at the time. We think we get a very good return on an economic basis for the investment that we share with Hawthorn. Not only in an economic return because of the games in the State, but also because of the marketing aspects and opportunities that we get as a result of that. There has been an analysis that showed for our 2007-08-09 seasons the games played in Tasmania added around $15 million each year and over that period there was in excess of 400 full-time equivalent jobs. The yearly media value that we get with the 15 million television viewers each year is around $2.2 million as well. So the new agreement is the five-year agreement with Hawthorn and includes the four home games at Aurora as well as the naming rights sponsorship and the benefits that we get from that. The annual value of the games, purchase and sponsorship component is $3.375 million plus CPI, with the game component valued at $1.375 million and the naming rights at $2 million. So they are the different aspects of this contract. It is not just buying games to come to Tasmania, it is a very valuable marketing opportunity for us.

Ms FORREST - The question still remains: how are you going to demonstrate a commensurate increase in economic return to the State based on the increase now that Tasmanian taxpayers' money is going to an AFL football team where that money goes out of the State that they get?

Ms O'BYRNE - We continually analyse the benefits in the outcome of the deal, but most importantly for us was the fact that the nature of the sponsorship dollar is certainly competitive. We believe we have got a very good deal from it. I am fully committed to the Hawthorn deal in terms of the return that we get and I think the risk of loss of such an investment to Tasmania would have been huge.

Ms FORREST - What was the risk of loss if they get the best deal any AFL team get in the country as far as sponsorship goes? The risk of them walking away without an increase -

Ms O'BYRNE - I think that is a bit of mythology, I do not think it is the best deal; it was certainly a different type of deal earlier on.

Mr WILKINSON - If you look into it as the number of games that they play -

Ms O'BYRNE - I think certainly earlier on if was a good deal for them, but I think we have seen the model picked up around Australia and seen some different engagements in the competition around that. We also have a partner in this with the Launceston City Council who put in substantial infrastructure around this as well, and are now partners in terms of our process forward.

Ms FORREST - What sort of increase in economic return do you expect then over the next few years?

Ms O'BYRNE - We are aware of the visitation increases - we already have those figures on the record and that is part of the $15 million that we get each year. But we are also leveraging an increased visitor opportunity through some targeted program with them and through the AFL. I am absolutely convinced that I will sit here in a year's time and talk about the value of this deal again.

Ms FORREST - What is it worth - for the last year?

Ms O'BYRNE - The new annual value?

Ms FORREST - No, what was the return from the deal under the previous arrangement?

Ms O'BYRNE - In 2008-09 the direct net value to the Tasmanian economy was $15 million each year.

Ms FORREST - So we will expect an increase on that next year?

Ms O'BYRNE - I am certainly hoping so. It is also wise to factor in the television exposure data that we get - the marketing impact we get from the engagement, which is worth about $2.2 million, advertising that we could not afford to buy any other way.

Ms FORREST - But that's not going to change, they are still only playing four games.

Ms O'BYRNE - Four plus one, and particularly with the roster as we move to the other competition, there will an increased opportunity for games.

Ms FORREST - But currently the deal is the same as far as number of games and exposure?

Ms O'BYRNE - Yes, four plus one.

Ms FORREST - Which is no different?

Ms O'BYRNE - Not until the roster changes, no. Although we are discussing with the AFL the opportunity for the fifth game.

Ms FORREST - But that is not part of the deal though?

Ms O'BYRNE - The current deal is $16.4 million and the new deal is $18.5 million, which is a $2 million difference over the time.

Ms FORREST - When I said that last week, no-one disputed the fact that it was an extra -

Ms O'BYRNE - I didn't see where you said it. I am sorry if I was not paying attention.

Ms FORREST - The rest of your team don't know either.

Ms O'BYRNE – Unfortunately, as much as I love listening to every one of your dulcet tones, we may have missed that one.

Mr HARRISS – On the back of that, Mr Chair: Minister, you just indicated to Ms Forrest that you worked very hard to secure a renewal of the contract with Hawthorn.

Ms O'BYRNE - Yes.

Mr HARRISS - Jeff Kennett doesn't share that view.

Ms O'BYRNE - I am sure that if you ask Jeff about me, he would share that view.

Mr HARRISS - He has said publicly he had to do very little to get the substantial increase in the contract.

Ms O'BYRNE - I think what Jeff is indicating is that the Tasmanian Government supports the outcome. Yes, there were negotiations. Not all of those took place with Jeff.

Mr HARRISS - But he says clearly on the public record that his club had to do very little to get a big new tick.

Ms O'BYRNE - I think what Jeff was trying to indicate is the great support of the Tasmanian Government, the Launceston City Council and the Tasmanian community for the excellent partnership that we have had with Hawthorn.

Mr HARRISS - No, that's not what he is saying. It's a nice spin, but it is not what he is saying.

Ms O'BYRNE - You may also be having some spin around it as well, Mr Harriss. The positive response we have had from Hawthorn is about the fact that we have all wanted to work together on this deal.

Mr HARRISS - Money for old rope, that's what they got.

Ms O'BYRNE – I think it is an excellent program.

CHAIR – There being nothing further from members, on behalf of the committee, thank you very much, Minister. We have had some interesting discussions, particularly right at the end. I think you and all of your staff today.

Ms O'BYRNE - Can I place on record my appreciation to the committee and the committee staff and also all of the agency staff who have worked hard to provide the best information that we can give you today. I will undertake to get those things we can to you by the end of the week; other ones that we have identified may take a longer period.

The committee adjourned at 5.44 p.m.