LC Monday 8 September 2014 - Estimates Committee A (Ferguson)

LEGISLATIVE COUNCIL

ESTIMATES COMMITTEE A

Monday 8 September 2014

MEMBERS

Mr Robert Armstrong
Mr Craig Farrell
Ms Ruth Forrest
Mr Mike Gaffney
Mr Greg Hall (Chair)
Mrs Leonie Hiscutt
Mr Tony Mulder

IN ATTENDANCE

Hon. Michael Ferguson MP, Minister Health, Minister for Information Technology and Innovation

Ministerial Staff

Michael Reynolds, Chief of Staff
Kyle Lowe, Health Adviser
Associate Professor Anthony Lawler, Clinical Adviser
Richard Pree, IT Adviser

Department of Health and Human Services

Michael Pervan, Acting Secretary
David Nicholson, Deputy Secretary, Strategic Control, Workforce and Regulation
Eleanor Paterson, Acting Chief Financial Officer
Ross Smith, General Manager, Shared Services
Lisa Howes, Acting Manager, Executive, Ministerial and Parliamentary Services (supporting role)
Dr Craig White, Chief Medical Officer
Ms Fiona Stoker, Chief Nursing Officer
John Kirwan, CEO, Tasmanian Health Organisation - North
Mr Matthew Daly, CEO, Tasmanian Health Organisation - South

Dr Roscoe Taylor, Chief Health Officer
Ms Karen Linegar, Acting CEO, Tasmanian Health Organisation - North West
Lyn Cox, Acting Chair, Tasmanian Health Organisations
Steven Shackcloth, Chief Information Officer
Dominic Morgan, CEO, Ambulance Tasmania
Tony Steven, A/Deputy Secretary Children and Youth Services
Sue Baker, Chair, Audit and Risk Sub-committee
Nick Goddard, A/CEO, Statewide and Mental Health Services
Mark Scanlon, Chair, Audit and Risk Sub-committee
Sarah Jordan, Chair, Audit and Risk Sub-committee
Matthew Healey, Director, Royal Hobart Hospital Redevelopment
Mark Scanlon, Chair, Audit and Risk Subcommittee
Dominic Morgan, Chief Executive Officer, Ambulance Tasmania

Department of Premier and Cabinet

Rebekah Burton, Deputy Secretary, Office of the Secretary
Mitchell Knevett, Director, Office of eGOvernment
Piero Peroni, General Manager TMD, TMD Directorate

Department of State Growth - ICT and Innovation

Jonathan Wood, Deputy Secretary, Investment, Trade and Sectors
Maria Dalla-Fontana, Manager, Digital Futures
Glen Dean, Finance Director
Dr Samantha Fox, Director Strategy and Research,

The committee met at 9 a.m.

DIVISION 3 -
(Health and Human Services)

CHAIR (Mr Hall) - I welcome you, minister, to the table for your first Estimates on that side. Please introduce your members of staff for the purposes of Hansard.

Mr FERGUSON - Good morning, Chair and members. This morning I am joined by Mr Jonathan Wood, Deputy Secretary, Industry and Business Growth in the Department of State Growth, and Dr Samantha Fox, Director of State Growth Strategy, also from the Department of State Growth.

As this portfolio sits across the Department of State Growth as well as the Department of Premier and Cabinet, depending on the wishes of your committee, I suggest that I might share an overview across the portfolio of IT and innovation. Bearing in mind that I will bring other people to the table for the outputs related to the Department of Premier and Cabinet at a later time this morning.

CHAIR - Thank you. I will just make a couple of comments first. When we had our meeting the other day, we were unaware of that and we had some chasing up to find out what's at

where. Could you give a quick overview of that IT stuff under State Growth 1.2 and DPAC 3.1 and 3.3? Minister, do you have an opening statement?

Mr FERGUSON - Thank you, Chair. This is an exciting portfolio. IT and Innovation is an important priority for the Government. From July of this year the new Department of State Growth was established with a mandate to help pursue jobs, to grow the economy, and to create opportunities for Tasmanians. That relates to all industry sectors. A key to the structure in the Department of State Growth is bringing together those key industries and economic drivers into one agency so that each is being utilised in a coordinated and focused way to get the best from each other.

It is particularly worth noting there are very clear synergies between the ministerial portfolios that exist within State Growth. Mine is just one of those and, for example, there are clear synergies between the IT and Innovation portfolio and the State Growth portfolio, we have a lot in common. IT and Innovations are enablers of State Growth, the IT sector on its own is a major industry sector opportunity for our state but importantly, it is not just about the sector on its own and the jobs it creates. It is also about the opportunities that it provides for other industries. In our Government we see IT as an enabler of job creation and productivity right across the economy.

I talked about synergies; my colleague Matthew Groom, the Minister for State Growth and I maintain a very close working relationship because, naturally enough, he and I share responsibilities in this area. It is with this in mind that I point this out for the purpose of Estimates.

Output 1.2 from State Growth, being industry and business growth, will be examined today, but given that we share it I would invite the committee not to declare it examined until you have also had a chance to speak to Matthew Groom later on this week.

Just forewarning as well, I also assist the Premier in this portfolio of IT and Innovation, so for the purpose of DPAC outputs, I draw your attention to Output 3.1, ICT Policy Development and Implementation and 3.3 Delivery of Information and Telecommunications Technology Services.

Chair, I've already said that ICT is a significant employer in Tasmania and a vital enabler of businesses across the sectors. We are very proud of the work that we did before the election and since the election in putting together an election platform that we would deliver on, which is intended to grow jobs and training opportunities so that Tasmania can start to deliver on those key areas that have been promised now for many years but we haven't always seen realised. We have established very positive relationships with our key stakeholder groups, particular TASICT from the industry side and the Australian Computer Society Tasmania branch from a professional side. We have agreed with them that we are going to work very closely and develop partnership agreements so that we can receive industry and professional advice that can be translated into real government action.

Importantly, we have exciting opportunities in IT space. One of those which has captured the imagination of many Tasmanians is our initiative to provide free public wifi. In the Budget $0.5 million is committed to install public wifi services in key locations around Tasmania, in partnership with local organisations including councils, chambers of commerce and tourism associations, and we have a paper out in the public domain right now which was released last month.

We are seeking input from all those organisations and telecommunications providers to ensure that when we go to tender we are as well informed as possible so we can ensure that the benefits to the economy are maximised. We have also provided in the Budget $800 000 to continue Digital Ready for Retail. That is funding over four years to continue the program commenced by the previous government. We believe we can get even greater outcomes from that because we want to work with small and medium business to grow their opportunity, to market their product into those areas which have seen market share decline to online sales. We want Tasmanian business to get opportunity there.

The last point I would make is funding for the Go to Market Incubator. That is an initiative deliberately designed to help small businesses and start-ups to not just innovate and create a new idea or a new product, but to take that to market. That is about providing mentoring support and training so that individuals in small businesses can be informed about how to protect their intellectual property, capitalise on their good idea, grow their networks and take the product to market in a way that can create income for them and economic growth for the state.

What I might suggest is that I will hold my overview in relation to the DPAC outputs till later and take questions you may have on the DSG.

CHAIR - Thank you, minister. Any questions?

Mrs HISCUTT - Minister, in point 10 you talk about assisting businesses and farm finance concessional loan schemes. Are you able to tell me more about that, being interested in farming as I am?

Mr FERGUSON - That would be best answered by the Minister for State Growth, potentially under the same output, but as I mentioned we will be sharing that output.

Ms FORREST - With the Digital Ready for Retail program, how much funding is there for that? How do you intend to roll it out and how do people access it? All we hear is that it is impossible to get new businesses started at times. Barriers, barriers, barriers, so what are you doing?

Mr FERGUSON - Digital Ready for Retail is based on the previous government's Digital Ready program. The Budget contains $800 000 over four years, so $200 000 per financial year. That is part of our small business policy that we took to the election. We will not significantly change or disrupt the previous practice, or what that program has commenced with, because it is based on eligibility for a start. Not any business can participate in that program and there are some eligibility requirements to ensure we can boast that it is targeted and providing the support on a reasonably intensive basis to the ones who are seeking and able to get the benefit from that.

You asked about how it is being rolled out. The new rotation of this program was launched in July in Launceston. Consequent to that, we have two groups currently in training in anticipation of the funding being in the Budget. We have a group running in Launceston and Hobart at the moment and it is based on three workshops, the first is an introduction to the digital economy, the second is an introduction to social media and the third is a workshop on online tools for managing your business. They are done in a group setting and cohorts are usually around 15 businesses. The one we have in Launceston at the moment is 17 small businesses. Having done those workshops, and interspersed with them, participants are given one-on-one coaching

opportunities and mentoring as well. So, you're saying the feedback you receive is that it is often impossible to get a small business up and running?

Ms FORREST - Yes, but the challenge is not just IT, it is broader than that. I am interested in the eligibility criteria as well. Do you have a copy of the eligibility criteria?

Mr FERGUSON - Yes, we can certainly provide that to you and the committee, and I might invite Samantha Fox to assist me, or Maria Dalla-Fontana. Maria Dalla-Fontana is the manager of digital futures in the department. Before we speak to Maria, it is not necessarily about supporting and engaging a new business to get started.

This is about predominantly working with existing Tasmanian enterprises to help them enter the digital domain. We know everyone talks about getting online, but often there is a misunderstanding about how easy or how difficult that can be. For example, many businesses might be lured into the idea that it is just about getting onto Facebook or going on Twitter. In fact, that may not help increase their sales online. That is what the Digital Ready for Retail program is about. It is about working through, for example, e-commerce solutions, integrating stock and inventory to being visible online, so that customers can see what you have in stock right now, or items that can be purchased and placed on order - so that you can see the product. You might see a photograph, not just of a catalogue-type image, but the actual pair of shoes in your store, or the tennis racquet.

It is also about providing some introductory mentoring support for businesses, for example with their online accounting systems. If you can support a business to get online, and they are doing e-commerce online and sales of real inventory stock online, then there is an opportunity for them to also be making sure there is not double handling on their accounting.

Maria, if I could ask you please to talk to the eligibility criteria for businesses.

Ms DALLA-FONTANA - The eligibility criteria relates to ensuring businesses have a computer that is less than five years old, and that they have an internet connection. We have in the past struck problems with businesses applying to do the program - they are allocated a coach and they insist they have a computer and internet connection, but when the coach arrives to do the coaching, they have neither. That is a problem. So we decided to set eligibility criteria. They are not extensive.

They also have to understand a little bit about online functions. Do they do their own online banking, for example; have they bought a plane ticket online, that sort of thing. So they understand the transactions and processes associated with doing business online. They have to have an open mind to understanding what is possible for them, and the coach works very hard to manage their expectations. None of them are going to become an Amazon through this eight-week program. It is a very slow burn, and the main purpose is to broaden their mind as to what is possible, show them what their competition is doing, and help them understand what time commitment is involved in participating online.

Ms FORREST - These are businesses that already exist. Hard to believe that some of them do not have a computer and internet connection. It is staggering to think that businesses out there are like that. But for some in my electorate, there is no point in having an internet connection because you cannot get it anyway.

Ms DALLA-FONTANA - That is another issue, but it is outside the scope of the program

Ms FORREST - The Go to Market Incubator - how much has been allocated for that, and again, the same sort of questions about that. Eligibility, and how do people engage in that program?

Mr FERGUSON - The Go to Market Incubator is funded in the Budget to $0.5 million. That is funding over two years. We see that as an opportunity to work with small and medium businesses in Tasmania that have an idea. They might have already passed the innovation hurdle - they might have already developed either a software product, or some innovative solution to a problem. Like the gentleman who came to see me with a tool he had invented; he is a motor mechanic. It is a tool which helps you get to a particularly difficult part of the engine and I shouldn't say much more than that or I will blow his intellectual property. The idea is that there are businesses in Tasmania that have already done the work of coming up with a good idea, one that has a market opportunity but they are not always aware of how to take it to market, how to exploit the opportunities they have without having their intellectual property stolen or somebody else rip them off in taking it to market for them. That is what this program is based on.

The department is doing some more detailed work on the proposal we took to the election so that we can make sure we get the best possible model. I believe that the incubator should not necessarily be a physical one subject to rent and other overheads but that we make sure that the funding is maximised so that we get the best possible level of support. I am talking about training, like a somewhat formal opportunity for businesses to go through the steps of knowing, for example, how to protect your intellectual property, how to gain a trademark, how to gain a patent, and then coaching opportunities to take it right through to you taking it to market and developing sales.

Ms FORREST - So how will you measure your success or otherwise?

Mr FERGUSON - Success or failure. This has been done in other states already. We have modelled the commitment we made prior to the election based on other incubators and laboratories in other states, particularly Queensland and Victoria. With our modest investment in comparison, we want to make sure that we take advantage of what is known from the other states. Additionally, it is worth saying that in the Federal Budget there were significant funds provided for enterprise infrastructure. I have asked the department to ensure that the design that we come up with complements that more recent announcement by the Federal Government so that we are not duplicating.

Ms FORREST - You don't have KPIs as such yet then? Is that what you are saying?

Mr FERGUSON - KPIs will be in terms of the number of businesses and Tasmanians that we support and take their product to market.

Ms FORREST - You mention the patents and trademarks. There are some very innovative businesses in my electorate that have no intention of registering patents because they want to keep ahead of the game all the time. As soon as you spend time and effort focusing on getting the patent you are behind the eight ball because the next innovation is around the corner. This company has kicked many goals in its area.

KPIs should not just be a measure of activity because they don't tell you about outcomes. How are you going to measure their success? If you are going to count patents then you will have a low number. Many of these innovative companies don't rely on that. They see it as a waste of time in many respects. I am interested in how you are going to measure it.

Mr FERGUSON - There are two ways to respond to that. First, if people make a deliberate choice not to protect their intellectual property then that is their own choice. We want that to be an informed choice because there is internationally recognised patent law in Australia. We are part of that international arrangement and it would be quite unusual for a business having come up with a very innovative product which is exposed to theft to choose not to protect their intellectual property.

Second, we want to provide opportunities for Tasmanian businesses to know what to know, where the pitfalls are, and to be able to take their product to market. I am not just talking about industries and businesses that have intellectual property to secure. We are also talking about businesses that need mentoring assistance to go to market with what they already have.

Ms FORREST - I will be keen to see what your KPIs are when you develop them and we see them in the Budget next year.

Mr FERGUSON - Sure. I will say it again. The KPI is supporting the number of businesses to successfully take their product to market and to commercialise it. In the past we have seen a lot of talk about innovation in Tasmania and it is unfortunately becoming a buzzword. Innovation is to our Government. The next step after innovation is to turn a dollar and to commercialise. That is what our initiative here is intended to support.

Mrs HISCUTT - Going back to the digital-ready and other ways of helping businesses move forward, I have seen your digital-ready programs in action and I find them very helpful and good. I heard about it online. Minister, have you set aside funds for advertising in other media? The people you want to direct it to are not necessarily online. Have you set aside funds and how do you intend informing people?

Mr FERGUSON - There is support in the Budget for marketing. I will ask Ms Dalla-Fontana to respond to that in a moment. I can tell you that we have limited space on our Digital Ready for Retail groups. I have mentioned that usually a cohort is 15 and at the moment we have 17 in our Launceston group and a similar number in Hobart. That is as a result of having already done the department's marketing work, principally by email. There have been press ads well and email marketing is the most effective way to get the word out there. For example, I receive an email bulletin from a chamber of commerce and I noticed that it was mentioned in there as well.

It is a very smart way for the Government to get the word out there in a cost-effective way, particularly targeting the businesses that are most likely to be interested in Digital Ready for Retail. The good news is that there is a waiting list of more people than there is room for at the moment. There are about 40 businesses on the waiting list waiting for the next iteration of Digital Ready for Retail. Maria, if you could briefly respond in relation to how we market.

Ms DALLA-FONTANA - Only that I would add that we directly market to all of the peak bodies that deal with small businesses and the trade associations, councils and other industry bodies to send out to their membership. We also have an extensive membership list of past

participants and we asked them to refer the program on to other businesses and colleagues and friends they may know who could benefit. We do place advertisements in the standard newspapers, local newspapers and we do sessions on radio in every region, for example, where we have either coaches or past participants talk about it.

Mrs HISCUTT - You would not think to make it a KPI that everyone who has participated that they then would have to inform at least five other businesses - word of mouth.

Ms DALLA-FONTANA - That works the best for us we have found - the word of mouth. We now have a series of video case studies that we have made available where past participants talk about the impact the program had for their business. That is across a whole range of different subject areas. We worked with four peak bodies for those: TFGA, Small Business Council, TCCI and the Tourism Industry Council. They sent them out to their membership as well and we use them in direct marketing to promote the opportunity.

Mr FARRELL - I have a couple of questions and they may relate to DPAC so do advise me. Is the Budget Information Management System project under you, or is that in DPAC? There is $7.5 million being provided to replace the budget management system.

Mr FERGUSON - That would be a Treasury question. Shortly I can bring forward our DPAC support team. I can give a preview here. That is a Treasury initiative but it is supported by DPAC because its whole-of-government ICT policy is coordinated through DPAC and it provides policy advice across government for acquisitions of new software products and hardware platforms. I am very happy to take the question and get you a fuller response if you would like to move to that output at some point.

Chair, if I might invite you not to declare that output examined so that Mr Groom can also respond to it later in the week.

I invite the DPAC officers to the table: Rebekah Burton, Deputy Secretary, DPAC, and Mitch Knevett, Director, Office of eGovernment. They will support me with output 3.1. I will invite Mr Piero Peroni, General Manager, TMD. He is available to answer questions with me on output 3.3. Shall we continue with Mr Farrell's question?

[9.30 a.m.]

By terms of overview, for the benefit of the committee and just before we go to Mr Farrell's question, output 3.1 relates to information and communication technology policy development and implementation. The Office of eGovernment provides this output through the coordination, development and the implementation of whole-of-government information systems, telecoms, information management strategies and policies and it has been engaged in quite a range of tasks In particular, they are tasked at the moment with revising existing government ICT strategy so that it aligns with the new government's priorities and agenda, particularly some of the work that we announced before the election about taking Tasmanian government data to the cloud.

I have also asked the Office of eGovernment to commence work on the development of an open data policy. We are one of only two states in Australia that does not have a formal open data policy and it is an opportunity for our state to get better richness and value from the data that the government already possesses and continues to grow.

It is working with the TMD division to address the future requirements for the government's wide area network, which is a key challenge and a key opportunity for the government as we progress into Networking Tasmania III, and also with the Department of Treasury and Finance to restructure the Government's ICT purchasing approach, which was one of our election commitments.

I invite Ms Burton and Mitchell Knevett to respond to Mr Farrell's question about the Budget systems.

Ms BURTON - The budget information system is a Treasury project - the refurbishment, improvement and replacement of the existing quite old budget system and it is a case in point of the process that is now undertaken by agencies in terms of ICT investment. There is a structured infrastructure investment review program, SIIRP, as we call it. ICT projects go through that hurdle dated process and then through the Budget committee process, funds are allocated.

Ms FORREST - It is an existing process, is it not?

Ms BURTON - It is an existing process and it sits under the aegis of Treasury but also the ICT Policy Board. We have a governance body chaired by the secretary of DPAC which looks at ICT projects across government; it is a way of funnelling valuable projects through a process to get funding. The budget information system is one of those projects but it is probably better to target detailed questions at Treasury - we would not have the detail of the specific question but the process certainly would have been involved.

Mr FERGUSON - The intention is that we get some coordination right across government so that agencies are not stranded, with some quite good at procurement and some weaker. The concept is to get some uniform standard for those purchasing decisions and also in implementation. I am sure you know, Mr Farrell, that we have seen some horrific examples of interstate governments and agencies, with all the best intentions in the world, exposed to projects which blow out cost or time and significant problems can occur. This is an attempt by government to provide support to agencies so that their decisions are successful.

Ms FORREST - Minister, you mentioned data in the cloud. What measures are you taking about security?

Mr FERGUSON - Security is, first and foremost, one of the greatest areas to be mindful of. I do not think anyone should assume that not going to the cloud is secure because if you are sitting on systems that are suffering from redundancy or lack of maintenance, you introduce security vulnerabilities into your existing systems. In Tasmania, we have a significant problem because we have a range of agencies using different technologies and different standards of data centre operations. Some agencies retain their own data in-house in their own facilities. Other agencies are using some of the data centres provided by TMD. TMD is in the course of exiting their own controlled data centres because it is not a function of government we think we do particularly well. We are seeking to outsource data centre procurement away from government where we can strive for much more robust industry best practice, where we can provide a greater level of security assurance to agencies, particularly those agencies that are responsible for maintaining, for example, patient or student privacy.

It is a key concern, but moving data to the cloud is, as much as anything, an industry growth strategy. We want to encourage the growth of data centres in Tasmania. I hope you will be

assured to know it is about providing more robust systems, because that is a known weakness - I should say, a known concern.

Ms FORREST - Have you allocated funding for this area? There are Tasmanian companies that are growing in this area - electronic data storage and security. I am sure you are aware of that. They have identified it as an issue. It is for every business, not just for the Government, but the Government needs to be particularly careful. Is there funding to progress this, if it is a known risk?

Mr FERGUSON - Not specifically. The policy direction of Government is to encourage agencies to go to market and get their solutions sorted, with industry best practice. Agencies are already funding their IT systems and there could be case made that if it is an inefficient system they are probably not getting a good return on their investment already. TMD and DPAC together are working to provide options to agencies, so they can get their data suitably secured. There is not a specific funding allocation provided for that because they already have their IT budget, but Rebekah or Piero feel free to add further information here.

Ms BURTON - The key point is the contractual arrangement. We have been going through the NTIII network in Tasmania, so it is on its third iteration - the wide area network contract. The funding for information security includes, as the minister has said, going out to the market, so there is funding involved. When you procure a service, information security is a key criterion and that is something we take very seriously.

Ms FORREST - If you are having a whole-of-government approach to this as the output group description suggests, wouldn't you encourage all departments to look at a consistent model rather than health having this, infrastructure having that, education having something else. It is hardly efficient.

Ms BURTON - It is probably best to answer your question in two parts. There is the contractual arrangement with providers and data centres and that is something Piero might talk about. Then we have an information security approach. We have an information security policy manual. We have policies and procedures within government. Perhaps you could answer that, Piero?

Mr PERONI - From a physical security perspective, we have been moving for about three years on this - seeking a common environment across government by acquiring that from the private sector. We have been seeking to grow the capacity of private sector data centre capacity in Tasmania. We have the contracts - whole-of-government contracts - in place. To facilitate that standardised approach, TMD, as a government service provider, is exiting data centre service provision. All agencies have been advised that by the middle of 2016 internal services won't be provided. As agency equipment ages and has to be refreshed, rather than spend the capital on new equipment, the agencies will buy services from private sector data centre providers that are already under contract with the Department of Premier and Cabinet.

Ms FORREST - Within their existing budgets?

Mr PERONI - Yes, because instead of the capital expenditure associated with upgrading their own data centre capabilities, in terms of upgrading their hardware, they will be able at the appropriate time, when that capital expenditure is required, buy the service from the whole-of-

government contract and they can even choose not to be buying technology if they wish. They can buy the service rather than invest in hardware.

Ms FORREST - That would be an option. That's what I am looking for.

Mr PERONI - Yes.

Ms FORREST - This is the way of the future, surely?

Mr PERONI - Absolutely.

Mr FERGUSON - The issue is that TMD will secure the services and place them on a panel from which agencies can purchase. TMD is funded this way by getting a percentage return on the purchase price. It does not receive any Consolidated Fund appropriations so TMD becomes the broker for those services. We are not suggesting that agencies and GBEs should necessarily be choosing from a particular provider. We would want them to be able to select from whatever businesses have provided contracts and availability on the panel.

At the same time, there's a lot to be said for encouraging competition and we wouldn't be proposing a one-size-fits-all. Some agencies might be willing to go to infrastructure as a service where they place their own equipment in the data centre and they are responsible for maintaining it and keeping it up to date. Some agencies might be willing and able to do that. Other agencies, particularly a small one, might see more value in having a data centre as a service where they are purchasing, almost like a subscriber, a contract from a provider and not being responsible for any hardware but knowing that there are certain standards of service which are going to be guaranteed. They can upload and download their data requirements.

Ms FORREST - So was there an expectation from your Government, minister, that encouraged the consideration of Tasmanian businesses in this because it is another potential growth, currently, as well as in the future.

Mr FERGUSON - The whole-of-government position on this is very strong. We want to ensure that we introduce local benefits testing to all of our government contracts that we engage in. At the same time it's difficult to exclude outside Tasmanian providers, but there is a policy opportunity for Tasmania to have a sense of security about where their data is stored.

Mr FERGUSON - Particularly as we are supposed to have the NBN first. I can get it in my office but I can't get it at home and I live about a kilometre from my office. Isn't that strange?

Mrs HISCUTT - Thanks, minister. You might like to give us an update on how the NBN is going. I have heard you are going to use an optimised aerial deployment with the rollout of the NBN. Could you explain what that is and how things are going with that?

Mr FERGUSON - Yes, thank you. It sounds as if Ms Forrest is having issues with NBN as many Tasmanians are.

Ms FORREST - It's fantastic at home.

Mr FERGUSON - If you can get it, because that is the issue that many Tasmanians have. Around 2009 that commitment was made that Tasmania would be the first mover on NBN and

have it virtually across the state, and five years later we haven't seen that realised. We have had progress in the number of Tasmanian properties that are passed by fibre. There have been significant rollout delays that have plagued the project and the very significant problems that have been experienced by subcontractors that have been engaged to participate in the rollout.

The Government recognises that it's not our project. It's a federally organised project that's done through NBN Co which is a Federal Government business, so there is some arm's length that already occurs between the Federal Government executive and the business that it owns but nonetheless it is a federal project.

[9.45 a.m.]

As a Government we have turned our mind to how we can support the rollout from the Tasmanian perspective and that is where we come in with what you have correctly titled 'optimised aerial deployment', Mrs Hiscutt.

This is about using above-ground pole assets more extensively to help speed up the delivery of NBN in Tasmania. As we know, the deal that NBN Co did with Telstra meant that the deployment was expected to be using Telstra's pits and ducts. That has been quite a slow rollout, as we have seen in many communities around Tasmania, particularly with asbestos pits. The whole purpose of using above-ground pole assets is to encourage the NBN to occur more speedily and more successfully.

Previously Aurora and today TasNetworks have been engaged by the new Government extensively to work on redesigning what we call FSAMs, fibre service area modules. There have been quite a number of FSAMs already designed for where fibre would go, through what pits and what ducts, and what underground assets would be used. We have actually had them redesigned so that in using much more of the above-ground infrastructure you don't encounter the same time delays and obstacles that have been experienced in the past. We have already seen two of the FSAMs - Riverside in Launceston and Glebe in Hobart - redesigned and they underwent construction commencement in May this year, but there were more. Those two were redesigned from their original all-underground design to incorporate aerial assets. There have been other FSAMs under construction as well since that time, Waverley in Launceston and Lindisfarne in the south, and together those two areas incorporate 839 poles.

There is a lot of interest by me in their success in terms of speed and cost, two key areas of concern for the Federal Government. That is why a cost-benefit analysis is undertaken of each FSAM area to determine the optimal rollout method. That is something we are very concerned about.

Our Government continues to support fibre to the premises as the aspirational best hope for our state. We are not in control of that but that is our position, and we continue to put that position to our Commonwealth colleagues. With all of the disappointment we have experienced with NBN in Tasmania, we nonetheless want to make sure that we have gained access to the best possible technologies so that Tasmanian businesses, homes and public institutions like schools and hospitals, have fast broadband and for other communities who have substandard broadband at all, access to broadband for the first time.

Mrs HISCUTT - The aerial wires used are rolled up and stapled to poles. There has been the odd complaint about that; has that settled down? Are people more accepting of these aerial lines now?

Mr FERGUSON - From an aesthetic point of view, we would all like everything to be underground. There are significant challenges with that and the aerial deployment gives us the opportunity to get fibre to the premises. We are seeing that in the four FSAMs I have mentioned. I should have mentioned there are a further six FSAMs that have also been redesigned and they are awaiting construction approval by NBN Co. If you look at all of the work that TasNetworks have done, they have redesigned FSAMs to the point that they are using 4 000 poles around Tasmania. That is providing opportunity and incentive to NBN Co to continue fibre to the premises in Tasmania. We want to see that occur and at the very least we want to see that the FSAMs have been redesigned and are under construction, and that when they are completed with their construction, that a cost-benefit analysis is undertaken so that the benefits can be proven.

Ms FORREST - You mentioned developing an open data policy. You would remember the last government, as one of their cost-saving measures they got rid of Tasmania Together and that was a very rich data source that was subsumed into DPAC, so I assume it is in your area - the data set?

Mr FERGUSON - The policy that relates to how we handle the data certainly would be.

Ms FORREST - This is the most extensive and amazing set of data. It is a shame it is not in the same format that it was, but that was a decision of the last government, which was supported by your party at the time. Is this open data policy designed to revisit some of the data that was available through that program?

Mr FERGUSON - Yes. Right across government we sit on a wealth of information, a wealth of data, that is often secured in ways that mean that other parties outside of government cannot gain access to it, and therefore cannot add value to it. That is for a good reason. Quite naturally, government data often relates to citizens of Tasmania, and it must be protected.

Ms FORREST - Some data, not all.

Mr FERGUSON - Much. That is right, and it is not all the data. There is an insecurity, traditionally, in government about releasing data, because you do not always know what you are releasing or what the impacts might be if it was released. It would be very disturbing if you inadvertently released some information that breached someone's privacy. The open data policy that I referred to earlier, and that you are asking me about, is a policy in development. It will provide advice to agencies about the opportunities to release data in a way that gives access to outside people of interest, or IT developers - software developers that can turn our data into something more useful, not just for the community, but for government.

Specifically you have asked about the TasTogether data, and that data is plainly valuable. We would want not want to lose the benefit of it.

Ms FORREST - It now seems to have been subsumed into DPAC and almost disappeared.

Mr FERGUSON - The board has been.

Ms FORREST - Access to the data I am talking about, because when they had their website it was a live interactive website. It had a huge range of tools to enable public access - anyone in the government could access it as well to inform policy.

Mr FERGUSON - It is that way of looking at data that is the whole point of the open data policy we are working on at the moment. It is not just about having the data, it is about how you use it. Over the passage of time data then becomes out of date and no-one has taken the opportunity to get the benefit of it. I will ask Ms Burton to speak to the 'Stats Matter' work that is already under way in the department. That is about providing a robust framework for the way government and agencies create and retain their data - the way they store it. It is a partnership with the ABS as well, so the information is catalogued in a way that can best protect the integrity of the data, so that others can use it.

Ms BURTON - We talked about the TasTogether resource. Effectively that was subsumed into DPAC, but through this arrangement with the ABS the people who were involved with TasTogether are now working on a statistical strategy for government - a good data, better government approach. Datasets are important, and, as you identified, the TasTogether dataset is an important dataset, although it is not currently being updated.

The minister has talked about the open data policy - as part of that there will be a portal that will enable access to government data, but sitting behind that, Ms Forrest, as you know, you need to have standards. You need good metadata, and you need to have agencies focused on collecting the right sort of data. So, there is a huge amount of work going on in agencies to identify - this is a bit like saying 'fruit fly free status' - state significant statistical assets.

Mr MULDER - So where does he sell these sea shells?

Ms BURTON - The ABS, I think.

It is focusing on determining the assets that need to be exposed, and also the ones that are important, as the minister has said, for internal government use. We certainly have not thrown the baby out with the bath water

Ms FORREST - But it is not being updated - that is the point. It was kept up to date, and there were regular reviews. As the minister says, data can become of less benefit if it dates, or is not updated. Is there an intention to -

Mr FERGUSON - Quite plainly this data will be updated, and will form part of the way that government shares data with the community. There is no intention to obscure or hide that data - in fact, we aspire to add to it and grow it. Other jurisdictions have done this in a way I would not like to copy. They have placed enormous amounts of data online and bragged about it but it is not very useful. It is often not machine readable, it might be merely PDF after PDF of screeds of data. For anyone to add value to them, they would have to manually re-enter them into an IT system. This is about not just the volume but about the quality of data.

This year saw the second GovHack event but I think it was the first time in Tasmania that we saw quite meaningful government data released to GovHack, which is an open data movement. We released Metro Tasmania timetable data. You would have thought that was a no-brainer. But it took a Liberal government to release that because the previous government did not wish to. What is special about that data that a government should not release it? By releasing it you are providing opportunity for IT-minded firms or individuals who want to have fun with it to create mobile apps and websites. And that is what they did, to show people how they can get from A to B using Tasmania's public transport. Other data that we made available was student achievement

through the NAPLAN data set. I was able, as Minister for Health, to release some data relating to the use of pharmaceuticals in the hospital system.

That might be regarded as data of only reasonable interest to government but if we are willing to share it in a way that does not compromise the privacy of the Tasmanian public, the non-government sector might be able to assist us in making better decisions. By visualising data sometimes we might be quite shocked at what the purchasing decisions of governments look like.

Ms FORREST - That was the beauty of Tasmania Together because it was not just PDF after PDF - it was a live website

Mr FERGUSON - Machine readable?

Ms FORREST - Yes, it was. It was very user friendly and you could interrogate it. That is lost now but maybe it will re-emerge.

Ms BURTON - Through the State Significant Disclosed Assets program we are looking at what are the priority data sets. With the ABS with their credibility in this fiscal space we are focusing on looking at those data sets for which there is a demand from within government but also from outside government. The focus in this process is on transparency of data, public value and improving service delivery. There are some key criteria that we are looking at in terms of those statistical assets.

Ms FORREST - Minister, you mentioned previously the free public wi-fi you are looking at in partnership with a range of bodies, including local government and tourism bodies. Where are you focusing on?

Mr FERGUSON - Do you mean geographically?

Ms FORREST - Yes.

Mr FERGUSON - That is an open question. We envisage around 50 locations. We are not being prescriptive about which vehicle that should be. We want to see the major metropolitans gain access to this and small and medium towns should be getting access to it. But importantly, and this is one of the purposes of releasing our pre-tender consultation paper in August, we want to discuss with the community the best way this can be rolled out so that we are not just giving free internet. We want to get some outcomes out of this for the broader Tasmanian economy. We believe that tourism is a major opportunity here. We can add value to the tourism experience which is why the Premier, as Minister for Tourism, is showing such interest in this.

There is a strong case that tourism destinations which may not be major residential centres could and should be considered for free public wi-fi. Imagine being able to get free wi-fi at Port Arthur, where the local infrastructure may not provide a wi-fi experience, but because of the tourism volume there we want to add value to the experience. We can do more. That is why I recommend reading the consultation paper because it talks about the way that the Government can start to gather usage pattern from that aggregate of data. We might be able to use that as a way of being better informed about the support we can provide to our tourism sector.

Ms FORREST - I commend the Government on that initiative. It is great. The challenge is going to be meeting sudden demand. As you know, the more risk the worse it is. Who is going to

pay? When I was in Europe last year there was a move in the European Union. They have a system where if you get enough signatures on a petition like that the government has to react and expected to positively, too. They had huge numbers of signatures, mostly the young people, about having free wi-fi all across Europe. It must be lovely. It is costly. How will it be funded and are you looking at trying to recoup some of the costs because it is not cheap?

Mr FERGUSON - First, we provided $500 000 in the Budget for the overall project. We have envisaged that Government would fund approximately 60 per cent of the up-front capital costs and we are looking for industry, local government and tourism partnerships to fund the other 40 per cent. We want to see mutual buy-in. Equally, the pre-tender consultation paper asks questions about the on-going data cost and maintenance cost, because it needs to be a sustainable model. We have made it quite clear that it is not just a fun project. We want it to be sustainable and to last over time. That is why any future partners that buy into this model will need to have also thought through the best way to pay for the ongoings.

CHAIR - Thank you, minister, we now have a quorum, so we will now move into the main game, Health. I invite you to give an overview and please introduce your two people to the table.

Mr FERGUSON - I introduce Michael Pervan, Acting Secretary of the Department of the Health and Human Services, to my right. To my left is David Nicholson, Deputy Secretary, Strategic Control, Workforce and Regulation. If required, we also have available today Eleanor Paterson, the Acting Chief Financial Officer, and Ross Smith, the General Manager of Shared Services.

CHAIR - Thank you very much.

Mr FERGUSON - By way of overview, I would like to say it is terrific to be here. I am extremely happy and honoured to serve as the Minister for the Health. It's been six months now since Tasmanians changed their government at the election. I believe we can say that we've worked very hard on getting on with the job and addressing some of the significant challenges that we find ourselves with.

The Budget this year constitutes a record investment in Health, $1 465 000 000. It is overwhelmingly focused on delivering for Tasmanians where they need it most, particularly at the front line. This is quite remarkable, especially given that the Federal Budget produced significant challenges for the state in our funding revenue source - that's certainly no secret.

Our focus at the moment, in coming to terms with those challenges, is on working to get the best health services in Tasmania with the resources that we have. We have an opportunity to spend Health dollars more wisely. That's why at the moment, and through our budget process and going forward we will be looking at every dollar and how it is spent. How can this spending initiative benefit Tasmanians, how does it benefit patients?

The Budget makes some significant reductions from the back line and reinvests those at the front line. We make no apology for that, naturally that brings with it at challenge that our agencies will be working through. This is a positive change and our vision reflects that, our vision is for positive change to do health better. It will require a lot of work and a lot team work for our health services to coordinate and work together and make those decisions in the interests of getting a health system that we can be proud of again.

Very briefly, on coming to Government and being sworn in as minister, we faced very early on some significant challenges, one of those being financial. We have seen the structural deficits of our THOs at present. We have continued to see some poor health outcomes that I am sure are very challenging to every member of this committee and the community. We have seen unacceptable delays of hospital access, for example, to the emergency department and to elective surgery. We have all experienced the unfolding and unacceptable problems that have plagued the Royal Hobart redevelopment and we have dealt with that. When we came to Government we were faced with dealing with the alligations that were raised with the Integrity Commission, and we are dealing with that. The report by the Commonwealth and state Commission on Delivery of Health Services in Tasmania, which is a very substantial piece of work, raised a synopsis of what health care looks like in Tasmania and the very deep challenges we face.

All of these challenges we have inherited, we want to deal with, and while we don't think we necessarily have all of the answers, I believe we have a very strong platform to get the Budget under control and how we can reform the health system while at the same time through, for example, our pay pause legislation, how we can support saving jobs.

We have provided in the Budget the extra resources required to deliver on our election commitment to increase the employment of graduate nurses. That is set to increase by up to 85 positions by the end of this parliamentary term in this Budget cycle. That commences this year with an additional 10 places, which are already in the pipeline. We are also funding in the Budget additional frontline patient services, in particular elective surgery, which I know we speak a lot about. Many of our offices receive letters from people who are in pain and struggling and often disabled by their illness and they are looking for leadership from the Government to help them get access to hospital, access to their surgery. As part of this Budget we are very proud to be delivering on our commitment to invest $76 million, specifically for additional elective surgery volume. When you add the additional investment of $23 million by the federal Government into elective surgery, we are looking at additional funding of nearly $100 million for up to an extra 17 000 elective surgeries over the next four years. This is very exciting for our state and we want to make sure the system is best tuned to receive that funding and deliver the best possible, and the greatest number of outcomes.

The Royal Hobart Hospital redevelopment - this is not just a concern to anyone who lives in the south of the state, it is a concern to all Tasmanians because the project has been left in absolute mess by the previous government. The advice we received on coming to government was really quite distressing. It was not just about the finances and it was not just about the time delays. It was about the project going forward, and the decisions that had been made in terms of the methodology, which had a significant and real impact on what is called the patient decant. The risk to patient care was the major concern we had. Rather than walking away from the project, or looking for an excuse to walk away from it, as a Government we have taken the decision to establish the rescue task force and that work is under way. The website and the communiques released by the task force show the work is very positive. Their job is to come back to the Government with a recommendation by the end of November as to what to do next, and we are determined to rescue that project.

We have also outlined the hidden waiting list. We said we would do that. We did not know what the number would be, but it turned out to be about three times bigger than the elective surgery waiting list. This is the list of 26 000 Tasmanians who are waiting for access to an outpatient or hospital appointment. They are often people who will eventually require surgery of some kind or some other diagnostic service.

Importantly as well, in the Budget, we have delivered on our commitment to hospital alternatives. It is a great thing to try to keep people out of hospital even if they require some acute care, so that we can retain hospitals beds for the people who need them most and provide the greatest level of access. The Budget provides for $3 million over four years for the hospital alternative program. Those familiar with the LGH will know that as the hospital-in-the-home, and there are other alternative models that will be funded through that work.

Mental health is an important issue for the Government. We believe we can review, and do better, the way that mental health services are coordinated and provided across both the government and non-government sectors. In partnership with the Mental Health Council of Tasmania we are embarking on a 'rethink mental health' initiative that attracts some funding in the Budget to resource it. We are determined to review how we do mental health and assess whether we provide the best models of care to people who require it. We are also providing continued funding to Rural Alive and Well because of the very valuable work they are doing in the community. There is $1 million over two years to continue that project and, as part of our overall sense of concern for what is happening in the community, there is $3 million in the Budget. It is a real and additional investment in doing our part to create awareness and the community infrastructure to, as much as we can, prevent suicide in the community. That is something that the Government is very serious about and determined to deliver improved outcomes. We believe that while it is the wrong choice and it is a choice, unfortunately people, are making, it is not the answer. Suicide is not the answer. Our message to the community is that there is help. That is why this funding is intended to provide additional support and it will be focused at the grass roots. I am happy to take questions on that because there is a lot to say.

We are also talking about reform of our health system. This is a huge challenge for our state but we can't ignore the challenges that sit behind it and the reasons why we need reform. In July the Government announced our reform direction. It is about one state, one health system, and better outcomes. The reforms draw upon the valuable feedback that the Government received, as I visited all of our major hospitals and many of our regional hospitals, and what Tasmanians have had to say. The core elements in relation to that are moving to a single THO model - we will call that the Tasmanian Health Service - and with an ambitious time line of 1 July to establish that single THO. We believe that is a significant reform initiative for our state to deal with. We recognise we are one state which should have one health system.

We are reforming the department to ensure it properly takes up its role as purchaser and system manager, continuing the reform that was stalled but was always intended to have taken place under national health reform. It includes the establishment of the Health Council of Tasmania, so that for the first time we can have clinical and consumer and community engagement to provide the highest level strategic advice to the Government on the direction of health in Tasmania. This is a significant opportunity for our state for the setting up of this health council. As much as possible, the way we are setting it up is to strive for consensus in health policy. I believe that will make a big contribution.

Finally, in relation to health reform, the development of a white paper. That is about setting an agenda for better service planning, profiling, and delivery of clinical services in Tasmania. This is the Government grasping the opportunity, knowing it has been tried before. We are a small state and a great state, but having divisions in the community around regional boundaries has not necessarily served us well. By planning on a statewide basis for what our health system can and should look like is a major opportunity.

I might spend a moment on the matter of pharmaceutical or medicinal cannabis. This has been, interestingly, one of the issues to which the Government has devoted considerable time, particularly in response to the concerns that have been raised by members of the community and members of parliament. I am not dismissing the issue when I say that this not something that had a lot of publicity prior to the election. It is one that has emerged since. I would like to put on record once again that our Government is sincerely compassionate in wishing to respond to this. Particularly for those Tasmanians and their loved ones who believe that this is the answer for their medical condition.

At the moment there is very limited clinical evidence about the effectiveness or safety of cannabis as a product, or cannabinoids as products, and a range of medications are available for the treatment of symptoms and conditions that medicinal cannabis is said to be effective for. In the framework we have in Australia, which Tasmania is a party to, is the Therapeutic Goods Administration and it is quite properly their job and their function not to be biased but to be independent in its analysis of applications for new medications. The Tasmanian Government is pleased to re-state the position we have made over a number of months that we support appropriately conducted clinical research to allow any claims of that nature to be tested in the correct way, in a robust, evidence-based fashion. It is science, not politics, which determines what new medicines enter the legal drug supply in Australia.

We have made a submission to the Legislative Council's inquiry on this. It is for that committee to decide when to make public any submission the Government has made but we would be happy for it to be released.

Ms FORREST - It has only just been received so the committee would not have a chance to publish it any time until now.

Mr FERGUSON - We are delighted to have been able to support that work. We support that inquiry and we look forward to its outputs. We will respond appropriately to any recommendations.

Finally, this Budget is a watershed for health in Tasmania; it is a record investment. We have kept our promises and we are determined to give Tasmanians a health system that delivers the right services in the right locations so that they can be supported when they need it.

CHAIR - Thank you, minister. That was a very comprehensive overview. I did allow you a bit of latitude with medical cannabis because that is a matter that is coming before a select committee of the Council as you are aware. We will move, then to output group 1.

Output group 1

Ms FORREST - You claim that there is record investment health in this Budget - more than there ever was before. The Treasurer has also said that savings need to be made across all areas, including Health, and you claim savings in the forward Estimates of $20 million by having one Tasmanian health service; I commend the Government for progressing down this path. I could not get those figures last year. I am interested in what the increase in funding for this year is and over the forward Estimates. The footnotes are wrong in the chapters - you probably noticed that they are out of sync.

I asked about the increase in real terms because the three output groups on page 4.13 - this is from last year's Budget papers - were under $829 million. This year it is $837 million and the forward Estimates are $829 million, $833 million and then $848 million in total. Last year's forward Estimates for the three output groups were $834 million last year , this year $837 million - not a huge difference there - $856 million in last year's Budget, $829 million in this year's budget for the forward Estimates going out and then $912 million in last year's Budget and $834 million this year. It is hard to detect any real increases, taking into account CPI increases and health inflation costs.

I am interested in how you claim that there is such record investment and additional funding in health.

Mr FERGUSON - It is plainly an increased investment in health. Previous budgets and forward Estimates are only ever estimates about future income and expense. The investment in health over the forward Estimates is $5.8 billion and this year it is $1.465 billion - that is more than last year.

I draw the committee's attention to the reality that first of all, the Budget was significantly deteriorating; the pre-election report and the risks report clearly identified that the public finances were taking an unhealthy dive. Additional to that, the Federal Budget showed a revenue reduction for Tasmania, which we naturally had to deal with as a challenge. We are proud to say we have addressed those issues and challenges, and they will continue to be challenges that we will have to address by providing record investment. We are keeping our election promises. While you see adjustments in forward Estimates - and I do not have last year's document in front of me but I take what you have to say - this Government has had to deal with a deteriorating Budget, a deteriorating set of numbers in federal revenue and the ending of a number of national partnership funding programs. But by taking the prudent action that we have taken, and I know that it can be controversial, the pay pause legislation that is currently before the Parliament is part of our budget strategy to get the public finances back on track and to ensure that the savings we can make in Health are reinvested back into patient outcomes - into frontline services.

This shouldn't come as a surprise to anyone in the Tasmanian community because this is what we said we would do. We said that we would focus on the front line. The budget savings task that is now being met by agencies and the THOs is around half of what the previous government placed as savings strategies in 2011. The difference with our Government is that we are ploughing those efficiencies back into frontline services. I accept that there will be debate around numbers and profiling and how numbers looked year on year compared to previous budget documents, but we are looking at a different budget scenario now. As we saw from the risks report, the state of public finance in Tasmania has deteriorated and we are determined to address that while at the same time keeping our promises.

If it weren't for that, we simply wouldn't be able to put $76 million into elective surgery, an additional $3 million into suicide prevention, and into additional investment for graduate nurses. It is about getting the balance, and I submit to the committee that we have struck a healthy balance.

Ms FORREST - You talked about the savings from the move to one THO. How can you ensure that the move to one Tasmanian health service improves the coordination of services and reduces duplication, administrative overheads and clinical support services, according to the budget papers? How are you going to achieve that?

Mr FERGUSON - It is an ambitious time line, 1 July. We are establishing the governance arrangements around that work right now. We will have more to say in the very near future about how that process will be steered.

Ms FORREST - I was going to ask you about that later.

Mr FERGUSON - We are not ready to announce that but it is imminent. There is an ambitious time frame there and a lot of work to be done. Thank you for your comment about releasing that information. I would hasten to add that is an early estimate of what is likely to be seen in efficiencies by moving from three THOs to one. We are not committed to the $21.3 million figure that was outlined. We have said that is an early estimate. That is indicative of the sort of savings that we could achieve. Naturally we want to achieve that.

Ms FORREST - I am asking you: how? The budget papers say it is going to be achieved through administrative overheads, so what are we going to see in that space and in the clinical support service to effect those savings, whether they be that much more or less?

Mr FERGUSON - You are asking specifically talking about the move to a single THO?

Ms FORREST - Yes.

Mr FERGUSON - When you have three THOs each doing similar administrative functions and then move to a single THO, naturally there is redundancy in the work and activity there. We want to make sure that the effort is not duplicated. It was one of the reasons why many people were agitating and pushing for a single THO, to save on the administrative duplication. It is the same case that was made for the merger of the water corporations. We have made a decision that that is the direction to take. We want it to be prudent financially but we do not wish to take away from the sense of community engagement at the local level. Each hospital will retain local management, but within a unified structure.

Ms FORREST - Are you saying we will see some positions go in administrative areas?

Mr FERGUSON - In a single THO, which we will call the Tasmanian Health Service, we do not want to see duplication. That is an obvious inefficiency.

Ms FORREST - Duplication of what? What are we talking about?

Mr FERGUSON - We would be looking at administrative functions that relate to the fixed costs that are met by any particular agency. As it is we have three agencies, the three THOs, each of them have obligations and responsibilities from a management and financial point of view.

Ms FORREST - So you are saying we do not have any shared services across the whole area at the moment. Is that what you are saying? That is what I am trying to nail down.

Mr FERGUSON - No, I am not saying that, and I am going to shortly ask one of these learned gentlemen to help me answer your question. There are some of the services that are shared, and there are also services that are shared with the department, so I would not be making a case that they are all entirely independent from each other. They are not. There is a whole range of relationships. There are some functions which are unique to each THO, and for which we

could see those efficiencies realised in a single THS. Before they answer that, you also asked about clinical improvements. You asked me about clinical support services?

Ms FORREST - That is what you say in the Budget papers. The clinical support services are where the savings are going to be made.

Mr FERGUSON - We have the white paper process. Shortly, the government is to release an issues paper which outlines the opportunities and the work that we need to do to move to a single THS. We have indicated that by the end of December we will be releasing for public consultation a green paper which outlines what the future can look like under a single THS. This is in terms of clinical services, and where they are delivered and how, and how we can do it better by working together as one state.

It is a major opportunity for us, but then we get to the nub of it. The white paper which is the conclusion of all that work and public consultation, will be released by March of next year in time for the July start of the THS. That is not to suggest that everything that is outlined by March will necessarily come into place on 1 July but it will set the agenda for where services will be delivered safely and effectively, so that Tasmanians can get access to better services.

Ms FORREST - It is always a challenge releasing a green paper over Christmas and the holiday period, if you want good input from the stakeholders who need to be engaged. People take leave over that time, so any chance it can be out earlier, before Christmas? You want the white paper developed by March. In realistic terms, this is a classic example of previous government's activities - putting out really important documents for public consultation in December.

Mr FERGUSON - Let me assure you that is not the case. We are going to meet our deadline. It is a self-imposed deadline, it is nothing other than that. We will have it out by the end of the year. I have also anticipated the issue that you have raised, and my office and the department are quite clear on this. The public consultation will not open the moment that paper is released, because we recognise that it is Christmas/New Year and many people are not going to be in a position to do that, so the consultation process will not open until some time later. In the interests of getting the information out, and showing what the green paper contains, we intend to have it released by December. The Christmas/New Year period will not count as part of the consultation period.

Ms FORREST - And most of January, I would suggest. Clinicians take a decent break over Christmas. The electorate winds right down over that time, for example, so

Mr FERGUSON - We intend to have a red hot go at consultation, not a pretend go, because I hope we all agree that this is an important reform.

Ms FORREST - It is the most important thing that you will do in your term as a minister, I would suggest.

Mr FERGUSON - You have set the challenge. It is also ambitious in its time line, so we accept that, and rather than moving to a white paper without consulting with the community, we want to share the green paper, we want to let the community know what this can look like. What the opportunities are, what the challenges will be. We want to make disclosure about that. We know that previous work has been done many times. The Richardson report, the 2007 Clinical

Services Plan. Lots of work has been done, but we have never come to the point where government has made a decision and followed through with it.

That is what this is about. Rather than simply presuming to have all the answers, we intend to release the issues paper very soon. We intend to release the green paper by the end of the year but we don't intend that the Christmas/New Year period take up, or be seen to take up, any opportunity for the public to be involved. The Health Council of Tasmania has a major role here. This Health Council of Tasmania will be comprised of clinicians. It will be comprised of members of the community, and consumer representatives, so we will have a whole of Tasmania health perspective. It will provide high level strategic advice to me, as Minister for Health, and future ministers for health. It is our goal, ambitious as it is, that this be a unifying experience for the state. It won't be easy all the time but the brief for that council will be to approach this task from a consensus point of view, and provide de-politicised advice to government about the future of health in our state.

Ms FORREST - Are those positions paid, minister, on that council?

Mr FERGUSON - I haven't announced that.

Mrs HISCUTT - I have a related question. Minister, can you explain to us non-medical people how the Health Council, the Tasmanian Health Service, and the governing council will interact? What are their individual roles?

Mr FERGUSON - Thank you, Mrs Hiscutt. The Tasmania Health Service is slated to commence on 1 July 2015. It is a unification of the three THOs - north, north-west and south. You might have called them hospital networks - we will have one established under the Tasmanian Health Organisations Act. There will be one Tasmanian health service on 1 July that is an amalgam of the previous THOs. Each THO currently has its own governing council, so we have three governing councils. Once again, on 1 July the one Tasmanian health service will have its own governing council - there will be one governing council. It is not determined exactly what the ideal number of members should be, but the legislation sets a maximum of eight. This isn't an announcement, but it may be necessary for Parliament to adjust that, taking account of the volume of work the future THS will have to do and the governance arrangements that would be required. We want to make sure we have a skills-based governing council. That answers that part of your question.

You also asked about how that intersects with the Health Council of Tasmania, which is quite a separate organisation. This is about bringing together clinical representatives, consumer representatives and the community. We will soon have more to say about he composition of the health council but that is broadly how it will be comprised. It will provide high level advice to the Government - to the minister - rather than to the governing council.

Mrs HISCUTT - So, the health council will advise your department and the governing council will advise the THS?

Mr FERGUSON - Yes, the governing council will control the Tasmanian Health Service, as its function under the legislation is to take operational responsibility for day to day functions as well as the longer term objectives of the THS. It will operate much as a company board would, and that's how it should be now. The governing councils of the three current THOs - their job is

to take responsibility for what happens in their emergency departments, with their elective surgery performance, with their employment, and with their financial management. That is their job.

I am not distancing the Government from this, but that's their job. Of course, the Government appoints governing council members in each case. It has been put to me that governing councils at the moment are too small.

Ms FORREST - As was raised in the debate in our House.

Mr FERGUSON - I wonder who raised that, Ms Forrest?

From 1 July there will be one Tasmanian health service, with a larger governing council.

Mr GAFFNEY - It says here 'with a spread of regional representation over those eight members'. Could you further expand on that? It might come up in the legislation. People in the north-west and on the west coast would be interested to know.

Mr FERGUSON - Yes, Mr Gaffney. First, I am not committed to necessarily introducing legislation on that point but I have said it may be prudent to enlarge the size - the maximum number of members - of the governing council. But the Government has not made a decision on that. I am advised that we are able to move to a single THS model, and we don't necessarily require legislation to achieve that. We may be able to do that through regulation.

You have asked me about representation. The role and function of the governing council is to manage the day-to-day affairs of the THO concerned and to do so professionally and with the right sets of skills and following the Government's framework which is set out in the act. It is also obligated to deliver on purchasing decisions made by the Government through the Department of Health and Human Services on the behalf of the Minister for Health.

We wanted to show good faith with the community because we know that there has been a lot of great work done by regional THOs, and the governing councils have in all cases been people who have committed to a task and acted as best they can in the situation they were placed. We want to acknowledge that. The other thing we want to acknowledge is that there is a sense of letting go here. In some communities people may feel they are losing something. You might see that more in the north, where people might have felt that they did not want to have a unified THO because they like their local representation and their own organisation. The Government has decided to move to a single THS and I want to put on the record today how thankful the Government is for the incredible and rare sense of consensus that we see. There is a fair bit of support for moving this way. At the same time we want to reassure local communities around the state this will not be a centralisation effort from the point of view of the board.

When it comes to engaging the governing council members, we will be acting in a way that will show to you that no region gets left behind, that every region will be seen to be represented, even though their job is not just to speak up for their local area but to work for the good of the whole state. I am quite serious about that, Mr Gaffney, and I will take the opportunity to thank governing council members from those three THOs who have supported that direction.

Mr GAFFNEY - You mentioned earlier about TasWater unifying to one. Very rarely when you have something like that are you going to experience savings in the first one, two or three

years when you have significant change in administration. I was wondering, when you mentioned that, how is that factored into the savings that you mentioned before?

Mr FERGUSON - You are quite right and prudent to point that out. We realise that those indicative savings that have been provided on advice to Cabinet are early estimates. You are correct - those savings would not be realised in the immediate term. We see a short-term cost in the Government needing to move to a single THS, and the benefits would be more medium term. I am advised that the upfront first year additional cost will be of the order of $300 000 in bringing the three units together and that the indicative $21 million would be saved over a three or four year time frame.

Mr GAFFNEY - That is important to get out there because people assume there is going to be savings straight away - and it has been put in the paper '$20 million over four years' - but they have to realise upfront, for the first one or two years there is not going to be a savings because of the nature of the beast. People will be more receptive if they understand that because it has happened in other areas as well.

Mr FERGUSON - Thanks for that helpful comment.

CHAIR - Put a media release out this afternoon explaining that.

Mr FERGUSON - That is a very good question.

Ms FORREST - My understanding is that the Tasmanian Health Organisation Act requires an order from Government to amend that to come back to Parliament as a disallowable instrument. It may not require legislative change but will require the approval of Parliament, as I understand it.

Mr FERGUSON - I would never presume either way in this regard. What I said earlier was that I have had some advice and we are continuing to take advice on the best way to achieve the unification of the three THOs. We would always respect the Parliament in anything that we do but as I did use the word regulation, I would have anticipated that any regulation would always go before Parliament in any event.

[10.45 a.m.]

Ms FORREST - Yes, as I understand, it comes back to the Parliament not to the Subordinate Legislation Committee as a done deal. Your adviser will no doubt follow that up.

Mr FERGUSON - I certainly will and I will be happy to take that on notice if you would like more detail.

Ms FORREST - Yes, just some clarification on the process would be helpful.

Mr FERGUSON - We have not made a decision on that, either. I have shared with you that there are two possible scenarios there, and I indicated that there is an open question about whether or not eight is enough governing council members to function to take responsibility for a single THS. The Government has not made a decision on that but we are asking ourselves the question and we are taking advice on that as well. It is important that we get the right skills set and that we show by our actions that we see each region has a voice on the table. Of course, if we are going

to change the maximum number of governing council members, it would require a change to the act.

CHAIR - Just a further overview question I have, minister, which is not really related to what Ruth and Leonie were referring to. I couldn't pick anything up on the budget papers and that is, as you are aware demographically, agewise we are getting on here a bit in Tasmania - speaking for myself, I am 65-plus - so do have you any strategies in place down the track to deal with that? You would almost think it will be a bigger drain on our health services compared to some other jurisdictions. Unfortunately, we have had quite a lot young people leave and we attract quite a few other people from the mainland to settle here but they have finished their working lives and whilst we welcome them, all of those matters are going to impact a bit more on our health services than probably in other states. Do you have any comment on that?

Mr FERGUSON - I certainly do. We are not just an older population by demographic compared to the national average. We are also ageing more rapidly than in any other state in Australia. South Australia might be not far behind us but the increase in our average age is increasing faster than the national average. You are correct in raising the issue because that has an impact on our health services and the capacity of our state as an economy to raise the necessary funds to pay for our health system. You could point to the emergency department and to the ambulance system, Ambulance Tasmania, as having increased demand as a result of an ageing population, and you will certainly see it in the elective surgery and diagnostic areas and in acute care, for example in cancer services. You will see demand increasing in all of those areas. If we are ageing, you won't necessarily have an increase in the capacity of the economy to keep up with the cost of that. That is why the Government has taken the position it has, in growing our population across the board and inviting Tasmanians to come back home, and for the Government to get out of the way of business and help business to grow and do well.

On the specific point you have raised, as we go through the white paper process, this is going to be a key concern for us because we want to make sure that Tasmanians, whatever their age profile, have access to the best possible health services. That means that we are fundamentally redesigning our health system virtually from the ground up. We are designing and redesigning a health system in Tasmania that takes account of the needs of the community within the resources that we have. That is why we are ending wasteful practices for identifying waste or identifying efficiencies that we can find across government and reinvesting those in frontline services. We know that is what Tasmanians asked for. It is what we said that we would do and we are delivering on that.

Mr HALL - Of course it also leads to the fact that we have, by all data, some of the worst health outcomes presently in the nation and that leads to the preventive health measures as I understand. There will be that joint House committee looking at those issues again, which is I think is very important. Do you have any succinct comments on that matter?

Mr FERGUSON - There are a few things on that. This opportunity should unify our community because you could see all these challenges as a negative and it is all very difficult, or you can see it as an opportunity. The challenge of our ageing demographic, the secondary challenge, is that we have the sickest population in the country. We have the highest rates of some of the indicators that we do not want - smoking, obesity and overweight; our cancer rates; and you saw recently the data released by the Health Foundation about cardiovascular disease and how Tasmania unfortunately has some hot spots there.

We are well ahead of the pack in the wrong areas. With those challenges, I think the community is well and truly ready and wanting health reform that focuses on the health needs of Tasmanians - doing it efficiently, ending waste, finding efficiencies from the back line and reinvesting those funds in the front line.

The Government has set itself another ambitious agenda, which is to have the healthiest population by the year 2025. That is a huge challenge and it is not for anyone to say that we cannot get there. We have to set it as our goal because if we do not we will continue to have a health system that runs out of control and does not deliver when you need it. It is about fine-tuning our health system. I am pleased that there is a continuing, even a new found interest in preventative health.

We are disappointed about the Commonwealth ending its involvement in the national partnership. We have made that clear but that is their decision they. We are working very hard with our Division of Population Health to mitigate that and come up with a transition to a long term future in preventative health. Some important programs were started under that federal funding and we want to provide as much security to them as we can, provided we get the benefits.

Although those programs - I will pick one, 'Move well, eat well' - were funded under the national partnership which ended on 30 June, we are continuing to fund that program through this financial year again while we work through the longer term issues.

Finally, you made reference to the proposed joint committee on preventative health. I note that the Legislative Council has moved to establish it to pick up the work of the committee of the former parliament. The Government has indicated that it is willing to support that initiative enthusiastically. We will cooperate and provide submissions, and we look forward to the findings of that work.

Mr MULDER - In all of that there is an assumption that as the demand is going to continue to grow whether you are well or not, has any work been done to say the health department over the next 20, 30 or 40 years cannot be everything to everyone. Will any work be done what level of service delivery they are going to cap? Are we going to work on the expectations management side or are we going to continue to plough money into ever-increasing levels and kinds of demands in the future?

Mr FERGUSON - Mr Mulder, we want to keep faith first of all with the community; we said we would get the health system working, find efficiencies in administration and the back line and reinvest that in front line. We said that we would invest in the elective surgery and other initiatives. I am sure you will point out to me they are all short and medium-term initiatives over the four-year Budget cycle.

At the same time, we made an undertaking to set a different goal for our state rather than stay in the doldrums imagining we will be the sickest state. We want to set a new goal: to be the healthiest state by 2025. Do you think we will get there? I hope we will.

Ms FORREST - I think the tough decisions are made.

Mr FERGUSON - That is my point. A lot of people believe that we will not get there - there is an assumption, a negativity that sits under that we could never get there. We have to get there because Tasmanians depend on it. The thing about better health is that you get a better life; you

enjoy life; life is better when your health is better. We want to provide support to people who are unwell, sick or patiently waiting on the elective surgery waiting list.

I support the premise of your question, which is that we want Tasmanians to - I am not going to say take responsibility - but share responsibility with Government for community health. Quite clearly there is a role for Tasmanians to recognise that if they live a particular lifestyle, for example if they smoke, illnesses will likely follow that will have an impact on their enjoyment of life and the ability of the health system to help them in the future.

Mr MULDER - Apart from expectations about a healthier state, how will the state health system work out which particular services are no longer to be the Rolls Royce services, funded from the public purse? That is your financial challenge, not in 2050, but today.

Mr FERGUSON - Yes, this is where I speak again about the Health Council of Tasmania. Their long-term job is to provide that sort of high level, strategic advice to government, and they will outlive this Government. It is a huge opportunity for us. I am excited about it and I can't wait to put the finishing touches to it and, with the Premier, announce the Health Council. Its job will be to answer those very questions you are asking.

Mr MULDER - So there will be services that we decide are inappropriate because although the outcomes might be brilliant, the cost to the public purse outweighs the benefit to be achieved?

Mr FERGUSON - Can I add to my answer? The white paper process is geared at that way of thinking - not just where services are provided but what services are provided in our state.

Mr MULDER - I look forward to getting a more definitive answer next year.

Mr FERGUSON - You will forgive me for not jumping ahead of what the white paper process might come up with. I wouldn't like to second guess it, otherwise the consultation I have promised we would do wouldn't be real.

Mr MULDER - That is what I am saying. I am looking forward to a more defined answer next year.

Mr FERGUSON - If I am still Health minister next year, we will have a great chat about that, because it will have been released.

Mr MULDER - Wellbeing issues?

Mr FERGUSON - I am loving the job, thank you for asking.

CHAIR - Minister, we have been going for a couple of hours so we might have a quick 15 minute break. We can all knock off and have a Chiko Roll and a Coke, and a smoke.

The committee suspended from 10.58 a.m. to 11.20 a.m.

Output group 1, Health Services System and Management.

CHAIR - Thank you, minister. We will start afresh. We will move now to output group 1, Health Services System and Management.

Ms FORREST - I commend you for looking to publish the hidden waiting lists, a problem that has been there forever. To publish them is great but how will that increase access to services or is that not your intention? What is your intention?

Mr FERGUSON - It is absolutely our intention to increase access for Tasmanians to any area of health service they require. The concern that the Government had was that we were all aware that there is a waiting list for access to hospital services, particularly outpatient, and that is part of the pathway through to elective surgery. I think I can say always the pathway through to elective surgery. The waiting list to that access which was hidden. We have published that figure and it comes out to just over 26 000 Tasmanians at early April this year.

We have also commenced steps to ensure that figure is updated in future progress reports of the department which come out quarterly. You cannot seek to improve an index that is hidden. So publishing it, being open about it and disclosing that figure every quarter, gives us another indicator to strive to improve.

Ms FORREST - Not all those people are waiting for appointments with specialists though, I assume? Some are waiting for other diagnostic tests and things. Are you going to break it down so we can see where the problems lie?

Mr PERVAN - Yes, we are in the process of breaking it down. One of the difficulties that we have is still with the inconsistent data capture. Which is why we are only reporting quarterly as opposed to the elective surgery numbers that we have far better knowledge across. We are looking at data improvement. The Commonwealth, through the Tasmania Health Assistance package, has funded a major initiative through Tasmania Medicare Local called Pathways, based on the Canterbury Pathways work which is about reforming the pathway from general practitioner through to outpatient and back again. That is a collaborative process that is happening between the THOs and the Tasmanian Medicare Local. It goes to improving that and weeding out the waste and making sure that when the patient gets to their outpatient appointment they are ready for care. They have their diagnostic work done and it is all done in a timely fashion. They have not had the diagnostic work done so far out from their specialist appointment that it needs to be redone. A lot of efficiency measures like that.

What we are waiting to do is observe how far that works gets so we can plan any further improvements around what they have not achieved, as opposed to doing something that could duplicate the work they are doing.

Ms FORREST - I notice there is a total of $21.8 million this year for all the THOs, to be saved. That is one of the saving requirements that Treasury has demanded. I am interested in how these savings will be recorded and reported. The previous government when they had a savings strategy, published an update and a report. Is that the intention, minister?

Mr FERGUSON - Yes. The figures that you referred to, did you mention just THOs or did you also mention the department?

Ms FORREST - There is $21.8 million for the THOs this year.

Mr FERGUSON - Together with the department that comes to $40.7 million for the year. That is a savings strategy that needs to be achieved by the agencies and that is part of our contribution to overall Government Budget strategy. That sits underneath the additional investment that we are putting into health and is less than the additional resources that we are providing in the Budget. Nonetheless, it is about providing efficiency in the health service and investing that in the frontline.

You have seen in previous government budgets where there have been saving strategies indicated in a table like that one but you have not necessarily seen those savings reinvested. That is what we will do. To answer your question, it is something that the department and the THOs need to work through as agencies with the advice and support of Treasury to achieve, and how they will do that.

Mr FERGUSON - They will be reported when you get to the preliminary outcomes documents and at the end of the financial year you will see a final outcome. You are referring to a savings strategy, but agencies have global budgets which are set later in the Budget as well; it is about coming in on budget, having met their savings strategies together with the additional funds that they have been appropriated. It is their responsibility to now reflect on what their budget allocation is and to achieve savings of the size that you have referred to in order to come in on budget. That is always an ordinary responsibility of an agency.

I acknowledge that two of those four agencies are not doing that at the moment.

Ms FORREST - I will get to them a little later. I am interested in the high level here - in the reporting of this. Will you demonstrate how the savings are being made?

Mr FERGUSON - How it is reported?

Ms FORREST - No. Will we be able to see a report that details how the savings were made? This is a fairly big task from an area - you talk about productivity. It is very difficult in a service-oriented area such as health, and education too, that has a really high labour component, to increase productivity. A nurse can only look after so many patients at once; a midwife can only deliver so many babies at a time. Teachers may be able to teach a greater number of kids. But where there is a high labour component, increasing productivity is not easy.

To create this level of savings, I want to see where those savings are made. Someone is going to make these decisions, and I understand from comment around the time of the Budget, from the Treasurer, the Premier and others, that it will be up to secretaries of departments to effect those savings. What I want to see in a report is where those savings were made, how they were achieved, and were they achieved?

Mr FERGUSON - That is a very reasonable request. How that would be published is a matter for the Treasurer - for example, in the updated budget documents that are placed before the parliament from time to time.

Ms FORREST - But the preliminary outcomes and the other reports do not go to the level of detail. They never have, and I do not think they ever will. What I am talking about is a specific report, like the attempt that the previous government made; I say an attempt, because it did not really describe where the savings were made. It just gave us motherhood statements. I hope it

will be better than that - a specific report that identifies how and where the savings were made. After the fact.

Mr FERGUSON - That is something that, looking forward, not knowing what those outcomes will be yet, is a question for a later date.

Ms FORREST - No, it is not. I am asking: will you report this information, and if you will, how?

Mr FERGUSON - Of course we will report it because we are obliged to, but I think you are asking for a greater level of detail after the fact as to what measures were achieved. I am quite comfortable with providing that at the right time, but I can not guess exactly when that will be, because some of these strategies will take longer than a quarter to commence, or even decide on.

Ms FORREST - But each of the THOs and the department overall have savings required this year, and I understand that the savings over the forward years are additional savings each year, not cumulative. So, $40.7 million this year across DHHS; $21.8 million for the THOs. I took them out because DHHS includes Human Services as well. I am trying to narrow it down to the areas that provide the services directly to the people. This is a concern about where we are going to cut and how. It is a big task. I would not like to be a secretary or a head of a department trying to sort it out where to cut.

Mr FERGUSON - Before I ask Mr Nicholson to provide some extra information, I will again point out that the savings strategies that have been identified as agency targets are somewhere less than 3 per cent of the activity that occurs there. A previous government might have called that an efficiency dividend; we do not. We are not dressing it up like that. We say that these are the saving strategies that need to be achieved. It is now for agencies, and in the case of THOs, for their governing councils to look at options and how they are going to best achieve them. The clear directive from the Government is that we expect those savings to be non-front line, but I will ask Mr Nicholson to update the committee about how that ordinarily would be reported, after those decisions have been made.

Mr NICHOLSON - Thank you, minister. Our immediate 'business as usual' management and performance reporting of the system will continue. Budgets are allocated based on the appropriation that is intended and we will be monitoring the uptake of savings initiatives through our standard finance and capital reporting processes within the DHHS. In terms of publicly available reporting on our savings initiatives, that is a matter to be resolved with Treasury, however Treasury produces a variety of publications throughout the year that will include some level of detail about the overall impact of the savings activities across the health portfolio.

Within the THOs, as they currently stand, the governing councils have their own financial and management reporting arrangements in place and those will continue as they observe the impact of savings implementation within the THOs. Through the service agreement that Michael's division normally constructs we will continue to monitor activity and through-put relative to the quality and price standards that are set within those agreements. Implementing the appropriation provided to us through the activities and services we provide to communities is very much business as usual. The larger scale communication of those initiatives will occur mostly through the prism of Treasury reporting. Where we have appropriate information we think is useful, or where people are interested in it, we certainly don't hide that information. Our finance and capital and other reports are available and produced regularly.

Ms FORREST - There's always other ways, like committees, that we can get it out of you.

Mr NICHOLSON - That's true. One of the lessons from savings last implementation - last time - was that you can set up a very elaborate reporting regime to report on lists of savings initiatives. That in itself is onerous, and we have large numbers of people occupied producing reports and not necessarily large numbers of people managing according to the appropriation provided to them by the Parliament. We are more interested in the latter than the former but obviously we want maintain good transparency with our activities at the same time.

Ms FORREST - Looking at the budget savings strategies on page 4.11. Minister, what do you consider 'back office functions' in the first dot point there? And what specific examples can you provide, if you are going to redesign and consolidate back office functions as part of a savings strategy.

Mr FERGUSON - Ms Forrest, at 4.11 you will see a list of descriptors of the savings we are pursuing - that we are requiring our agencies to pursue. You have pointed out one of those. I don't want, at this Estimates, to lay out information that may not be helpful or, potentially, turn out not to be the case. If I start giving examples or instances, I am jumping ahead of what we are asking agency heads to do. I am asking agency heads to come in on budget, on their appropriation, recognising, as I do, that two of the four agencies are already not delivering on that because of some structural deficits they have.

But I can speak generally to it. You have pointed out the consolidation of the corporate back office functions undertaken by the department, and I can be more helpful on that one. There is an agreement between me and my fellow minister from the DHHS, Mrs Petrusma, that we can do a better job from a department point of view. There's duplication in the corporate departmental support for two separate ministers - one health and one human services. We have directed DHHS to consolidate those two sets of functions so there is central departmental support for all of the activities of the department. It is a duplication elimination initiative and it's about identifying areas where we are spending a dollar that doesn't necessarily result in a patient outcome or, in my colleague minister's case, a human service outcome.

Ms FORREST - Having two ministers must make the duplication more likely to occur in the one portfolio area.

Mr FERGUSON - That is perhaps a fair comment because the department is the Department of Health and Human Services. It has two publicly identifiable roles but the activities of that department run across quite a range of areas. The two gentlemen sitting beside me support principally me in my role as Minister for Health, but also support my fellow minister. The department works as a unit. There is no issue with that, but you have seen the historical development. When you take a look inside the department, you see that there are opportunities to consolidate the corporate back office, not just to support the ministers but also to support the activities of the personnel right across the department. That is what that is all about.

Ms FORREST - I take you then to the third dot point - Reduction of Operational Costs.

Mr FERGUSON - I might add to what I said. An example of that would be finance. In Health and Human Services you have two finance sections, one in Health and one in Human Services. That is an example of where corporate consolidation can, and should, take place.

Frankly, I think a lot of people would be surprised and disappointed to know that there are two financial functions in the one Department of Health and Human Services.

Ms FORREST - To move on then, in relation to reducing operational costs you go to consultants, property cost, travel, advertising and transport. This is across both the DHHS and the area of Health and the THOs. Are you able to give us the current costs for the last two years across DHHS for consultants, property cost, travel, transport and advertising?

Mr FERGUSON - We can provide that information. We might need to come back to you and take on notice what you asked for the last two years. I believe we can and will provide that.

Ms FORREST - While on that, Mr Chairman, I would also like, in the second dot point under the THO savings, the information on 'carefully managing expenditure on travel, communication, advertising, procurement' for the last two years as well. We will put that in writing to the minister.

CHAIR - Yes.

Ms FORREST - A matter we should get to under the THO when we get to there is the range of statewide contracts and also specific contracts. Would you prefer to talk about that under THOs or here, minister?

Mr FERGUSON - The THOs do run their own tender procurement processes so, given that we have three of them, you won't want to ask the same question three times.

Ms FORREST - No.

Mr FERGUSON - From a policy point of view, I might introduce Mr Ross Smith, who is the General Manager of Shared Services because there is a policy role here that he can speak to.

Mr SMITH - Through Shared Services there are 29 statewide contracts totalling about $33.8 million per annum in goods. That goes across the four agencies, the three THOs and DHHS. Probably over the last few years, through better coordination of procurement processes with THOs, we have been able to deliver savings on a comparable basis of in excess of $4 million per annum. That is just through better coordination with the THOs taking advantage of competitive processes under the Treasurer's Instructions. It is very difficult to get meaningful comparisons across all jurisdictions and we cannot rely on the ones that are in the AIHW because they measure something different. We have undertaken a narrow comparison of our cardiac consumables types of things. That covers about five jurisdictions that we measured.

Ms FORREST - Five jurisdictions being the other states?

Mr SMITH - Yes. There is only New South Wales that did not participate in this particular survey but all of the other ones did. That showed that Tasmania's average price of the items that were matched across the jurisdictions was the lowest average of all - about 6.32 per cent lower than the average of all the jurisdictions surveyed. We have a lot of improvement to make and we are working very closely with THOs on that. We believe that through the process we are putting in place and exploring options of health purchasing in Victoria about where it makes sense -

Ms FORREST - We are progressing in that, minister, looking at joining with Victoria in purchasing?

Mr FERGUSON - I am not sure that we are looking at joining with them but there has been an offer, and you might have some experience on this prior to the new Government's being elected and my being health minister. I have discussed with Dave Davis, the Victorian minister, an offer for us to participate in their purchasing arrangements. I can see people nodding beside me. We are interested in getting the best deal for the state and I am not yet sure that is the best way to get the best deal for the state. It might be, but it is something that I have asked the department to be aware of and to investigate. There are already some procurement arrangements in place in Tasmania that are getting excellent value for the taxpayer and in some cases we might be better off not participating for some purchases through Health Purchasing Victoria.

Ms FORREST - In terms of economies of scale, that was where the last suggestion was.

Mr FERGUSON - Yes. If you would add to my answer but before you do, we are interested in joining a buying pool if it can be shown to provide an outcome and an improvement for the Tasmanian Health budget, knowing that we are a significant consumer of health consumables and pharmaceuticals is another one. It would always be subject to a benefit test.

Mr SMITH - Correct. Following on from the minister asking us to explore that further, the secretary and I have met with representatives of Health Purchasing Victoria to look at where it makes sense and where it might make sense to work together. Cardiac devices with the cardiac consumables is probably one area where we are doing significantly better. It has to be on a case-by-case basis.

Mr FERGUSON - It is a good point because we are small state and Victoria is about 10 times our size, and they have significant buying power that we do not have. Yet at the same time, there are some individual groups of items where we are already getting a better deal.

Ms FORREST - Maybe it is our high rate of cardiac disease that creates the better figure. Are you aware of any areas of service provision that are not performing as well as they should be or not producing effective outcomes that could or should be cut, rather than just reducing staff numbers? I am asking because there have been suggestions in the past that rather than trying to trim people out of the system where there are additional people, which may be one way of saving money and not an appropriate measure at times, sometimes it is about cutting whole programs that are not delivering the outcomes that they should be. Do you measure all those outcomes and the effectiveness of all service areas and, in that process, have you identified areas where we might have to make that hard decision?

Mr FERGUSON - Ms Forrest, that is a good question because it is exactly what the white paper process is intended to canvass. We are not setting out to find services that we can eliminate. The whole point of the green paper and the white paper is to determine what other services we need to provide and where and how. It needs to be equitable across the region which is, I know, important to you. It needs to be open to the possibility that there are services that we do not currently provide that we might be able to, particularly when you are looking at it from a unified statewide perspective. At the moment there may well be. and can I assure you I have not any in my mind. There may be services we cannot currently do because we are divided geographically but a unified system may mean it is possible.

Equally there might be some very specialised services which we do currently provide which, going through the white paper process, we might be able to go through a fairly mature sensitive conversation with the community so we could potentially get better outcomes by providing appropriate transport arrangements interstate.

Ms FORREST - That was another question I had. Will that be part of the consideration?

Mr FERGUSON - It certainly is. Let us be clear what this is not about saving a dollar or reducing people's access to health services. It is entirely built on the question of safety and effectiveness of the range of procedures that we provide.

Ms FORREST - And outcomes to patients?

Mr FERGUSON - I guess that is what I mean when I say safety and effectiveness. It might also mean that we need to be mindful of training implications in our states. Those are significant subjects and we will not be making decisions willy nilly about that. It will need to be clinically informed as well as carefully costed by the department so that we can be absolutely confident when we say we have provided the best health system with the right services and the right location so that people can rely on them when they need them.

Mrs HISCUTT - I would like to touch on something the member for Murchison originally started on. The 26 000 on the waiting list - if they are on the waiting list for the waiting list, what is the block there? Is it because they cannot get a referral or because they have a referral and cannot see a surgeon or because the surgeon does not have the time to perform the operation?

Mr FERGUSON - I will ask Mr Pervan to supplement what I say. First, they have already been referred. These are people who have already been seen in primary care settings. They have seen their GP, they have complained about a pain or a problem or a concern, and the doctor has referred them to the local THO for further specialist follow up. Often, although not always, it is an outpatient environment. Is it always or usually?

Mr PERVAN - Most often it is an outpatient.

Mr FERGUSON - It might be diagnostic. For example, a GP would need a specialist to effectively refer onto a gastroscopy, so that is diagnostic, but equally, if there is a suspect hip or knee or cataract surgery that the GP believes needs to be done, the process is that the GP will refer their patient through to the THOs outpatient specialist clinic. It is all of those people who make up the 26 500 people on the, until recently, hidden waiting list. We do not say they are all waiting for surgery but we know that anyone who is waiting for surgery will be a significant part of that 26 500. Whoever they are and whether or not they need elective surgery, they are all waiting for access to a hospital service of some kind.

Mr PERVAN - The number on the waiting list is generated through a number of system failures, to find a better set of words, because we have no well articulated standard for outpatient referral. People can arrive for their specialist outpatient clinic with a two-line letter that just says, 'I am referring this patient to you for hip pain', compared to a letter that has current imaging x-rays or CT scans attached, pathology, and an entire medical history of the patient.

How quickly they moved through the system will depend on how recent their tests are. The specialists may decide tests are too old and they need a more recent scan or a more recent test.

We need to get the system organised so that when a patient is referred, they arrive in a timely fashion with current imaging and current pathology and enough of their medical history such that the specialist can make a decision about their requirement for further care, if they are ready for that care, and when they can be booked.

These are the systems, which are necessary but which are absent at the moment. At the moment it comes down to the quality of the referral, and how well the clinic is organised. The specialists who are delivering the clinics are also the same specialists delivering the care. It is a matter of much of their time they have to see patients and the quality of the referrals. One specialist recently commented to me that 70 per cent of the patients coming to him in Outpatients, he should never see. They should have seen a physio before they got to him, the GP could have managed the case themselves, or other things.

Mrs HISCUTT - How are you going to manage that?

Mr PERVAN - It all depends on the quality standard, and criteria that you attach to the referral. Providing more information to general practitioners about when a patient should be referred, and to whom they should be referred, is part of building an outpatient referral system. A lot of the pathways work TML is doing will cover that, and then it is just a matter of observing to see if we need to enhance or extend it in any way.

Mrs HISCUTT - That training is not part of the $76 million for elective surgery?

Mr PERVAN - No, the $76 million is for the delivery of surgery. There is some work in there for a form but that is more about making sure people on the lists are ready for care and are booked and monitoring them and, where possible, giving them a choice of access. So if there is a specialist in that area with a shorter waiting list, letting the patient have the choice of whether they stay with the specialist in the hospital they are in, or move to a surgeon or a stream with a shorter waiting list.

Mrs HISCUTT - I will touch on the Rural Alive and Well program. A couple of years ago with the Circular Head floods they were integral to the psychological welfare of local farmers. You have $1 million over two years allotted to the program. Do you see that continuing in the future? Are you in a position to make a comment on that?

Mr FERGUSON - Yes, I can. Thank you for the question, Mrs Hiscutt. Rural Alive and Well predates much of the political support it has received from the Commonwealth and Tasmanian governments in recent years. It started out as a small targeted program. It might even have been one gentleman in his vehicle roaming around rural Tasmania, particularly the southern midlands and the east coast. It has grown and it has been a terrific success for Tasmania in terms of the support it has provided to many Tasmanian rural families. It has led to better outcomes than otherwise would have been the case. We are particularly challenged by the suicide statistics in our state. We are not doing well. The media reporting of this is largely responsible reporting. Because of that, we are not aware of the extent to which this is a problem in the community. It is a major problem. I have already talked about our $3 million support initiative, but $1 million is provided for Rural Alive and Well. You asked me what the future looks like. This is why we have provided this funding - so that they can have some security in the future, because they had other sources of funding which were not necessarily guaranteed into the future.

We support the program. We think they do a marvellous job. We are particularly impressed with the way they been able to spread into more parts of regional Tasmania.

Mrs HISCUTT - Do you know have many FTEs are involved and where they are situated throughout the state?

Mr FERGUSON - I don't, but I am happy to find that out for you. The bottom line is that we want to support their mission.

CHAIR - Thank you, I think we will finish with the overview and we will move on, Ruth, to output group 1.

Output group 1

1.1 Health Services System Management -

Ms FORREST - As I understand it, minister, and I am sure you will correct me if I am wrong, this is the department that is left after we take out all of the THO staff and functions, and this is the Health side of DHHS, the former department.

Mr FERGUSON - I think you could describe it as Health department minus Ambulance and Population Health and the funding for the purchases it makes off THOs.

Ms FORREST - And Human Services, this line item.

Mr FERGUSON - Of course, I beg your pardon.

Ms FORREST - DHHS is the whole shooting match. I am interested particularly in this area. When we established the THOs and that separation, the DHHS was supposed to be quite a small, lean operating machine. How many DHHS full-time equivalents are there, and in what areas do they remain? I am not so much interested in Human Services because we are dealing with Health here, so how many FTEs are there now in the DHHS staff remaining in Health? Over the last two years would help us to see where the changes are. Also, where are they physically located in their positions?

Mr FERGUSON - Ms Forrest, I apologise, we have overall numbers which we could easily provide you with; as for breakdowns, we have access to those but I am not sure we have them with us at the table, but am very happy to provide those. At the final pay period for last financial year, there were 8 964 FTEs across Health and the THOs, and that is the whole department and the THOs.

Ms FORREST - I am interested in the department.

Mr FERGUSON - I understand that and I will be delighted to get that information for you. We can probably have it to you very shortly.

Ms FORREST - And broken down by region, where the DHHS staff are.

Mr FERGUSON - We will certainly get you the first lot of information and I will provide you with whatever additional detail I am able to.

Ms Forrest, I am also able to take the general question on notice but I can give you some numbers right now. For the pay period ending 21 June 2014 in Ambulance Tasmania, which is a subset of the department, it was 389.24 FTEs. For the department in total, which includes Health and Human Services, that is 648.18 FTEs. THO North, 2 412.33. You didn't ask for it but THO South?

Ms FORREST - I am going to ask that later when we get to THOs because I am interested in the last two or three years since they were established, what their movements and their employment have been.

Mr FERGUSON - That probably is best in this output because this is where the system management takes place and the department takes that role. I am happy to take those during this output. We are up to THO South 4 115.72. For THO North-West 1 398.56. That gives you the grand total of 8 964.03. What we have outlined is the entire employment by those sub-categories.

Ms FORREST - At a point in time in June.

Mr FERGUSON - Correct. It was the last pay period, 21 June.

Ms FORREST - Are we able to get figures at the end of the last two financial years.

Mr FERGUSON - Yes, we can get that for you.

Ms FORREST - That would be helpful, to see what the numbers were from the department and each of the THOs, for the last three years.

Mr FERGUSON - Taken across the whole health system, and including Health and Human Services, that that's an increase of 252 on the previous financial year.

Ms FORREST - Right.

Mr FERGUSON - That is primarily relating to an increase of 221 FTE across the three THOs.

Ms FORREST - Yes.

Mr FERGUSON - In the one financial year jump.

Ms FORREST - Right.

Mr FERGUSON - But if you would like further detail and I think you are asking for the previous two years, or since they were established.

Ms FORREST - Yes. Just the figure at the end of the financial year each year. There is always movement up and down. I understand that. So the extra 200-odd positions, were they predominantly in medical or nursing staff?

Mr FERGUSON - My information does not say what disciplines they come from. That is attributed to FTE counts from the THOs globally and as for the same numbers in previous

financial years, if I can get that broken down by the output, which is health without human services, I will provide that to you.

Ms FORREST - Where does dental services fit?

Mr FERGUSON - That sits within THO South as a statewide service.

Ms FORREST - Right.

Mr FERGUSON - THO South carries oral health for the whole of the state and it is provided regionally, in all parts of Tasmania, but, administratively and financially, it is all contained within THO South as a statewide service.

Ms FORREST - Once you have one health service, it will all be part of that one contained health service?

Mr FERGUSON - I think that is the point. What you see with oral health will be the case for -

Ms FORREST - Mental health as well.

Mr FERGUSON - For the full range of services that we provide. We don't encourage any assumption that it means a particular service will end up in a particular centralised location. That's the purpose of the white paper, to work out the best way to arrange each of those services.

Ms FORREST - So this comes under the Community and Aged Care Services in the Southern THOs, where that funding sits?

Mr FERGUSON - Yes.

Ms FORREST - Yes. Thank you.

Mrs HISCUTT - Minister, does sick leave come under systems management?

Mr FERGUSON - Depends if you are asking about individual THOs or across the board. What would you like to know?

Mrs HISCUTT - I was going to ask for each and every one, so I am happy to leave it for individual THOs if that suits.

Mr FERGUSON - The department's role is as system manager and purchaser, so on behalf of Government it purchases services from the THOs, virtually on a contract or service agreement basis. It also plays a major role in managing the overall systems. So it is fine to ask it now, particularly if you are asking about what different awards cover.

Mrs HISCUTT - I am interested in frontline nurses. How many sick days are available to them? Is it accumulative? How many sick days do they take? And the average sick day per FTE if you have that information?

Mr FERGUSON - I do have that information. Sick leave days for a nurse. An employee is entitled to a maximum accrual of 152 hours in each personal leave year, which is 20 days. A part-time employee who works between 20 to 30 hours per week is entitled to a maximum of 114 hours. A part-time employee who works 30 hours or more is entitled to a maximum of 152. If the full period of personal leave is not taken in any leave year the portion that is not taken is cumulative from year to year without limitation. It builds.

If at some point in the future you wish to draw down on that sick leave you need to be sick.

Mrs HISCUTT - This is as opposed to workers compensation and that sort of thing?

Mr PERVAN - Workers compensation is dealt with separately. It would depend on the compensation and the injury. You get sick leave while you are injured until it progresses to a worker's compensation issue.

Mrs HISCUTT - This is just sick leave. So it is cumulative forever.

Ms FORREST - You can only use it if you are sick. You cannot get it when you retire or leave, unfortunately.

Mrs HISCUTT - Are there different awards within the system?

Mr FERGUSON - Yes there are. For allied health professionals an employee is entitled to a maximum of 152 hours in each year. In the first year of service an employee is entitled to a maximum of 12 hours and 40 minutes for each completed month of service. If the full period of personal leave is not taken in any leave year the proportion that is not taken is cumulative from year to year without limitation.

Health service officers - it is the same, so I won't read it out again.

Salaried medical professionals - for the first year of service it is 12 years and 40 minutes for each completed month of service.

Ms FORREST - Twelve years? I think you mean - 12 years, you said.

Mr FERGUSON - For a full time salaried medical practitioner, for the first year of service it is 12 hours and 40 minutes -

Ms FORREST - You said, 'Twelve years'.

Mr FERGUSON - for each completed month of service, which works out to 20 days over 12 months. For every other year of service a maximum of 20 days sick leave or personal leave may accrue every year. Unused sick leave days accumulate.

Mrs HISCUTT - Are they regularly taken up minister?

Ms FORREST - Only if you are sick.

Mr FERGUSON - I can provide you with some advice on that, Mrs Hiscutt. If I do it by division and then award I can give you some helpful numbers. This would be best read in conjunction with the numbers I outlined earlier - the numbers of employees in each division.

In Ambulance Tasmania -

Ms FORREST - Would it be easier to table the information, perhaps?

Mr MULDER - Can we just table it, if the information is in a document?

Mr FERGUSON - I will table this document. For the benefit of Mrs Hiscutt, who is asking for the information, the total is provided for each element of the department and the THOs and it shows the average sick days per pay period. It sits at 2 632 for the whole of the health system including the THOs.

Mr FARRELL - Minister, in relation to the regional hospitals - New Norfolk, Beaconsfield, Smithton, and St Helens - what plans are there for service delivery into the future? I understand you are working under a tighter budget, and I am wondering if you could outline any effects that may have on these regional hospitals.

Mr FERGUSON - The government is very supportive of the role of our major hospitals, as well as our regionals, and throughout everything we have had to say in relation to health reform in Tasmania, we have been quite explicit on two things.

First, we do not want to see the integrity or the status of the major hospitals downgraded. That is not the motivation for health reform.

Second, the role of regional health services, in terms of regional hospitals and primary health care sites, we have said that none of those will close. There have been statements made by a number of voices in the health area that that is what the government's intention is. I can assure you that is not the case.

As I shared recently at the launch of the Health Services Innovation for Tasmania, which is being hosted by the university, I am hoping, and am working to, interrogate if we can use our regional hospitals more than we do. When I visit the regional hospitals around Tasmania I often see a great waste of capacity. I have just come from the Royal Hobart Hospital and I have looked at the emergency department. The ED is doing a brilliant job at looking after the people who are there, but then they face bed access issues for patients who should be admitted to a ward. I then go to a rural hospital and I see empty beds, and I think 'what a shame'. I am not saying that is always the case, that that is a bed that could have been used for a particular patient on a ward that would have made space for a patient who is in the ED, but when I see that capacity not being utilised, I ask myself - and I am asking the health system - can we better utilise the capacity that we have in our regional hospitals?

Ms FORREST - We have been asking that for a number of years.

Mr FARRELL - That is pleasing to hear because I know places like New Norfolk, with their small hospital, there have been people sent there to recuperate, and there have been quite positive reports. People are initially not all that happy to be moved out of town but it is probably a good use for that hospital.

Mr FERGUSON - Mr Farrell, that is exactly where I went after that visit and the New Norfolk District Hospital provides a terrific opportunity. It has great staff, it has lovely facilities, and for someone who is need of some recuperation, whether or not they live in that particular Derwent Valley area, it would be great if we could offer that to more patients as a place to go with the explicit purpose of providing them with a very satisfactory level of care, at the same time as freeing up space in the Royal, or in another acute care setting, to make it possible for better patient flow across the board.

Mr FARRELL - You mentioned the empty beds in the hospitals that you have visited regionally. Do you have any data on the occupancy rates of the regional hospitals?

Mr FERGUSON - I do not have it here unless someone can pull it up for me, but that data is collected, and I can tell you that in large part the occupancy is quite low. It depends entirely on the models of care in those places. It might be the case, for example, that a particular site might only have two acute care beds, and they are never used because maybe the employment and the models of care provided there are not geared around the acute care. They might be more focused, for example, on aged care. So the average occupancy, and I will not table this document, but I will table the data, which shows the occupancy in places like our regionals, is in some cases as low as 29 per cent, and as high as 81 per cent. There is scope for better utilisation

Ms FORREST - Can you table the figures for all the rural hospitals?

Mr FERGUSON - Can I table?

Ms FORREST - The occupancy rates. I assume it is for the 12-year period?

Mr FERGUSON - Twelve months.

Ms FORREST - Twelve months, sorry.

Mr FERGUSON - It is a 12-month average over 2013-14. I will have this table tabled within 20 minutes because there is other information here I am not able to table.

Ms FORREST - It would be great if you provide the details of the occupancy rate.

Mr FERGUSON - You may be interested to know, by the way, that in the contracted beds in non-DHHS or non-THO facilities the occupancy rate is higher - between 62 and 101 per cent occupancy.

Ms FORREST - Which ones are they?

Mr FERGUSON - I will table that but it is, for example, Huon and Tasman. We will table that information for you.

Mr FARRELL - In relation to regional hospitals, are there any plans to contract out catering or laundry services?

Mr FERGUSON - I am not aware of any such moves. In any event, it would be a matter for a THO and/or its governing council to make a decision like that. I am not aware of any at the

moment. I draw your attention to what is happening at Scottsdale at the moment. The Government isn't interfering with or disrupting the work that had been commenced by the previous government. For Scottsdale's aged care component - the James Scott Wing - they are exploring and investigating a transition to Presbyterian Care as a private NGO aged care provider. I don't believe that is concluded and I am not blaming the previous government for that because it would be a decision of the THO - deciding whether they are best placed to provide such a service or should it be done by a dedicated group like Presbyterian Care.

Ms FORREST - I want to look at the funding of the THOs. I assume it is under this output, when we are talking about the administration. When we debated this issue Mr Nicholson provided a very good flow chart on how the funding would work. It was as confusing as everything else related to the whole setup. No fault of his - it was the way it was. When we have one Tasmanian Health Service, how will the funding flow? Will the state component and the federal component change? Is it possible to understand that at this stage?

Mr FERGUSON - In broad terms it will not change. Certainly from 1 July you will not see any changes to the current method by which activity is costed and purchased and the way in which we report to the Commonwealth the level of activity in the THS. The way we would qualify for federal funding will not change. We would still, from a Department of Health and Human Services point of view, be purchasing in exactly the same way. We would be approaching the new THS with a service agreement. We would seek to obtain agreement and if we were not able obtain agreement we would impose, and work with them to achieve their purchased activity. That is how it works under the current system. It is not proposed that would change.

The rider is that national health reform in this country seems to have failed. In many respects we have seen structures set up that are quite useful in terms of measuring activity and purchasing against it. You should realise that our decision to move from three THOs to one THS, as opposed to moving from three to zero THOs, reflects this Government's continuing support for recognising and purchasing actual activity from a separate entity.

It was always open to the government to actually absorb the hospitals back into the department, where they came from in the first place. We decided not to do that. Where this leaves national health reform is uncertain because there have been funding changes that were made by the Commonwealth in the recent Federal Budget that we were not anticipating, no state was. It has implications for us. We are managing that. We are working with the Commonwealth as, for example, with the recent announcement that we were able to get funding directed toward active surgery purchasing.

The final point I will make is that from 2017-18 the Commonwealth has indicated they will be moving back to a block grant method of funding.

Ms FORREST - Away from activity based funding?

Mr FERGUSON - Not necessarily. From 2017-18 the Commonwealth will move to an index model of increasing funding per year to states and territories. We will not see any departure from the current arrangement where you see activity based funding but from the Commonwealth point of view you will see a departure from the way in which the growth funding was to be calculated.

Ms FORREST - I noticed the Australian Government, according to the Budget papers, as well as the Federal Government's announcements will index contribution to public hospitals by CPI and population growth. That is a real risk for Tasmania. CPI has a lower rate of inflation than health inflation and our population is declining but our health needs are increasing. In terms of acuity and the age demographic we talked about earlier, how will that affect Tasmania and the Budget? What sort of interventions would you be doing as minister to look after Tasmania's interest in funding for health?

Mr FERGUSON - It is difficult to answer what will happen because there is a lot of water that is going under the bridge yet. There is still a federal election to come and there is still ongoing constructive discussions that are happening between this Government and the Commonwealth in where this places Tasmania. It has to be said, and this is a political point I make, no-one knows, if the previous federal government had been re-elected, if they would have been able to offer the sorts of funding that was talked about in their forward Estimates.

There are different views about the capacity of the federal budget to continue to have funded at the levels previously forecast, especially when you are talking over 10 years and longer. That said, there are risks and we are very mindful of those. We raise it in a constructive way with our Commonwealth colleagues but there is another process which has started up in the meantime which is the Commonwealth's white paper process into the Federation.

There is going to be a substantial rethink about what level of government funds, which services, and how the funds are raised to pay for them. I would say there is that water to go under the bridge before we know exactly where that places us three years from now. There are concerns, we have raised those concerns, and I am happy to tell this committee that I continue to raise those concerns and they are quite constructive.

CHAIR - The Federation white paper, when is that due to be released?

Mr FERGUSON - I am advised that the white paper is expected some time in the new year but in the meantime there will be preliminary consultation documents. Each state and territory government is involved in this and the Department of Premier and Cabinet is leading that process on behalf of our Government. Each head of agency has already been briefed on this and is expected to make a substantial contribution to the Tasmanian Government submission on that process.

Ms FORREST - I would like to have some information about the overtime worked by nurses and midwives, and in general and specialist areas, all the THOs, and allied health professionals and medical officers.

Mr FERGUSON - Are you looking for policy or are you looking for numbers?

Ms FORREST - I'm looking for numbers in the last 12 months.

Mr FERGUSON - We have a new method of reporting this. It will be possible to get you the numbers but you have asked a specific question which I do not have in my paperwork in front of me. Previously, the way that double shifts were reported was done through exception. It was reported as an incident through the electronic incident management system. A person requesting to use double shift would enter the incident proactively, if I can put it that way, would step out and make that incident reported and would also give the reason for the double shift.

Ms FORREST - The person who was working it or the supervisor?

Mr FERGUSON - The person requesting someone else to do the double shift.

Ms FORREST - The supervisor.

Mr FERGUSON - Yes. That has been changed. Earlier this year, it has moved to a new system where double shifts are now recorded through the ProAct rostering system. It is a proprietary-branded roster management system. This means it is now much more accurate. If it is not the complete record, it is a much more accurate record of all the double shifts that have been taken. While the numbers are coming to me we would expect that under the previous arrangement it would have been quite conceivable that not all entries were made.

Ms FORREST - I am not just talking about double shifts because sometimes you work two or three hours overtime and then you can go home. Double shifts are one thing but overtime per se is not necessarily the same.

Mr FERGUSON - Can we take that on notice?

CHAIR - Yes.

Ms FORREST - Another thing I would like is the locum costs across each of the THOs. How much has been paid over the past two years? Two years would be good so we can compare year to year.

Mr FERGUSON - I can provide for the committee the following data. It is by component of the health system. In the department, agency worker costs, which is payments to third parties including locum nurses, doctors and consultants. I cannot provide locum on its own but as a group, for the department itself in 2013-14, it was $3.898 million. That includes consultants. For Ambulance Tasmania, it was $118 240; for THO North-West, $7 446 672; for THO North, $4 172 727; for THO South, $1 679 185; and for statewide and Mental Health Services, $0.

Ms FORREST - For THO North West, it was $7.4 million, nearly seven times more than the south. Clearly we have an issue there. Do we have a breakdown in the north-west from Mersey and Burnie?

Mr FERGUSON - Can I invite question if it is specifically about THO North-West, I am sure that we will be able to get you better detail during that output when Professor Linegar is here.

Ms FORREST - Do we have re-admission rate figures? They seem to be glaringly absent, and the Auditor-General has commented on the lack of information for some key performance indicators. This is probably one for the THOs when they are here. I would like re-admission rates across the THOs and the reasons for re-admission.

CHAIR - Which page are you on, Ruth?

Mr FERGUSON - I think Ms Forrest is saying it's not there.

Ms FORREST - No, it's not there. It's a glaring omission. It is one of the most important outcome measures, in terms of key performance indicators, and it's not there.

Mr FERGUSON - We keep some data on that and I am happy to invite the acting secretary to advise on that.

Mr PERVAN - We keep data on re-admission rates but it is not part of the national health reporting regime through the National Health Performance Authority. Our performance indicators reflect the national standards. There's a national debate about what qualifies as a re-admission and what doesn't. That is one of the reasons why it didn't make it into the national dataset. That doesn't mean we shouldn't be looking at it. You will find that the criticism of the Auditor-General is echoed by his colleagues in every state and territory -

Ms FORREST - It is.

Mr PERVAN - that health struggles to move to outcome-based indicators because of different definitions and different ways of collecting data. There is even disagreement between jurisdictions about the difference between an output and an outcome.

The re-admission rates are available if you like to ask us a specific question about what they are and how they have moved over time. But once again, at a local level we get into debate about what is categorised as a recognisable re-admission or re-work, as opposed to a brief discharge between admissions, especially on more complex patients. They may not necessarily be re-admitted because of a complication arising from a procedure or stay they have just had.

Ms FORREST - Do you keep figures on re-admission of patients as a result of a complication, or something that occurred during their stay in hospital for a particular condition, or conditions?

Mr PERVAN - We can provide that information.

Ms FORREST - Should I ask that now, or when the THOs are in front of us, because the rates would be different for each THO?

Mr PERVAN - It's a system management issue so it is appropriate to ask in this output.

CHAIR - So, do you want to ask the question?

Ms FORREST - Do you understand what I am seeking?

Mr PERVAN - Yes.

Mr FERGUSON - You are making a note?

CHAIR - Yes, I have a note.

Ms FORREST - I am interested in re-admissions for things like infections, or other circumstances where discharge has probably been a bit hasty and there have been post-operative complications that may not have occurred had the patient remained in hospital. I am looking for reasons for re-admissions, in broad terms, as well as the numbers.

Mr PERVAN - Minister, do you mind if I answer? Are you interested in a particular time period - within 14 days, within 10 days or within 28 days?

Ms FORREST - Generally 28 days is the time frame that's considered appropriate, and that includes obstetric patients.

Mr PERVAN - I will get that under way.

Ms FORREST - Thank you.

Mr NICHOLSON - It is interesting though, isn't it, because output and outcome measurement for the purposes of the Budget, and the patient outcome are not always the same thing.

Ms FORREST - That's right.

Mr NICHOLSON - So it's a real challenge to structure the Budget papers with a performance indication of those sorts of things.

Ms FORREST - Even with department's annual report we don't get outcome KPIs. It is still 'output'. I know we operate under a national framework, and I accept the argument about different definitions, but I am not interested in other states. I am interested in what happens in our hospitals, and how we can make the system better for our patients, so they don't end up back in hospital. Often it's the worse place they can be.

Mr FERGUSON - I would like to complete that answer with a comment about the way we are reporting data to the Tasmanian community. The department publishes a quarterly document called the Progress Chart, and we are having another look at that to provide a greater sense of commitment to data that reflects what the Tasmanian patient experience is and we are working toward a range of measurers that we can have in somewhat real time, so that people can see the progress that we are making in the department rather than just going through a bureaucratic exercise.

Ms FORREST - Yes, activity.

Mr FERGUSON - It is not quite open data but it is on the way. If you do not measure it and you do not publish it, it is difficult to hold someone to account for it.

Ms FORREST - If it is not documented, it did not happen.

Mr FERGUSON - We need to measure our performance against the collective Tasmanian patient experience and we are much better informed that way and governments can be held to account for how they are addressing those challenges.

Ms FORREST - I have one more question before we move to the THOs. Under your Rebuilding Health Services elective surgery program, and we have those across all of the THOs with a specific amount to the allocated for each THO, what are the procedures under these categories? Do you have children waiting for procedures longer than they should and those in

different time frames, in category 1 and 2 patients? I am interested in what surgery we are talking about here.

Mr FERGUSON - Mr Pervan is the person to answer that and I know we have this data because we issued it to the THOs when the first tranche of the $16 million was provided in the lead-up to the new financial year. You have correctly represented that. We made it a purchasing decision, as a matter of policy, that we would target all over-boundary children across the categories and that we would use the balance of the funds to target over-boundary category 1 adults, and as many of the long waiting patients in other categories.

I hope that it will please you to know that is, from a purchasing point of view, conducted very intensively down to the point where the department is able to identify the particular patient who ought to be receiving that care. Michael, if I could ask you to provide any extra information.

Mr PERVAN - It varies a great deal from THO to THO. There are some opthalmic procedures in there, not cataract removal, but other opthalmic procedures. There is also a lot of general surgery and, not surprisingly, some orthopaedic work although not as much as there would be in the long-wait patients who are being targeted by the Tasmanian Health Assistance Package (THAP). One of the blessings that came with the THAP and its focus on the longest wait patients was that it provided a very strong financial incentive for the THOs to focus on clearing those out. They were specifically contracted to do that work and that put pressure on category 1 and 2. To balance the assistance package we have gone through and looked at the patients who are over-boundary in category 1 and 2 and entered into service agreements and specific business plans with the three THOs to target a range of procedures with the main criteria being that they are ready for care and they are over boundary, so it is right across the board and different from THO to THO.

Ms FORREST - Yes, because the nature of the service provide by different THOs has a bearing on that. Are there many in the highly specialised areas like neurosurgery and others that are difficult to get when you have a limited number of surgeons that can conduct the surgery, for example?

Mr PERVAN - There are a few in neurosurgery, particularly things like spinal infusions with the new surgery service tending to focus on aneurysms and emergency cases and category 1. So there were some but they are not very large numbers but they were still out of the boundary so we were approaching those. Similarly, there are ENT procedures. We have an issue with paediatric surgery access in Tasmania.

Ms FORREST - This takes me back to the comment we talked about a bit earlier. In cases where they are highly specialised, paediatric surgery and neurosurgery, will you consider sending patients to the mainland for this treatment under this funding or access the private sector to clear them?

Mr FERGUSON - We want to be flexible on that. We particularly want to make sure that we get the safest and most effective treatment for a patient. That is our primary concern. We are quite flexible as to where it should take place. We favour being able to do it here if the services allow for that. There is also an argument to consider whether or not our state offers the service as compared to where it is best provided for a particular patient. Our general view is that. Our longer term view is that this needs to be captured by and contemplated by the white paper process so we can plan what it looks like and it may identify opportunities for doing things differently to

how we currently do it. For example, you may have a surgeon who is quite competent at a particular procedure but because of the small size of our state, they may only do five to 10 in a year, taking into account the whole demand. That may not be enough to maintain a patient flow to keep the skill at a level that would be required. So we are open to that.

Ms FORREST - Patients who have been well over boundary in neurosurgery, for example, from the north-west or anywhere, all have to come down to the Royal - that is where it is. For some of them it would be easier to get on a plane in Wynyard, go to Melbourne and be there in an hour. Will that be considered?

Mr FERGUSON - It already happens and it can continue to happen. I was looking at some data last week that showed the volumes of interstate Australians who come to have procedures done in Tasmania. We have a cost-charging basis with other states and I also looked at how many Tasmanians gain access to services interstate. That is about three or four times as many. We are already using a lot of interstate services, particularly in Victoria, where we have natural affinity.

Ms FORREST - Funded by the state?

Mr FERGUSON - Funded by our state because they are Tasmanian patients and that is how it should be.

Ms FORREST - How long has that been in place, minister?

Mr FERGUSON - It is a long-standing arrangement, as far as I am aware.

Ms FORREST - I worry about a particular constituent, for example, about whom I had a communication with you. She has been well over-boundary for neurosurgery. Why are patients shunted this way when they are clearly deteriorating, clearly over-boundary?

Mr FERGUSON - Can I invite you to write to me about that?

Ms FORREST - I already have written to you about this one.

Mr FERGUSON - I will be pleased to investigate that. In general terms, if we can do it in Tasmania, we should, unless there is a compelling reason not to.

Ms FORREST - She will be pleased to hear that if she gets something done in a reasonable time. That is good.

CHAIR - Thank you. I think we are done on Output 1.

Output Group 2

CHAIR - Minister, we might move to Output Group 2 and the DHH. Do you need some more personnel?

Mr FERGUSON - Mr Chairman, would you like to do one THO at a time?

CHAIR - We are deliberating on that. I think they cross over a fair bit. We have Mr Cox coming in -

Mr FERGUSON - Can I just explain? Mr Cox is the acting chair for each of the three governing councils. I would ask that the committee recognise that while he is the acting chair for each of the three, his home governing council is THO South. I would ask, therefore, that he not be expected to answer questions about THO North and North-West, but he can in relation to any governance matters. We have from each of the THOs the audit and risk subcommittee chair and each of the CEOs. It is open for the committee to do one at a time, or I could invite them all to be at the table.

Ms FORREST - It would be good to have them all at the table with the crossover.

[12.45 p.m.]

CHAIR - If it is all-encompassing, minister, we will do the whole lot at once.

Mr FERGUSON - I will ask the acting CEOs to join me on my left. I will ask Mr Cox to join me at my right, and the others I have at my disposal if required. Mr Cox is on his way.

CHAIR - We will just pause for a second until he gets here, he is close. While we are waiting for Mr Cox to come, minister, could you introduce, for the purposes of *Hansard*, your people at the table, the three CEOs.

Mr FERGUSON - I introduce Mr Matthew Daly, the Acting CEO of THO - South; Adjunct Associate Professor Karen Linegar, Acting CEO of THO North-West; and Mr John Kirwan, CEO of THO - North. Shortly I will introduce you to Mr Lyn Cox, who is the Acting Chair of the governing council.

If I may be proactive at this point, there was a question outstanding from earlier that Karen Linegar is able to answer in relation to locums if you would like the answer now.

CHAIR - Yes.

Mr FERGUSON - I can introduce Mr Lyn Cox to the table as well.

Prof. LINEGAR - The answer to the question related to the locum cost by breakdown for each of the hospitals for the THO North-West. The figures from the data that I have been given are: Mersey Community Hospital was $3.04 million, North-West Regional Hospital $2.12 million, Primary Health $1.18 million, and Mental Health $1.08 million.

Ms FORREST - A point of clarification there, I thought the minister said there was no locum cost for mental health, when you provided the previous answer.

Mr FERGUSON - Good pickup, Ms Forrest. That has been amalgamated into the THOs in this financial year, so it was provided, whereas the table I was reading from had year-on-year. That explains it. That service was a statewide service. It has now been amalgamated into the THOs.

Ms FORREST - So each THO has its own. What about the other THOs then, do we have the breakdown for those, for the south and the north?

Mr FERGUSON - I gave you each of the THO figures, so it would have taken that into account within their overall number.

Ms FORREST - There would be locum costs in mental health areas in the south and in the north.

Mr FERGUSON - Yes. Because of the changes to the Mental Health Act. With mental health coming into the THOs, with provision, the numbers now reflect that body of work as well.

Ms FORREST - Can we have a figure from the south and the north as to what their locum costs were? Otherwise we are not getting a true picture. We were told it was zero.

Mr FERGUSON - That was only mental health as a statewide service. I gave the locum and consultancy and agency costs for each of the THOs including the north-west. So what are we not clear about?

Ms FORREST - Where the other mental health locum costs have been experienced. The north-west has $1.08 million, in locums, for mental health.

Mr FERGUSON - We should be able to but I am trying to be helpful to the committee without slowing it down. In some cases it may need to be brought forward.

Ms FORREST - Is it possible to get a comparison for the last financial year of locum costs right across for medical nursing, primary health and mental health?

Mr FERGUSON - What I suggest, so that we can provide the transparency I wish to provide, let each THO take that on notice and I will ensure that is provided. That is a different subset of data.

Ms FORREST - I was going to ask each of the THOs what their final budget overrun or under-run was.

Mr FERGUSON - I am happy for each of the CEOs to speak for themselves. We have some significant challenges that the Government inherited and the THOs are dealing with. In both cases of north-west and south THOs, we have a different acting CEO now to what has been the case in the past. Both Karen Linegar and Matthew Daly are now grappling and dealing with the structural challenge that sits within their organisations with financial performance, both of which are experiencing financial overruns, spending more than it received in income. The Government has placed both of those THOs in a position where we require remedial action and we want to see recovery plans provided. I am happy for some discussion around that, bearing in mind that work is ongoing in relation to each of the THOs. I am happy to lead off with Mr Daly.

Mr DALY - The THO South finished last financial year with a reported deficit of $22.2 million. There was a one-off cash transfer, quite legitimate and appropriate, and we picked up another $2.5 million which otherwise would have added to the deficit, if not for that cash. The underlying budget for .. THO South is the accumulation of those two figures.

Ms FORREST - Carry over for the previous year?

Mr DALY - Yes. In the expenditure stream THO South, is expenditure amounting to $22.2 million which is where it finished its financial year.

Ms FORREST - Can the overrun be linked to anything specific? What area does that predominantly fall to?

Mr DALY - Predominantly salaries and wages. That cash deficit was largely driven by an increase in full time equivalent staffing across the THO and across a range of disciplines, as well as an increase in activity above the service level agreement.

Ms FORREST - Minister, perhaps I could ask you that question. If the hospital is providing services above its service level agreement, who signs off on that and why do you allow that?

Mr FERGUSON - It is not sanctioned; it is not supported. Each THO has a service agreement with the Department of Health and Human Services. There is an expectation that THOs and their governing councils will address what is in the service agreement and will come in on budget. You are asking what we are doing to address it?

Ms FORREST - How does it happen if there is a service level agreement that is signed of by the minister and, I assume, the governing council?

Mr FERGUSON - That is right.

Ms FORREST - What was undertaken above and beyond the service level agreement?

Mr FERGUSON - This predates Mr Daly's involvement in that role, but I can tell you that it would be said they were meeting demand. The governance structure we have in place now devolves responsibility from the government to the THO governing councils. But the government expects financial discipline to accompany the opportunity - provided by the three-region model - to have local management.

At the end of the financial year the new Government had to provide additional funding to address that issue with a $20.3 million supplementary payment. Mr Daly is in the difficult position of developing a financial recovery plan for his THO, even though they will be amalgamated from 1 July 2015. There are still some structural cost pressures that he and his governing council need to address because, whether we like it or not, they cannot spend more than their budget allows - money is not limitless. That is a special challenge for THO South. THO North-West is in a similar position.

Ms FORREST - Can I come back to THO South? You said there was service provided above and beyond the service level agreement - and I am not having a go at anyone here. I am just trying to understand what has happened. We have been told, for as long as I can remember sitting around this table, that the departments will stick to their budgets, and time and time again, they don't. Except for the odd one, and we will get to the odd one in a minute.

I can understand that an unexpected outbreak cannot be factored into a service level agreement, but that was not the case - they were just meeting demand. Where did the demand come from? Was it additional surgery? What was it? Someone said that over 200 extra staff were included in this.

Mr FERGUSON - That was across all of the THOs.

Ms FORREST - What was delivered above and beyond the service level agreement?

Mr FERGUSON - I would not just put it down to meeting demand that was not planned for or purchased. I would put it down to a whole range of cost pressures within the entity. THO South is a big organisation and, clearly, costs can run out of control in a big organisation. They might not be addressed promptly, or brought back within budget as required. I am unaware of the previous government's approach to this or what expectations were set.

Every THO is asked to meet its service agreement and purchased activity levels. That is not to dismiss how difficult that can be, but when the government provides a budgeted amount for the financial year, clearly we want them to come in on budget, having met their purchased activity for the Tasmanian public. That is why I would not just put it down to demand for patient services. Within an organisation there are structural cost obligations that sit there - particular management structures, for example, or the way some procurement decisions are made.

Ms FORREST - Would that be addressed partly through having one Tasmanian Health Service or is it these sort of things that are not going to be addressed in that process?

Mr FERGUSON - I think both need to happen. Within the Tasmanian Health Service from July we will still have a Royal Hobart Hospital, with much of the administrative overhang it has now. It is the job of THO South as part of the recovery plan. The first request by the Premier of the acting CEO there is to develop that financial recovery plan. Three THOs or one, we need to get the Royal Hobart Hospital and services currently provided in THO South coming in on budget.

Ms FORREST - How much of this relates to supplies and consumables with the overrun? Is there a significant proportion of that or is it more the wages? It says it is mostly salaries and wages. Consumables are obviously costly.

Mr FERGUSON - I will be helpful and suggest that I don't think you can put it down to a single line item in the THO South's budget to find an explanation for the $22 million budgeted deficit. It is the whole activity of the whole organisation which contributes to those cost overruns.

CHAIR - Minister and members, an interesting discussion. It is 1.00 p.m. and that is the time we said we are going to knock off for an hour for lunch.

The committee suspended from 1.00 p.m. to 2.00 p.m.

DIVISION 3
(Department of Health and Human Services)

Output Group 2

2.2 Tasmanian Health Organisation - North

[2.00 p.m.]

CHAIR - We will resume.

Mr FERGUSON - Chair, if I may also introduce the committee to Mr Mark Scanlon, who is the Chair of Audit and Risk Subcommittee, THO North.

Ms FORREST - With THO South, page 4.14 in volume 1 of budget paper 2, in relation to the funding of THO South, it says: 'The movement in Tasmanian Health Organisation South primarily reflects a more accurate Budget estimate based on activity purchased in 2013-14'. We were talking about this before the lunch break. There is actually a reduction from last year's budget, and we were told about the $22 million overrun so it is less and they were saying that the THO spent more than they were meant to under their service agreement. How can less money meet their likely requirements to provide a service?

Mr FERGUSON - I am going to invite Eleanor Paterson, the Acting Chief Financial Officer, to the table. If we are going into those numbers which relate to accounting treatments on centrally determined budget papers, it would be good to get that advice from the Acting Chief Financial Officer.

Ms PATERSON - The note you were referring to reflects a movement between state and Australian Government funding. With the way the National Health Reform now works, the component of state and commonwealth funding is based on the service agreements and what is activity and block funded. Whilst it looks as though there is a reduction on the DHHS side of the THOs, you are probably best to look the actual THO chapter which has the total funding in it because what you are seeing in the DHHS chapter is only the state component. There can be a movement in ABF and block funding which then may have an increase in the state component but a decrease in the commonwealth component or vice versa, and that is what that note is reflecting.

Ms FORREST - I understand that, but what is provided by the funding from the state that there is less need for that is picked up from Commonwealth funding, because there is an increase overall. Some of that is capital expenditure that is done and then handed over to the THO and that includes your grants, doesn't it?

Mr FERGUSON - I think Eleanor would be well placed to respond to that. I invite you to have a look at the THO South chapter in budget paper 2, volume 2. The point that Eleanor was making was that when you look at the entity as whole you see the bigger picture on spending of last year by THO South of just over $600.5 million compared to the 2014-15 budget year of nearly $623 million.

That is nearly a $23 million increase. There is a relationship between state-funded activity and then our eligibility to access federal payments that goes alongside that. There are two components to that. One is the block funding and the flexible, floating, activity-based funding. Eleanor, can you add to that?

Ms FORREST - Before she addresses that, the other point I was raising was in budget paper 2, volume 2, page 23.9 where you are looking at the grants income for the THOs. I understand that some of this is capital funds that have been expended to undertake capital works and then they are transferred to the THO. The increase, as I understand it and I guess this will be clarified, picks up capital works and not just service delivery here. When you look at the amount of money allocated for THO South, some of that relates to money that is spent and then the asset is transferred across.

Ms PATERSON - The output expense group summary that the minister is referring to is only the expense component; it does not reflect the capital. If you are looking at page 23.3, it shows the increase. That does not reflect the transfer of the assets and DHHS to THO South.

Ms FORREST - It is under the statement of contents of income -

Ms PATERSON - Yes. That would be shown in the grants payment. If I may go back your original inquiry about the reduction in THO South in the budget chapter of DHHS, the reason why we have a reduction is because we have undertaken a review of our overheads and we have a number of areas, such as shared services and SCwork, [?unknown acronym] our strategic control workforce manipulation, which we allocate under the outputs across all areas.

In looking at the review of the overhead allocation we reduced the overheads against the THOs because we looked at it and said that SCwork does not reflect in the THOs, so we have reduced that. There is a significant reduction - around $14 million - for THO South in the budget papers. If that were taken into consideration there would have been an increase in the THO South numbers.

Ms FORREST - THO South is required to make a range of budget savings as well, and I am interested in where you think they will be made. I know that the acting secretary has the job but looking at page 23.9, supplies and consumables do not tend to decrease unless you are doing less activity. The budget this year is for $169 million then it drops back and comes up again in 2017-18. That is nothing to do with the wage freeze as one of your savings strategies that the Government has decided on, so how are you going to achieve that?

Mr FERGUSON - I will ask Eleanor to continue to walk us through how that is constructed. If you are asking a question about how the THOs will manage with their resources, I will come back to that shortly.

Ms PATERSON - If you are looking at supplies and consumables, what this reflects is expenditure associated with all funds, not just the state funds. What we have within all of the THOs is a significant proportion of National Partnership Agreements and [inaudible TBC2.10.58] expenditure. The reason why there is a reduction from 2014-15 to 2015-16 is because of the cessation of a number of those NPAs. This does not necessarily reflect the savings strategies you have alluded to.

Mr FERGUSON - The issue here is that THO South now know what their future expense opportunity looks like. It is reflected in chapter 23 of budget paper two. Now it is the job of the governing council and the acting CEO to work on a plan to, first of all, acknowledge what their future spending can be, and then to live within that. Clearly, we have an overspending problem at THO South. We have an overspending problem at THO north-west. That is not a criticism of individuals but it is a reflection of reality and we need to see that come in on budget and we need to see a plan for that to be achieved. Both organisations are fully aware of their obligation to respond to those parameters.

Mr MULDER - Your obligation, minister.

Mr FERGUSON - Good point, Mr Mulder. It is my obligation back to parliament also. The Government wants to see these figures responded to by agencies because we do not live in a

world where agencies can spend whatever they want and even if they could make a case that they could spend it very wisely, it is for Government to determine budgeted amounts which is what this whole process is about. We need to see those agencies coming in on budget.

I would acknowledge, in making that point, that while we have an overspending problem and we expect it to be addressed by the respective THOs, I also acknowledge that the THOs are quite young, they are two years old, and there has been that implementation period. The Government acknowledges that it is not as efficient as we could make it. That obviates the purpose of us going to a single THS. Making those acknowledgments, we need to see financial discipline and we need to see THOs taking responsibility for this issue.

We have to acknowledge that the THOs have built up FTEs, significantly, in the time that they have been in existence. That has only added to the burden. With all of that said, we are professionals and we are dealing with professional people. Everyone knows what their task is. It is going to be very challenging but we are determined to send this clear signal because we cannot have, year on year, agencies coming back to the government with an overspending problem that has to be topped up by Treasury.

Ms FORREST - I was asking what are the expected areas that you could make savings in and you said that there has been an increase in FTEs. I assume that is what is traditionally considered to be frontline, as well as those who might be considered not frontline which is arguable in some cases. Where do you envisage the savings that are required can be made? Admittedly they are new but the area health services are not. They are effectively the same structure and given by previous governments as well and you will stay within your Budget.

Mr FERGUSON - When I have talked about FTE growth in the THOs. I would not concede that they are all frontline or I would not even like to say that a majority of them are. I would hope that they are but I am not confident that is the case.

[2.15 p.m.]

I will not single out one or two THOs, I will talk generally. The THOs have an obligation to manage their staffing in accordance with purchased activity and their budgeted expenditure. There is a fair bit of flexibility provided under the law to THOs and to governing councils to manage their affairs.

It is intended thus that Government does not dictate everything day to day. You might have seen quite recently the Government and I provided a ministerial direction to one THO in relation to emergency departments and how, if we see an issue, we want to see it addressed. But that is the exception. The broader approach is to provide broad parameters, purchasing intent provided by the Government and by the department, and then to allow the local governing council to get on with the job and respond to local priorities along the way.

In that ideal picture that I have just painted, something hasn't quite worked. We have seen a build up in FTEs which could almost be mapped up against what the overspending burden looks like. It is the case that we need our THOs to recruit staff and retain staff in accordance with their purchased activity, which is another way of saying their funding. We need to see people and governing councils taking responsibility for that. That is not a criticism of individuals but a reflection on the system that I found.

Ms FORREST - Doesn't this mean that potentially there are too many staff in some of the THOs in broad terms? That may be more the issue than the need for a wage freeze.

Mr FERGUSON - We have two issues there. First of all, a majority of expenditure in any THO is employment expense. It stands to reason that if THOs need to come in on budget they have to ensure that their workforce is the number that is required to meet purchased activity and so as not to overspend. Secondly, you mention the Government position on the pay pause. As you know, we have a bill in the Parliament at the moment and it is for the Parliament to deal with that. Embedded in our numbers is the fact that the pay pause legislation is critical to our budget success strategy. The pay pause legislation is about saving jobs. It is about securing employment. The risks report released by the Treasurer identified that in the forward Estimates it was assumed there would be a 1 000 FTE-equivalent reduction. To try to mitigate that and to try to save jobs, we have introduced this policy. We believe it is balanced and fair and it will mean that THOs, that is, hospitals, can retain their staff to a much greater degree than otherwise would be the case if they are not able to do a pay pause.

CHAIR - Just on a point there, the pay pause is going to be reflexed across all four agencies. That is a government policy and we have legislation coming up. It is probably a matter that we should be talking to the Treasurer about tomorrow morning because it is part of the budget development. It is something that otherwise we will get bogged in an ideological talkfest.

Ms FORREST - On this very point, minister, by your own admission you have said the numbers at THO South, for example, almost equate to the overspend of the additional employees who have been put on - isn't that where you should be looking first in terms of savings? The wage pause is a short-term solution to a structural problem. You are talking about a structure here where we have too many people delivering a service above and beyond the service that the THO was to provide under their service agreement.

Mr FERGUSON - You need to look at it more globally than trying to segment individual policy issues. In the overall government statements around the Budget that the Treasurer has outlined, the overall reduction to the public service is put at 700 FTEs and that takes account of the budget papers which sit in front of us. That includes the pay pause. I am not trying to earmark particular positions to a particular THO's overspend. What I am pointing to is that we have seen a growth in THO employment which sits alongside an overspend, and that is a real concern to the Government. From a budget point view, this is about working closely with our THOs. Two of our three THOs have a financial performance matter to deal with and they are diligently working through it. We respect all the people who are doing it - we have terrific relationships with them and we expect good results. At the same time we are determined not to let our health system hit a speed bump here. We want an increase in frontline services. It is a big call but we think it is the right call. Which is why we are seeing the extra investment, particularly in elective surgery. The best result from our efforts in this Budget is that we are making health more efficient, and the benefit of that result will be enjoyed by the public.

Mr MULDER - The size of the public service is a matter we will discuss tomorrow in greater depth, but there was an implication that the pay pause is an alternative to job losses. I give you the opportunity to correct that impression, if it was a false impression, or to confirm that it is an either/or situation, rather than a both.

Mr FERGUSON - I do not remember saying that but I look forward to reading what I had to say in *Hansard*. The point is simply that the Budget in front of us takes into account the pay

pause policy. This is about getting the balance right, so that the THOs - which are by far the biggest component of spending in the health system - can continue to operate in a responsible budgetary way, protecting frontline staff and protecting frontline resources.

Mr MULDER - Would you concede that if the pay pause is part of the strategy, the other strategy is a reduction in staff?

Mr FERGUSON - I do not see a better alternative, so I would not be categorising it into alternatives. On coming to office, the Government was presented with a report from Treasury that showed a 1 000 FTE reduction assumed in the future forward Estimates, and we have responded to that in what we believe is a proper, responsible way.

Mr MULDER - Staff reductions is not an alternative, but another part of the same strategy?

Mr FERGUSON - Every THO has a responsibility to manage on budget. We have already talked this morning about the work of amalgamating the three THOs and finding efficiencies there. That has employment implications, I am very open about that. I am not rushing to a number because that work is still to be done. This is all about efficiency and working in a financially responsible way. It is now the task of the agency heads and their governing councils to address this.

Ms FORREST - The acting CEO of THO South will be asked to give effect to the required savings - where are those savings, aside from the wage freeze?

Mr FERGUSON - It is going to be a difficult task for the governing council, advised principally by the acting CEO, to determine how they will achieve those savings. But that work is now in front of us, not behind us.

Ms FORREST - If you put a figure on how much you expect each THO to save, where do you think the fat is?

Mr FERGUSON - There is certainly fat in the health system - there is no question about that. With the THOs themselves, we have identified at an earlier Estimate something in the order of $21 million of efficiency.

Ms FORREST - Over the longer term?

Mr FERGUSON - Yes, over the forward Estimates. You are asking where the fat is - it is the job of the governing council and the acting CEO, not the Government, to interrogate their systems, look at their practices, look at where their spending takes place, and give a return back to the taxpayer. We want less inefficiency and we want more health services for the Tasmanian public. That is what our health indicators are calling for. They demand that across the health system in total, and I unfortunately include Human Services in this, which is not my portfolio, but we are looking at a savings strategy of less than 3 per cent, which I think is achievable. That is reasonable to ask of an agency head - but turn those savings back to frontline services. So they are not losing the resource, but they are being asked to manage it in a different way.

I suppose that helps to answer Mr Mulder's early question as well. We are seeing a record investment in health, not a reduction. We are saying to the THOs, 'We want to reconfigure how

we organise your respective agency or your THO - we want to see a reduction in the back line and we want to see a reinvestment in the front line'.

Ms FORREST - What was the final budget status for THO North, minister? Where do they end up? It's not a deficit, clearly.

Mr FERGUSON - THO North has reported a budget surplus in 2013-14 of $16.2 million after taking into account committed funding of $16 million which was predominantly for capital works. THO North has had a cash surplus of $189 000 and carried forward $28.6 million in cash in its operating account, which consisted of $8.5 million in tied funds, including donations; Commonwealth own purpose expenditure funds and research funds; $3.9 million in respect of the state component of its cross-border payment; $16 million for capital projects; and the $189 900 surplus. THO North also carries forward $11 million against its patient trust and legal bequest account. A strong result from THO North.

Ms FORREST - When you read footnote 5, page 4.14, again the numbers were wrong, so 4.9 on page 5 relates to the north? The decrease in Tasmanian Health Organisation will primarily reflect the budget Estimate based on activity during 2013-14. Now it may be the same numbers we received for the southern THO on this. But the way that read meant that THO North received more than they needed. They still had quite long waiting lists as are demonstrated in those progress charts and other publicly available information. I ask why that money wasn't expended in delivering patient services when they had a surplus. I am not saying they should have overspent; I know it is not a huge cash surplus.

Mr FERGUSON - You have correctly pointed out that the cash surplus was very modest and it is pleasing to see that it is not an overspend after everything else I just had to say earlier today. I might ask Eleanor if she could step us through that, but we acknowledge that the waiting lists at THO North are not where we want them to be. That helps to add further weight to all the other things the Government is doing in health reform so that we can have a patient focus on everything we do.

Once again, it is not a criticism of any individual but we need to see a planning of the way that we deliver health services in Tasmania taken as a whole state, not as three regions. For example, in elective surgery we will move to a single statewide waiting list, treating patients in turn when their turn comes up, not based on where they live. For example if the LGH - I am now speaking hypothetically - had a slower performance in a particular type of surgery and a longer wait, there is no reason why a person living in Launceston or Scottsdale shouldn't be able to choose to have their procedure done at a different hospital if they have a shorter wait. That should be their choice, we can do that if we move to a single statewide THO and if we have a single treat-in-turn surgical waiting list. Eleanor, if you could step us through that.

[2.30 p.m.]

Ms PATERSON - You are correct that the majority of the decrease between 2013-14 to 2014-15 is because of that movement between state and Australian Government funding. The issue is that when we were creating the 2013-14 budgets, the state ABF funding model at the time was not finalised so we are going to have these movements with all of the THOs. During 2013-14, when the ABF funding model was finalised, there was a reallocation between state and Australian Government funding and that figure reflects the activity which is outlined in the service agreements.

The state funding reduced significantly in the THO North and there was an associated increase in the Australian Government funding. That is where we need to go the THO North budget chapter, which is on page 21, and if you look at the sources of revenue that shows that there is a decrease which is offset by an increase in the Australian Government revenue.

The statement of comprehensive income is 21.9 but if we go the sources of revenue, which is 22.4 on page 22.10, you can see that the Australian Government revenue increases compared to the Tasmanian Government's. Again, with the THO North there was also a reduction because of a reallocation of overheads. There was also a reduction because we reviewed how our business services network charged and there were some minor transfers.

What you are seeing in the DHHS budget chapter doesn't accurately reflect what is happening in the THO financial position. If we look at the output expense summary, again, we see an increase in expenditure. It is going from $365.7 million to $371.9 million.

Ms FORREST - It does drop down the following year.

Ms PATERSON - Again, that would be in relation to NPAs coming out of the Budget. I am trying to find the NPAs that drop out. The NPAs associated with the National Health Reform sub-acute beds, for our national access target in elective surgery, are dropping out in the out years. Some of them drop out this year and the big one is the sub-acute beds that drops out in 2015-16.

Mr KIRWAN - On the question of why we had $190 000 surplus and why we didn't spend it on activity, can I go back in history. Our capacity to do elective surgery particularly isn't one of capacity and we have been rebuilding the LGH and our little five significantly as those on the public sector. The committee that has reviewed that goes back probably four years since we presented - the Public Works Committee. That rebuild is now in its last year and a little might flow over to the next financial year but hopefully not very much. That has meant we have been down on occasions to only three theatres from what would be normally be an operating model of five, six or more. That has been our capacity. The other one is that we did reduce surgery post-GFC quite intentionally, and that has been reported here previously and before the other committee of this House, so there is a physical capacity.

Having said that, the previous minister did say wherever we had any capacity, spend it on activity. So, within our own activity we did, but we were quite limited. We increased our contracted activity with The Eye Hospital. We also were quite innovative, and with the North West Hospital and their support we did some cataract surgery there as well. For those north-west patients who were referred to us through the model, we managed to repatriate about 60.

The other thing is that the surplus we had is a non-recurrent surplus, so building up current capacity until the new funding comes from the state and the Commonwealth money, you really cannot do that. You cannot spend non-recurrent savings on recurrent costs. On the question from the member for Murchison - anything between 20 and 30 per cent of our patients come from the north-west. About 20 per cent are in-patients, about 30 percent are out-patients. We provide that referral service to those areas as well.

Ms FORREST - Is that for procedures they cannot access in the north-west?

Mr KIRWAN - A mixture. Referral pathways are referral pathways. It depends on the referring doctors as to where they refer. That is often dependent on the general practitioner,

including their private practice referrals. Given most of our surgeons are private practitioners, what you will find is that a referral pathway is not as geographically neat as people would like. It is often dependent on who they refer their private patients to, because that is the bulk of what they would see, and they tend to refer their public patients the same way.

Ms FORREST - That referral framework will be a much more streamlined process with one THS.

Mr FERGUSON - That cross-border work should in some ways not change because as Mr Kirwan has pointed out, if a GP wishes to refer to a particular specialist, then they will, and they will continue to do that. It might be based on some past experience in excellent service, or some knowledge they have of a particular specialist or surgeon. But equally we would like to see the cross-border arrangements no longer be required because we will be using a statewide Tasmanian Health Service which could not care less where you live in terms of treating you in turn and ensuring that you get a safe and effective outcome. That provides opportunity to support people getting their health care needs addressed wherever they live.

Ms FORREST - You have an allocation in the budget for investigation into palliative care services for the north. Is that funding coming out of the allocation for palliative care under the current? I was trying to find in the Budget where that is included.

Mr FERGUSON - While we find where it is located in the budget, I can tell you that it is discretely funded. It is not coming out of any other existing resources of the THO. Are we talking about the same thing? The $100 000 dollars for palliative care to feasibility test the hospice model? Also for that funding to support the updating of the statewide palliative care plan. That is discrete, and should be itemised in a convenient place in the Budget.

So on page 4.4 of Budget paper number 2, you will see that our election commitments are funded there as specific appropriations from the Consolidated Fund. Third item down.

Ms FORREST - There is no money there to implement anything; you have to wait for the feasibility study first.

Mr FERGUSON - Correct. It is a one-off. It is a process that we undertook to do prior to the election that we said to that dedicated group of volunteers and other health professionals who were interested in a hospice model for Launceston. We felt that the time was right to give them some support to test the model that is being proposed to see if it is feasible, from the government point of view, to provide that much support, and then we would assess whatever the findings of that report might come back with. There is no funding that you can see and there is no suggestion one way or the other as to what the Government would do with that report.

One thing that will not change is that the Government continues to support the provision of public palliative care beds in Launceston, which is available to people not just in Launceston. That commitment is ongoing and does not change in light of the hospice model feasibility study.

Ms FORREST - The learning that can be gained from that may be applicable to other areas too, because a person on the west coast or Circular Head has three or four hours to get to a hospice if it is in Launceston or Hobart, depending on where they are. The palliative care in the home as opposed to a hospice, I imagine it is still part of the palliative care services in the state.

Mr FERGUSON - It certainly is, there is no attempt to depart from that because for many people that will be not just be their preferred setting for palliative care provision, it might even be clinically the most appropriate for the patient. It has been put to me that not everyone is able to have that palliative care support in their home, for whatever reason, family or other. For some people an inpatient experience of palliative care is what will suit them best. We do see that already with some regional hospitals, as I am sure you know, providing palliative care.

CHAIR - That is the fire alarm so I will suspend the committee until further notice.

The committee suspended 2.42 p.m. to 2.57 p.m.

CHAIR – Okay, we will resume.

Mr FERGUSON - It is about assessing the feasibility of that hospice model in a particular region and it does not diminish from the existing arrangements where we provide as much choice as we can, particularly with the additional Commonwealth-funded initiative for palliative care in the home.

Ms FORREST - Can we have the updated waiting lists and times for each of the THOs?

Mr FERGUSON - You can; we publish it every quarter. As of 30 June 2014 there were 8 546 patients on the elective surgery waiting list. That is represented by numbers as follows: Launceston General Hospital, 3 951; Royal Hobart Hospital, 3 061; Mersey Community Hospital, 754; and North West Regional Hospital, 780.

Ms FORREST - Do you have you a breakdown of the categories of surgery and the waiting times?

Mr FERGUSON - I can get you the waiting times but the breakdown by category is for LGH category 1 -

Ms FORREST - No. I am talking about orthopaedic, general, ophthalmology.

Mr FERGUSON - I will take that on notice if I may.

Ms FORREST - And the categories as well.

Mr FERGUSON - I will give you as much detail as I have access to and I will take it on notice if I may.

Ms FORREST - That would be great, thank you.

[3.00 p.m.]

Mr FERGUSON - Of all the patients who were on the elective surgery waiting list 3 678 or 43 per cent have waited longer than clinically recommended for their surgery. Despite the increasing numbers on the waiting lists the number of patients who have waited longer than clinically recommended has decreased slightly since June last year. In 2013-14 of all the patients admitted from the waiting list, 17 per cent waited longer than one year for their treatment.

Ms FORREST - Across all categories?

Mr FERGUSON - Correct. These are the numbers that stir our government into health reform and we were very confronted by those numbers. It is only a statement of fact that people continue to come on to the waiting list however many we are able to treat and able to provide surgery for. It does not change the fact that members of the community continue to come back on to the waiting list. What we are focussed on in our immediate action right now is to provide that additional burst in energy which we were able to start on 1 July even though the Budget had not come down.

We built those into new service agreements with the THOs and we were able to give the THOs lots of guidance about what sort of funding they would see in the budget. Secondly, it again makes the case to fix the system. We have an opportunity - the times suit us in addressing our system failures. While health will always be a difficult portfolio and while the hospital system and the way in which we respond to the needs of the community will always be very demanding, if we are all grown up about it we will all admit that we will never address all the needs of the community.

It is our obligation as policy makers and legislators to ensure that the system we have is capable of giving the best outcomes for health, for patients, along with our investment, so that in the future when additional funds become available, we are injecting those funds into a system that is ready to receive it and get the best value for money. That is what our health reform agenda is all about.

Ms FORREST - We do not know yet what will happen with the $7 co-payment. Hopefully, your party will maintain their rage on that. There is a risk that it is going to push more people toward our acute health services and particularly departments of emergency medicine. The performance information across the THOs shows increasing demand; the more you open the door more people come in, regardless of whether it is the department of emergency medicine or elective surgery.

What is your contingency plan should the $7 co-payment be implemented? I assume that you would expect an increase in demand in the departments of emergency medicine. Will you consider a co-payment to attend the department of emergency medicine?

Mr FERGUSON - Thank you for that question. We are watching that space very closely. I note that you have made your perspective on that known. I am not going to defend or explain what the Commonwealth is doing. From a health perspective federally, we want to see Medicare retained and strengthened and we want to see patients have access to primary health care because we know that is the primary day-to-day connection Tasmanians have with their health system. We are aware of the obvious potential for people to hold off their treatment at the primary health setting, for it to potentially turn into one of two things, either a later emergency episode which did not get treated at an earlier time when it should have been, or second, for there to be a flow of patients out of the GP sector and walking in off the street into the emergency departments on the basis that that is free. We are aware of that possibility. I think that it is untested. We do not have any evidence for that. It's a fairly difficult case to make that people would be willing to wait for the sorts of times we know they are having to wait in EDs, in order to save $7. While we are watching the Commonwealth very closely - and it would not surprise anyone here if we see changes occur at the federal level - we have made a policy decision that we won't be introducing

any kind of emergency department co-payment. No attempt to match it or provide any disincentive for patients to come to an ED.

My position and our Government's position is that if you need an ED we want you to present. If you don't need an ED, we would rather you didn't and we would like to manage patient flow in that way. There is a huge set of reasons to not introduce a co-payment at the ED. One of the most pragmatic of them is the fact that we are not sure we could collect a $7 co-payment in an affordable, responsible way.

Ms FORREST - Administrative costs.

Mr FERGUSON - The administration burden that would potentially be associated with that would take it out as an attractive option. Also, it would quite difficult to extract any amount of money from someone who is in an emergency situation.

Ms FORREST - Can you provide numbers from the DEMs across the state, on a monthly basis for the last 12 months, or even six months? The GPs in my electorate say, anecdotally, that there's been a significant drift away from them because people thought the co-payment became automatic as soon as the federal government announced it. They have noticed a significant drop off in patients. I have had a lot of concerning calls from GPs in my area.

If you are able to provide a monthly breakdown for the last six months, I would be interested to see the attendances. I understand there are seasonal effects, and a general tendency towards increased numbers, but I would like to see the detail.

Mr FERGUSON - I don't think I will be able to provide you with the exact data you have asked for, by month. We have some data. Do you have that by month, Mr Kirwan?

Mr KIRWAN - We can report on five triage categories by month. The triage categories you would be most interested in are triage categories 4 and 5.

Ms FORREST - Yes.

Mr KIRWAN - Which are the ambulatory, so called GP-type, presentations. We collect those by month, except that there is a bit of a delay. The LGH is the only hospital in my area that has a true emergency department, and we are not seeing any big increase arising from the risk of a co-payment. Whether that means they are not attending GPs, we just could not comment.

Ms FORREST - Do the other THOs have similar information?

Mr FERGUSON - I have a range of data I can share with you and I might ask for that data to be presented while these other folk answer your question, but it does look like the numbers are reasonably static. John, Matthew?

Mr DALY - We can cut data almost any way you like. For example, in the month of July just past at the Royal there were 4 528 presentations in the emergency department and in July the previous year, before the announcement of any co-payment, it was 4 394. That would imply it has not had any impact. It's a 6 per cent increase, which is the average growth, year on year, that we have experienced at the Royal. But, certainly the information would be available in the way the minister has described.

Dr LINEGAR - The figures for the last financial year indicate that both Burnie and Mersey hospitals saw a decrease in numbers, which is different to what we have previously seen. July and August are not useful months to look at because of the seasonal variation. Certainly the presentations in those months have seen more of a peak and trough, but they have been related to the respiratory viruses and some gastro-intestinal illnesses. It has been minor - we are certainly not seeing any major changes in that data.

Ms FORREST – It is difficult to know. The question is whether they are going to a doctor at all, or wait at home until they are really crook.

CHAIR - This question comes through from one of our members on another committee, the member for Elwick, Mrs Taylor, and she has asked it of the acting CEO of THO South. The Royal Hobart Hospital is doing a restructure. When he is only going to be there for another few months and in the process adding another management player with three additional managers, why is this so, when it is possible that the next CEO might want to do it again, as is normal with incoming permanent CEOs?

Mr FERGUSON - First, I want to say how grateful the Government is to Mr Daly, the secretary of my department. Given all of the history and what has happened there with leadership, the governing council of THO South recommended, and the Government accepted the request, and Mr Daly accepted the request, to act in the Acting CEO role at THO South We are grateful for that and we have every confidence in him. He has a difficult task to do.

In relation to the restructure, I will be careful how I describe that because we are not necessarily looking to restructure the Royal Hobart Hospital or THO South. I hope I have not misrepresented what Mrs Taylor had to say. What we are looking for is a financial recovery plan for the significant financial overspend that has been, year on year, sitting in THO South.

We want THO South to set up a pathway to financial sustainability. At the same time I am not prejudging where this goes in terms of what changes would need to take place in THO South. Clearly, change needs to be made and it needs to be the right change. We do not want to diminish from local leadership because as we move to a THS from July, it will have a single CEO in the future.

Nonetheless, we are going to make sure that we do not deprive local hospitals of local management. That is appropriate, so what Mr Daly is doing, and what he is expected to do, is to set up the Royal Hobart Hospital so that it sits happily within the family of hospitals of THS in a financially sustainable way. We are very confident in the work that is being undertaken by Mr Daly and his governing council.

CHAIR - The second question is, with regard to the service level agreements and funding, what happens when the service levels are met and more cases present than there is funding for?

Mr FERGUSON - This is always a challenge for THOs which are set up under the act to respond to purchasing of government to anticipate future demand and to manage their resources responsibly. It is a difficult juggling act. The THOs can never, with certainty, predict what the future holds in terms of demand. As a financial year progresses you can start to build up a picture of demand patterns, and that is what they are expected to do, and they need to manage within that.

CHAIR - Third, how much is the Royal budget being cut by and how many hospital bed closures does that equate to?

Mr FERGUSON - I will invite Mr Daly to help me answer this question in a moment but first of all we are increasing funding to health. There is a huge assumption in that question that budget saving strategies attached to any agency of Government, including THOs, means that there will be a reduction in frontline services. Our objective is the opposite of that. We want to achieve savings of the nature that reduce our administrative overhang. We want to see those savings achieved and reinvested it into frontline services. THO South, along with the other THOs and the department, have a savings strategy to deliver. It represents less than about 3 per cent of turnover and it is a reasonable argument to make that it can be achieved. It will not be easy, no-one says it will be. But the savings strategy, from my memory, is around half of what the previous government sought to do in 2011. The difference here is that we are showing faith in the Tasmanian public and reinvesting those funds into front-line services. Any argument that there will be beds closed because of this Budget is rather problematic.

[3.15 p.m.]

CHAIR - Finally, the Acting CEO of THO South has brought three senior managers with him who are being paid out of the THO budget. That is three more managers and before the THO came into existence, the question is why, and what is the impact of the Royal Hobart Hospital budget?

Mr FERGUSON - The impact on the Royal Hobart Hospital is that we are stabilising that entity. We are very disturbed at what we found when we came to Government about what was going on in our health system. I am not going to dwell on the Integrity Commission report other than to invoke it. There were quite clearly some big matters being raised around the health system and we had performance issues in the health system that we have had to deal with.

Until now, I have spoken generally. Now I speak particularly about the THO South and the Royal Hobart Hospital. We have had a need to provide leadership at the Royal Hobart Hospital. I have already outlined how we came through that process and arrived at Mr Daly being willing to take up that role. The support team that he is provided with is there because I told him that whatever support he needed would be provided. He didn't ask this of me but I made it clear that would be the case because we were not going to just drop him in and forget about him. He has an important job to do.

We are proud of the Royal Hobart Hospital and what it can be in the future and we are determined that Tasmanians be rightfully proud of the Royal Hobart Hospital, not just people in Hobart but wherever you live in the state. It belong to all of us. As it happens, the two - or even three - people who Mr Daly works with and who are supporting him have come from the department and they are being paid for by the department.

2.3 Tasmanian Health Organisation North-West

Ms FORREST - Minister, do you have the final budget overrun for THO North-West?

Mr FERGUSON - The THO North-West reported a budget deficit of $7 million in 2013-14. This was offset by a $3.8 million supplementary payment received from the state Government and the Parliament. It also was offset by $3 million of special one-off funding that we were able to provide through the department. That resulted overall in a cash deficit of $197 000. For the

information of the committee, THO North-West carried forward $5.2 million of cash in its operating account. This consists of $1.8 million in tied funds, including donations and Commonwealth own-purpose expenditure funds. It also includes $3.6 million in respect of the state component of its cross-border payment which has been offset by the $197 000 overrun. THO North-West also carried forward $1.3 million against its Patient Trust and Legal Bequest Account. I am quite happy if the committee would like to delve into that any deeper.

I want to be very careful here that from a Government point of view, we naturally are concerned when we see these overspends take place, but I moderate my own comment by saying we are very thankful for the amazing and professional people who work at THO North-West, in the particular the management and the staff on the floors, and the governing council. They have a difficult job. Everyone working in THO North-West is working in an organisation created by others for them. They are working within that environment created by, in this case, the state parliament. They have some difficulty, especially the fact that it represents a small community, in population numbers, and it also has a continuing reliance on the other THOs.

Ms FORREST - It serves quite a decent population when you take the whole area. It is nearly as big as THO North in terms of population.

Mr FERGUSON - I will have a look at that but I still maintain that it has a small population to maintain a THO; it also has a split campus model which presents an additional challenge. Their overspends are more modest than THO South, thankfully, but having said that, we have made this a performance matter for the governing council and for the acting CEO. Naturally, like anyone else in this space, we are looking for progress on that so that when we move to a single THS in July, we do not inherit the same old problems under a unified model and that we can make progress in the meantime.

The last thing I want to say about THO North-West is that they have been working on some specific projects and I will ask Karen to outline some key ones. THO North-West has been identifying projects to deal with their financial model and the leadership that has been shown by governing council has been terrific. Karen, did you want to outline some of those key priorities you are working on?

Prof LINEGAR - Some things in the North-West that make it a little bit unusual are the contractual arrangements we have, both in medical imaging and radiology. There has been a lot of work to reduce the cost under those contracted models and we have been quite successful in doing that. The third big one is maternity services - public maternity is outsourced through a private model. Again, we have been working very closely with North-West Private Hospital to do the best under that contractual arrangement to decrease costs and to get a more realistic costing. I think it was raised earlier that one of the big challenges for the North-west has been the cost of locum services, in particular at Mersey Hospital, but it is across all of our services.

We have a recruitment plan in place, particularly around our medical and emergency department positions and you will understand that it takes some time to recruit staff into those specialist positions. We will have three of our medical service positions filled in the new year; in the first instance that will not save us a huge amount of money because of the cost of recruiting our locums. What it does is to position us for the following financial year in a much more sustainable manner.

The other big cost driver for the North-West is our GP services contract for King Island and West Coast. We have been doing a lot of work moving to a tender process to enable us to recruit in a different way to those GP services contract. One thing we are looking for there is a sustainable service but being more innovative and using more medical technology, such as video conferencing, and more support through the larger centres at North-West Regional Hospital to support the GPs in those areas.

Ms FORREST - Maternity is the contract that has no end. We have talked about this in previous years; it is an unbelievable situation. Will the government consider returning public service to the public hospital in the North-West?

Mr FERGUSON - The Government takes the view that everything that happens in health can be done better. The Government took into parliament the view that all options are on the table. I am not trying to give you a hint one way or the other as to what we might do in answer to your question, but as we work through the white paper process, we are interested in safety and effectiveness. Along the way we are also interested in cost and cost benefit analysis of everything that we do in health.

To be very particular in answering your question about the maternity contract, naturally I respect the fact that there is another player there contracted by government to provide services and I would simply give the committee to understand that THO North-West is in constant contact with their fellow hospital, the North-West Private.

Ms FORREST - I can take a degree of comfort, then, from the fact that it is not off the table. It should be one of the things up for debate through the white paper/green paper process and we may yet see a sensible decision made.

Mr FERGUSON - What you might say, Ms Forrest, is a sensible suggestion might not be what someone else would agree is a sensible suggestion. The white paper process can canvass those kinds of matters, and, in fact, all services, everywhere, wherever they are provided. The THO North-West also has a special responsibility to get their budget situation under control. So, naturally they talk to their contracted partner, the North-West Private Hospital. It is no secret that these conversations happen all the time to determine the best value approach, and that is what I have asked the THO North-West to continue to do.

Ms FORREST - If a private maternity patient requires an epidural during labour, currently they have to become a public patient to access that service. This puts the cost on the public purse, as opposed to the private health fund the woman has chosen to access for her maternity care. Has that been resolved in the north-west?

Prof LINEGAR - We have been working with the anaesthetists at North-West Private Hospital for exactly that reason. We now have an agreement whereby the anaesthetists restructured their on-call roster so we are able to accommodate those requests as required.

Ms FORREST - Private patients no longer need to become public patients at that point. Well done.

Prof LINEGAR - With a caveat that the system is still settling in, but on most occasions we are able to accommodate.

Mr FERGUSON - I believe that query goes back a few years.

Ms FORREST - A while, yes.

We have talked about what is collected and what is not, with regard to performance information. We all get inquiries through our offices from people who have been waiting for surgery for a longer time than they would have liked, or expected. It is great to see aspirational targets, which you have here. For example, the THO North-West elective surgery patient seen-on-time data. Does that mean they are having surgery?

Mr FERGUSON - It would.

Ms FORREST - Category 1 - admitted within 30 days. The target is 100 percent of patients in category 1 will be admitted within 30 days. This is across all THOs, not just North-West. An audacious goal, perhaps, but admirable.

I tell constituents the Government has a target of 100 percent - if you are in category 1, you will be there within 30 days. But they are waiting 60 days. So, how realistic is this? Do you really believe you can achieve that? When I look at category 3, you say 95 percent of those patients will be admitted within a year. In recent years it has been the case that if you are category 3, you might as well forget it because the chance of getting surgery at all, let alone within a year, has been almost nil.

Whilst I commend the Government for setting such high goals, in realistic terms do you think you are going to reach them?

Mr FERGUSON - Thank you, Ms Forrest, you have raised one of the key questions that 8 500 Tasmanians have been asking lately. That is, 'When am I going to be seen on time?'. We have 8 500 Tasmanians waiting for elective surgery in the various categories, where one to three are the order of priority, are the most pressing. I think we will find that when you are seeking the number of people to be seen within 30 days, for example, ideally they should be seen within 30 days. I understand, and I do not wish to be held to account on this, because I do not have the number in front of me, but I understand that quite a high percentage of people are seen well before 30 days. Maybe even in the mid teens or early 20s. But not 100 per cent.

Clearly the target sits around people being seen within 30 days and many of the people who are category 1 are seen within a few days. Ideally, we want to see that 100 per cent figure realised. It reflects the government's aspiration, and the purpose and motivation for health reform. It is focused on patients because we should all be willing to admit that we can do it better.

As for the following categories, you have to look at past performance as you approach your future targets, and we are a long way off, a really long way off, so at next year's Estimates we will be reflecting on how we went on this and it is a very ambitious target to achieve, for example, category 2 from 34.9 per cent up to 92 per cent.

It is a big jump, but we have additional funds for elective surgery and we have additional Commonwealth funds for elective surgery. We have health reform and we have professional people working hard to deliver on purchased expectation. We have a special approach at the moment with the first tranche of that funding to target people who are sitting longer than is clinically recommended. These are the goals we set ourselves and I submit myself to be accountable for performance in the future.

Ms FORREST - We can look at it again next year, rest assured. I commend you for having targets as ambitious.

Mr FERGUSON - We need Team Tasmania on this. It is not just about me, or the health ministry, or the government. We need Team Tasmania on this case. Health reform is for all of us. It is not my special project. It is for all of us. If we do not have all hands to the tiller on this, we will not succeed. I am really pleased, really deeply thankful, for what we have seen out in the community, both in the clinicians, in the THOs, the governing councils, and the wider public, and politically. Nearly, very nearly, we have consensus, and that is an excellent platform for us to deliver something special.

Ms FORREST - I will be happy to help.

Mr FERGUSON - All welcome, all welcome.

Mr GAFFNEY - I will come back to the Mersey hospital a bit later with the special investment funds. There are some specific questions there. I suppose I want to put on the record there has been an interesting relationship between the Mersey hospital and the Northwest THO. I suppose the question has to be asked when it is transferred to the Tasmanian Health Service, will that same relationship exist under that mantle, because that is something people in our patch would need to understand. Every now and again it flares up where people, particularly some politicians from down south who do not understand the two [inaudible 3.34.45] model, take the opportunity to make some comment about the future of the Mersey. I am wondering, minister, how you see that relationship existing with the Mersey hospital, and the THS?

Mr FERGUSON - The Tasmanian Government strongly supports the Mersey continuing to be part of the Tasmanian hospital fabric. We do not see that an argument has even been made yet as to why any hospital should close. I know that some are calling for hospitals to be closed; others are shouting their concerns that hospitals might close. The government's position is that no hospital should close. We are willing, through the white paper process, and the reform process, to take the difficult step of re-evaluating what services are provided and where. I make a plea again to the community to stay with us on this journey, because we need to see. The bigger picture is that we can do more with what we have if we are willing to reinvent ourselves and to refashion what clinical services are provided and where.

I want to assure you, Mr Gaffney, and your community that while the Mersey is not a state-owned or state-run hospital, we are contracted to do that for the Commonwealth. We maintain a strong posture with our Commonwealth colleagues that we expect them to continue to fund it. It is their hospital and we stand ready to work with the Commonwealth to ensure that the greater Devonport community - the Mersey community - continues to enjoy the benefits of having that hospital as part of the Tasmanian Health Service.

Mr GAFFNEY - Thanks, minister. I will come back to questions later. Just for the record, two or three years ago when the question of having one THO came up, I was in favour of the one THO, not the three. My parochialism for the area of Mersey does not stop with the hospital. It is what is best for the state.

Mr FERGUSON - Thanks for that very helpful comment. Let's be parochial for Tasmania.

Ms FORREST - That is right. That is what we were at that time.

CHAIR - Any further questions on THOs? If not, thank you very much, minister.

Output group 3 - Statewide Services

3.1 Ambulance Services -

Mr FERGUSON - I invite Mr Kirwan to provide the answer to Ms Forrest's earlier question and I will table the emergency department data for you.

Mr KIRWAN - I have the figures for THO North locum payments for the last financial year, broken down into LGH Primary Health North and Mental Health Services North across our occupational groups, which is how I understand the question.

Working backwards, for Mental Health North, it is only locum payments paid for salaried medical officers and that was $411 781. The only locum payments were for our medical practitioners in Mental Health. For Primary Health we had $19 776 in admin and clerical; $615 709 in nursing; and $1 617 930 in rural medical practitioner locum costs; and $5 100 for visiting medical officers.

For the LGH, it was $270 401 for admin and clerical; $27 774 for allied health; $46 209 for nursing; $156 993 for operational areas; $987 764 for salaried medical practitioners; and $13 290 for visiting medical officers. All of that adds up to $4 172 727.

Ms FORREST - Can I just clarify, when we are talking about locum nurses, are we talking about agency nurses?

Mr KIRWAN - Yes.

Ms FORREST - We are not talking about additional.

CHAIR - I extend my appreciation to the officers at the table and thank you for your service today.

Mrs HISCUTT - Just before the minister dismisses them, I wanted to speak specifically on the North West Regional.

CHAIR - Did you want to do that in capital works?

Mrs HISCUTT - If that is appropriate.

CHAIR - We are still going to go there for that anyway, so you can do it a bit later.

Mr FERGUSON - Is it capital or operational?

Mrs HISCUTT - I wanted to get an update on cancer services in the North West Regional Hospital, Burnie.

Mr FERGUSON - Cancer services? They would be better now, Chair.

Mrs HISCUTT - I have just noticed that for the statewide cancer service - you have $22 million allocated to infrastructure at the North West Regional Hospital. I presume that was probably going to building of the North West Cancer Care? Can you give me an update on how that is going and with a future budget in due course on target.

Mr FERGUSON - We have quite a broad project plan under way for improved cancer services across the state, particularly in the north-west. I will ask Prof Linegar to provide a more detailed response, but I can tell you that the new North-west Cancer Centre is something we are very supportive of and it is great to see the progress there.

I have visited two or maybe three times to see progress and it has been encouraging to see the physical manifestation of that work. More importantly, it has been great to see the staff and the community response to something which has been requested now for a number of years. We expect the centre to be operational in 2016, so there is still quite a bit of work and commissioning to do. There is a substantial body of work that we still need to do to plan for its operations to commence, including the financial implications and recruitment. A lot has already been achieved and I invite Karen to bring the committee up to date.

Prof LINEGAR - In answer to your question, the Cancer Centre is both on target and on budget, which is pleasing. It is changing the face of the hospital. For those of you who have driven through, the second floor has now been poured and they are working on that level.

On staffing, we are working with our colleagues at the LGH; it is a partnership model which is consistent with the statewide cancer services plan. We have recruited one key staff member around the installation of our linear accelerator. I am grateful to two staff who work with Peter MacCallum at the LGH; we have now developed our staffing model and are working through the fine tuning of that. It is on target and, pleasingly, on budget.

Mrs HISCUTT - Did the funds from the Elvingston group of companies did that go to this or did it go to the pool for cancer? Did it go directly to the north-west or into the state wide cancer services pooling?

Prof LINEGAR - It has gone to the north-west - it is specifically for that area. Part of that funding was a longer term strategy around recruiting staff in a specialist area, such as the radiation oncologist. We have been able to provide a scholarship through the University of Tasmania and we are now in the third year of that to have a pool of staff who have been able to be re-employed.

Ms FORREST - Just on that point, they are bonded, aren't they?

Prof LINEGAR - Yes, that is my understanding.

Mr FERGUSON - One of the first pleasures I had as Minister for Health was to announce that and visit THO North-West. It has been great to see the generosity of the Elvingston family in partnership with the university.

Mr GAFFNEY - My first question is simple: it is under the capital investment funds, the $1.9 million which comes out of the 2007-08 hospital capital fund for the Mersey. What is that money for?

Mr FERGUSON - One of the things we have discussed with our Commonwealth colleagues is their continuing investment in the capital improvements needs of the Mersey. There have been some fire standards changes and they have met their obligations on that. That was realised in the Federal Budget in May. I am not sure if that is funding because we are talking about a fair bit more than that. Karen, could you tell us about the $1.9 million.

Prof LINEGAR - I think the funding you are talking about may be more the element that is being undertaken in terms of the redevelopment of pharmacy and stores in the area. That is to meet standards within both of those areas.

Mr GAFFNEY - Put that one aside, here is the next question and that is why I appreciated that you have stayed. With the $68 million in the Budget showing Mersey Community Hospital funding from revenue from the Australian Government, is there a base funding? They have implied in a couple of their releases that there is a base funding of $62.7 million in the 2014-15 Budget from Australian Government revenue. How does that relate to the budget Estimate where it has $73 000 610? I am just wondering what the relationship between them, is that Australian Government funding? I am asking because then Mr Abbott said that in 2014-15 there was $13.6 million extra funding. I am trying to appreciate the relationship between the base funding and the extra funding and what is shown in the figures here. If that is the revenue from the funding, there is two or three million dollars not accounted for. I want to understand the relationship before I ask those questions.

There was $3.1 million for the fire upgrade from the 2011 audit report, but my understanding is it is about a $2.448 million spend, so there is another $600 000 there, so I wanted to find out where that money is.

Mr FERGUSON - I can advise you - and if I am wrong about this I will be pulled up - my understanding is the $62 million figure was a starting figure from the beginning of the deed of agreement between the Commonwealth and the state. The real cost is much higher than that now, seven years on, and that is why you will be seeing figures in the order of $70-$73 million in the Budget. That takes account of indexation over those years, and that is the real cost of running the Mersey as it is.

Mr GAFFNEY - I am not sure if you, minister, were involved with the signing-off of the federal funding for the one year, 2014-15, or if it was your predecessor. Isn't there some concern because it was supposed to be for a three-year term and it is only for a one-year term? What role did you play in that?

Mr FERGUSON - Our Liberal Government signed the deed of variation with the Commonwealth for the extension of the heads of agreement for a further one year. I should correct my previous answer to you, which is that the recurrent figure of running the Mersey is $70.5 million, which I think is the figure that you used. It is this Government which agreed to that deed of variation. It was previous government which agreed with the Commonwealth to extend the formal negotiating period which is required under the heads of agreement. That is the process that has taken place. I think it takes account of the fact that we have a federal and a state election in the meantime and it was just agreed all round that it would be a sensible move to get it secured in the immediate term, and we are now are furiously negotiating around the next agreement. Can I make it clear? We expect the Commonwealth to continue funding that hospital.

Mr GAFFNEY - And that is why you have it in the forward Estimates as you have, that's fine. If $62.7 million was the base and then Mr Abbott came out with his $13.6 million in his Budget, that means to me it works out to be $76.3 million and yet showing in this Budget there is only $73.6 million so there are some millions of dollars and I was just wondering where it is?

Mr FERGUSON - What are you saying are the missing funds?

Mr GAFFNEY - According to the Federal Budget of this year, there was $13.6 million in the 2014-15 Mersey Community Hospital from the heads of agreement for one year for the cost of upgrading essentially fire safety systems. Now, $13.6 million is way over the top because it is only about a $2.5 million spend. I am just wondering, if the baseline was $62.7 million plus the $13.6 million, that comes up to $76.1 million and yet in the Budget it shows as $73.6 million in Australian Government funding. What accounts for the discrepancy? I may have this incorrect as it has just happened recently and it was confirmed again by a media release from the Government. There is a $3 million difference in the figures. I want to know where that might be.

Mr FERGUSON - With the indulgence of the committee I might provide the answer I believe is correct and provide, and an update to that if it is in any way deficient. My information is that the heads of agreement comprises $70.5 million dollars for the ongoing management and operation of the Mersey, in addition to $3.1 million for capital upgrades to fire safety systems and the pharmacy department - described in the agreement as 'specified capital works'. The deed of variation included three key amendments to that heads of agreement. The first is the extension of the expiry date through to June next year. The second is the inclusion of a funding quantum received of $73.6 million - the higher amount - for 2014-15, and a requirement to carry out the specified capital works.

Mr GAFFNEY - I thought that initially the $1.9 million funding was for the pharmacy and the $3.1 million was separate funding from the Australian government for the fire works.

Are they together, or are they two separate funds?

Mr FERGUSON - I will need to come back to you on that. It is possible they have been grouped in the meantime. I am happy to double check that.

Mr GAFFNEY - Another question on notice - what is the actual spend on the fire work that was the allocated $3.1 million? I would like to know the actual spend on those works.

The Committee suspended from 3.53 p.m. to 4.08 p.m.

Output group 3 - Statewide Services.

CHAIR - I call the meeting to order. Minister, we will move to output group 3 Statewide Services.

Mr FERGUSON - May I introduce a familiar face Mr Dominic Morgan, Chief Executive Officer, Ambulance Tasmania.

Mr FARRELL - Minister, the big issue of recent weeks has been the ambulance ramping issue and you made the decision to re open the Nell Williams unit. If you would kindly explain to us where this extra funding came from and what impact that may have on the budget being that it is a fairly recent occurrence.

Mr FERGUSON - Thank you, Mr Farrell. The issue here is that we have had some high profile instances raised with the government and increasing community concern. Ramping is not new. Ramping is a long standing problem that this government inherited from the previous government. It has not been addressed. At different times, seasonal times, the ramping issue has been more of an issue and at other times less of an issue. Unfortunately there is a misunderstanding in the wider community about what ramping is and what causes it. I do not want to be too detailed in giving a story here but the truth is that ramping is not where people are waiting in an ambulance on an ambulance ramp, which is what some people do think when they see a line of ambulances in a photograph; they may be forgiven for thinking that the patients are in there with the ambulance paramedics, they are not. I am sure that we realise that they will be inside the hospital itself, accompanied by their paramedic team, in the care of their paramedic team, but they have not been fully handed over as a patient to the THO or the emergency department and they are waiting in line.

Another misunderstanding in the community is that somehow it is a reflection on the performance of the emergency department, which, by and large, it is not. It is a reflection of the patient flow. It is a reflection of the stop-start nature and the blockages that sit within a patient flow from the emergency department waiting room through to the emergency department through to hospital wards and then to being discharged. Where that flow is interrupted or blocked in any way, when you then start having ambulances arriving at the ED with patients who need care, you then start to see that ramping. From the ambulance perspective we call it ramping, in an ambulatory case we refer to it as someone waiting in the waiting room, patiently waiting to be admitted.

It is about patient flow. I wanted to put on record once again that the Government does not dismiss or denigrate in any way the work of the emergency department. We do denigrate ourselves here in that we could have and should have, as a system, managed patient flow much better.

Mr Farrell, you have asked me what the Government is doing about it and you mentioned the Nell Williams Unit, which was a unit that sat inside and alongside the emergency department and was closed by the previous government. It is no longer the Nell Williams Unit as such but the beds are still there and available, and they have not been used.

I have issued a Ministerial Direction to THO South. Among other things, I have directed that they should produce a performance improvement plan which deals not just with opening up more beds but deals with that patient flow issue. That is what we need THO to deal with. To support their efforts, I have also directed that they should reopen those beds and make them available in the best possible way to address what is commonly known as ramping. I have given THO South some flexibility and some time to come back to me with a coherent plan - not a reaction but a plan that will address patient flow issues. The biggest problem here is that ambulance paramedic staff are accompanying and looking after their patient in the ramping environment and we would rather that they were on the road looking after the other person who is waiting for an ambulance response.

You asked me about cost. I am still waiting for that advice. However, I told either Parliament or in a media statement I made a disclosure that it would be less than $1 million.

Ms FORREST - Just to reopen those beds?

Mr FERGUSON - I put an upper limit on how we would describe that. That is not a final figure by any stretch. I am not being defensive when I say it but this is an example of a reminder that there is a governance structure that sits above a THO and their job is to run the hospital. Their job is to deliver on expectations. It is when that does not deliver adequately that a minister should step in. We have stepped in, we have provided that leadership, we expect outcomes and we want the problem to be addressed knowing that it will always be an issue, and it always has been an issue, but we want to minimise it.

Ms FORREST - This is getting off ambulance slightly, ramping occurs when the patient flow is interrupted and one cause of that is bed blockage at the other end, can't get a bed. The patient is already in the department of emergency medicine. In past times one of the problems has been people who would be better off in an aged care facility blocking beds in the acute medical and surgical wards. Is it still the case that those patients are blocking beds?

Mr FERGUSON - It is the case and it is also not just aged care but people who, having occupied an acute care bed in an in-patient hospital or a ward who could have been just as well suited in a step-down or sub-acute facility but in which there may not necessarily be places for them. This is why we talk about our work with the aged care sector to try to allow people to move into the appropriate setting as well as working with our regional hospitals. Specifically on aged care, Mike, you might have something further to add?

Mr PERVAN - From time to time there are people who should be in nursing homes or in supported care out in the community and what we don't yet have well-organised as a system is a way to keep track of those people, as they come into the beginning of their acute episode, to start planning for their discharge into an alternative level of care. What usually happens is that as they become ready for discharge, that is when we start looking for their alternatives, whereas a better functioning system will identify that patient as requiring a sub-acute or a step-down bed at the end of their acute episode and we would begin planning for that, negotiating with the placement if they needed a home care package, working through all those steps as soon as they were admitted to hospital.

Ms FORREST - So discharge planning should start on admission?

Mr PERVAN - Yes. And discharge management. I know it sounds like I am splitting hairs, but we are quite good at doing the planning. There is a discharge plan in everyone's patient file. It is in doing it that we seem to be dropping the ball a little. That is part of trying to get a systems approach across the state to deal with these cohorts of patients.

Mr FERGUSON - We have asked the Health Service Innovation Consortium that the Government is a member of, and the University is managing, to focus particularly on patient flow and the journey of the patient in terms of discharge practices. If you represent it graphically you can see that the build-up of patients happens over the weekend. You see that peak in demand for the service but you see the peak in discharge not taking place until early in the following week, so there is a mismatch.

Ms FORREST - When patients are trying to get in.

Mr FERGUSON - Exactly. If we can map those practices graphically and then put them on display, we can start to change behaviours in hospitals and encourage people who don't often think about the emergency department but who nonetheless control some of its ability to function - ward staff and specialists - to have a little more regard for the patient journey. THO South has been directed to engage with HSI as part of its work.

Mr MULDER - I will ask my annual question in relation to helicopter services. Minister, you have moved the portfolio, but I hope you are aware of the 2010 Ambulance Tasmania study into optimising the state's aeromedical services, which included a major consultancy by the UK specialist emergency service consultancy firm, Operational Research and Health Ltd. ORH noted that while demand on the ambulance service is increasing and a significant portion of response times are very long, particularly for paramedics arriving at the scene, the 24/7 helicopter based at Hobart Airport is used for only 5.5 per cent of its time. In the context of such under-utilisation of the helicopter service, it still incurs standing charges. Would you give us an idea of what those charges are?

Mr FERGUSON - If I can. I have Mr Dominic Morgan to assist me through what no doubt will be a few questions from you, Mr Mulder, and I am happy to assist here in sharing with the committee that information. In terms of the police helicopter that you referred to, that is a contract with Rotor Lift; it is a five-year contract with the option of an additional five years. That agreement is due to expire in July 2017 should the option for an additional five years not be taken. You have asked about our contribution to that. Government contributes 33 percent of the contract cost, with the Department of Police and Emergency Management contributing 47 per cent, and Ambulance Tasmania contributing 20 percent. I am not sure if it is possible for us to give that in dollars, because it may be protected, but Dominic, can you help?

Mr MORGAN - There is approximately $800 000 per year from us (Ambulance Tasmania), which is a combination of our standing charge and our utilisation rates.

Mr FERGUSON - Can you break that down to standing charge only?

Mr MULDER - What are the standing charges?

Mr FERGUSON - We can get you that on notice. Utilisation charge pus standing charge is $800 000 per year.

Mr MULDER - The minister should also be aware of NSW economic modelling. I refer particularly to a report titled 'Reform Plan for NSW Ambulance' conducted in 2012 by the Director of the NSW Medical Retrieval Unit, Dr Ron Manning. It shows that for emergency patient retrievals under 100 kilometres, the use of a helicopter service is the most cost effective option. Do you have any comment on that?

Mr FERGUSON - I will invite Mr Morgan to answer that question

MR MORGAN - It depends entirely on the model of helicopter operations being used. NSW has a fully staffed 24/7 on-site base model. That is different to what we have here in Tasmania, which is a standby model. The nature of a standby model means that, on average, the deployments for the helicopter in Tasmania commence at approximately 47 minutes before take

off. It is uncommon that a deployment closer than 100 kilometres could be served better by helicopter than by an ambulance responding and transporting the patient directly back to a hospital. It is very line-ball as to the benefit of immediate extrication of a helicopter patient in this state due to the distances and the time involved.

Mr MULDER - Operational research into health also identified the reason for the reluctance to use helicopter services was the poor response times. The figure they noted was 49 minutes, rather than the 47 minutes you mentioned. They also suggested that could be reduced to as little as six minutes by placing a paramedic on base - not for 24 hours, but from 8am to 6 pm when most missions occur - and also removing the requirement for a police crew, which seems to be part of the standard requirement. ORH identified these two measures alone would reduce response times from 49 to six minutes, which would then give the service the efficiencies that NSW identified. What is your response to that?

Mr FERGUSON - My response to that is that it comes with a funding cost. The subsequent value management study clearly identified a difference between an emergency rescue helicopter predominantly used to retrieve patients by winching them - which is appropriate for a patient that needs to be extricated in a short period of time - and a medical retrieval helicopter that is predominantly set up to rapidly transport a medical specialist to a patient in need anywhere around the state. For example, a major motor vehicle accident. To have a doctor immediately deployed to that scene, or for example to retrieve a patient back to a centre of excellence, such as cardiology to have a stent done. These large intensive care helicopters are usually predominantly designed to transport multiple intensive care patients at once. That is very different to small, manoeuvrable rescue helicopter. And of course, it comes with a commensurate price tag.

Mr MULDER - This was in the context of patient retrieval - getting them from the accident scene back to the hospital.

Mr FERGUSON - Or both, and that is one of the things that is sometimes lost in the discussion about the place of helicopter emergency medical services. It has to be a conversation about the clinical outcome we are seeking to achieve, and the best available mode of transport to achieve that. Sometimes we get very caught up in the discussion - is it a big helicopter, a small helicopter, does it have a large down draught, or a small down draught. It needs to be shifted back to the clinical outcome we are seeking to achieve. On that basis, a decision can be made as to whether a medical retrieval helicopter is a good investment for the state, or, for that matter, putting additional medical services into different hospitals.

Mr MULDER - It is a question of the cost efficiencies to be obtained by investing in a dedicated medical helicopter. Are there any moves to go down that path, or have we just accepted that 5.5 per cent utilisation is appropriate, despite the capacity to make it a more efficient cost, as well as response times.

Mr FERGUSON - The technology needs to suit the purpose. What Mr Morgan has pointed out is that a range of technologies might produce certain outcomes but for Ambulance Tasmania to undertake to assess what its best technology is to retrieve a patient, or to take clinical staff to a trauma scene, we would have to define what the clinical outcomes are that you are seeking. Would you be willing to say what you think we should be seeking differently to what we have.

Mr MULDER - It is not for me to make those sort of judgements. We ask the questions -

Mr FERGUSON - I comprehend that. I am trying to understand where you are coming from.

Mr MULDER - The New South Wales economic modelling, by Dr Ron Manning, talked about patient retrieval being the most effective over 100 kilometres by AME (Aeromedical Evacuation). I am not talking about delivering specialist nursing staff to a field, we are talking about the current role that an ambulance does most of the time which is to pick up a patient from a road accident and slip them back to the hospital. The New South Wales study shows that with that particular medical outcome in mind, helicopters are the most effective means within 100 kilometres of the hospital.

Mr FERGUSON - That is interesting and thank you for the feedback. The state of New South Wales is a lot bigger than the state of Tasmania and we have our population located the way that it is around the west coast, north west, midlands, east coast and south east. The task of Ambulance Tasmania is to invest in the modes of transport that give it the best opportunity to retrieve patients, between the type one ambulance and the fixed wing that we purchased through RFDS south-east section. I am not trying to deflect the issue because we are open to better ways of doing health. Inevitably, with something of the nature of a HEMS service (Helicopter Emergency Medical Service) we would be looking at a very significant outlay and you would only expect that a minister would be looking for a pretty strong business case before you looked at that. I draw the committee's attention to the fact that the previous government started to look at this way but withdrew from that process on the basis of the budget in mid-2011.

Mr MULDER - Sometime you have to invest a little to gain the efficiencies and you have a clear report about a particular role and, despite all this material, we are still not making any moves in that direction. What is the strategy of Ambulance Tasmania in terms of an aero system? Does it intend to eventually move down that path or does it intend to now renegotiate a contract which represents the 5.5 percent usage and therefore not avoiding the standing charges which are accruing which you are not getting the benefit of?

Mr FERGUSON - You have pointed out a figure of 5 per cent utilisation which I take at face value is broadly correct.

Mr MORGAN - It is 100 percent of the contract hours. However, if you divide the contract hours by the hours in a day you arrive at 5.5. It is 100 per cent contract hours utilisation.

Mr MULDER - I am talking about the standing charges are for the utilisation but then you have the surface capacity standing on the runway and it is only being used 5.5 per cent of the time available before its deployment.

Mr FERGUSON - Mr Morgan may help to clarify that matter. I was about to make the point that it is available 100 per cent of the times that we need a rotor wing. It is there for us. It might not be the very best in technology but we have to target our resources to get the best return on that investment. Mr Morgan, feel free to fill in my answer. I am happy for you to tell the committee the extent to which our current understanding of other options represents good value.

[4.30 p.m.]

Mr MORGAN - Our current understanding of other options represents good value. I ask the committee to be mindful that we have a standing contract and we need to be sensitive to that. That is germane: there is a contract held by the Crown under the Department of Police and

Emergency Management. Ambulance Tasmania, as one component of the health system, accesses the police rescue helicopter on the basis of paying 30 per cent of the standing charge. Emergency cases we refer to as primary responses.

Under the current configuration and funding model it is 100 per cent utilised - over-utilised, I might add. That is a different proposition; this is the point I was trying to make before. When you take a broader view of health and human services it is not just about Ambulance Tasmania, it is about how many tertiary hospitals exist in this state and where those hospitals are. Is it a question of a particular clinical specialty done at different locations; once you have decided all those questions, is cardiology done in the north-west or in the north? All of a sudden you are having a conversation about how we move patients around to meet that need. That conversation has not been had yet.

Is there a role for medical retrieval helicopters in the future? That is a question best answered after we have done a proper rebuild and taken a new look at the whole health system rather than just a single component, which is the logistical one we are talking about at the moment.

Mr MULDER - Getting back the Royal Hobart redevelopment: is it still intended to create a capacity there for helicopters to land on-site for emergency deliveries? That would be a huge impact in cost effective medical retrievals.

Mr FERGUSON - I would be happy to answer that at the end of the CIP but if you wish me to answer that now, I would rather answer when I have the specialist next to me. The previous government made a decision that an ambulance helipad would not be built into the tower. There was some consideration given to future proofing to allow an opportunity for a helipad. The Royal redevelopment task force is looking at the whole project and they will have perspectives on that.

Mr MULDER - What consultations did you have with Ambulance Tasmania?

Mr FERGUSON - In our term of government the task force - and I think we should be holding this now for the CIP output - has to talk to all stakeholders, including clinical, and I would be doubtful if they have not spoken to Ambulance Tasmania yet. Have they? Has the task force spoken to Ambulance Tasmania?

Mr MORGAN - Not yet.

Mr FERGUSON - I am not embarrassed by that. The biggest movement of support for a helipad is among the medical workforce at the Royal. The task force has already consulted with the medical staff and will continue to do so. The task force's job is to get the project back on track but it does not contain a helipad at this point.

It does not change the fact that helicopters can land at the Domain and patients can be transported by road to the Royal where that is deemed to be the best clinical response.

Mr MULDER - That is the whole point - if you are going to pack them up in an ambulance once you might as well have done it at the scene. That is the point of a helipad and the context of my question is not so much about the redevelopment - it is about the strategic direction of aeromedical evacuations. I would like you to take that on board because you can expect some criticism in the community if you are not factoring in a cost effective move. It is desired by the clinicians; it is interesting water to walk on.

Mr FERGUSON - It is very interesting but Ambulance Tasmania do what they do very well with the resources they have and the technology they have. In relation to the Royal redevelopment, there is no helipad in the project as it was left to us by the previous government and as it stood that project was between $23 million and up to $70 million over budget so it is difficult to bring it back in, but I am happy to answer further questions on that. I do not dismiss in any way that people want a helipad.

Mr FARRELL - I take note in your performance information comments, that there is a high reliance on volunteer ambulance officers. I was wondering how many volunteer ambulance officers you have and whether there has been a model done on what that would cost for employees. I know a lot of people out there do volunteer and it would be very difficult to imagine the ambulance service without the volunteer element but I wondered if that had been factored in to any costing.

Mr FERGUSON - That is a great question, Mr Farrell, and it gives me the opportunity to join with you, and no doubt everyone else here, in thanking our VAOs for the work they do, particularly in regional communities and also in some suburban communities which is really quite touching, I have spoken to a number of them and Ambulance Tasmania do a terrific job of recognising that support. You are right in asserting we would be struggling to fill the gap if we did not have those volunteers and we are very grateful for them.

Mr Morgan, if you would like to respond, I do not think we put an equivalent value on that in terms of dollars but we recognise that they do an enormous amount of outreach work to support Ambulance Tasmania generally.

Mr MORGAN - Without any doubt, our work with the volunteers is probably one of the more fulfilling things about my particular job. They are a genuinely terrific group of individuals who, in the main, only do this for the benefit of their own community and it is very reassuring and very focusing.

To directly answer your question, there are approximately 550 to 600 volunteers. The numbers vary by about 10 per cent each year, up and down. Five years ago, we only had about 450 so fortunately we are heading in the right direction with our volunteers. There is no doubt that we struggle in some of the smaller rural and remote communities, as many of the communities themselves struggle. Our estimation is that they contribute well in excess of 550 000 hours of volunteerism per year which is not an insubstantial amount. By rough estimation, we figure that is the equivalent, if they were turning up to work and manning stations for that whole period, of about 400 FTEs which is roughly about the size we are now, so you can imagine you would be having a conversation about another $40 million plus. That is not financial modelling but it gives you an indication of how much these people contribute to their communities.

Mr FARRELL - Your numbers at the moment, you have indicated that you could probably do with more people. Is it a difficult thing to source more volunteers?

Mr MORGAN - It tends to be related to the smaller, rural and remote communities and the challenge that we have is they invariably have a bit of critical mass. If volunteer units fall below a certain amount, it puts a great pressure on the handful of individuals who are dedicated to really keeping the service going. Your question is perfectly timed because we are looking at a program

now in partnership with University of Tasmania to potentially train some of the student paramedics as volunteers, to target them, to go into these communities during university breaks which is the same time as these families wish to have a break and go away and travel on the mainland themselves.

So it works for the students, it works for the small rural towns and it is based on a program that we are aware of that is coming out of South Australia so we are trying to look at all of these more clever ways of engaging with volunteers and the community to meet both of our needs.

Mr FARRELL - Per person, what is the cost of training a volunteer ambulance officer, and how do you cover that cost?

Mr MORGAN - It varies, because we try to pitch the volunteer model as going as far or as short as you want. They have to do central skills training. They have to do level 1 training, and they can go up to level 3. There are multiple levels and it is all geared to trying to keep it fresh and new and interesting for the volunteers, and they get increasing levels of skill as they go along.

In terms of the infrastructure behind volunteering across the state, there are four dedicated volunteer educators. There is a coordinator of volunteer strategy whose job it is to make sure we have support around the volunteers and focus on how we can retain them. I suppose a rough estimate is - at a minimum the infrastructure is at least $500 000 per year, probably closer to $700 000. Then you have the other infrastructure around them like stations and vehicles and uniforms and training and reimbursements. We have strong view, that I personally believe in very much, that they volunteer their time, not their money.

Ms FORREST - Just on that point, medical students also participate in the volunteer ambulance service in some areas.

Mr MORGAN - Not just medical students; we have a number of doctors. The changes to the Ambulance Services Act have allowed us to look at developing models where we can have volunteer ambulance officer - registered nurse, volunteer ambulance officer - medical practitioner. There are often willing medical professionals in small rural communities who, if they at least knew they would have some form of indemnity, would be very keen to offer their services to the local community. Now we have a good lever to do that. That is one of the things we are considering.

Ms FORREST - Could they operate within their scope of practice?

Mr MORGAN - We haven't gone to the extent of exactly determining what will be in or what will be out. If you think about it, volunteers come from all walks of life. Literally from health professionals to the local butcher. These individuals are often happy to support a health professional but are sometimes not as keen to take on all the responsibility themselves.

These hybrid systems are a fantastic way to support that. And because of the way we incorporate volunteers into our blended service, we have the most response points per capita in the country for ambulance paramedics. The larger states do not have as many and it is because we have this blended system. Where they have volunteers in other states, they tend to be either salaried staff or volunteers and they stand alone. Our model serves the community well.

Ms FORREST - Not all ambulance officers are paramedics and not all ambulances have paramedics on board when they go out, do they?

Mr MORGAN - No. In Tasmania, all salaried staff that are in ambulances are paramedics. And we have an intensive care paramedic.

Ms FORREST - If you have a volunteer who is a doctor, is the paramedic in charge and the doctor has to take orders from the paramedic?

Mr MORGAN - We are getting into the hypothetical, but they are all clinical professionals. In my time with Ambulance Tasmania I am yet to come across any of those professional dynamics that we sometimes hear about in other jurisdictions. It would be unlikely. Our paramedics come across medical practitioners every single day.

Ms FORREST - Are you talking about mutual respect?

Mr MORGAN - I believe that is true. Off the top of my head I cannot think of a complaint where there has been a challenge in the field - where a paramedic and a medical practitioner have disagreed about a course of treatment.

CHAIR - Perhaps the analogy of the local butcher as a volunteer is not a good one.

Mr MORGAN - That was one of the first things I told our minister about. We have an automatic external defibrillator in one of the butcher shops. Anyway, let's move on, or the analogies will just get worse.

[4.45 p.m.]

Ms FORREST - Is the ambulance service required to make cuts under the budget savings requirements?

Mr FERGUSON - The answer is yes. We want to work with every element of the department. Ambulance Tasmania sits within the Department of Health and Human Services. Health and Human Services have a savings strategy to achieve. Bearing in mind that the savings strategy is not a pure budget strategy on its own. In the case of Health, we are providing additional funding on last year's Health funding taken as a whole so it is not about reducing an appropriation. We are increasing the appropriation overall. In relation to Ambulance Tasmania, there will need to be a contribution from its back line to help meet the department savings strategy in order for us to be able to invest in the front line as we have said we will.

Ms FORREST - I would have thought that the back line was pretty lean in the ambulance services.

Mr FERGUSON - You are probably right. This is why the Acting Secretary has a difficult task. If it is too lean in order to find savings of that nature from the back line of Ambulance Tasmania, then the Acting Secretary will need to look elsewhere.

Ms FORREST - I am not sure if this situation still exists but I know that is has been that ambulance officers can be called out unfortunately a significant number of times to things that really don't require the attendance of an ambulance, they just need someone to drive them to the hospital or the doctor or just to see their mum in some cases. I say that quite honestly, because

seriously some of the people that call an ambulance just need to see their mother. As far as ambulance officers being able to treat on site and not transport to hospital, I assume that still goes on and if it doesn't then the question ends there. How many of those sorts of cases have there been in the last 12 months, where the officers have treated on site whether it be home or a sports field and not transported?

Mr FERGUSON - If I can understand your question, are you asking for how many instances there were of an ambulance not being required that were then not transported?

Ms FORREST - Not necessarily not required because the ambulance officers may have provided treatment that was necessary but didn't require subsequent transport to hospital. There are two different cases there, ones where the ambulance was not required and they shouldn't have called the ambulance in the first place, and the other when it was right to call for assistance but it was someone who has stabilised and they are okay.

Mr FERGUSON - There is also the instance where it might be an ambulance not required but they were transported. Do you have that handy?

Mr MORGAN - Not specifically on what we didn't transport, but I can tell you it is generally about 20 per cent of all cases. One in five is treated by paramedics and not transported. We are doing a lot of work in this space. We were fortunate enough to get a national partnership grant up some years ago that led to the development of what we call criteria-assisted pathways, or something like that. Essentially it means that we are trying to focus on strengthening the framework around decision-making to support paramedics to safely leave people at home where their clinical condition allows it. We were just involved in a national pilot of a program called Extended Care Paramedics, which was evaluated in the pilot area through the University of Wollongong as leaving targeted patients, but up to 60 percent of targeted patients.

What is good about that is, it is a distinct possibility as a proof of concept that there are real costs avoided from the hospital system. We are really interested in looking at this and how these structured programs can work. In Gosford, New South Wales, they are doing a really good program at the moment where they are discharging patients from paramedic care. They are looking at and considering the paramedic services the front door of the hospital system and saying you can be, within this cohort, safely assessed, safely treated by the paramedic and safely discharged to an alternative referral pathway. I think there are great opportunities for us in the area.

Ms FORREST - Are there some that are still at a trial at this stage?

Mr MORGAN - No, that finished right across the country on 30 June. That was federally funded and literally in the last couple of weeks the University of Wollongong has released a summary of the outcomes.

Ms FORREST - That will go back to government to have a look at, I assume, minister?

Mr MORGAN - I am not sure that at this stage it is a business case per se. It was right across the country and there were different models done. I can tell you our model was considered highly successful but there were some states where it wasn't. So we have to understand what that was. We have been working with the University of Tasmania around post graduate qualifications, around extended care paramedics and what that means and what that looks like. The notion of

discharging more patients from paramedic care in the community to a safe alternative referral pathway, we are probably landing that the evidence is good. There are multiple ways to go and we have to understand it a lot better than we do. But the idea is looking promising.

CHAIR - Thank you very much, minister. I think we've finished with 3.1. We will move to 3.2.

3.2 Population Health

Mr FERGUSON - If I could introduce and welcome Dr Roscoe Taylor to the table, Chief Health Office and Director of Population Health in the Department of Health and Human Services.

CHAIR - Thanks, minister. It is a little unclear - perhaps it's the way it was written - but it seems that it indicates a drop off in immunisation with the 12 to 15 month age group, which has now become below the national average, if that is the case. That would be of some concern. I have seen, as maybe you have, documentaries on the fact that, Australia-wide and world-wide, there is a bit of an ideological opposition to immunisation which has caused some drop off in some of those numbers. Have you any comment on that?

Mr FERGUSON - I do and, Dr Taylor, I will ask you to help me. The numbers that you have referred to in the performance information for this output show a marginal trend away from vaccination with that age group and something of a more stable nature in the next older age group. What we haven't included in this performance information, but I will invite Dr Taylor to share with the committee, is take up rates for the HPV vaccine for boys and girls. I think there might be a concern there too.

The issue is that we have the opportunity to keep people well with best practice and evidence-based medicine. Providing vaccines saves lives and saves illness. It is misunderstood among some sections of the community, where you might arguably say - I am not putting this view - that there's at least 10 per cent of the community who for some reason feel that immunisation for their child is not for them. That is a pretty high number and it does concern me and I have discussed this with my department in the past.

We need to come to a better science-based consensus on this. In the end our Government will not force people to vaccinate their children and I don't think any of us would want that in a country like Australia but we need to make sure that the information base is clear and reliable and that it's articulated in a way that debunks the mythology in relation to vaccinations. This is something that I have raised at the national level with my ministerial colleagues from the other jurisdictions. It is something I know population health are concerned about. The numbers are still l quite good, but you would not want any further deterioration. I am not qualified to say this, so I am about to stop talking, but there is a threshold below which you do not want to fall because of herd immunisation that occurs. The Government is interested in measures that demythologise some of the more outlandish things that get said about vaccinations. For example, that it makes your child sick.

Dr TAYLOR - One of the reasons for the small decline in the immunisation rates is something of an artefact in that the scope and number of vaccines being included in the count has recently been increased. We have had varicella vaccine, meningococcal vaccines now being added; when that happens, there is more opportunity for small changes for parents, not yet

catching and flowing on through the system, and not every child receiving every one. The bar has been set a bit higher because of what we count as fully vaccinated. I think that will flow on for the next year or two before the system gets on top of that and we see a return, I hope, to the levels Tasmania has always had. We are not the only state where this decline has been witnessed - it is the case across the country. That is the part of the explanation, rather than the decline in community willingness to be immunised.

There is another factor which concerns me a little - the cessation of the Australian Childhood Immunisation Register and the GPII incentive scheme for GPs from the Federal Government. We lost a little in the coordinated approach through the old GP divisions, now TML - Tasmanian Medicare Locals - to support GPs in their catch-up of children who are noticeably behind. That part of the system is no longer present and that will also flow through to slightly reduced rates. That means we have to work a little harder to catch up.

CHAIR - In regard to breast screening - I notice that we have dropped a little below the national average. There might have been a 'catch up' later on. In the last paragraph, the second last sentence of page 4.19 it says that the state participation rate within the target is currently in a particular range which is below the national accreditation standard target of 70 per cent.

Mr FERGUSON - I was looking at a different paragraph. So, interestingly, in relation to breast screening, we recently agreed with the Commonwealth that we would extend the target age range. I believe we lifted that to 74 per cent.

Mr TAYLOR - That is correct, from 70 per cent to 74 per cent

Mr FERGUSON - We are now reaching out, in partnership with the Commonwealth, to a larger age range of Tasmanian women. The target population has now broadened. It is a better opportunity for women to receive the benefit of the screening service; we want to encourage women to be mindful of the service so that early changes can be detected and medical care provided to deal with whatever might be identified.

CHAIR - Normally Budget Estimates time is in the May period. That will return again next year. We always ask the inevitable questions now coming from the influenza season - we are now at the back end of it.

Ms FORREST - We all had it last week in the Chamber.

CHAIR - Hopefully we are all past that. Was there an issue this year and, if so, were the vaccinations effective? Have you any data?

Mr FERGUSON - Before I throw over to Dr Taylor I will simply say that it worked for me. I would welcome your input on that.

Dr TAYLOR - This season has been relatively average for influenza. Over the last three weeks - perhaps the last month - the winter epidemic finally occurred, with very significant rates in some states. Tasmania has not been tracking quite as high as some of the other states. I believe we are at the plateau now and possibly just coming off the top of the normal winter spike. On average across Australia, it looks to be similar to what was experienced in 2012 - not too untoward. Vaccination helps to reduce the incidence of the disease, but especially it helps reduce hospitalisation and complications such as death.

Mrs HISCUTT - Of the people who were admitted for influenza, do you know the percentage that had been inoculated compared to those that hadn't been?

Dr TAYLOR - No, we don't collect data on individual influenza cases as to their vaccination status. We rely on other research approaches across Australia to determine that.

Mrs HISCUTT - So how do you determine whether it has worked?

Dr TAYLOR – Follow-up studies have only recently been published on the efficacy of the 'flu vaccine and they suggest the vaccine has about 60 per cent effectiveness for reducing complications and hospitalisations. It is by no means 100 per cent effective and that is why it is important to practice things like hand hygiene, cough hygiene and the standard public health infection control measures for combating epidemics.

CHAIR - Worldwide, opinion seems to be that there is a potential over-use, and therefore a diminishing effectiveness, of antibiotics, particularly in the USA. I notice there is a crack down on the overuse of non-prescription drugs. Is that a concern here in Tasmania?

Mr FERGUSON - These things tend to be handled more at the national level through the national committees and the NHMRC, and the TGA (Therapeutic Goods Administration). I sometimes receive reports of resistant strains that affect patients in our public hospital system so quite clearly we have a build up of resistance to antibiotics and conventional therapies, which clearly points to the broader issue you have highlighted. I am not aware of any specific measure but I would invite any comment that Dr Taylor has on that. I know that, particularly at the GP and medical level, there are certain requirements that they are obligated to only prescribe under certain indications and to strongly encourage patients to complete a course of antibiotics. That would be right - wouldn't it?

Mr TAYLOR - That is correct, minister. There has been a fairly strong focus on educating GPs in their prescribing patterns, over the last five years or more. Inside our hospitals there has been some good work with what we call antibiotics stewardship. The use of antibiotics in the hospital system, at least in Tasmania, has become more and more frugal and there have been better and better prescribing practices, which is a win-win in the sense that it reduces the risk of anti-microbial resistance, but it is also cheaper for the system to manage their pharmacy supply. It remains a strong focus through the Australian Health Protection Principal Committee, which is a subcommittee of ARMAC, the committee that reports to health ministers. A particular group has been established there to monitor and recommend strategies against anti-microbial resistance.

CHAIR - Thank you. Any more questions on Population Health?

Ms FORREST - There are a few areas where Roscoe has done a lot of work, minister. In regards to smoking rates, we still tend to lead the nation in being higher than the national average use; obesity is another leading cause of health outcomes that result in hospital admission ultimately. What are the priority areas for the Government in this area, in Population Health, and what programs do you have that you believe can make a difference? Or programs that you think we are not getting outcomes from that we should dispense with?

Mr FERGUSON - Programs we should dispense with or programs that we should engage. Thank you for the question, it is a great question and one of the most pressing and important

long-term issues we have to grapple with as a state. Unfortunately it is all too easy to skip over the numbers when you are addressing, for example, emergency department waiting time or elective surgery access. I know it is not an original metaphor but talking about building fences at the top of a cliff to try to prevent people from falling off will be a familiar metaphor for what we need to do.

We need to work closely with Tasmanians without taking on the nanny state too much to make sure that people make informed choices about their life. Not everyone who is overweight or obese could have done very much about that, but many can. As a Government, our aspiration is to have the healthiest population in the country by the year 2025 and that is a challenge both at a corporate and a state level, as well as at the individual level. How can each of us be the healthiest we can be?

I see a future where we can't afford to provide health services to the growing numbers of people who in decades to come will be looking for those health services on the basis of what we see right now: just to pick one, our obesity and overweight rates, and, to pick a second, our smoking rates. I am very challenged by that; we don't sit proudly in the national picture here. Our statistics are as bad as in any other state and in many cases worse.

What is the Government doing about this? We have identified this as a priority for the Government, particularly in the Health portfolio, but couple that with the Premier's own aspirations here. In the fullness of time we will be announcing more about what the Government is going to do in this area from a whole-of-government point of view. I don't mind saying that we welcome the joint select committee process that you, Ms Forrest, have commenced work on from your House, and Government will be supporting that when the opportunity comes for our House to support that as well.

In terms of our policy and a healthy Tasmania and how we will get there, there is work which is going on right now on exactly how the Government can construct a process by which we can move together from a whole-of-government point of view, working very closely with the community sector. We have stated before the election that we will create an umbrella organisation to deal with a healthy Tasmania preventive health approach to this, because we know a Health minister or a Health department can't do this on their own. We want to get a deep connection; we want to have our policy deeply embedded into the community by engaging at the deepest levels possible so that people can be part of this. The message is: we will continue to reform and rebuild our health service as best we can, but we have to do something about the demand side in the preventive space where we know we can do more.

We are open to other proposals and that includes the work of that inquiry I mentioned. We will continue to work with our stakeholder groups, for example, the Heart Foundation, the Stroke Foundation, Diabetes Tasmania and others who have an interest in this, and I am sure there are others, together with our work with Tasmania Medicare Local, which will morph and its work will need to morph into the Primary Health Network, which commences from July.

With all of those things, I want to make it clear that this policy area, from a government point of view, has been underdeveloped in the past. We want to invest in this area and get some whole of government and whole of community priorities under way.

Ms FORREST - On that line, then, a Federal Government decision recently to cease the national partnership agreement on preventative health - a little short sighted in terms of long-term

outcomes. What are you going to do to overcome the challenges that will present by not having that additional funding support for some of these programs? What funding will be cut as a result of that?

Mr FERGUSON - The funding has been cut; it ceased on 30 June. Speaking politically, it was very disappointing. We were not satisfied with that decision and said so. Nonetheless, it has been made and we are now responding as best we can. We are working within the department and the population to overcome that funding withdrawal. We have made it clear that in large part we intend to transition organisations and projects that were funded through that at least for a year. I am working with my department right now to work out how we fund those organisations and programs and what sort of future they may have after that transition.

Ms FORREST - What programs are they?

Mr FERGUSON - It is difficult for me to be specific because that work is ongoing. I did mention one by name, 'Move well, eat well'. That will continue for at least this financial year. The state is stumping up for the activity. There are others. We need to go through a careful process here of determining what resources we have access to and which programs are a priority to continue funding, at least for now. The programs that were running on 30 June, except one, are all still running.

Ms FORREST - Have you identified any that are not achieving the outcomes that they could have and you have decided not to continue with them? I know it is a work in progress, as you said, but what was the one that has not continued?

Mr FERGUSON - That was the Healthy Young People program. That was not funded anyway so there is no change in the community there. The other programs that were funded under that MPA continue. We are funding them out of department resources. The other one that Roscoe has just reminded me about was the Healthy Coaching Hotline. We terminated that early because we saw it as poor value.

Ms FORREST - That is what I am asking for - those that are not producing outcomes so why should we keep funding them. It is a difficult decision to make.

Mr FERGUSON - It is difficult. I am sure that the committee, when it is established, will want to know more about what we are going to do. We have wanted to provide some security. The other that I was trying to think of was the Tasmanian School Canteens Association. They are another in that same category; they have funding certainty for the financial year while we work through the transition.

Ms FORREST - There was concern I asked a question about in parliament last week. Again, it crosses more into the Department of Education rather than health: there are schools in my area and maybe in others engaging fast food chains to provide school lunches for their children on one day a week, when children can order a particular brand. The food appears wrapped in the brand and the surveys that were sent out included the brand. We have an enormous problem with obesity in my area - and childhood obesity - and I was disturbed by that. The Government does not appear to have a policy about that - they leave it up to individual schools. I find that disturbing. As Minister for Health, what is your view?

Mr FERGUSON - It is a free country. You should see the rubbish that some parents are putting in their children's lunch boxes. It does not even go close to comparing with what a particular branded product might be on one day a week at a school. I have been to plenty of schools in my time and the pastries you see in the pie oven and soft drinks that are full of sugar concern me, but at the same time I am trying to recognise that simply banning things will not get an outcome. I have worked in a high school, and I know they will get their lunch on the way to school from the local takeaway.

This is about working closely with parents in schools, and this is now treading on my colleague's areas so I will retreat quickly in a moment. But from a health point of view, we want to work with school communities and parents to help them understand what are the right combinations of foods to put in their children's lunch boxes, and what are the right quantities. Overweight and obese children now make up the majority of children. Overweight and obese adults make up a majority of adults.

As a community, we have an obligation respond to this. It is not always just about the food either. You can eat very healthy food and a large amount of it, but if you are not getting exercise you are going to have a problem. It is about all the factors that cause people to have good health or poor health.

We have continued to fund the Tasmanian School Canteen Association because we support the notion of providing information to parents and schools, as well as the rather remarkable accreditation process they lead. Can I just make the gentle point - if we banned a particular brand of fast food it would do nothing for the obesity epidemic we face in this country. It would only be replaced by another.

Ms FORREST - Making it an option to buy at school is my issue. I know that school canteens are fraught and getting people to run them and all that sort of thing is a challenge. I accept that. We need to send a strong health message and hopefully that program will have some impact and support parents and children to make appropriate choices.

Mr FERGUSON - I know the school, and I know the product you are referring to. Although I haven't looked at it in any detail whatsoever, I don't tread on my colleague's portfolio when I say I could think of a lot worse things to buy and have for lunch.

Ms FORREST - I am not disputing that. It is the fact that it is a fast food outlet. It is a commercial entity - why them and why not two or three of the others?

The other question I have is about the suicide prevention work that is being done. I assume it fits in this area?

Mr FERGUSON - No, it doesn't.

Ms FORREST - It is in mental health, is it?

Mr FERGUSON - If you would like to discuss that we can, but it is not in this output. I am available to talk about it.

Ms FORREST - You might be able to answer the question anyway, minister.

Mr FERGUSON - Can I tell you about one of the programs I mentioned earlier? One of the programs we cut quite proactively was the 'Get Healthy' program - the coaching program. That was a $1.6 million spend over three and a half years. We saw that as poor value, as only 295 people completed the program - less than 100 in a year. At that rate, each completed case was at a cost of nearly $6 000 per person. We felt we could end that spending and put ourselves in a better position to support other projects.

Ms FORREST - The previous Government a few years ago put in place a suicide prevention strategy. Do you plan to re-do the strategy with the $3 million you have allocated? And will the Government consider publishing the suicide toll, like a road toll, without identifying individuals? With the number of suicide deaths we have seen in the state, which is alarming, people don't appreciate the extent of the problem and we worry about other ways people die in overseas conflict, our suicide rate is turning into a shadow.

Mr FERGUSON - I am glad you raised it. I have told you how personally committed I am to this, and our Government is, and I am sure I speak for any other member of parliament who would feel the same way. It's very difficult to talk about because you don't like to be a contributor to the mixed messages that can sometimes get out there in the wider public and in the media.

All people try to do the right thing in this area but often fall short of what are the best messages that can be communicated. I'll depart briefly from answering to say there are many ways that people grieve and people feel the need to honour the life of someone who has died from suicide. We, as a community, and I as a minister, have a lot learn. We need to be willing to listen to evidence and advice about the best way to discuss this in the community. Sometimes some of the ways that it has been discussed in the media may not have been the best and healthiest way for a community to grieve publicly. Respecting that people are all different and find it important to memorialise somebody but I think we can do more as a community to educate ourselves about the best way to do that.

In relation to the broader issue, our rate is the second highest of all the Australian states and territories. The latest data I have is from 2012 from the ABS which is that our age standardised rate for the period 2008-2012 sits at 14.1 per 100 000. At that rate you could nearly say that affects, especially over a four or longer year period, a vast percentage of the Tasmanian community, simply by the ripple effect, the people who are affected by it and the people who knew that person.

It is the second highest, and our suicide prevention approach is not dissimilar to the one we inherited from the previous government. We think there's further work and improvement that can be done. You mentioned to me the state's first suicide prevention strategy that was due to shortly expire. I have approved an extension to the current strategy to take us out to the end of June 2016. There is a lot of work that we want to do in the lead up to that so the next round of that strategy can be informed by the best and robust evidence that we intend to now gather.

In the Budget there is $3 million additional for suicide prevention initiatives. This is potentially exciting for us as a state.. We can do more in this area and the good news is everyone can play a role in being a positive influence. So the increased funding is about supporting implementation of some very targeted and proactive suicide prevention strategies. They include working at the grass roots of communities, looking for champions, looking for opportunities through community groups to provide more resource people. One of the things that we believe can be done is better resourcing, better support for people who have made an attempt and stronger

pathways to follow that up. We see that as an opportunity and we are exploring this at the moment.

You mention data, and publishing data. I am not sure about that only because I would want to take some advice on that. One of things that we are contemplating as part of our approach on this, is to do more work with the research community, because we don't have what is colloquially called a suicide register. We don't collate that data in a Tasmanian sense. There's a possibility that we could do that in a very sensitive and careful way and make the data available in such a way that it could inform the research community and inform us about future measures we could take.

Ms FORREST - We cannot make policy decisions if we do not understand the extent of the problem.

Mr FERGUSON - That is the point. The support and goodwill from the community groups involved in suicide prevention is really terrific. We have really terrific buy-in from the Mental Health Council of Tasmania, terrific buy-in from Rural, Alive and Well, and I am delighted to be able to advise the committee, in case you do not already know, Suicide Prevention Australia, whom I met with last week, are bringing their national conference to Tasmania next year, which is a great achievement for our state. That provides opportunities both for us as Tasmanians to contribute to the national effort, as well as for Tasmanian community groups, practitioners, volunteers in community groups, teachers, school chaplains, school psychologists, a range of health professionals, to be able to gain access to that conference. That is coming up next year, which I find very exciting

CHAIR - If we are done with 3.2 we will move to CIP. I will ask members if they have any questions.

Mrs HISCUTT - At Burnie they are doing a lot of car park development. Are you in a position to give an update on how that is going?

Mr FERGUSON - Do you have a specific question? I know that the work is under way; I think it might even have been completed.

Mrs HISCUTT - Not specifically, I just know every time that you go in there, there is a turn left, turn right and arrow parking between all the works. It is good to see it happening. I wondered whether you knew

Mr FERGUSON - I would be delighted to answer your question, but it was about three weeks ago that I was there, and I too saw the deviations and the various directions to walk this way. In relation to the car park, I will probably need to come back to the committee on that. I have been told that it is predominantly complete. Parking at the north-west regional hospital has been a long-standing problem and people have been parking in all sorts of weird and wonderful places, and often it was on grass and on nature reserves.

Mrs HISCUTT - I think they are putting a $10 a week parking fee there.

Mr FERGUSON - Please do not quote me, but I understand that is a $2 a day charge for staff. Is that right?

Mrs HISCUTT - It was something like that, I presume the cost was to keep other people out of the car park that were parking in it and going elsewhere.

Mr FERGUSON - I will need to come back to you on this, because with Ms Linegar gone, she could have competently answered this. I know that there is an arrangement that was tendered out. It has been a long-standing part of the plan.

Ms FORREST - With regard to the King Island hospital and health - I assume this $130 000 is the last, the final spend on that project.

Mr FERGUSON - I apologise. Usually at this point I would invite Mr Ross Smith to come back to the table - General Manager of Shared Services. I am advised that the answer is yes.

Ms FORREST - The rural breast screen clinic refurbishment and upgrade, can I have more information on that? Which clinics are these?

Mr FERGUSON - I am just looking at an advice on this, that is $1.2 million indicative project. That is currently at the process at the tender evaluation which is under way at the moment.

Ms FORREST - Is it for a new breast screen bus? Is that meant to be an extra bus, or is the other one being decommissioned?

Mr NICHOLSON - I will have to clarify that Dr Taylor, sorry.

Ms FORREST - A new bus or an additional breast screen bus?

Mr FERGUSON - It was actually a project from last year's budget so we are very happy to get you the extra information. I can simply advise you that I am only reading what you already have access to but it is funding that was allocated in the 2013-14 Budget over two years for a new mobile breast screening clinic dedicated to north-west Tasmania to refurbish the existing mobile screening unit, establishing a new clinic site, and upgrade existing sites. I am happy to unpack that in further detail and bring it back.

Ms FORREST – It sounds to me that it is the one bus being refurbished as opposed to a new bus to replace it. If you can clarify that anyway.

Mr FERGUSON – I think there is even more to it than that so we will get you the more comprehensive advice.

Special Capital Investment Funds

Mr GAFFNEY - The member for Apsley raised in the House the other day about the St Helens hospital redevelopment program which I see is for the 2016-17/2017-18 period. But there was a $50 000 budget figure but I got the impression that that was for looking into its consultation and design. I am just wondering where that is at. She did raise it in the House and I thought I would mention it here. Because the council bought some land -

Mr SMITH - Yes, that is right and at the direction of the minister we are working with the council around a number of issues in terms of the suitability of that land and with the consultants

report we received identified a number of issues that need to be worked through including zoning issues for council, including surveys of local residents around that particular area, and particular siting requirements that we have as well. We would expect that that process will take, in terms of the zoning issues and everything we need to work through the council will be two years, and that the cash flow that is reflected in the budget papers effectively reflects that. It really covers things like the acquisition and some preliminary site works and design and things as well. Over the next two years we will be planning out the details around what we will be doing. The discussions with the council have been very productive.

Mr FERGUSON - Very positive. I am sure Tania will appreciate you asking.

Mr GAFFNEY - Councils can be difficult to work with sometimes.

Mr FERGUSON - Well, for the record this one has been excellent.

CHAIR - Thank you, minister. I do not think there are any further questions so on behalf of the committee I thank you and all your staff today on the presentation and the proactive way that you have given answers. Obviously we still have quite a few matters outstanding which we will deal with in a moment as a committee. Hopefully we can get some of those responses as soon as we can.

Mr FERGUSON - Thank you. It has been terrific. I can now table some further advice. There was a question today about the cost of mental health locums across Tasmania over the last two years by region. I know that some of the start has already been provided but I can now provide that on a comprehensive basis. Ms Forrest asked about re-admissions and so I have that data by site.

Ms FORREST - And reason?

Mr FERGUSON – No, it does not include reason but it does describe the ones that were re-admitted within and after 28 days. I am not sure if what you have asked for is readily accessible. We have nothing to hide. I am happy to -

Ms FORREST - If it is possible to get that, it would be helpful.

Mr FERGUSON - Noting that it is not a datum that is collected federally.

Ms FORREST - All these things are not. That is why it is in the interest to be there.

Mr FERGUSON - I also have costs for consultancy and travel for the last two years for DHHS and the THOs. You asked for FTEs for the last three financial years across the department and THOs, and I have provided that by awards, so that is pretty deep data.

Mr Chair, if I may just have your indulgence, there was a question about the correct process of the approval of moving from single THS to three, and including the possibility of expanding one governing council. The answer is in respect of the Governor's order, section 8 of the THO Act 2011 provides powers for the Governor to amalgamate the three THOs into a single THO called the Tasmanian Health Service rather than by amending legislation.

Section 8 also has the effect that the Governor's order, like regulation, must be tabled before both Houses. The order is not debated unless notice of disallowance resolution is made within 15 days of being tabled. If no notice is given in that period, the order like regulations is taken to be accepted by the Parliament and legislative amendments to expand the governing council would only be required if a decision was made to increase the number of members beyond the current limit of eight. We have not stated an intention to do this, but I broke my usual rule of hypothesising about things and I feel suitably chastised by myself.

Ms FORREST – It is 15 sitting days after this is tabled too, not 15 days, I think you will find.

CHAIR - Thank you once again.

The Committee adjourned at 5.39 p.m.