THE LEGISLATIVE COUNCIL SESSIONAL COMMITTEE GOVERNMENT ADMINISTRATION A MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART WITH A LINK TO HENTY HOUSE, LAUNCESTON ON FRIDAY 16 NOVEMBER 2018

ACUTE HEALTH SERVICES IN TASMANIA

HON. MICHAEL FERGUSON MP, MINISTER FOR HEALTH AND **Mr MICHAEL PERVAN**, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WERE CALLED AND EXAMINED.

CHAIR (Mr Valentine) - Welcome and thank you for coming to our hearing. Welcome to those in Hobart, officially. I know you are aware of the procedures and privileges associated with committee proceedings. As Mr Pervan has previously been sworn before this committee, we can proceed. The hearing is being recorded by Hansard and all parts of the open session will be published on the committee website. We note you wish some evidence to be provided in camera. For our due process, the normal procedure for committees is that we request you provide reasons for requesting that.

Mr FERGUSON - I haven't requested it at all, Mr Chair. Good morning to you all. It was an offer I provided. It was up to the committee to decide if you would accept the offer. I offered an in camera opportunity to be briefed on budget, with the support and advice of the secretary. I hope that is useful.

CHAIR - It will be useful but we need the reasons. As normal process we ask for the reasons to be put on the record and then we move in if the committee is happy with that.

Mr FERGUSON - I guess what I wanted to do was to be as full and frank with you as I can be about a confidential government report. More importantly, though, it was not just the report contents, but to get a feel for the implications of our recent budget announcements and the impact they would have on Tasmania's capacity to fund health services. That was my best endeavour to meet with what I acknowledge is your natural interest in the contents of a report that will not be released.

CHAIR - Minister, we would really like a copy of that report. It is of interest to the committee, as you can appreciate. Are you saying you are not prepared to release that report?

Mr FERGUSON - I am saying that. That is nothing new, with respect, Chair. I am not prepared to provide you with a report I am not empowered to give to you.

The KPMG report was commissioned. It is internal budget management advice. Obtaining external advice has been longstanding practice in Health and other agencies for decades. It is the case in the private sector. Somebody became aware of the report and attempted to RTI it, but it was assessed under RTI as not for disclosure.

As I explained at my previous hearing in providing evidence, governments need to be able to take advice. I am sure that members of the Legislative Council would want to think that government does take advice; so, when you seek advice you need to know it is going to be proper advice - frank and fearless. When you start releasing advice you have been provided with, it actually compromises your ability to get advice in future. It will change the behaviour of the person providing advice if they think, 'This might be released; I might not be quite so frank and fearless'. That is the principle I am adhering to. I do not mind saying to you - and the secretary would be a better proponent of this than me - that I am happy to share with you some thoughts on my interpretation of the KPMG report, but not if we are going to go through this process of you continually asking me to come forward and give evidence at your committee, asking for things you know I'm not prepared to provide you with and then still saying to me that you want the report.

CHAIR - It is our understanding is that RTI is not something that prevents a report being provided to the committee. Obviously, there is a difference of opinion there.

Mr FERGUSON - If I were you I would perhaps say the same thing, but I am in executive government and I have responsibilities to abide by. Documents produced to help assist the preparation of budgets are never released. I'm trying to do this respectfully.

CHAIR - I appreciate that.

Mr FERGUSON - I understand the position each of you is in.

Ms FORREST - Minister, can I just clarify this? You are relying on the RTI assessment of it as a reason not to provide it to the committee. Is that what you are saying?

Mr FERGUSON - I have referred to that, but it would not be my point that is the only reason, no.

We are not prepared to release the report because the RTI process is entirely separate to my reasons and articulation, because that is an independent process. I also make the determination that I am not prepared to hand over reports provided to Government for budget preparation purposes.

Ms FORREST - You understand that parliamentary committees have a power to request such documents?

Mr FERGUSON - Sure.

Ms FORREST - To not provide it would require more reasons - in my view and the view of others with more legal brains who have looked at this - other than you do not want to release because it might be an issue for a future provisional advice. That has not stacked up in other jurisdictions. For us to accept that, the committee would really require a much more robust reason for its not being provided.

Mr FERGUSON - Again I understand why you would say that but I am under no obligation to provide a report that has been solicited by government to help it prepare for budget preparation. I respect the House of the Legislative Council; I respect its interest in this matter. But I am not prepared to release a report even though there are things about that report that I am not offended or

troubled by. There is a principle I am adhering to here. I want to protect the ability of government to obtain advice and ensure that advice is frank and fearless.

The reference to the RTI is relevant insofar as it helps explain why there is not a public interest served under the independent assessment of it, but I appreciate that is -

Ms FORREST - That is members of the public not parliamentary committees. They are two completely different processes.

Mr FERGUSON - I was about to say that I appreciate that is a public interest test.

CHAIR - Minister, if we can move on. Before we do the in camera session, last time you were with us -

Mr FERGUSON - Are we not in camera, right now?

CHAIR - No.

Mr FERGUSON - That surprises me.

CHAIR - In my opening statement I said that our due process is that when someone asks for an in camera session we need to get on the record why, as with any committee.

Mr FERGUSON - I am unfamiliar with that.

CHAIR - That happens with us,

Mr FERGUSON - I thought I was in camera.

CHAIR - That happens with us all the time. Last time you were with us, I cut off a series of questions that were being asked in relation to a number of issues. Would you would mind if we just cover a couple of questions before we go to your briefing?

Mr FERGUSON - No problem, but I must express to you that I feel concerned I may have felt I was in camera when I wasn't. I am not concerned with anything I have said, except for the sense I had that I was in camera. I may have shared with you information I thought I could have trusted you with, but it is on the public record now.

Ms FORREST - With all due respect, minister, the Chair did tell you at the outset.

CHAIR - I did open with that. I said that I note you wish some evidence to be provided in camera but for our due process we need to have the reasons placed. The record will show that. Nevertheless, if we can move on.

A question with regard to the second and third stage developments of K Block on the corner, if you are happy to handle this.

Mr FERGUSON - I am. I would just perhaps preface my comments by saying this is the third time I have attended this inquiry.

CHAIR - Which we very much appreciate.

Mr FERGUSON - I am limited in time but I wanted to offer this as a substitute to your request for the KPMG report. I am happy for you to manage your time with me as you wish.

CHAIR - We do not really want to take too long over this. We appreciate the offer you have made with regard to the other. It is important for us to hear that information in camera as you are asking, but we need to see if we can cover a couple of questions we have.

Ms FORREST - We will ask questions so we get everything down. We are very aware of the limited time.

Minister, last time you appeared before us we were just at the end of our session when we ran out of time. We were talking about K Block and the acute psychiatric care unit. The AMA made some comments about a potential second or third stage development with a bit of a different reference to that as to what stage it might be on the corner of Campbell and Collins streets. You said that there was some flexibility in your approach as to how the K Block area may be considered. Would you like to elaborate further on that because we ran out of time?

CHAIR - It was my fault and I have been caned ever since.

Mr FERGUSON - I will ask the secretary to assist me here. When we last met, I had recently made an announcement in parliament regarding the reconfiguration of level 10 of K Block with the ability to have a choice of use for the current Assessment Planning Unit, which is adjacent to the Emergency Department. This allows for expansion and a different approach to rehabilitation care, all of which is now announced. I have provided the detail in my ministerial statement.

Ms FORREST - I am more interested in the acute psych ward.

Mr FERGUSON - The engagement is we are proceeding with the redevelopment. The Government's commitment at the election is being implemented and is within its final year. We have commenced an entire site master plan for the Royal Hobart Hospital that can consider any and all possibilities external groups might like to propose. The intention is that this will allow a desirable longer term vision for the site, services and models of how the building can support this. If you have questions on psych, I am happy to take those, but we are taking an open-minded approach on the development of the master plan.

Ms FORREST - There has been constant criticism of the design of the acute psych ward in K Block. I accept there are differing views on this, but there appeared to be an openness from you to consider a new facility on the corner of Campbell and Collins streets. What is your view on that?

Mr FERGUSON - I do not have a view on that. I am open-minded and have encouraged the master plan - and so has the secretary - that is being developed and I can countenance those ideas. That is not something I support or do not support in terms of a notional new building on a corner but we want the master plan to be robust, well informed and done by experts. We have engaged experts to lead that work or to provide the expert advice into the group under the Clinical Planning Taskforce chaired by the Chief Medical Officer. Thank you for acknowledging that while there has

been published criticism of the acute psych inpatient unit, there are mixed views and increasingly an acknowledgment that it is a far superior service to the one we have now or had before in B Block.

Ms FORREST - Thank you.

Mr FERGUSON - Does that answer the question? There is an understanding that future longer term redevelopment on the site needs to be informed by a master plan and needs to have special -

Ms FORREST - There will be input available for those genuinely concerned members of the AMA in the design?

Mr FERGUSON - Absolutely. A specific southern reference group has been appointed to provide engagement to the Clinical Planning Taskforce.

CHAIR - A question on Dr Duckett's observations on avoidable mortality. Is the Government aware of his observations when he says -

> It is not necessarily about what happens in hospitals but about the general health of Tasmanians. If you compare Hobart with Melbourne and take into account the age distribution, the avoidable mortality rate is much higher in Hobart than Melbourne with 295 per 100 000 in Melbourne versus 381 in Hobart.

Do you have any comment?

Mr FERGUSON - I am not expert in those demographic and statistical models, but I appreciate you have highlighted, Chair, that the Duckett comments were not an attempt to say this is about the treatment you get in the health system, but a whole-of-population model. If you would like to address that question to the secretary, he will be far better placed than me to speak to that.

Mr PERVAN - Thank you, minister and Chair. Yes, Professor Duckett's observations are interesting. It is a very controversial report, with the Australian Commission on Safety and Quality in Healthcare raising some concerns at some deductions he drew, based on the data available. Notwithstanding that caveat, I think we can all agree due to the age demographic and, more importantly, the morbidity of the Tasmanian population, particularly as it applies to patients with multiple chronic condition, that there is a higher risk, but it is a statistical risk. That puts a challenge on the system to better manage those people as they enter and exit the system and to work closer with general practice and primary care to maintain the heath of those people once they are returned into the community.

As the minister said and as, Chair, you pointed out previously, it is a valid statistical observation to say there is a higher level of risk with our population because of its morbidity, but that is just an issue that the health system needs to manage.

CHAIR - Thank you for the answer. We have to keep moving on, otherwise we will not get them in. With respect to clinical directors, the AMA's position in its submission is basically a need for onsite clinical directors. I quote a bit of its submission -

[TBC]

> Acute mental health units manage many patients at high risk, and are inherently highly stressful environments, with many and varied needs. The acute mental

> health system at the RHH has gradually lost resources, and a loss of the on-site dedicated-to acute-inpatients Clinical Director has been particularly important in this context. As such, it is the firm view of the AMA that all three acute mental health inpatient units in Tasmania should have their own on-site, dedicated Clinical Directors. These Clinical Directors should play oversight, governance, leadership, resource allocation, strategic, and advocacy roles. They should also provide leave backfill, therefore assisting in the provision of a critical mass for staffing.

Do you have a comment on that?

Mr FERGUSON - Again, I would throw to the secretary's expertise, but I would support any idea that we have strong clinical leadership in all our disciplines. That is a given from my point of view, and is something we have been strengthening through our local hospital governance approach, which was introduced in the last 12 months but especially in the context of the new legislation that commenced on 1 July. I know there have been workforce changes in mental health and the secretary would be well equipped to provide you further detail on that.

Mr PERVAN - Thank you, minister, and thank you, Chair. Before I answer, may I ask what the date of the AMA submission was? That might influence my understanding of the question.

CHAIR - It was last year. It was submission number eight.

Mr PERVAN - Since that time, Dr Lennie Woo has been appointed to fill the position of clinical director at the Royal and Dr Ben Elijah fills the position of statewide clinical director. That was all consistent with the structures that the minister mandated. Dr Woo and Dr Elijah are also working in close collaboration with the chief psychiatrist, Dr Aaron Groves, on the Mental Health Integration Taskforce, which complements the work the minister was talking about earlier around the Clinical Planning Taskforce in that the Mental Health Integration Taskforce also focuses on community and allied services - the whole model of care, the whole spectrum.

CHAIR - Thank you. We have about three minutes left.

Mr FINCH - Minister, there was quite a bit of publicity about the Calvary bypass in the ED department. Can I ask you about the indication of that impact - how you felt about that and what the possibilities might be for closer collaboration into the future?

Mr FERGUSON - That is an important issue. You have zeroed right in on a particular pressure point we have experienced. It has been around for a while but more so we have experienced the impact of that in the last two years. You mentioned Calvary. The Hobart Private Hospital also went on bypass at the same time, about a month ago - maybe six weeks ago. I am speaking rhetorically - it is a choice an independent private hospital operator can make, but it is not a choice we cannot make. As a public hospital provider, we never closed our doors and so the Royal Hobart Hospital experienced significant demand peaks as a direct result, not of its internal pressures, but because of the two privates going on bypass. You asked me how I felt about that. That was something I felt very concerned and even angry about because it was in my mind something we need to have better controls and support over, and it draws the mind back immediately to how our public hospital system needs to be able to collaborate with the private system. While respecting each other's different sectoral responsibilities, we need to be able to rely on them to keep their doors open.

I, and our department, spoke to the operators and one of the key issues identified, or at least highlighted, by those operators was their ability to continue when they are experiencing workforce shortfall.

That is something we have to manage, so we invite them to manage as well through their recruitment strategies. We have our private hospitals, therefore a reason to support them, particularly with their co-location.

We want to see that as a benefit to the public hospital system. The real challenge I have laid out to the private hospitals is to ensure they have done everything within their power to make sure they stay open. Those emergency departments need to cater to the percentage of people who are either privately insured or who have the capacity to pay.

Mr FINCH - To that end, do you feel the collaboration will improve, be stronger, be enhanced in the future?

Mr FERGUSON - I will ask the secretary to speak about both the collaboration with Calvary and Health Scope, the owner of the Hobart Private Hospital. I can speak immediately regarding the Government's approach to looking at the long-term future role of Hobart Private onsite with the Royal.

We are looking to Healthscope for a greater level of collaboration and a shared plan for the services delivered, so it is not only two hospitals on the one city block, but it is genuinely two hospitals symbiotically working together and helping maximise the ability of patients to get access to health.

Ms FORREST - We made need to write to ask a few other questions on this, minister. We did not get a lot of evidence from your or any other person on this particular term of reference in regard to what collaboration there already is with the private sector and how it is going, so we might actually put that to you to further understand what is working, what is not and what opportunities there are.

CHAIR - We have quite a quite a few questions we would like to be able to have you answer if possible. We will write. There is one with regard to third party services or goods provisions that might be seen as something that interrupts service provision that is outside of your control.

You would be happy to receive a letter with further questions we might ask?

Mr FERGUSON - Happy to look at your questions.

CHAIR - Thank you, I appreciate that. We thank you for your cooperation in that regard.

It is time for us to move to your particular briefing you have come along for today. Over to you, minister.

Mr FERGUSON - Thank you. I understand the awkwardness here from both our point of view, because we are not releasing the report you want, but we want you to be informed about how our budget is managed and how well prepared we are for the future.

I have asked the secretary to be here today so he can provide more of a technical knowledge to the committee than I am equipped to provide.

In short, we are in a situation where the report you are seeking was written in the context of budget numbers that go back a number of years. They are historical, not current, and since the report was commissioned and provided to government, three key things have occurred: first, an election; second, significant health spending commitments that build into baseline funding, not special one-off initiatives; and third, the budget itself. The entire landscape is quite different to the years running up to 2015-16 countenanced in the KPMG report that was commissioned.

The secretary can bring to the committee a more rounded view about the impact of the long-term situation, and I will make a policy discussion point, which is that we have seen increased demand. Nobody could see and predict its nature, it has been quite real. Last year we had a record flu season and this year we have barely had a flu season.

I think our preparedness has been excellent. Yet the demand is as high as it was last year. You might have expected, and others did expect, that this year we would see the abatement of demand based on the lesser flu season we were hoping would occur. Yet the demand is more or less the same; it could be marginally higher. That is very significant. It costs money. As in my previous discussion with Mr Finch around the fact that we do not close our doors, we keep our doors open. We do our best as a public hospital system manager and funder to meet the demand. That costs money. So, when the cost of providing that service exceeds the planned budget, we are in the situation where we know supplementation will need to be provided. I think the Treasurer has been quite open, at least on one occasion publicly, that we expect that will occur again this year.

CHAIR - During this session there may be information you provide to us that you would be happy to have on the record. Could you please indicate when that is the case?

Ms FORREST - Minister, before we go to the secretary, I think everything you have said would be helpful to be in the public arena. There is nothing, in my view, sensitive about that last comment you made. It would be very informative for the community to understand that, particularly the demand pressures. Is there any reason why the opening comment you just made cannot be in public?

Mr FERGUSON - I would be happy to review the *Hansard* at the end of the session and indicate to you if I felt that there were some things I would rather not be on the public record. The rest you could publish.

Ms FORREST - Okay.

CHAIR - That would be very much appreciated.

Mr PERVAN - I am just trying to frame my comments so they are useful for the committee. I think in addition to the significant increase in demand and the complexity of the demand we are seeing, it is also worth pointing out that the dynamic nature of the system is such that relatively small changes outside our hospital system have profound effects on us.

Moments ago, you were talking about what happens when the Emergency Department at Hobart Private closes. It is always good to bear in mind that is not what we would consider a tertiary-level emergency department. They do not have a full suite of emergency specialists, equipment and resources, so they tend to deal with the lower acuity cases that come through. Even then, when that small capacity goes, there is a measurable and significant impact on our ED. In respect to the relevance even of that on our budget movements, that is an issue.

In the background to that, we saw the Tasmanian Health Assistance package funding expire. It had been channelled through Primary Health Tasmania for a whole range of community-level services. A lot of those services were around care coordination and the management of people with complex and chronic conditions. As those services wound up because it was fixed-term funding, those patients also started joining the queue to the ED.

We are seeing the demand the minister spoke of earlier. Notwithstanding that it was what people keep referring to as a 'mild flu season' simply because of the low number of people who were infected and attended our service, demand was higher and acuity was higher coming through the ED.

For people in the very unfortunate position, as the minister is as the owner of the state system, of being caught in the middle of attention between our own parliamentary budget appropriation process and the Financial Management Audit Act, which says, 'Here is your budget that parliament gives to you and this is the budget you have to live within', and the Commonwealth Federal Financial Relations Act, which says that Commonwealth health funding is dependent on services being delivered in accordance with Medicare principles, which is that anyone who is an Australian citizen is entitled to treatment free of charge.

In terms of us managing within a budget, our capacity to do what other organisations of government can do, is non-existent because we are driven by the Medicare principle of providing all the care that we can to anyone who needs it.

CHAIR - Secretary, I do not want to take too long over this question. With respect to services like Calvary were providing and now may not be because they go into bypass or whatever, are there any contractual obligations they have in the system to provide certain levels of service?

Mr PERVAN - There are, in the conditions of the licences we now issue, which are far more robust documents than they used to be. By way of an aside, until five years ago the licence for a private hospital in Tasmania consisted of a handwritten name in a ledger book. I still have the licence book in my office that goes back to 1901. They are now given a very thorough document that specifies the services they are licensed to provide, as well as particular reporting requirements, such that if, for any reason, they are unable to maintain a licensed service, they have to notify me immediately. We will seek reasons for that. Most often it is because of workforce shortages. We will discuss the time they have before they have to reinstate that service and what our expectations are of them getting that back up and running.

One of the challenges they have is that the emergency departments, so-called, at Calvary in Lenah Valley and Hobart Private are largely staffed by locum medical officers. When they lose the locum, they lose the service.

There isn't a contract in place as such; there is that licence and, ultimately, if they are unable to sustain that service, I can have that service deleted from their licence. That has revenue consequences from private health insurers for those hospitals.

CHAIR - Are they bound to give you a heads-up days before that this is their intention?

Mr PERVAN - No, they are not. Under the licence and under the legislation they are only required to tell me when the service is lifted. We have, through collegial relationships, managed to get a better relationship with Calvary. We had a very good relationship there until there were some recent staff changes, and we are just rebuilding those bridges with new staff who have come in. We are getting into a much more interactive environment.

We are also just starting a conversation around transfers of medical patients and surgical patients who are coming down to the Royal and who are taking up space in the ED. The staff at the Royal raised their concern that they were seeing increasing numbers of transfers from the private sector. Once again, that goes to workforce issues in the private sector and their not being confident they can hold those patients. Transferring them in the interests of the patient is just adding to the pressure that is on the public system.

CHAIR - Thank you for that.

Mr FINCH - Minister or Mr Pervan, in respect of those numbers you are talking about - that we didn't have the flu season, we had a milder effect, but there were still the numbers maintained of people using the ED - is there anything revealing there about those numbers that might give some guidance to where things are increasing and where work might be put into assuaging that growth or development of areas of concern?

Mr FERGUSON - I will speak in general terms, Mr Finch. First, the numbers are up and the secretary will hopefully have those numbers at his fingertips. I can tell you that increased service levels to the end of 2017-18 include 12 400 more people being seen in emergency departments, so that is an increase of 8 per cent since 2014-15.

Ms FORREST - Across the state?

Mr FERGUSON - Yes. I think we discussed this at Estimates as well. When we were looking at performance output information, it wasn't just an increase in the number of people presenting, it is also an increase in the number of people at the acuity, which the secretary touched on there, requiring an admission. I remember sharing with the committee then that what was remarkable about that was that it was not just those who needed to be admitted who were - and that has increased by 11 300 people since 2014-15 - and that was not just the number who needed a bed, but the number who got a bed. That is a testament to the effort there.

The proportion of presentations resulting in admission increased from 26 per cent to 31 per cent since 2014-15. That on its own would be challenging enough but couple that with the increased absolute number of presentations and that is a lot of extra work for staff and it is a lot of extra beds that have been provided. While that has occurred, we have needed to be able to meet that demand by opening those beds all of which will be supported far better when we have got the new building in place when it is completed and commissioned to allow us to grow into spaces and flex at periods of high demand.

Mr FINCH - What was of interest to me, Minister, was in fact the reasons for people being in the ED departments and whether there was something revealing there about the reasons. Why there was not so much the increase in numbers but the maintenance of numbers and something that could be worked on -

Ms FORREST - Other than flu.

Mr FINCH - other than flu in the preventative health care sector.

Mr FERGUSON - The Secretary would be well equipped to respond additionally here but I would put it down to a number of factors. First of all, our population is ageing, we are getting an older population each year. As that occurs it would only stand to reason that we could see a higher level of presentation and a higher proportion of needing admission. That second reason is that we have a bigger population as well in Tasmania so we are seeing population growth. Then of course the third and compelling factor is the increase in chronic disease and that is a message about our whole community health and it is why we need preventative and primary health initiatives that drive down the demand for acute health services in the first place. I think that we all agree on that.

In my mind, those three factors help explain why we are seeing the more or less natural population requiring and feeling the need to present at emergency departments.

There is a fourth that I am not expert in but I will mention and that is the ability of people to access primary care, GP care, support in their home community has to be factored in as well. I am not suggesting it is the full explanation but I am saying it is a small factor, that if somebody could be getting support from their GP but they are unable to access that for whatever reason whether it is opening hours or the cost of that service naturally that does have an impact on the number of presentations at an emergency department. It would be only one of the number of factors.

Ms FORREST - I have a secondary comment then I have got a question to follow up with.

Mr PERVAN - Thank you minister. In addition to the Minister's comments I would throw a few other things in there. We have mined that data as you would expect trying to identify a segment or cohort of people presenting to the EDs that we could divert off into alternative services. What has been both challenging and interesting is that the growth or the stand out cohorts tend to change week to week. Last week it was surgical patients at the Royal, the week before that it was mental health patients, but it is not mental health patients every week.

What we have done is spent a lot of time and, with Government support, got some initiatives in place to try to pull people out of that ED queue and back into the community through the community rapid response service, or ComRRS. We are in the process of getting the ambulance secondary triage service up which is intended entirely to divert people away from that ambulance trip to hospital into safe alternatives as well as going through the data far deeper to see if even with the mental health patients that are coming into the ED there is a faster pathway that we can put in place such that they go from presentation straight to the service they need as opposed to coming into the ED being assessed and going through all of that kind of process. In order to cope with the demands that the minister has been talking about we are needing to re-engineer the front end of our system rather than just making it bigger because as we have seen when we make it bigger that just seems to increase the demand in front of it.

Going to Mr Finch's original question, there is not a specific group that we can isolate, but we are working on diversionary or alternative services so that people who do attend do get treatment and they do get care but in the most appropriate place for them which is also the safest.

Mr FERGUSON - I am aware of time, but the secretary mentioned the Community Rapid Response Service, and I will undertake to provide the committee with some information on that. It was trialled in Launceston as a replacement to the Hospital in the Home model - we have stood that back up. The central figure in the referral pathway is still the family doctor - the GP - and then the THS service that attends the patient at their home. It has seen 1600 referrals in two years and has visited 16 000 occasions of service and so on evaluation we have declared this a success and at the election we promised to roll this out in the south and the north-west over coming months.

CHAIR - That is roughly two cases a day.

Mr FERGUSON - I believe the rate was around about 500 referrals a year, but you can have up to four visits a day. It depends on the length of care. It has been a diversion from hospital but also is in many cases better care for the patient. It allows them to continue their daily routines going to work and study.

Ms FORREST - Do you want us to write to you on this one?

Mr FERGUSON - No, I will be happy to provide you, because I think the committee will want to see it and also know that is-

Ms FORREST - As a public document we are talking about?

Mr FERGUSON - Yes and would be useful because it is intended to abate demand at the Royal and at the north-west hospitals.

CHAIR - It would be good to have this part of the hearing on public, but you can review that.

Ms FORREST - Minister, following up with this general conversation because the demand pressure is the DEM, obviously, but hospital overcrowding generally creates the problem of backlog. What modelling has been done on demand leading up to where we are now and modelling for the future?

Mr FERGUSON - In fact the department has been working on this.

Mr PERVAN - We are at a very interesting point in the modelling on demand right across the board - not just acute bed demand - and it indicates that once K Block is opened, it will give us the acute capacity we have needed for a while. This is the reason we are building K Block in the first place and it will address a lot of the challenges and issues we see every day across the state, especially for the statewide services only offered at Royal Hobart. The more interesting part is the work we now need to do around subacute primary and community, to make sure the demand at that level is met with strategies within the resources we have because not every pathway into the system leads to an acute bed admission.

There are multiple reports going back over 20 years on one of the issues Tasmania has been challenged by for a very long time, an absence of subacute capacity. We have been greatly assisted

with the expansion of the repat. in the last year and the 22 beds there. That has given us a measurable and noticeable difference on subacute demand in the south. We need to look at subacute services and particularly subacute services in the home. Rehabilitation and palliative care in the home - those sorts of services across the north and north-west so we are keeping those acute resources - the high-cost, high-complexity resources - for acute patients. That will also help us manage demand far more efficiently.

Ms FORREST - On that point, minister, the secretary mentioned that once the K Block opens - and you have mentioned this yourself - it is expected to meet the current demand. We know population is likely to increase. We are not going to see any change in patient acuity and complexity in the short term, because that creates much greater investment in preventative health. What modelling has been done beyond that? The secretary talked up to where we were about how there is other modelling to be done in the subacute area, but is the modelling showing we are only just going to manage capacity when the K Block opens? What about the future?

Mr FERGUSON - Thank you. Secretary, I will ask you in a moment to touch on the work of the Clinical Planning Taskforce. In short, the new redeveloped Royal K Block is going to provide in excess of 250 bed capacity theatres, birthing suites and the like. It is a modern building and, in many cases, will allow the breathing space the site has not had for many years. Services moving into the building will leave behind wards and areas that while not as contemporary as the new structure, nonetheless provide that ability to flex. That is about providing the supply.

Ms FORREST - So you are saying the existing buildings now will meet the additional demand beyond what the K Block would meet under current demand levels?

Mr FERGUSON - The new K Block tower will provide more bed stock than is currently provided for even in the services that will move in. There are growth spaces. There are more beds.

Ms FORREST - I am trying to get this nutted down.

Mr FERGUSON - In addition, the areas that will move into K Block being vacated suddenly become available for bed growth. We have committed in our budget, in our $757 million policy package which speaks directly to opening more beds, to not only building more structure, but even opening more beds in areas that will require some refurbishment but nonetheless the capacity will be there to staff them.

Ms FORREST - What does the modelling show on this? I was concerned when the secretary said that the new K Block will deal with the current demand, which all of us would reasonably expect is not going to get less and it is not going to stay the same. It is going to get greater, so what does the modelling show in that regard?

Mr FERGUSON - I will ask the secretary to speak about demand projections and prediction. The work of the Clinical Planning Taskforce is material there.

In my comments I am trying to explain that the redeveloped RHH, obviously a beautiful expansive building -

Ms FORREST - Yes, I am interested in what the modelling shows, Minister.

Mr FERGUSON - It will allow us to refurbish the older areas not in K Block and allow us to open 200 -

Ms FORREST - I am interested in what the modelling shows in terms of demand. That is my question.

Mr FERGUSON - The demand question I would like the secretary to take up. We have a special taskforce.

Mr PERVAN.- Thank you Minister. I will deal with this very quickly. The modelling shows that it will actually have excess acute bed capacity for about 10 years.

Ms FORREST - Right, that is the answer I was looking for.

CHAIR - Can I ask a question? I alluded to this in open session. I appreciate that you may have sensitive information associated with this. Does any third party service or goods provision the state uses create any slowing of service provision overall? Whether it is getting consumables, pathology, laboratory services or other services that you rely on in the acute health services system to be able to do your work and that is creating a bit of a bottleneck. Can you comment on that at all? I would be interested to hear.

Mr FERGUSON - I do not feel well equipped to answer that at all. Is there a specific example you are looking for?

CHAIR - I am asking about third party services.

Mr FERGUSON - Something that we could be doing, but which is held up -

CHAIR - No, not something that we could -

Mr FERGUSON - by supply that is not available.

CHAIR - Sorry. It is whether or not third party services have helped you to do your work in the hospitals that are slowing down your work because you cannot, for instance, get pathology results quickly enough in one of the hospitals or other services that might be provided.

Mr FERGUSON - I am not aware of any of those sorts of issues. There may well be some but none come to mind or have been brought to my attention as a concern.

I can think of one only and that is when the prison has experienced a lockdown, sometimes there has been an interruption to the supply of linen. That is the only one and it is not a good example because it doesn't happen very often.

CHAIR - Well, it is a government service. It is not your area; it is an external area.

Ms FORREST - Different department.

Mr FERGUSON - Secretary, I think you are shaking your head. I am not aware of any particularly. We have pretty robust contracts in place these days. I am not sure if there is anything further to add.

Mr PERVAN - Yes, minister, I agree with that. In terms of the pathology services provided in the north-west by Sonic, the imaging radiology service that I-MED provides to the LGH, all the feedback we get is those contracts are performing really well. All our supply contracts are performing quite well.

The only challenge, which has nothing to do with the organisations or providers, has been that we have had a few moments over the last three to four years where there has been a shortage of particular drugs. Being such a small purchaser, we have had problems obtaining drugs, particularly very specialised antibiotics and drugs like that. We would send a thank you to our colleagues in Queensland who have always come to our aid and enabled us to purchase some of their stock.

We have also entered into a more strategic monitoring relationship with a few of the other states through the Australian Health Ministers' Advisory Council, such that when there are international shortages of those drugs, we are buying appropriately and then sharing that stock across Australia.

CHAIR - It is almost like a group purchasing arrangement?

Mr PERVAN - Almost.

CHAIR - You might want to put that on the public record later so that we can report on that.

Ms FORREST - Minister, at the outset you mentioned budgetary pressures. We are aware that the Health budget consumes a large percentage of the state Budget, do you want to comment further and on the role of Treasury in screwing the screws down? I am sure they do.

Mr FERGUSON - It is the law that agencies have to manage their finances in accordance with the Budget, isn't it?

Ms FORREST - Yes, it is.

Mr FERGUSON - It is not only Treasury, it is the law. Heads of agency, like Mr Pervan, have a serious responsibility to make sure the public dollar is being used appropriately and we are meeting budgets. You are right, you have pointed out that we would all need a very long memory to find a year where the public health system in Tasmania came in with an expenditure that met its predicted, allowed-for budget from the budget for the financial year. That has been the case recently. As a Government we have always been willing to make the additional funds available before the end of the financial year so the THS is able to come in on a balanced budget. We've always done that. We must also be prudent with the spending of money and make sure the public is getting excellent value for that.

Ms FORREST - I understand all of that. There seem to be problems within our hospital system, patients aren't getting seen in a timely manner, either with elective surgery or with access through the Department of Emergency Medicine, particularly when they need admission, which is the key bottleneck. You are repeatedly having to request for additional funding and/or

supplementary appropriation. We saw both this year but not very much in the RAFs. Is there undue pressure to deliver what you need to within the budget you have?

Mr FERGUSON - I was recently asked a different question and I will tell you how I answered it. I was asked what our biggest challenge is in the health system. My answer wasn't that my biggest pressure is the finances and in how Treasury supports us. The biggest challenge is the constraint on physical capacity that we have, which doesn't explain the demand but they do explain why we're not always able to bring our supply to meet that demand. Our biggest challenge is the construction program we are under. Until it's finished and we are able to commission and build those new services, we are having to provide today's demand with yesterday's hospitals. You commented on elective surgery numbers; while the additions are up, we have managed to get the waiting times significantly down. Were it the case that finances were our biggest pressure I would not have been able to get the extra $20 million in the Budget this year, which I did.

Our biggest challenge is not a financial one. From a patient's point of view, another $100, another $1000 or another $1 million wouldn't be the answer to the question of why they're waiting too long in an ED. The reason is because the beds are all full while we're building more beds.

Ms FORREST - Tasmanians are still waiting longer for elective surgery. I know you've made some improvements because it was pretty bad, more than four years ago when your Government took over, but we're still seeing longer waiting times when you do peer comparisons. There is still a challenge. We can talk about the physical infrastructure all we like. Once you open the extra beds - I know the out years of the forward Estimates have additional money for the funding of those beds in terms of the opening of them - it still seems like we're chasing our tail.

Mr FERGUSON - We're still catching up on the long wait list we inherited from the Labor Party. We had 10 one-year[tbc 11.24.45 a.m.] patients, as you know, and we're down to two. We've reduced the longest-wait patients by 80 per cent but that is not the compelling story. The compelling story is of the number of people who are being treated within the recommended time. I am pleased to tell you and reinforce with the committee that we started with just over 50 per cent of patients being treated in clinically recommended time frames, whether it was a category 1 at 30 days, category 2 at 90 or category 3 for one year. We have increased that from 50 to, I think, 74 per cent on a state average, taking in the whole picture. That means a lot more people getting their surgery but it also means that our performance has been consistently improving over the life of this Government -

Ms FORREST - What date applies to the figures you are referring to now?

Mr FERGUSON - The end of June 2018.

We had a five in front of our waiting list at one point and it has increased in line with additional referrals and additions to the list. The waiting list size should always be part of the public narrative but the more important narrative is the waiting time. How long does a person wait? The data on that shows consistently improving performance and the improvement has been better than any other state and territory, I am advised.

Ms FORREST - You are saying that the waiting list has gone below 5000 -

Mr FERGUSON - At one point the size, the magnitude of the waiting list, was below 6000.

Ms FORREST - It is not now, it has gone back up again. I am clarifying what you are saying.

Mr FERGUSON - When I said it like that, yes.

Ms FORREST - On your dashboard at the moment it is just short of 8000.

Mr FERGUSON - Yes.

Ms FORREST - Okay.

CHAIR - There is no reason this could not be on the public record, let us see if we can come to an arrangement on that. With regard to an academic medical centre, you showed an interest in the concept last time. If you remember -

Mr FERGUSON - Dr Walpole.

CHAIR - Yes, Dr Walpole. Have you given any further consideration to that, given how it could improve our opportunity to get the specialists we need, if they have practice, research and education all wrapped up, it might be that we have a greater opportunity?

Mr FERGUSON - We do not have a plan to implement that concept but the secretary has been doing some work with the university which, I think, attempts to deliver the same kinds of qualitative outcomes for the medical community and the patient community. It means closer collaboration with the university. I am not taking credit for this, the university deserves credit because the university has been refreshing the nature of its clinical academic roles, making sure that the university is getting the best possible value out of people who are doctors in the health system in terms of academic teaching and research.

Mr PERVAN - Yes. There is also strong collaboration around a bid to the Commonwealth Government between the university, the THS and the department for a centre in rural health, which will be an academic medical centre also specialising in rural and regional health issues.

There is also very strong collaboration going on between the THS, particularly the Launceston General Hospital, and the department and with UTAS around the design of the new Inveresk campus, which will be an academic campus and there will be opportunities for health services to be delivered there in a teaching context. That will go to exercise physiology, physiotherapy, nutrition, and so on. We are working closer and closer with the university.

An academic medical centre - and I do know Dr Walpole quite well - is a concept from the United States and the United Kingdom which actually involves the university running the health service. There are all sorts of complexities implied by that, particularly around Commonwealth Health funding, which is why you will see some academic health science centres and things otherwise named around Australia with a very strong university and teaching presence in them, but you will not find that pure model of universities running public hospitals here because there are legislative and funding reasons that would get in the way.

CHAIR - As long as we are moving down the line to reduce the need to employ locums because we have the specialists available to do various things, I suppose that could be good.

Ms FORREST - Minister, you mentioned the KPMG report earlier. I am interested what detail that provided that really is sensitive. I am not asking you for the actual detail, I am asking what the barrier is to us seeing that. I know it is historical, but the history reflects how reached where we are and can inform the future.

Mr FERGUSON - Can I indicate that I found myself, as a science teacher, not the best reader of that document. It is highly technical and provides advice to the department on the cost pressures, which we have often talked about in terms of demand, and it deals with the contributors to price increases, if I can put it in those terms. It is to allow government, the Health department, to understand the push factors in cost increases in Health. Some of the public commentary by some has tried to put a different colour on what that report is attempting to provide advice on.

Ms FORREST - Isn't it important for all of us to understand what those push factors are?

Mr FERGUSON - It absolutely is for Government, for sure.

Ms FORREST - Isn't there an interest for the whole of the Parliament to understand what they are?

Mr FERGUSON - I understand the point but it is advice to government to help it frame its budget preparations. That is why I am so limited in what I am prepared to say about it, not because I am embarrassed by it when I read it or anything like that. It is not of that nature. Would the secretary like to say something further?

Mr PERVAN - Minister, I think you have covered it quite well. It is a technical paper. It is not so much the information Ms Forrest is seeking around the reasons for those push factors, those cost increase factors. It is a highly academic piece that goes to exploring this concept that has been in the public domain for many years, of health indexation and querying whether health indexation is different to every other sort of indexation. I would say it is not a very high-quality report, it certainly isn't very informative and it doesn't provide, in that context, anything more interesting in the public domain than what the minister has already alluded to. The big push factor is simply activity. It is more complex patients and more of them coming through the front door; it is not due to drugs and it is not the cost of labour or workforce. There is nothing special or magical in there that would explain why our costs are going up.

There are other parts of the report we are not able to share, which have informed past budget submissions and the one we are about to put to the minister for next year's budget. There is some sensitive financial information in there that we are quite protective of but, in terms of those other factors, there is nothing that we haven't provided today that is superior and more current to the material that is in that KPMG report.

Ms FORREST - Thank you. Minister, you made the point about patients' waiting times. You said it is up to 70 per cent across the board. It is down from the beginning of the year, 76 per cent down to 70 per cent across the board, but only 52 per cent of category 2 patients are being seen in time. These are the people who are in pain. They are waiting for knee and hip replacements, a whole range of necessary but not life-threatening surgery, at that point at least. Clearly, it looks okay across the board but it is not good when you drill down into it. Do you agree?

Mr FERGUSON - We provide all that information in the interests of transparency but the only prudent thing is that, if I am going to prepare current whole-of-state, treated-on-time data, I can only compare that with whole-of-state from when we came to office. Some areas were less than 40 per cent previous to our election. I take the point. The data is there and it is provided on a monthly basis every quarter, which is the highest level of transparency we have ever seen. It allows you to look it up on your iPad and check things I have said to you.

CHAIR - You can then ask questions of the minister.

Mr FERGUSON - Exactly the point. When you have that transparency, it does drive effort and it does drive decisions of Government because we want to continually improve. We have an ambition to bring it to 90 per cent.

Ms FORREST - Admirable.

CHAIR - Thank you, minister. We appreciate you giving us this briefing, it is very important. We will send you a copy of the in camera *Hansard* for you to review. It would be good if we can have much of that on public record.

Mr FERGUSON - I will give that my best endeavour. Thank you very much.

THE WITNESSES WITHDREW.