THE LEGISLATIVE COUNCIL GOVERNMENT ADMINISTRATION 'A' COMMITTEE MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART, ON MONDAY 21 NOVEMBER 2011.

COST REDUCTION STRATEGIES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

Mr GREG JOHANNES, ACTING SECRETARY, **Ms ALICE BURCHILL**, DEPUTY SECRETARY, HEALTH AND HOSPITALS, **Ms PENNY EGAN**, CHIEF FINANCIAL OFFICER, **Mr JOHN KIRWAN**, CHIEF EXECUTIVE OFFICER NORTHERN AREA HEALTH SERVICE, **Ms JANE HOLDEN**, ACTING CHIEF EXECUTIVE OFFICER SOUTHERN TASMANIA AREA HEALTH SERVICE, AND **Mr GAVIN AUSTIN**, ACTING CHIEF EXECUTIVE OFFICER NORTH WEST AREA HEALTH SERVICE, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Ms Forrest) - Just before you make a start, Greg, I am sure most of you are familiar with presenting to committees, but just to remind you that everything that you say here is recorded on *Hansard* for the purpose of preparing a report at a later time. Everything you say is protected by parliamentary privilege while you are under this process but if it is said outside, it may not be. You have a copy of the terms of reference in front of you. We are focusing particularly on the budget strategies as related to elective surgery and the areas around elective surgery and acute services, front line, but obviously we may need to get a broader picture to put that into context.

I think you wanted to make an opening statement, Greg.

Mr JOHANNES - I will make a few opening comments, if the committee would like.

I am Greg Johannes. I have been the Acting Secretary for Health and Human Services for three weeks now so in that light I will be directing, I expect, a large number of the questions to my colleagues around the table who will be able to answer those, having been in the system for a considerably longer time than I have. With me I have Alice Burchill who is the Deputy Secretary, Health and Hospitals; Penny Egan, Chief Financial Officer; John Kirwan, Chief Executive Officer of the Northern Area Health Service; Jane Holden on the line, Acting Chief Executive Officer of the Southern Tasmania Area Health Service; and Gavin Austin, Acting Chief Executive Officer of the North West Area Health Service.

I note that all of my departmental executive are standing by so if the committee would like to explore particular areas of the budget and the approach to savings in say, Human Services, just let us know and we will get those individuals down here, get them to take the oath and have them available to give information to you. We just note that given the focus of the inquiry, to start with these were probably the right five or six people to have in the room to help the committee go through its inquiries.

There is no doubt that the $100 million savings requirement that we have been given is a pretty challenging target, notwithstanding that our budget for the year is still over $1.8

billion. It is a matter for the public record that in addition to finding that $100 million, we also have to manage a range of internal and external cost pressures, including those due to the ongoing rise in the cost of health care, particularly acute health care, from year to year. The department is focused on meeting that challenging task while at the same time minimising the impact on patient care and on our people within the system.

We will try to limit the number of questions that we take on notice today and give you as much information as we can, noting that much of the process of developing the budget saving strategies actually occurred through the budget subcommittee of Cabinet. So there will be some cabinet-in-confidence matters that I think will inevitably go through today but we will try to limit the number of times we say, 'It's difficult for us to answer that because of cabinet-in-confidence' but that is something we will have to have a mind to.

We will also be making a submission to the inquiry and we have a reasonably well-developed draft of the submission. One of the things that today will allow us to do is that if there are particular areas of information where we need to do a little more work to get you the answers you want, then we will have the opportunity in the submission that we make by the end of the week to pick some of those issues up.

We are very keen to participate fully, honestly and openly today and look forward to the discussion over the next few hours.

CHAIR - It may be that we need to call Treasury at some stage anyway.

Mr JOHANNES - It could be.

CHAIR - To lead off, Greg, I am not sure if you are able to provide at the outset an organisational chart that will give us, as committee members, an overall view of the structure. I think it is important to understand where everyone fits and where the cost centres are.

Mr JOHANNES - I only have half of the annual report that deals with the finances -

CHAIR - That is all I have, too.

Mr JOHANNES - I do not know if anyone has the wall chart with them but I will get one sent down right now.

CHAIR - Okay, we will get that when it arrives.

The next question I want to ask, and in more broad terms, is can you provide a breakdown of the $100.2 million of savings required by the minister between output group 1 in Health and other output groups - in particular 1.2, which is Medical Services and 1.3 which is Surgical Services? Can we have a breakdown of that in the first instance? I think we need to know what that is before we can go further.

Ms EGAN- We did not cut it as per the budget papers. The savings strategies were allocated operational areas so we can certainly indicate to you where the savings were found

against southern Tasmania and the services versus the north-west, versus Disability Services. We have not done it by output group but we can provide that information.

CHAIR - You can't do that now, though?

Ms EGAN - Yes, we can tell you where that is. The task given to us was for $100.2 million - the Southern Tasmanian Area Health Service was allocated $29.7 million; the Northern Area Health Service was allocated $20.67 million; the north-west, excluding Mersey, was allocated $9.1 million; ambulance, $2.5 million; Children, Youth and Family Services, $4 million; disability, housing and community services, $10.2 million; statewide Mental Health Services, $8.1 million; Population Health, $850 000; the department, including the business services network, was $8.8 million; and the grants area, which was associated with the reduction indexation, had a reduction of $3.6 million. We kept $3 million in contingency. Bearing in mind we had a very tough budget going ahead, that $3 million probably wasn't going to go very far but it was something that we could use if we were caught. So that was the $100-odd million. I can split that back by output but we do it internally by a statewide management accounting practice in putting it back to operational areas.

CHAIR - The reason I ask that is that when you look at the budget and look at the output groups, we are seeing significant cuts in elective surgery - that is 1.3 in output group 1 - and you provided information pretty much across the whole of Health in the community services line.

Ms EGAN - I did.

CHAIR - Do you know what the percentages are of each of those cuts in terms of the whole budget?

Ms EGAN - Yes, I can give you the percentage of their budgets. I suppose also worthy of note is that about 7 per cent of our budget is the acute sector so we have to allocate accordingly. Bear in mind that the budget is the baseline budget that is in the paper so it's not based on the out-turn of last year, so budgets and where people end up the year before are two quite different things.

Regarding the percentage of the budget, the Southern Tasmania Area Health Service is approximately 10 per cent, the Northern Area Health Service is approximately 7 per cent, the North West Area Health Service is approximately 10 per cent, Ambulance Tasmania is 5 per cent, Children and Family Services and Disability Housing is approximately 2 per cent and 6 per cent, statewide Mental Health Services is 6 per cent and the department was 10 per cent.

CHAIR - Population Health?

Ms EGAN - That was 4 per cent.

CHAIR - Just going back to the point you made about the starting point and the end point, can you talk about when you were looking at the budget? We know that generally there have been overruns in almost every cost centre, how did we start the year?

Ms EGAN - Those percentages were based on what we determined was a net savings requirement, so there was an allocation of the savings of the $100 million. We also took into account where they ended up at the end of the financial year, 2010-11. It is known that we had a budget overrun of approximately $60 million, so we took those into account. We are also very conscious of where the department sat in all this and that they needed to bear a bigger brunt of the savings cuts. Bearing that in mind, some of the strategies were already agreed and put in place - I think of what has been happening in the housing disability space - it was already identified that housing rents would increase, there was some maintenance that we would reduce and the $3 million for TAHL was going back into the bucket. So they already had a defined amount of money that they had to find. The rest of the savings were then split accordingly. We took into account a few varying factors but, unfortunately, the health sector is 70 per cent of the Budget so they had to bear a significant amount of what had to be found. There was also some new money that went into the base, so albeit we overspent the budget last year for a number of reasons - a lot of internal and external pressures - we were funded $50 million to go forward to help with that base, but the net savings requirement is still $100 million plus because of all the other pressures that we are not funded for, so there was a significant amount of money that we still had to find.

CHAIR - As to that $50 million, that came through -

Ms EGAN - We had a savings requirement, an overrun less $50 million and we still ended up with about $111 million that we had to find this year.

CHAIR - So the overrun was about $60 million, and there was the additional $50 million into yet we are still looking at more than $100 million?

Ms EGAN - Absolutely, and that doesn't include all the other pressures that we have to find in the system, which are inherent savings strategies in their own right.

CHAIR - When you look at the budget savings measures, are they measured against last year's budget or this year's budget?

Ms EGAN - Last year's budget at this point in time is finished so we are now looking at a new budget with new cost savings required and some new base funding.

CHAIR - Can I ask the three CEOs if they agree with those percentages of cuts to their areas?

Mr KIRWAN - I don't have the figures in front of me, but our original estimate of our savings ask was 14 per cent, when you put in all the cost escalations. Our current figure, using that $28 million savings target, is just below 10 per cent, so the target we are required to achieve to not go over the budget that has been allocated currently sits at around 10 per cent for the whole area health service.

CHAIR - So the 7 per cent that Penny gave us -

Mr KIRWAN - Is based on budget-to-budget figures; that's the qualification.

CHAIR - But the reality is it is much more difficult than that.

Mr KIRWAN - To achieve the direction we have not to go over the budget allocated. We originally started the year in July and our first assessment was based at 14 per cent. We have now reduced that to just under 10 per cent, which is $28 million.

Ms HOLDEN - Our share of the $100.2 million savings was just under 8 per cent. Our target to meet budget savings is just under 15 per cent.

CHAIR - The reality is quite different, isn't it?

Ms HOLDEN - I think it was giving the numbers on $100.2 million.

Mr JOHANNES - All three of the hospitals have been given a savings strategy but, on top of that, they have to manage, fairly aggressively, natural cost escalation in the business that they undertake.

Mr AUSTIN - The north-west is in a similar position - budget to budget, 10 per cent. Our figure is 13 per cent for the north-west region.

CHAIR - Are those savings achievable? When we received the budget this year and the savings strategies were outlined, there was a fairly significant requirement and you have described it as even bigger than what was initially described. There was some suggestion that for the savings to be achieved you would have to make significant cuts right on 1 July. How are we tracking?

Mr JOHANNES - I can talk broadly. We manage information on the $100 million worth of saving strategies on a weekly basis and from the last report of the $100 million worth of saving strategy, our assessment is that there is about $8 million, so about 8 per cent of the $100 million that requires more attention from the executive to make sure that it can be delivered by the end of the financial year. But currently the business units - and there are business units across the department who are responsible for one or more strategies - are reporting to us that $92 million worth of the $100 million is on track to deliver by the end of the financial year. The other $8 million in our parlance is at risk and at risk means there are factors arising which make it more difficult to achieve than we thought might be the case. That means there needs to be some management attention to how we can work with the relevant business areas to see if we can remove those barriers.

Dr GOODWIN - Is that $8 million a defined area of costs that you are talking about? Can you elaborate on what the issues are with those?

Ms EGAN - There is a defined set of strategies. I think the area health services and individual CEOs have developed something like 275 individual strategies across the board. Out of those 275, based on their information, there is about $8 million worth of individual strategies. We have called some of them at risk. That is not to say that they will not be achieved but they may be dependent on the fact that you have to get people out of the system and you might need some union approval to make that happen and a whole range of things. We have said to the areas, if project A cannot happen, what is project B that can take its place? That piece of work is ongoing.

CHAIR - I want to go back to the fact that $100.2 million savings is required but what you have told me is a different story. What is the reality figure? It is not $100.2 million, it is much more than that.

Mr JOHANNES - It is difficult to put an exact number on it because you do not know until the end of the year exactly what growth pressure there is going to be within your system for expenditure. It clearly is more than $100 million. John, Gavin and Jane have given you their estimate of what it means for their area services, and those are the targets that they are working to, but across the system it would be misleading for us to give you a figure and say that is it.

CHAIR - We have been told in the budget, I think, that an $50 million will be required next year?

Mr JOHANNES - I think it is $27 million.

Ms EGAN - It is $150 million over four years. So it is $27 million next year.

CHAIR - Is that likely to change as well? If you are saying that this $100.2 million is probably well short of what has been required this year, what are we going to be looking at next year?

Mr JOHANNES - At the moment the Government has been pretty clear to us that the expectation is that we will come in on budget. In areas like the $8 million worth of saving strategies, if we form a view, for whatever reason, that some or all of those are not going to be delivered by the end of the financial year then it is incumbent upon us to find other areas within the system that can compensate for the shortfall.

Similarly, if John, Gavin or Jane were not successful in their efforts to deal with the natural cost increases within their system on top of the savings target, then again it is incumbent upon us within Health to find offsetting savings opportunities elsewhere in the portfolio.

At this stage we are planning, as instructed, to come in on budget. So we are not considering what component of that might roll into the next financial year.

CHAIR - Just to put it into context, are you able to -

Mr JOHANNES - That is the wall chart.

CHAIR - I might get some copies of that. Do you mind?

You said that there have been budget overruns, particularly in the acute health setting. Can you provide details of those budget overruns for the last five years?

Ms EGAN - Yes, we should be able to but I suppose what you have to understand is what is the overrun. The budget is a budget at a point in time, so the budget can actually change over the course of a year. So a budget is set by Treasury as at 1 July. That budget changes because additional funds come in from the Commonwealth or there could be different structural changes in the organisation, so budgets move around.

The overrun we talk about is the budget overrun as at 30 June compared to that adjusted budget, so we can find some of those figures for you. Regarding figures for last year, for your information, the Southern Area Health Service was 31.7, the northern was 5.1 and the north-west, excluding Mersey again, was 9.1.

CHAIR - That was last year's figures.

Mr JOHANNES - We can go back over the last five years and give the best indication of the extent of any overrun. We can do it departmentally. It is difficult to do it by area because the areas have not existed for that full period of time.

Mr HALL - Could you also give the quantum that has come in? You talk about an influx of Commonwealth funds each year. Could you also give a quantum for each of those years?

CHAIR - And the purpose of those grants as well.

Mr HALL - Yes.

Mr JOHANNES - We should be able to break down Commonwealth versus State expenditure for that period.

Mr HALL - What are the expectations this year?

Mr JOHANNES - In terms of?

Mr HALL - Influx of funds.

Mr JOHANNES - Expectations. I have no expectation of any influx of funds from the State.

Mr HALL - No, from the Commonwealth.

Mr JOHANNES - We are working actively with the Commonwealth through programs like the HHF to bid for competitive funding. Regarding the National Partnership Agreement on Mental Health we are bidding again on a competitive basis with other States and Territories for funding. I would love to think they will be successful, but until such time as I see the cheque I will not be counting on it. Of course those funds are always heavily tied so it is not as if the Commonwealth would say, 'Here is $20 million to put into your system, spend it where you would like it'. It is always very specific exactly where that funding will go. If the Commonwealth comes through, it will come in with an expectation that there will be new infrastructure or added functionality within the system. It does not enable us to deal with some of the challenges we have now.

Mr HALL - If it did come in, what would be the approximate timing? When does it usually come in? Is there a set time or not?

Mr JOHANNES - I suspect it would not be until next financial year at the earliest, to be honest with you, Mr Hall.

Mr HALL - Okay, so not in this financial year?

Mr JOHANNES - No. We tend to bid this year so if you look at the HHF and that was the source of funds for the last 240 for the Royal Hobart Hospital redevelopment, you tend to find out about April or May and it tends to come in the following financial year. We put in three bids as part of this process. We would expect to hear March/April/May and then of course you have to negotiate the actual instrument that allows the funds to flow so I would be surprised if we saw significant injection as a result of applications currently in the system of funding this financial year.

CHAIR - What are those bids for?

Ms EGAN - We have three major bids in. There is one for e-health. There is one for Mental Health Services in the north-west for the facility, I suppose, to upgrade, replace the Spencer Clinic. The third one was for the Mersey. How could I forget the Mersey?

CHAIR - What do we want at the Mersey now?

Ms EGAN - There was a range of initiatives in there. We were advised by the Commonwealth that even though it is a Commonwealth-funded hospital, we need to put significant capital into the Mersey. That has to be NHHF within its own right.

CHAIR - So that is capital at the Mersey we are looking at?

Ms EGAN - Yes. It is not recurrent. All these bids are capital bids.

CHAIR - Going back two or three years when there was the elective surgery funding package and incentive funding - this is when the former Treasurer was in the place - there was an expectation, or there was a reality, that any State would not get the incentive funding if they did not meet certain benchmarks and Tasmania was deemed to be a bit behind the eight ball to start with. I think from memory it was a $125 million bonus package that was going to be provided to Tasmania to get us to a point where we could actually have some hope of achieving the requirements to get the incentive payments. What happened with that money?

Mr JOHANNES - You are talking not about the National Partnership Agreement we have negotiated in the last 12 months which has facilitation -

CHAIR - No, no, before that.

Mr JOHANNES - Okay. Alice, can you speak to that?

Ms BURCHILL - The only incentive money for elective surgery was something like $3.6 million that we could not achieve which was due to the fact that we could not reduce the over-boundary cases to the level that the Commonwealth was expecting us to do.

CHAIR - That was across the board that had to be achieved?

Ms BURCHILL - Yes, of course it would have been. All the other targets we achieved.

CHAIR - What other targets were there that had to be met?

Ms BURCHILL - The number of patients treated off the list, producing percentiles. The number of over-boundary ones were the only ones we could not do because there were so many over boundary. For all the other elective surgery, all the other Emergency department targets -

CHAIR - With the latest agreement, what is the status of that?

Mr JOHANNES - We have signed up the National Partnership Agreement around elective surgery and Emergency department targets and we have been working actively towards that. We were always very clear with the Commonwealth that for the amount of funding on offer the elective surgery targets were going to be very challenging for Tasmania. Now with the need to reduce expenditure on elective surgery as part of achieving the budget that the department has been allocated, it will be even more challenging to meet those targets.

You would be aware that minister-to-minister discussions have taken place. I have not participated in any discussions at a bureaucratic level but it is clear that it will be very challenging for us to achieve the elective surgery targets. If we do not achieve those targets then the reward funding that is on offer under the National Partnership Agreement will be at risk. I believe the reward funding is $8.9 million.

Ms BURCHILL - It is $4.4 million for elective surgery and $3 point something for emergency care.

Mr JOHANNES - Okay.

Mr WILKINSON - Greg, why is it that it is going to be challenging to meet your elective surgery targets?

CHAIR - What are the targets? Can we look at that first?

Mr JOHANNES - The target is 100 per cent seen within clinically recommended times by -

Ms BURCHILL - 2015.

Mr JOHANNES - So it is 100 per cent of people in Tasmania receiving elective surgery within the clinically recommended time by 2015.

Ms BURCHILL - That is category 1 patients to be seen within 30 days; category 2 to be seen within 90 days; and category 3 and above to be seen within one year.

Mr JOHANNES - It is challenging in the Tasmanian context, firstly because we started significantly behind most other States and Territories; in terms of when the funding was provided most other States and Territories were seeing more elective surgery patients within the clinically recommended time than Tasmania.

We started behind and we also have a large number of what Alice refers to as over-boundary patients - that is, those who have already waited more than their clinically recommended time - so the bottom line is, Mr Wilkinson, the reason it is particularly challenging for

Tasmania is that we started significantly behind the starting point of other States and Territories, it is an aggressive trajectory, and the amount of funding on offer makes it difficult for us to meet the target that we need to meet to get the reward funding.

Mr WILKINSON - One of the big areas I suppose you are saying is that you started behind other States. If we find out the reason that we started behind other States we might be on the track, and it is probably a bit simplistic but some might argue that we might well be on the track to be on a par or even better than other States so what are the reasons? Why are we lagging behind?

Ms BURCHILL - Some of the reasons we are behind is that we did not have adequate facilities within the various hospitals and over the last few years the LGH has had extensive re-profiling and expansion of services like new theatres and intensive care and so forth and that is why we are rebuilding the Royal Hobart Hospital - to make sure that we have adequate facilities there for the elective surgery and emergency patients coming through the system.

Mr WILKINSON - Obviously at this time of the year when it is in the paper people and medical practitioners ring me up a couple of times a week, I suppose, sometimes more, saying that there is a culture in some of the hospitals that they do not carry out the same amount of operations, similar operations, as in other parts around Australia. Is that right and, if so, what is that culture?

Mr JOHANNES - I think that is a difficult question for us to answer but maybe it is something that the hospital CEOs would like to talk to given it goes directly to the way their areas of the world work. I do not know. John, do you have a comment?

Mr KIRWAN - It is difficult to respond to generalisations, as you would appreciate, if there is something specific but I can assure you that certainly in our program, and I cannot speak on behalf of the others, I do sit, as the other two CEOs do, on our statewide surgical committee. Our surgeons complain to me when they cannot do surgery. We have a very progressive culture. Our theatres and theatre utilisation are at 100 per cent or over, our surgical wards are very busy; they are two of our busiest wards in turnover and they are also in the high 90s in occupancy. Our issue, as Mrs Burchill has indicated, is that our capacity is full and that's why we are undergoing a major redevelopment level 4 and 5, which will allow us the capacity to deal with more surgical cases. It would be fair to say that our pursuit of elective surgery figures, and our figures keep going up, but the cold hard reality is that the maths keep beating us - that is, more people keep coming onto the list than we can take off. We cannot deliver on that demand.

The other issue in the north of the island is the private sector not having an intensive care unit or other areas; that means we are the catcher of all complex cases. We have the ICU with the high-dependency cases, so there is an issue there. There is an issue already for training because some of our surgeons complain that they don't get to see the minor work that they used to do as part of their training. That is why we are trying to get surgical registrars also training in the private sector, where a lot of that work is being done because of those issues. It is complex but in our surgery they are productive, they work hard and complain when they can't do it. They have introduced quite interesting innovations in respect of scheduling. We have waiting lists, which does get us into trouble because we contact patients and say, 'You might get on if this one finishes early'

and when we say, 'Sorry, you didn't get on', they take it as a cancellation and then complain. When we try to explain to them that that is not listed for surgery, it is listed for 'if this case finishes early'. If we have a major case and it finishes early, we can fit in a smaller case, so they are doing innovative work like that. The surgeons, anaesthetists, nurses and others work very closely together. I have no question about our productivity in that and I would put that up against anyone.

Comparing us with the private sector is not fair, if that's what they are doing. The private sector generally is lower complexity. They put bars on what level of obesity or weight a patient is. In the north of the island, without an ICU and other support, they don't deal with all that we deal with and they don't deal with emergencies because we are the only emergency hospital in the north. What we deal with increasingly is a larger number of emergency cases simply because our ED keeps growing and when you are dealing with another 30 or 40 patients than we were three or four years ago, we admit about 20 per cent of those patients. It just means there are more being admitted for emergency surgery and emergency procedures. There might be one or two cases but I think our surgeons do a magnificent job and they run those theatres very efficiently and hard.

Mr AUSTIN - The North West Area Health Service around the management of Jane Holden reduced the people waiting longer than their clinically recommended time frame from 54 per cent in 2007-08 to around 10 per cent now. We have been increasing productivity, both the North West Regional Hospital and the Mersey Hospital, consecutively year by year. The Mersey Hospital is 28 per cent greater than it was in 2007-08. Up until 31 October raw separations for the North West Regional Hospital were 2.5 per cent above the same period last year. At the Mersey Hospital it was just below 1 per cent less than the year before but the theatre activity is 5.3 per cent above what it was the year before. In terms of throughput, we have been highly productive.

CHAIR - That is all separations, Gavin?

Mr AUSTIN - Yes.

Ms HOLDEN - The idea of generalisation is very difficult to respond to with anything specific. With the numbers that we have to work with, I believe that the Royal is dealing well with the resources it has. That is not to say that working with the heads of surgical departments we don't think that we can get even better; we do. We are looking for opportunities with that. Like the north, we run contemporary short-notice lists as well as our planned elective admissions. We also have the same sort of problems where sometimes the emergency demand influences what we have planned on the list and that can have an impact on our ability to work through the elective list. Looking at options with additional facilities for dedicated emergency sessions is an important part of our strategy.

Again, everybody is working hard within the resources and I think the key to improving our performance will be working together to look where we can make an incremental improvement - so they're not quantum leaps but they're incremental.

From the data, the Royal does deal with a number of patients that come onto the list on an annual basis but there is a backlog of patients and we need additional funding to deal with that. That backlog roughly represents about a year's through-put, not across all

specialties, but that's a rough kind of guide. So we have a one-off challenge that we need to address over time.

CHAIR - So, in broad terms then, the fact that what you describe is 100 per cent occupancy in operating theatres, 90 per cent in the surgical wards and I assume it's probably similar in the north-west -

Mr KIRWAN - It's the high 90s. It's to 100 per cent for us.

CHAIR - High 90s, which is really an unsafe environment in lots of ways.

Mr KIRWAN - Not necessarily.

Members laughing.

CHAIR - We won't debate that. We've identified that the system is chock-a-block. The direction's been given to save $100.2 million this year. The decision's been taken to cut elective surgery. Surely by cutting elective surgery, we're not going to be able to reduce those. This way we're going to get the incentive payments. We're also going to increase the demand on the DEMs because people will come in as emergencies, ultimately, and we have beds closed so the bed-block issue starts.

Is this an unrealistic expectation that's been placed - and I'm asking the CEOs here - on you to meet the savings targets? Most of us understand the budget position - I'm sure that everyone across the table certainly understands the budget position - but is this totally unrealistic because are we going to be ending up with more costs next year and the year after if the savings were made by 2015, I think, was the requirement? Is that near-on impossible? Jane, do you want to go first?

Ms HOLDEN - It depends which context you come from. You can make savings any way and I think it's worth looking at the Royal performance to date, which is pretty impressive, in my view, that prior to making any direct impact on patient access to the hospital, we're forecasting half of the savings being achieved through systems management, new controls around staff and deployment and beginnings of the program on procurement so I think there are some savings that we've been able to find.

As I shared with the staff at the Royal, the challenge - nobody want this; nobody thinks it's a great idea - now is some steps looking at how we're managing access and that's because most of the money that we're spending in health, we're spending on patients. So to make the next step of savings, we need to look at the services we're providing to our patients.

We even see some other mechanisms to try to mitigate the ideas we are trying in terms of patient access and I do recognise that the risk of reducing access to planned admissions is that they may become emergency admissions. To that end, we've targeted the access that we are supporting into the high-acuity, long-wait patients so that we're trying to make sure they don't slip into the emergency presentation.

Also, we are looking at creating precincts and things that give us a bit more cohesion in how we're working. How I'd like to respond to the point you're making is that I do

believe the steps we're taking now do have some risks for our patients because we're slowing down access to planned work, but does that mean that they are unrealistic? That's a decision that goes beyond my level. I think at this stage I'm still absolutely satisfied that we're managing quality and safety with the plans we've put in place.

I run a fortnightly risk register against the risks we identified when we started this to reassure myself that that remains the case.

Mr KIRWAN - In respect to the Northern Area Health Service, our $28 million savings strategy, it was made very clear that we had to deliver a savings strategy after our first strategy didn't reach the required objective of not going into deficit. That then meant that in the period of September-October we developed a range of different strategies, some of which were announced by the minister and some of which have been finalised as we speak. That gives us 61 savings strategies, most of which are on track. A couple are at risk and a couple have already been achieved. In essence, that is broken into $7 million of additional revenue and accessing funds from other areas; $3 million of reduced costs; $4.5 million of reduced staffing costs, but the bulk of it, the $13.5 million, is reduced services. I say that because it is not just elective surgery, it is closing a medical ward and reducing other areas across the site and in Primary Health North.

In respect of the specific question of elective surgery, it is not just elective surgery for us; it is medical procedures, some oral and probably some limited mental health procedures as well. That is the work that goes through our theatres and day procedure and surgical wards.

CHAIR - What medical procedures are you talking about?

Mr KIRWAN - Endoscopy and other work such as that.

When you close two theatres effectively and 20 of your 60-odd surgical beds, that is the effect is has. In respect to the direction, it was to find cash savings this year. We have some serious concerns about what that means because it is a case of deferring and causes an issue for the patients who can't then get in. It will significantly reduce our capacity to do category 3s and a significant inroad into our category 2 work in surgery. It is not just surgery; it is the other areas as well. We are closing a whole medical ward, reducing and amalgamating positions in other areas and closing beds where they are under-utilised, as we are doing already, to stay within safe staffing hours.

The impact is likely to be negative. It is likely to mean that people - we have to be honest - category 2s and 3s, we are already well over boundary. I don't think that has been addressed. Unless there is a significant investment, it means those waiting lists will continue to be fairly long. We are now in the process of assessing those and will be advising the patients as to what it is likely to mean.

CHAIR - Just on that point, the closure of the medical ward, what sort of patients would normally be on that ward and what are you doing with them? What impact could that have come next winter?

Mr KIRWAN - We are doing the assessment and the modelling at the moment. The medical ward is already down to 24 beds. It already has eight closed beds on it. It has longer

stay patients in there. A number were moved to Eskleigh. It will have an effect and we are doing that modelling at the moment. It is already working on a reduced capacity as we speak. There are a number of renal patients and they will need to be accommodated elsewhere. The ward at this stage will not close because we will use it to move our oncology patients who require day work in respect to medical oncology - infusions - while we redevelop the regional cancer area. That provides us with a short-term opportunity to allow that to happen, therefore the redevelopment of the Holman Clinic can happen a bit quicker. That is a bit of a bonus, if ever there ever can be in this exercise. In that area we are talking about the closing the ward and we have no plans to reopen it. We are still doing the modelling. We have been having the discussions with the department and others; we have a quite aggressive winter management strategy, which has been quite successful in the last couple of years, but we had had difficulties this year with norovirus outbreaks. We are doing modelling on that as to what it might mean so that we can assess our existing strategies, policies and procedures for escalation that they are okay and if not we will change them, because we are moving into some unchartered territory.

Mr HALL - We know that it is a far from ideal scenario but it is reality. I think Jane Holden mentioned a minute ago that there was some risk to patients, however she was evaluating that on a regular basis. So my question is given the scenario that we have, do you consider that there is a risk to our community in terms of health outcomes? Yes, it is a simple as that.

Mr KIRWAN - Access denied or access delayed when it has been clinically assessed that it should be occurring within acceptable national procedures, like time frames, is suboptimal care and in some instances people will escalate and we will see them attend the ED. We will see an increase in ED presentations.

Mr HALL - What sort of presentations.

CHAIR - Emergency.

Mr KIRWAN - And we will see people deteriorate on the waiting lists. Simply if you look at the age profile and chronic disease profile and there is no joy to say that it is what is happening now but unfortunately that is a pre-existing issue, irrespective of the savings strategies which you have already touched on.

Dr GOODWIN - I was going to pick up on that point. You mentioned the age profile and the chronic disease profile and I think what you were alluding to is the demand that is growing for elective surgery is probably related to those two factors. Can you elaborate on those issues?

Mr KIRWAN - We have a relatively unhealthy population in Tasmania. It is not just age related but for a whole range of issues we are seeing our acuity increasing quite significantly in medical and surgical patients. This is going to make that more difficult for those that require surgical interventions, but I do have to emphasise it is not just surgical areas that are being reduced or constrained.

Mr JOHANNES - Can I make one observation in response to a question Mr Hall asked. I want to make very clear that we actively manage risks, including clinical risk, in our

hospitals every day and we will continue to actively manage clinical lists including in the context of the saving strategies. It was part of your question, I think. John has talked about the risk to people that are not going to be seen within the system as a result of reducing the number of procedures. I want to make very clear that within the system we do not let up on our management of risk and management to standard. That continues.

Mr WILKINSON - Am I right in saying, Greg, that the only way you can properly manage risk is by knowing what is out there? In other words, if an endoscopy is not carried out within a certain time - you are looking for cancers, no doubt - the cancers can grow and become fatal if they are not done within an appropriate time span. It is a difficult question.

Mr JOHANNES - It is a fair point, Mr Wilkinson, but I was responding to Mr Hall's question. I think he went to two aspects of risk. One was external and one was within the system and John spoke about outside the system so I just wanted to reassure people that within the system, when we get them in the system, we actively manage the risk around their care and we will continue to.

Mr WILKINSON - I understand that because I think John put it very diplomatically when he stated it, but it seems that if you cannot do the procedure, there is going to be the added risk that things may exacerbate to a critical level. Is that fair, John?

Mr KIRWAN Yes. Each one will be an individual. Some people can live. My hospital is out of step with the other two hospitals. Our surgeons argue, for example, for a category 4 - that is, we believe the three categories are inconsistent. We believe there is a category 4. That is people who can wait more than 12 months and wait safely. Our waiting lists would justify that. I think our worst case, I don't know what it is now, but it was about nine years for cosmetic surgery. It is there; it has been diagnosed as a procedure that is required. Is someone in pain? No. Would they like it? Yes. Is there a clinical need for it? Yes. Obviously the GP and the specialist would not have put them on a list if that were not the case. Therefore we have always argued that in our view there should be a category 4 list of people who can wait longer than that. That is not a position that the State or national level follows. We accept that, therefore we have to just wear it. It is not unique to us, but it is, I think, probably a bit more of an honest approach if people are not in pain and can wait to tell them how long they can wait, and then they can make all sorts of assessments themselves.

Mr WILKINSON - Then they can make decisions, can't they, as to whether they stay here to have it or move elsewhere.

CHAIR - Take out private health insurance if you have to wait nine years.

Ms BURCHILL - A patient whose condition is exacerbated can go back to the GP and be re-referred as an emergency and will be seen relatively quickly, so if the patients deteriorate they are seen.

Mr WILKINSON - Let us say - and I am just using endoscopies as an example - without a look-see it is very difficult to tell, isn't it?

Ms BURCHILL - There are other methods, I agree.

CHAIR - Can I ask, Gavin, your comment -

Mr AUSTIN - On the original question.

CHAIR - Yes, the original question, if you can remember what it is.

Mr AUSTIN - The answer is yes, it is challenging. The north-west has taken a stiff approach to budget savings. We looked at all the easy things - efficiencies, electricity reduction; we carried out reviews on all our non-clinical areas and have reduced staff in all our non-clinical areas - and then because our target for the North West Regional Hospital is $12.9 million, we looked at elective surgery. Like John we were looking for quick wins and this year, just for the component part, joints cost us a minimum of $10 000. We carried out 250 joints last year and we are looking at 110 joints this year so there are substantial savings in doing that, which will be realised immediately. We have reduced our theatre by five elective sessions per week and we will be, like John, closing a ward. We have reallocated our surgical beds from Surgical Ward West to Surgical Ward Central and we are doing a Christmas shutdown for the theatres of elective surgery from 19 December to 16 January.

We have made a commitment to ensure we keep category 1 acute surgery on time. We are still going to do 110 joints this year but, based on our modelling, in six months' time it would have been 209. There would have been 197 people waiting for orthopaedic surgery and based on our modelling there will only be 11 people more on our wait list after six months.

CHAIR - I want to get back to that original question of whether it is realistic.

Mr AUSTIN- The north-west is in a good position to be able to achieve this. Is there clinical risk? Yes, there is clinical risk.

Dr GOODWIN - In terms of the elective surgery cuts and I suppose even more broadly, are the impacts being tracked in terms of patients and whether they are presenting as emergencies down the track because they haven't been able to have their surgery at an earlier point and, if so, is there any data so far about what effect there has been? Obviously, the worst-case scenario is a patient dying while waiting for surgery. Is there any evidence of that occurring so far?

Mr AUSTIN - The strategies were only put in place and signed off by the minister on 4 October. The north-west, along with the other two area health services, will be closely monitoring the data coming through the emergency department. I personally am signing off all requests for emergency joints to monitor the actual usage of the joints to see if it is going up through an emergency reason or through the elective, so we all have risk management strategies in place around that.

Mr JOHANNES - In response to your question, the bottom line is that this particular aspect of the strategy hasn't been in place long enough to start seeing what impact it has on outcomes. All three hospitals actively monitor their throughput and actively want to do acuity on a day-by-day, week-by-week basis so going forward we will be able to tell what impact this is having on presentations within the system.

Dr GOODWIN - That is fine. The crux of it was will it be monitored and will it be possible to determine the impact down the track.

Mr JOHANNES - It is standard business for the three hospitals to monitor what comes through, what the level of acuity is, the levels of performance on a day-by-day basis. That will all be accurately monitored.

CHAIR - I think it was John who said that there was no intention of reopening the medical ward. I assume that means into the longer term but he didn't actually specify that. As you rightly pointed out, we have quite an unhealthy population in the north and the north-west of the State. We have an ageing population, we have a high rate of co-morbidities on the north and north-west particularly, so if these beds are going to be closed and the population doesn't decline, are we looking at a long-term, complete backlog here? We did hear initially from the minister that it was a temporary measure, but what I am hearing from you is that it is not all that temporary. Can you expand on that?

Mr KIRWAN - Certainly in respect to the LGH - and again, I need to differentiate it - it is not our intention to keep the surgical slowdown and shutdown forever, in part because we just do not think it can be maintained. We think that we are doing it for cash and we are doing it for this year. It is our intention to try to find additional savings and meet the additional reductions next year and the additional known cost escalators in the system. It would be our preference in the areas of surgical and other intervention work not to continue that any longer than we necessarily have to, in part because we know that it is not something that we can continue on forever; the risk is too high.

In other areas we are accepting that we have to reduce. In round figures, our assessment is that the northern area health service, including the LGH and Primary Health North, have to reduce to a figure of about 85 per cent of its current level of activity in funding to get to a sustainable budget based on the $520 million that has been taken out of Health and our share of that, plus the known escalators in the system, most of which are unavoidable for us.

That is now what we are cutting our cloth to, to meet the figure that the minister keeps mentioning that we have to get down to. The only way we can see that occurring is to focus on the 85 per cent that should remain, to make sure that is the highest quality health service that we can deliver and we would be comfortable and confident on that because we start from a high base as well. Then we need to identify the 15 per cent that we need to manage either down or close down, and that is the really hard part.

CHAIR - What you are talking about, as I hear it, is rationalisation of services, deciding what we need to provide where. Are we going to have this discussion? Is this the discussion that needs to be had about a statewide approach to services provided to Tasmanians within Tasmania to improve health outcomes and not trying to be all things to all people in every part of the State? Is that what you are talking about?

Ms BURCHILL - I think it is far to say, John can elaborate a little bit further on the new services that are happening at the LGH, the integrated care service and the acute medical unit which are both expanding areas.

Mr KIRWAN - These things never happen at a good time. It is always better to invest in a service to grow it but we already had it pre-existing. We took the approach with our capital works funding which we have been quite attracted to and a number of members of at this table have been on the Standing Committee on Public Works, which is aware of what we are doing. We took the advantage of our capital works funding from the State and Commonwealth with new models of care, with changes to our workforce, with the new ICT that is coming, with the national reforms, particularly activity-based funding which is interesting to us because we think we will benefit from it, to bring all those things together and remodel our care. The Integrated Care Centre is a new model of care, particularly using telehealth that allows us to look at chronic disease and hospital avoidance - or hospital delay is probably more accurate - so managing those there, particularly for the outer communities, the communities on the east coast and others, to avoid people travelling. The telehealth is quite exciting, as is the new technology that comes with that. The Acute Medical Unit, which is now going to be a little bit delayed in its implementation, is important because it allows an acute medical unit to deal with that chronic disease profile, particularly in that category 2, 3, 4 cohort that is attending the ED. Again, based on the successful work in the UK and New Zealand and other parts of Australia, we are quite confident that will work very well for us in the ED. We are confident that within a couple of years we should be well on target to meet all of the national indicators in the ED presentations. That is quite a promising direction for us. The elective surgery is a capacity issue for us. We have surgeons who are happy to work -

CHAIR - You cannot do surgery at home.

Mr KIRWAN - Again, in Launceston, all but one of the surgeons work private and public, so you get the best of the best. They are all busy and they all like doing surgery. The anaesthetists are good and the nurses are good and in 18 months' time when we have finished the rebuilding, they will have the best.

CHAIR - Can we go back to that question of rationalisation of services? I would also like the CEOs to consider this health reform we are looking at, imposed by the Commonwealth with even the three health organisations. You were talking about trying to get streamlined services, providing services where they best fit and not trying to be all things to all people, is this a discussion we should be having rather than just tinkering around the edges and avoiding the hard discussion?

Mr JOHANNES - On 1 July the world changes, we have hospitals at arm's length through independent boards and a single chair, assuming the legislation that is currently before the House goes through in its current form. If not, it will be in some other form but we will have independent THOs. In theory, the process of interacting through a commissioner with the department should lead to some decisions around where it is most cost-effective for hospitals within the network to deliver particular sets of services, though the Government through its service level agreement will still have the choice, if it wishes, to purchase services at a price at any of the three major hospitals, assuming they want to continue to deliver that service. There is an opportunity for rationalisation of services within the State through the THO model, but to be honest with you I don't think it's any greater than we have with the current model. We could rationalise, if we were prepared to, the delivery of services into particular areas.

Ms BURCHILL - The overall savings strategy that we adopted at the beginning of this process in April-May-June had a three-pronged approach. We wanted to build an efficient and sustainable strategic future for Health and Human Services across the State. One element of this budget control was setting a realistic budget within the available resources we had and trying to get budget control across the whole of the system. The second thing was strategic savings, work force reforms, productivity and efficiency gains and organisational structures, making sure that we were fit for purpose going forward. The third element was part of the reforms that Mr Johannes was referring to in terms of the establishment of the THOs, and that was within the department's established commissioning unit. We looked at what services we should be providing and where across the State. Part of that is looking at statewide clinical services, role delineation and clinical pathways for care. That is a strategic approach. It is not a quick fix and it won't happen this year; it will happen over the next three to five years. Until we get that well-imbedded within our system, we will not get the gains we need from the THOs.

CHAIR - Do any of the CEOs want to comment on that broader question?

Mr KIRWAN - The one or the three THOs?

CHAIR - That, but also in the context of having a fully integrated health care system in the State. We are focusing on the acute health services here particularly with acute medical and surgical services, but we are also talking about integrated health care centres at the LGH and the need to cut our cloth to suit the available money to provide a health service for Tasmania as a whole. I am interested in that view and why we would be going down that path of three when we clearly need a statewide focus and approach here.

Mr KIRWAN - I don't agree with the premise of your question. If you speak to the clinicians and from a patient-centric approach, the movement of patients within the State and to the mainland is done by clinicians on clinician judgment. They know what they can deal with, they know what they can hold and keep or refer. It happens on a daily basis. There is an integrated model. People understand what we can deal with, what we can cope with and what is unsafe. You will see a constant flow of patients from the north-west to us or from us to the south on occasions or from us to the mainland. That is a clinical decision-making and they understand the capacity. On occasions there are bed access issues at all of our sites. It is terrible when it's all happening at once because then life gets very exciting and is not a lot of fun, but generally that is managed well by the bed allocation staff, the ambulance service and others. There is an integrated model in that exercise and I suspect the clinicians would take some offence if they thought that people were saying they don't meet -

CHAIR - I'm not suggesting that. Clinicians make clinical decisions, but we are talking about administrative decisions here.

Mr KIRWAN - There is a centralised model already; it's the one department. We don't have control of our capital, equipment, resources and others. It is a centralised model as we speak.

CHAIR - Why are going down this path at all then?

Mr KIRWAN - Because the Commonwealth reforms are based on local decision-making at the local level and clinicians making their decisions. That is a national reform that the rest of Australia is following.

Mr WILKINSON - And the argument could be, could it not, that you have the one body with local input from the three areas?

Mr KIRWAN - My personal views and my organisation's views are well known. That is, we will support a statewide approach in integration. We will not support a centralised approach where everything is centralised in one area, be that LGH or be that the Royal. Because if we are seen as the annexe of the Royal, which is the bad old days of the past - not recently I have to say - if that is the view of people that will be the reaction because the underlying philosophy is care close to home: the most appropriate care, the appropriate price and the appropriate quality. I do not think anyone disagrees with that.

Mr JOHANNES - Ms Forrest, if I could go back to your original question which I think was, if we want to take a truly state-based approach, if we want to manage the system as a system and make choices about where we deliver services both from a clinical perspective and also from a cost-effectiveness perspective, should we be going to a single THO instead of three? I guess my response to that would be: the current system, a system with three THOs and a system with a single THO, if there is strong central direction around the system and what it will deliver where all three of those systems could deliver the outcome that you are talking about, I do not think any one structure guarantees the right outcome. Some structures are maybe more supportive but we all know of systems that work beautifully in spite of terrible structures and we all know of systems that work terribly in spite of fantastic structures. So I think the existing system in either of the two THO models in principle could deliver the sort of statewide focus that you are talking about. We would argue absolutely that we need to take a more statewide and a more systems-based approach and part of that is making sure that whatever model we deliver on 1 July enhances that and part of that is also doing things like looking at the way that we bring clinicians into the debate statewide about where services should and shouldn't be delivered and having them helping us make some of the more difficult decisions.

Mr AUSTIN - From the north-west point of view I agree with the Acting Secretary's comments. Whether it is three or one, it is how efficiently we run it. The north-west is dedicated to local north and to be the most efficient under activity-based funding we can be. Hence we increased our elective surgery and made sure we can continue to produce efficient, quick, in-out day surgery at the Mersey and carry the more complex security at North West Regional which has the ICU and HDU. We are working towards being the most efficient. Our rationalisation is to make sure our clinicians refer on, as John said. They do that as a matter of course.

CHAIR - And would under either model?

Mr AUSTIN - Yes, they would under either model. Under activity-based funding, if you read some of the literature, it is very much a case of the more of one thing you can do or the more efficient you can be at something the better you will do. So if you are going to specialise in something, then specialise in it and do a lot of it. So the North West has adopted that model and is very much good at referring things.

CHAIR - Which shifts costs to other areas, which is another potential issue with three THOs. Where is the cost, where does the money stay, with the patient - it makes it more complex.

Ms HOLDEN - There a couple of things I would just like to add to that. Just on your final point, we are not population base funded so costs do not travel with patients. They are actually attracted to the organisation that provides the services.

The second thing is that I do agree with John Kirwan and Gavin Austin that we have integrated clinical system and I do agree with John that we are working together to make that even more integrated from a southern/northern perspective as well and there is room for that, I believe.

I think from an administrative point of view we are in a situation where demand - and it's not unique to Tasmania or Australia, in fact - for health is going to outstrip resource allocation so that we stand back and have a look at where that demand is and where we've invested in facilities, organisations, professional response things to deal with that is a very healthy thing for us to do. I think it's healthy for us to do that as a State as well as locally and have a bottom-up and top-down approach so that we can marry something.

That may result in a change of how we work and it may not result in a change of how we work. I think it is a process worth going through and, indeed, the work is underway to do just that through looking at world delineation for each of the hospitals, looking at some of the demographic demands from the populations that we've corralled in each of our area health services.

I'm on record of saying the least money we spend on administrating health systems, the more that goes to patients. In that regard, the least expensive model of single-governed THO, but I balance that strongly by increased local voice and I do believe that sooner and more convenient access to health gives better health outcomes because people tend to access it if it is close and convenient.

CHAIR - Would you agree that there are some things, as we currently see now, like neuro and cardiothoracic that are only provided in the south and will only ever be provided in the south, and we need to accept that, as a State?

Ms HOLDEN - Yes, I do. I do believe that and I think it is accepted and I think this is where the south will work more in an integrated fashion and provide evidence to the north and the north-west that that's the most cost-effective model. We always have our eye on the pressures to keep that integrated but it's also beholden on the south where we are the statewide service provider that we are transparent about those costs and that we have good access and have good communication with them in that regard.

CHAIR - Thanks, Jane.

Dr GOODWIN - There are saving strategies around work force reform, which I'm interested in. In particular, what staffing changes there have been at the hospitals, if I could maybe ask for some information on that?

Mr JOHANNES - Do you want take it hospital by hospital?

Dr GOODWIN - Yes, if I could.

Mr KIRWAN - Can I ask for a bit more definition; I'm not too sure.

Dr GOODWIN - In regard to hospital staffing, have there been any changes in terms of their staff positions being lost so far?

CHAIR - Can I break the question up? I have a similar question.

Dr GOODWIN - Okay.

CHAIR - I guess what we need as a starting point, what were the end of the year staff numbers for the last financial year broken down to the nursing FTEs - the living/patient care, medical staff delivering direct patient care, nursing FTEs not delivering direct patient care and then you could start on direct patient care and then your ancillary staff, like ward clerks, cleaning staff, hospitality staff, hotel services and that sort of thing and then other staff employed within the health department.

So we need a starting point but then we also need - I think what you're asking, Vanessa, is how many people have actually lost their jobs in those areas - like the nursing FTEs who are providing direct patient care, nursing that aren't, medical staff that provide direct patient care and medical staff that don't, your ancillary staff and departmental staff.

Mr JOHANNES - Overall we've reduced as of the last pay period in October, and I'll be getting another report today, pay period seven, by about 201 paid FTEs across the Department of Health and Human Services of which over 40 paid FTEs came from the department and the rest came from other areas, including the three area health services.

We regularly get asked this question. Basically Ms Forrest tries to differentiate between frontline and non-frontline. We don't actually code people as frontline and non-frontline. I am not sure whether we actually break down our staffing, Alice may know, to the extent which talks about medical non-service delivery, medical service delivery; I do not know if the hospitals do but I have not seen any report to indicate we break it down to that level. Do you know if we do, Alice?

Ms BURCHILL - We do break it down by the award. Nurses' award, doctors' award, allied health professional's award have them 1 to 5 and 5 to 9. So we do break them down in that sense.

We started off the year and we used pay period 26, which was 30 June last year as the baseline number, which I think was 979, and our plan is to monitor the work reduction as we have by pay period and as Mr Johannes says period 7 has gone down by 201.

CHAIR - Are you able to give us the actual job numbers?

Mr JOHANNES - We could break that down by classification.

Ms BURCHILL - Classification by areas.

CHAIR - We will be able to identify the number of nurses who have lost their jobs?

Mr JOHANNES - We could not tell you whether they were on a ward delivering patient care or whether they were in some administrative role. We would not be able to clarify that.

CHAIR - Do you think that is important to have that information available? I think it is important for us and for the general public to know if nurses are losing their jobs. Are we talking about all nurses who provide direct patient care, hands on, on the wards in the Outpatients wherever, or are we talking about nurses in policy and strategy and that sort of thing? Will you be able to identify those? We talk about the department and you said some came from the department, are some of those nurses?

Ms BURCHILL - Some would be nurses, yes.

CHAIR - So how are we going to know? Can we get that information?

Ms BURCHILL - It is difficult because we are continually recruiting them and losing them. There is a high turnover because we have 3 200 nurses employed so it is pretty difficult to monitor who is in administrative roles and who is in clinical roles because they do actually move between roles as well. Who is in direct clinical care and who is in indirect clinical care would be really difficult to monitor.

CHAIR - But you can provide us with the positions of the nursing, medical, allied health, and department staff -

Ms BURCHILL - I could, yes.

CHAIR - who have lost their jobs as a result of these budget saving strategies, not because of natural attrition, not because they have gone off to have a baby and they have decided to retire.

Mr JOHANNES - Just to be clear, if somebody leaves and we do not replace them, they have not lost the job as a result of budget savings strategies, they have left the department and we have chosen not to replace the position behind them. While we have reduced by 201 FTEs I would not want there to be a suggestion that all 201 have lost their jobs because of budget savings strategy because that is not the case.

CHAIR - But can you identify those who have?

Ms BURCHILL - It would be highly difficult.

Mr JOHANNES - Yes, also if somebody puts up their hand and says I would like a voluntary redundancy or somebody puts up their hand and says can I access to up $20 000 in a workplace renewal incentive program payment that is being delivered consistent with budget savings strategies but would you say they had lost their job as a result of the budget savings strategy or they took the opportunity because they were close to retirement to take advantage of potentially some top up funding that saw them leave a little bit earlier? So it is difficult to say that individual lost their job because we reduced the expenditure in the area as opposed to that individual perhaps took an opportunity to

leave a year earlier than they were planning because there was a financial incentive to do so.

CHAIR - You could break up the 201 FTEs anyway.

Mr JOHANNES - We will happily break down that 201 in as much detail as we can for you.

Dr GOODWIN - Would that show which hospital they worked in as well?

Mr JOHANNES - We can also show you that. We can show you which area individuals of various classifications came from. So that may go, Ms Forrest, to your issue of did those nurses come from the centre or did they come from the area health services and all we are saying is just because a nurse comes from an area health service doesn't by definition mean that they were in the front line, but we will break that down for you as much as we can.

Ms EGAN - It is probably worthy of saying it is a net reduction. We are still putting people on as well as reducing the numbers so it is a net reduction.

Mr KIRWAN - Can I just give some clarification about the issue? We have already done a review of all our nursing positions. Part of what we chose to do has lead us, in a couple of instances, to say positions that are not seen to be direct clinical care in one instance not to proceed with appointing an associate professor's position and in another instance to indicate that program is to be completed and that is being worked through as I speak so I would prefer not to probably go into what might be difficult circumstances for the individual.

All of our other areas we have reviewed. I am just trying to be clear because we have nurses working in infection control, bed allocation, theatre list allocation and we see those as front line. I just want to be very clear. Our NUMs, our CNCs and CNEs all work a clinical workload so we see those as front line.

CHAIR - I would agree with that, John.

Mr KIRWAN - Just as long as that is clear.

CHAIR - Yes.

Mr KIRWAN - Because that leaves us with a very small amount in that area and, as I have said, we have been through that and in fact even our Executive Director of Nursing has a direct responsibility once she is on call, so she actually has a responsibility. She runs the infection control and other areas so she actually has a direct clinical load herself as well, so we struggle to make that differential certainly at an operational level.

Ms HOLDEN - Can I just endorse that? I think in the area health services there are very few nurses who are not providing essential nursing services. I guess what I can say in terms of pre-empting the final breakdown is that as at the end of October, 92 positions had been removed from the Southern Area Health Service and most of those, as a percentage of occupation, came from administration and clerical so they came out of the management side of the organisation. There were 22 of those.

The highest number, in fact, were nurses, who represent just over a third, about 36 per cent, of our workforce. That core number was 44. Those numbers related to, by and large, a review of the casual pool as well, as Greg Johannes has referred to, some people wanting to take voluntary separation from us, nearing retirement - those options.

By and large there is a new approach around the casual pool, from the greater the pool the easier everything is, to an analysis of the pool identifying that these are not free people, they are quite expensive, that they need to be trained every year. They need to have uniforms, they need to be updated, they need to be sitting as part of the work force and actually reviewing that and saying there are a number of people that we do not use regularly or who on contact do not wish to be used regularly, so we are going to take them off the pool.

Up until we implement the next savings, which we are in the process of doing now, I do not believe front-line clinical nurses we needed lost their jobs and no permanent staff that did not request a voluntary exit lost their jobs. But we have identified some reductions in nursing positions as a result of the changes we are now implementing.

Mr JOHANNES - I might just add one other piece of information. Of the 201 reduction since the start of the financial year, 83 of those have accepted workforce renewal incentive payments and 44 of those have accepted voluntary redundancy payments.

CHAIR - How many was that?

Mr JOHANNES - Forty-four. That is 127 of the 201 - oh, that is people. So 83 people have accepted workforce renewal incentive payments - they are up to $20 000 - and 44 people have accepted voluntary redundancy.

CHAIR - How much is that going to cost the department?

Mr JOHANNES - I have a cost figure here of $2 480 000 but we only make those payments when we calculate that there is a significant rate of return within 12 to 18 months. Particularly with the voluntary redundancy obviously the position is not filled subsequent to the individual leaving so immediately after they leave you have got a lump of money that you pay them to incentivise the separation and then after a period of time you start to recoup that because you are no longer filling the position.

The principle behind the workforce renewal incentive program is that you take more experienced, more expensive people that are close to retirement at, say, the top of the band and they move out with an incentive and you replace them with somebody at the bottom of the salary band and so you make your savings there and it is a smaller savings. You do not, in many cases, get rid of the position altogether.

CHAIR - Can you tell us what the employment costs across output group 1 are in percentage terms of the operating revenue?

Ms EGAN - A general rule at the moment is that there are about 70 to 75 per cent. When you look at the budget, our employee costs including payroll tax which is in there, are about 70 per cent of our costs. So, about $1 million plus this year. Each area is very

similar. Administration in the department is probably a little higher but certainly in the hospitals it is about 70 per cent of our costs. So it is significant. On top of that there is also probably another 10 per cent of other types of fixed costs that are in the system, whether it be cost of power which will be a variable, but fixed costs, leasing costs, a whole range of things. The actual amount of a variable cost that fits in a budget that allows some flexibility is not much in our entire budget. Hence the ability to find costs and bring them out of the system quickly is a challenge.

CHAIR - The only way you can achieve this is by getting rid of staff costs?

Ms EGAN - Staff reduction is certainly going to be a large part of what we do. But to do that systematically versus tomorrow is also difficult, with the rules around taking staff out through redeployment of somewhere six to nine months on the redeployment list. So even if we identify people tomorrow, they do not leave the system tomorrow. You probably still have them in your system for at least six to nine months, so you are still paying their salaries. Hopefully we can find other alternative work for people we identify this year, but if not and they leave, the full benefit of their reduction is going to happen from 2012, not this financial year.

CHAIR - I think it was Penny who made the point that you continue to engage people as well. Obviously there is a relatively high turnover in a large population, particularly of youngish females in the nursing profession who - John is shaking his head?

Mr KIRWAN - Not at the LGH, there is not.

CHAIR - Not a turnover? Do you have old nurses up there?

Mr JOHANNES - John has a remarkably low turnover of about 3 per cent,.

Mr KIRWAN - Our permanent nursing workforce is about 4.5 per cent. Last year our sessional doctors was zero. Last year our full-time medical officers was 0.5. We have a very low turnover rate. As the minister commented when she was giving a 25-year award presentation, where there were 140 across the area, there were 3 500 years of service. So we have a low turnover with a long length of service.

CHAIR - Very good.

Mr WILKINSON - You can go home, John.

CHAIR - I know where I used to work too, I think there were a lot of us who had been there since the place opened, which was a worry in itself.

Mr JOHANNES - On the other hand, that does pose some challenges in the system.

CHAIR - Ageing workforce.

Mr JOHANNES - Also, from a financial perspective, given 70 - 75 per cent of costs within the health system are people's salaries, the opportunity to manage the natural attrition achieving your savings target is particularly limited in areas like the Northern Area

Health Service because, John, for example, manages the entire hospital with a highly motivated team of people and he does not get the turnover that some other areas do.

I want to go to one other thing that Penny talked about and that is, within our system, under the new rules, if we make a declaration to the State Service Commissioner that the State Service Commissioner accepts to declare someone surplus, then they have up to six months within our system with which we have to continue to try to find them another opportunity. That goes to Penny's point that if we took a large group of people today and said we are going to declare you surplus and the State Service Commissioner accepted that, then we would not realise any significant savings, even if they went early under a voluntary redundancy, until next financial year.

Just to go back to the earlier point about people who have lost their jobs as a result of the saving strategies, to date, we have not declared anybody formally surplus. We have managed the downsizing to date through voluntary redundancies, workforce renewal incentives and not renewing positions when people leave.

CHAIR - You said that people are employed - maybe not at the LGH; they do not put new people on, but I am sure there have been some. Can you provide some information about the additional employees that have been taken on in Health in the last five years and what those positions have been and where they have been engaged, particularly looking at, if they are nurses, are they providing direct patient care? I accept that the majority of nurses do provide direct patient care, but if there are nurses being employed in policy or other areas that clearly are not direct patient care. I accept that nurses managing operating lists and all those and your NUMs and all those do provide direct patient care.

Mr JOHANNES - We can come back to you with disaggregated numbers of FTE trends by area over the last five years, recognising that there have been a number of restructures within the portfolio over the past few years but certainly within hospitals, for example, and we would be able to show you those trends over the past five years.

CHAIR - Any additionals into the Health department and not just in the hospitals because we are talking about the department as well here.

Mr JOHANNES - The only issue there, Ms Forrest, as I said, we will try to make sure you are comparing apples with apples because the department has changed somewhat over time but -

CHAIR - And it is always difficult for us to get to the bottom of the stuff.

Mr JOHANNES - Yes, but we will certainly go away and try to come back in the context that maybe with our submission, which I think is due at the end of the week, we will put those numbers in for you.

CHAIR - We might just take a five-minute break.

Ms HOLDEN - Can I just make one point before we stop, I just don't want there to be an impression that necessarily low turnover equals great outcomes -

Mr JOHANNES - I tried for you, John.

Ms HOLDEN - but I heard a comment that having a tight hospital motivated work force equals low turnover but not necessarily so; sometimes a turnover is a good thing in a work force and sometimes you wish there was more turnover. I would just like the committee to understand that there is a balance in that and it is not of itself necessarily an indication there is some good or bad.

Mr KIRWAN - It just reflects how good the north of the island is to live.

Mr JOHANNES - But, of course, in John's case it is all good.

CHAIR - Talk about parochialism, we need to break that down. Jane, do you just want to hang on by the phone and we will come back to you in five or 10 minutes?

Ms HOLDEN - Will you call me back?

Mr JOHANNES - Just put it on mute on your side.

Ms HOLDEN - Good, thank you.

Mr KIRWAN - Chair, we might call back because the line is pretty bad.

CHAIR - We will call you back.

Short suspension

CHAIR - To look at a broader area, from your perspective, Greg, the logistics of managing the budget task - that would be your job overall; I imagine that is the one you've been handed - could you tell me who is charge of that? Is it you? Whose responsibility is it to ensure that the savings are identified and realised?

Mr JOHANNES - At the end of the day the buck stops with me. The person who has most day-to-day involvement with monitoring achievement of the savings strategies across the department is Penny and her team. I am supported in my role as acting secretary by a group called the 'business control team'. The business control team is currently meeting weekly. It comprises representatives of Treasury and Premier and Cabinet, providing advice to the secretary of DHHS on the implementation of the strategies. We are also reporting regularly to the budget subcommittee of Cabinet.

CHAIR - So you sit on that budget control team?

Mr JOHANNES - I do, so notionally I chair it and the role of DPAC and Treasury on that is to advise me. It is also about holding me and the department to account.

CHAIR - So if the newly appointed secretary was available, would he be doing the secretary job and you'd still be the budget control team chair?

Mr JOHANNES - No. The secretary of DHHS has always been the chair of the budget control team and the terms of reference of the BCT is to provide advice to the secretary on implementation of the budget savings strategy. It is not the role of the control team to

identify the strategies; it is the role of the team to support the secretary in making sure that they are implemented and that there is appropriate reporting on their status.

If Matthew Daly showed up tomorrow and took on the secretary's role, I would disappear the next day back into the Department of Premier and Cabinet. I would probably resume my role on the business control team as DPAC's representative.

CHAIR - But you'd still be on the team that looks at Health, though?

Mr JOHANNES - I suspect so. When I came across to undertake this role, I formed a view that independent scrutiny by the two central agencies and holding me to account in this role was important and I couldn't wear the hat of DPAC holding myself to account in Health, so John McCormick in the Department of Premier and Cabinet, who is a director in the policy division there, has taken on my role and Tony Ferrall is the primary representative from the Department of Treasury and Finance. Our next meeting is this afternoon.

CHAIR - Has that budget control team ever expressed concern about the state of the department's budget and the extent of the budget task or the capacity of the department to manage that task?

Mr JOHANNES - The business control team has expressed concern that it hasn't seen sufficient evidence to give it confidence that all the budget savings strategies will be delivered. That is not to say that it believes that they won't be delivered, it is just saying that we haven't seen the evidence we would need to have the same level of confidence that the department does that those strategies will be delivered. A lot of its work has been such that this is the nature of reporting we would need to see to give us more confidence and part of that, for example, is now meeting regularly with individual major unit managers. So last week we spent some time as a business control team with Jane Holden and this afternoon Gavin and John are coming to talk about the state of progress for savings within their two areas of responsibility.

CHAIR - You said 'the nature of reporting'. You can report whatever you like but operationally, do you have a role there as the budget control team to say you get a report saying - as Jane has already alluded to and the other CEOs as well to a certain extent alluded to - where they are at as they see it. Do you get more directly involved in the operational side of the budget management?

Mr JOHANNES - No, we don't. I might go to John and say, 'You are telling me that you are quite confident that this saving strategy is going to be delivered. Can you give me some evidence to show me that you are making progress with that?' but I would never go to John and say, 'Let me give you direction on how you should achieve that budget saving strategy'. John has been given a savings task, Jane has been given a savings task, statewide mental health have been given a savings task. They have identified as the responsible managers how they will achieve those. They are reporting on progress but they are not being directed in the minutia of how to achieve those.

CHAIR - Has the budget control team expressed concern about the rising employment levels in DHHS over a period of time and the lack of action -

Mr JOHANNES - As in the past?

CHAIR - I am talking about the past here. Remember back in 2008-09 we had the budget management strategy from the former Treasurer. The belt tightening was supposed to happen, the belt loosened quite a bit, put a bit of weight on, the employment levels rose again and the minister then came out and blamed the CEOs effectively in the media. That is how it was reported. Whether that was actually what happened, I am not privy to that of course. Has the budget control team expressed concern about that issue?

Mr JOHANNES - The budget control team has noted that there was growth in FTEs from 2008-09 to the beginning of this financial year including significant growth within the three hospitals but it has not formed a view as to whether or not that was appropriate or not appropriate. I know if I was to ask any of the CEOs to talk about the reasons for the growth of FTEs within their systems, they would be able to speak with authority on why that growth took place and in many cases it was in response to specific Commonwealth funding that came into the State that required specific new deliverables or commitments from the Government to deliver new functionality through hospitals. So the business control team hasn't, nor is it its role, said it was inappropriate to grow by that much but it has noted where there has been growth in FTEs.

CHAIR - Has the budget control team issued any directives to the department or business units regarding financial management, and if so, what?

Mr JOHANNES - As I said, the role of the business control team, by its terms of reference, is to advise the secretary in implementation. The team itself cannot issue directives within the department. It could encourage, as part of providing advice, the secretary to provide a direction to the department. So the business control team could say, 'You are not doing enough to reduce your expenditure on tongue depressors. We really suggest that you should write to the three hospital CEOs' - I am taking a ridiculous example deliberately so I do not get too close to anything - 'so we advise you, Secretary, that you should write to the three area health services and instruct them to take a joined-up approach to the procurement of tongue depressors', but it could not provide that direction itself. It does not have the authority. Its role is to advise the secretary on implementation.

CHAIR - They could be building an extension to the hospital with them - the tongue depressors, that is.

Mr JOHANNES - For insulation. A very interesting look.

CHAIR - It could be occupational therapy for the patients who are waiting in the DEM or waiting on the elective surgery list. Now I am being facetious myself.

Greg, are you able to provide copies of all advice, including where there are briefs, e-mails - you said there were no directives - from the budget control team and provide information about the state of the health budget and what needs to be done to the committee?

Mr JOHANNES - I think we could happily provide you with the minutes of the meetings of the business control team, but I would have to get some advice on the extent to which we

can easily give you correspondence just on the basis that many of the matters considered by the business control team go to the budget subcommittee of Cabinet so we just have to work through whether particular pieces of information go to Cabinet in confidence or not. But in principle, we would be more than happy to give you correspondence around the business control team and its operation. That would just be the one proviso that we would have to work through.

CHAIR - There is the opportunity, of course, to receive some things in camera if that was necessary, but it would be best if most things were provided publicly of course.

Mr JOHANNES - I cannot see any reason that we would not be able to provide, as I said, the minutes as a start point. Other correspondence is limited but certainly we can go and do a trawl for you and provide as much as possible.

Dr GOODWIN - I have a question around alternative savings strategies. There is a fairly significant list of savings strategies, over 200 or something. Were there others that were canvassed in addition to the ones you ended up with?

Mr JOHANNES - I think it is fair to say, Ms Goodwin, we left no stone unturned across the Department of Health and Human Services to try to find appropriate ways to reduce our expenditure to the budget task.

A number of those savings strategies were considered and dismissed internally for any number of reasons from achievability to the likely impact and a number of those were considered and not accepted as part of the process, through a budget subcommittee of Cabinet and Cabinet, of developing a budget.

The short answer to your question is we cast the net across the width and length of the department to consolidate on those as the best savings strategies to adopt given the nature of the task and other constraints.

Dr GOODWIN - It was predominantly an internal approach in terms of identifying them?

Mr JOHANNES - I might go to Alice or Penny to talk about that since they were there at the time.

Ms BURCHILL - We went through an extensive process of trying to identify savings and there was a whole range of things, as Justin said, considered down to the operating level and whether it was appropriate for their areas or not, but it was an extensive list from anything from saving paper clips to actually getting rid of hospitals, pretty extensive.

Dr GOODWIN - In terms of that $8 million that you are not confident of being able to achieve within the time line that has been set, I think you mentioned you might need to look at some alternative strategies. When do you think you might make that assessment?

Mr JOHANNES - We are doing that now. We are getting updates on the state of savings strategies on an almost weekly to fortnightly basis so the advice as of last week was there were $8 million worth of strategies, were to use our parlance at risk, which does not mean they will not be delivered.

It means there are some variables and we need to look at them in detail so we are now looking at them in detail and at the same time we are asking departmental executives to look at alternative savings opportunities in what remains of the financial year. If some or all of them subsequently prove not to be deliverable we hopefully have alternatives that we can put in place to compensate for them.

Dr GOODWIN - You might have a reserve list of strategies.

Ms EGAN - I suppose we could say in plan B strategies, if they were that easy should have been plan A, so the list is not easy. At the same time we are also looking at what are the strategies we need to think about for next year. So 2012-13 will be here before we know it and budget papers need to be prepared so the next piece of work has already commenced around how we keep moving in the same direction.

Just to support Alice, the other things we looked at around the savings strategies were not just around strategies to reduce expenditure but strategies to increase revenues so there are two parts we can look at. We did canvass a whole range of things - even looking at what a whole of government initiative they need to look at. Albeit DHHS has its portion of the savings strategies to find and budget reductions to manage, are there whole of government initiatives that could be looked upon. We took that upon ourselves to provide some ideas.

We looked at possible any assets sales, we do not have a lot but there are one-off opportunities of course. They are not going to provide a recurrent saving for the future. We also looked at election commitments that had been made previously - that is something that the Government may or may not have been interested in and of course they obviously at that point stopped the helicopter service, which was something that they had before. We did look at a whole range of ideas and the probabilities of them being achieved and the risks around those as well going forward.

Dr GOODWIN - John, in the list of savings strategies there is a figure for reducing elective surgery volumes for 2011-12 but not for the following two years. Do you have a figure for that now or are you still working on it?

Mr KIRWAN - We are still working on it. As I said that is a six-month figure so the original proposal we put forward was a nine-month figure. The exact configuration of that is dependent on a range of things and one is obviously the closing of the surgery, the two theatres. It then does flow into our redevelopment of level 4 and 5 so some of which we need to factor into what was our reduction capacity going to be anyway so there is a bit of a balancing act there and it would probably be a bit too coy for me to claim, there was always going to be planned reductions because of capital works programs with, say, introductions. That would be too cheeky by half.

Mr JOHANNES - To be fair to John, too, we haven't allocated the savings task for the next couple of financial years, we are still working through that so John doesn't actually know exactly what component, if any, of the additional savings task he will be asked to deliver.

Mr KIRWAN - And in that same list to which you are referring, the one the minister released in early October and is on the website, there are still some other saving strategies we don't know. For example, the laundry still has to go to the market and there are a whole

range of things like that which, again, if we are more successful than our conservative estimates that reduces the effect in other areas. There is some of that balancing act and the CFO has indicated we really are also focusing on next year because these savings have to be recurrent. They are not one off, they are not a political system and that is the real challenge for us as we move to a sustainable model, whatever that is.

CHAIR - Isn't that a concern then that the intention is to keep the beds closed. Unless we really focus on, and I think you said John yourself, keeping people out of hospital in the first place the demand is not going to go away for those beds. If you are operating at 90-plus per cent in your surgical beds already, isn't that going to make the task very difficult?

Mr KIRWAN - The surgical bed capacity is an issue because it is a throughput exercise and the two surgical wards are very high throughput relative to our medical wards, but in the medical wards they are a longer stay. Some of those are not about our making it is the absence of other providers out there be they rehabilitation, and the recent issues with rehabilitation and others. The difficulty with the model in Tasmania is that our hospitals are, in my view and I am not speaking on behalf of the others, but my observation having worked in other jurisdictions is there are not alternative providers. You don't have a Mersey or a sub-acute hospital sitting in Hobart next to a big teaching hospital that can absorb the elective workload. We have to do the lot and we therefore become provider of last resorts for all sorts of areas. At the moment we have a whole range of issues on family violence orders and others where they are sitting in our wards where they probably shouldn't be. We are employing security officers because there aren't services in the community.

CHAIR - Because you can't send them home, do you mean?

Mr KIRWAN - Because there is nowhere for them to go. When I first started that was an issue in aged care but that seems to be significantly improved, but it is an issue that is traditional and in part because the LGH is so large relative to our regional community it has always had that role.

Dr GOODWIN - I just have one other question. I think you mentioned you were writing to category 2 and 3 patients about what the impact would be on them. What do you anticipate that the impact would be?

Mr KIRWAN - We will contact them once we know and, to some extent, this comes back to our argument about openness and transparency and an argument for category 4, which we keep raising and losing. I can appreciate that but we would prefer to be absolutely upfront with everyone and we are doing that already with our responses to complaints and saying, 'This is the amount of people on the existing waiting list, this is the average length of time, this is when you can expect'. We don't go out and say it will be within one month, three months or 12 months, we actually say, 'This is what is expected' because we just don't have the capacity at the moment. In 18 months' time that will be a different situation and we hope things will turn by then and I would go one step further, I would prefer a model like you see in some of the other areas where we actually publish our waiting lists so the GPs know, the patients know and they know what the average length of time is likely to be. I just think that is a far more open and transparent way. From my experience in accepting - and I agree with Alice Burchill's comment - if

someone's position deteriorates they can always get reassessed and we always encourage that and say that in all of our responses, so for a deteriorating patient they will be categorised, they will be seen but for others I think it is better that we are honest and fair about what their average length of time is likely to be and then they can plan their life around that.

In my experience in other jurisdictions a lot of people, when you actually say it is likely to be three years, we are not going to con you it is going to be a year, they actually wear that because they know what it is likely to be. What they don't like is when we say it is one and we mean three.

CHAIR - Yes, three years come and it doesn't happen.

Mr KIRWAN - Yes, or that.

Dr GOODWIN - Do you have a figure for the two and three years?

Mr KIRWAN - We are probably talking between 1 000 and 1 500 procedures but again with some of that modelling, as Mr Johannes said, until we actually work through some of the out years it is our intention not to do this permanently.

Dr GOODWIN - In terms of their wait time do you have a figure?

Mr KIRWAN - No, again as Ms Burchill said, each one actually differs - the orthopaedics to the plastics to urology, there is a differential in those areas.

Ms HOLDEN - Could I just add some comments around a couple of things there? One is around the category 4 issue. I think the other side of that debate is not that there are patients who are waiting more than a year but rather saying those patients should not be put on the waiting list, they should be sent back to their GP with an open and transparent letter saying we cannot do this within a year. We refer them if you think we need to. It is just a different focus but the idea of being open and transparent with out patients applies right across the State. None of us are comfortable about saying things to patients that we just cannot deliver. It is inappropriate and in that regard we are looking at exactly what we are saying so letters say this is where we think you rate but we do not believe we will be able to provide this within this period of time and those letters are being currently review as a result of the changes we are making now.

The other important point that I wanted to raise was that I think probably for all the idea of reductions and access to services being long-term is not our thinking. With more time we actually are able to look at other systems reforms, procurement and the like, that actually pull out the savings but take more than a year to put in place. So we want to see sustainable cost-efficient services across a range of services not necessarily impacting on patient access.

CHAIR - Thanks, Jane.

Mr HARRISS - I was going to focus on the matters you are investigating with regard the mix of employment and flowing from that the mix of cost savings initiatives. My observations over the years have been that there has been historical and constant

commentary by clinicians that we are bureaucracy heavy. So is it possible in any way to identify the percentage mix of savings between the bureaucracy and the delivery of clinical services?

Mr JOHANNES - This is probably based on an assumption that everything happens within an area of the health service is clinical and everything that happens within a department is bureaucratic but let us just go with that broad assumption and I think Penny can give you those figures.

Ms EGAN - I do have them here actually. Five per cent of the budget sits within the department and that is about $88 million worth and the remainder sits within Health and Human Services and then the grants area. So we have five per cent of the budget and we had to find 10 per cent of savings compared to the 7 per cent average of the rest of the unit. I hope that helps you, Mr Harriss.

Mr HARRISS - Yes, in terms of percentage it does so what dialogue has been undertaken with clinicians - if I can use that broad term - to in effect, I suppose, somehow garner their support or hose down some criticisms? There have been comments of recent times, I do not know whether it was the AMA or individual GPs, that the substantial cuts to elective surgery will equal more deaths. So what sort of dialogue has there been with the clinical side?

Ms EGAN - Probably something but certainly from the department's point of view we are really looking at our costs. We are going to pull out about $8 million from the department this year. There are about 150 positions that we have identified that will also come out of the department and so we will continue looking at other ways to reduce that.

The dialogue with the clinicians is probably something I cannot respond to as easily as the three chief executive officers.

Ms BURCHILL - Can I just comment and then the CEOs can pick it up? I spoke with the Tasmanian Clinical Council very early on in this process, early July, end of June period, to discuss with them the extent of the saving that we had to make and consideration of the areas that we were looking at and asked them for their advice and guidance on that and they were very open with their advice. I also met with the AMA and spoke at one of their branch meetings and had a similar discussion with the doctors across primary and acute care in Hobart. I do not think there was anybody from the north or north-west at that meeting and, again, shared with them some of the concerns that we have and some of the concerns they have. They were looking to give advice to us and we certainly listened to that advice. But they did not raise the issue of patients that die in either of those two meetings. But the chief executives probably had much more indepth and intimate discussions with individual clinicians.

Mr JOHANNES - I will add one thing again before we go to the chief executives. I make the observation, Mr Harriss, that in my very short time in this role it has become very clear to me that we need to find a more effective way to engage the most senior and respected clinicians within Tasmania to help us make some of the more difficult choices around service delivery. I think it will be much easier to make those decisions in the eyes of the community and make bureaucratically and politically difficult decisions if you have doctors and nurses, who are respected in their community, with you saying this

is hard but it makes sense from the perspective of delivering services in the interests of patients and clients. The three CEOs will talk about what we have done but I will take on the chin, I think, that we need to do better moving forward and it is in our interests to do so because it will enable us to make more difficult decisions which are more defensible from a clinical perspective way. I do not know if any of the CEOs want to comment.

Ms HOLDEN - I think that is right. We have to get the strong, clinical voice and anyone who talks about clinical leaders and forum, and in my previous experience on the north-west there is no doubt that the best decisions we make are ones where we have strong, clinical input with full disclosure of management challenges, working through the risks and the opportunities and finding agreement and those are the sustainable, strong decisions we make. So I am very keen to support that. Of interest, I note that with the changes to the Peacock Unit that I announced that one of the union' s comment was, I was trying to put a clinical spin on a decision. I think people would be very concerned if there was not a clinical spin on the decisions that we make. There is always a clinical input, a need to understand that impact and of course that is our primary basis on which we look at cost benefits as clinical, the impact clinically on these decisions.

Internally, in the south we have a medical executive, we have a nursing executive, we have an allied health executive and they all provide advice through to the executive of the organisation as a whole. We also have the medical advisory committee, which is established to advise the CEO on a broad range of issues. Without fear or favour, I get fed back the senior clinical staff's view on a wide range of issues including budget savings and that committee is open to staff specialists, in fact, all medical staff are there.

There is a forum and I think that will only strengthen the Tasmanian health service and I see that as a positive.

CHAIR - Thanks Jane.

Mr AUSTIN - Regarding the North West Area Health Service, we developed our saving strategies as a team including the Executive Director of Nursing, Director of Allied Health, Director of Medical Services, and once those strategies were accepted, I talked individually with each of my clinicians, met with them and discussed the reasons behind the strategies. I have asked them to highlight any concerns with me on a clinical or on the sort of basis that you are talking about, is there any unjust bias in any direction, and we have had robust and good dialogue. I haven't had that feedback at the north-west that there's too many administrative people. In fact, the first cuts that we did were to the administration area.

Ms HOLDEN - Sorry, I'll just add that I think it's a universal truth that there are too many admin and bureau people, and certainly it's been a reporting requirement from me through to the organisation what numbers we are pulling out. There is an interest in that area and it's one that I report on back through to the executive.

Mr AUSTIN - One of the challenges we do have in all the area health services is the ongoing requirements around quality and at each accreditation process we enter into we find we have to do more, more and more to be reaccredited and we have criticisms that our quality units are growing but unless we resource our quality units, we won't be

accredited. There is an enormous amount of work involved with each accreditation process.

CHAIR - That's every three years, Gavin, and an 18-month review?

Mr AUSTIN - Yes, it's like a rolling cycle. It seems to be primary health and then you have the north-west region - it's a rolling cycle.

Mr KIRWAN - We have a slightly different story. We didn't consult with our senior staff until the embargo to consult was lifted in early October so our savings strategies were developed very much between the director of finance and myself, based on our assessment. That was a decision we tried to get changed. Since October we have been consulting.

I suspect some of the reports that Mr Harriss has referred to respond to some of the comments that some of the LGH doctors have made. I can only say that their comments are supported by their peers. I can't comment, I'm not a clinician, and I won't comment in respect to some of those comments but, as I said earlier, some of the implications do give us some concern from a quality and safety perspective - not for the patients within the hospitals as I think we have enough strategies and systems to deal with those, but in respect to the general health of the population, we're there to serve.

Mr HARRISS - Are there consequentially then any threats to accreditation as a teaching facility?

CHAIR - It's a different accreditation process.

Mr HARRISS - Yes.

Mr KIRWAN - Yes, clearly for us. We have over 20 areas accredited as a teaching hospital facility and if in a number of those they don't do the number of procedures and they can't provide the assistance and training, then we could well lose positions. That is registrar positions or we could lose registration in total.

CHAIR - Which areas particularly?

Mr KIRWAN - We're still going through doing assessment. Until we know the impact on all of our elective surgery and other areas - and I repeat that it's other areas as well - we have a list of all of our areas that are accredited and some of those accreditations are at odds or at different times. Some of those that have just been completed we're probably reasonably okay on but the ones that will be coming up, if we are adversely impacting the level of activity in those areas, then the accrediting authority may take an adverse view. We have had those problems before, as the other hospitals have, and we identified that as one of our risks because some of these are not immediate risks. These are risks that go to if we lose doctors, if we lose activity and we lose critical mass. It is a formula-driven model, it says what you need to be doing in respect to the teaching and the providing of the teaching.

CHAIR - Is it possible for the three area health services to provide a list of their accredited teaching areas?

Mr JOHANNES - Sure, we can provide that.

Mr HARRISS - Will it be possible in that process, though, to identify the areas of teaching accreditation that are at the greatest risk, bearing in mind what you've just said, John?

Mr KIRWAN - We probably won't know for a couple of weeks at least, but probably not until early next year until we finalise all of our reductions and activities across all of the areas.

CHAIR - If you provide us with a list of what you're accredited for now, we can ask that question perhaps later on.

Mr KIRWAN - We are looking at it.

Mr JOHANNES - Chair, that is probably a better question to then ask at Estimates because when we get to Estimates we will have the forward budget as well and some sense of how it has been allocated within the system. So John will be able to comment both from the perspective of what we reduced delivering in the last six months and what in light of the savings he now has to deliver and what the service agreement that he has with the commissioning function has to deliver in future. I am happy to give you that list of all the areas in which each hospital is currently accredited and then maybe from a time frame perspective that is the logical time to follow up with a question.

Mr HARRISS - Maybe, Chair, Jane would like to respond to that same area.

Ms HOLDEN - It is exactly the same answer really. It is the formula we follow for meeting value for accreditation. I can tell you that we are also looking at every single service. A criterion that we included when considering the reductions to any of our elective throughput was the acuity of the patient, the length of time they have waited, the impact on accreditation status and whether there were statewide tertiary services involved, and availability elsewhere in the State. That is an important criterion for us to consider. We can respond to that but we are looking at those. At this stage we do not believe our cuts are threatening our accreditation status in that regard but it is a thing we watch all the time.

Mr HARRISS - I take that then Jane, as a broad possible impact on accreditation. But are there streams of the teaching accreditation process, the sort of things that John mentioned, which would be under threat rather than the overarching, the overall accreditation as a teaching facility?

Ms HOLDEN - Each service is accredited. So where in effect general surgery is accredited, obstetrics and gynaecology are accredited, and you would be aware that accreditation was removed for a period until certain aspects of the department were changed to meet the college's requirements for accreditation in O&G. All are accredited separately as programs for training rather than the overall organisation being accredited as a general hospital.

Mr HARRISS - Thanks, and then the same from Gavin.

Mr AUSTIN - It is the same answer again.

CHAIR - I think it is important to state that there are two types of accreditation. There is the accreditation as a teaching hospital and there is the accreditation under ACHU.

Ms HOLDEN - Yes. We were talking about accreditation for teaching.

CHAIR - As opposed to accreditation of a facility.

Mr KIRWAN - And there is undergraduate and postgraduate, just to make it clear.

Mr HALL I think you started talking about ratios between admin versus sharp end, if you like, and I think Jane Holden mentioned the universal truth that there are maybe too many admin people. Is there any national benchmarking as to how we perform here in Tasmania with regard to health outcomes and delivery of services per head of population and some of those ratios of bureaucracy versus admin et cetera? I am quite aware that we are a pretty decentralised jurisdiction here in Tasmania, so I might address that to you Greg, if you can answer that.

Mr JOHANNES - Mr Hall, there is certainly a great deal of reporting on health outcomes and health expenditure by head of population relative to other jurisdictions, so there is lots of that. I do not know. I will defer to my colleagues on the left and right. I do not know if we actually measure administration within a health service as a ratio and compare it to other jurisdictions. I am not aware of it.

Mr HALL - I just thought perhaps if the Commonwealth are offering funding, and we have this $300 million coming up, that they would look at the various jurisdictions and ask whether or not they deserve it.

Mr JOHANNES - We will look into that, Mr Hall. I would make two comments about that. The first is, the former Prime Minister somewhat famously said that, as a result of health reform, there would not be another additional health bureaucrat anywhere in the system - as a broad Commonwealth perspective. But equally, I think the Commonwealth's philosophy would be, 'We are going to pay up to half of the efficient price for delivering a service within a hospital. It is up to you within your hospital to decide what mix of people you want to employ and you within your health system to decide what mix of people you want to employ.' In a sense, I do not think the Commonwealth would be so prescriptive as to say, 'We will award or withhold funding based on ratios of administrators to front-line service deliverers.' What they would say is, 'You need to deliver at the efficient price because that is what we paying at.' I suspect that they would implicitly believe that we have to reduce the amount of administration per service delivered in order to meet the efficient price. But I would welcome one of my colleagues correcting me.

Mr KIRWAN - Mr Hall, I was involved with fairly major reviews in Western Australia, including significant downsizing and also then the creation of a metropolitan health service board that amalgamated all the metropolitan boards, including 100-year-old boards, into one. We visited and looked at the other States. We looked at an interesting review that came out of Tasmania at one stage too, which probably goes back 10 or 15

years which was quite a well-written review and really explained some of the functions here.

CHAIR - The Richardson review?

Mr KIRWAN - No, before Richardson. It was really interesting in that there was not a direct comparison. It really was difficult and you then in health tend to try to group the size of the States. Western Australia, South Australia and Queensland, of course, that has now become problematic for obvious reasons. Tasmania, Northern Territory and ACT, not a good comparison - a city State, a very diverse State and here. It really was very hard for me to try to get benchmarks because, in fact, my minister who was then a Liberal minister, was asking exactly those questions and it was really hard for us to work out because Western Australia want a two-model system - very similar to this - that provides the country services centrally in a centralised model, which is now even further centralised and quite large in Western Australia. The metropolitan area is quite diverse because they have critical mass in their hospitals and others to do. So it was difficult.

What I tend to use as a health service manager now is the case mix data, the current data, round 14 is still being worked through. The round 13 data at least gives you a national average price not a nationally efficient price but that has big variances and differences because, again, Victoria is significantly cheaper than we are, too much to justify the differences when you look at their system. So there really is a data integrity issue of what are we capturing, what are we counting and what are we are reporting. Then, as the CFO would probably say as well, some of these are still cash versus accrual. It really is a hard exercise. But I use the case mix data, the DIG-based data as a comparison, which is really only good for inpatients, so then you have another problem because that is where we are going to. My view is, if that is the game plan for the next couple of years, you might as well start playing the game according to what the rules and the laws are now, rather than playing in the past.

CHAIR - This starts on 1 July, doesn't it?

Mr KIRWAN - Yes.

Mr JOHANNES - The transition starts.

CHAIR - Yes.

Mr JOHANNES - The one other complication I would add is that, unlike some other jurisdictions, we do not run just a Health department, we run a Health and Human Services department. So a significant amount of administration is involved in supporting the human services component and the children's component. One of the challenges we would have in defining a ratio is this: if an individual who works in NHO and supports both the hospital side of the business and human services, how do we attribute their cost in terms of calculating a ratio? But we would be happy to go and have a look at whether, under a review of government services, reporting or other, there is a benchmark. We are happy to have a look at that for you.

Ms EGAN - We should say, though, that inherently we are trying to reduce our costs in the department, as we should and, as John said, under an efficient price. There are certain

services that they may need to buy from the department. If we cannot provide a quality service at a good price then you might not want to buy it from us. Therefore, we are left with a department of some services that are not saleable. We have an incentive, very much so, to reduce our costs and make department more efficient, not just for Health but also for Human Services, for Children and for the department itself.

Mr WILKINSON - In relation to purchase of goods and services, is there any ability at all to have one bulk supply? Let us say that the Commonwealth purchases and then on-sells to each State and because of the bulk that the Commonwealth would purchase, hopefully the States and Territories would be able to purchase at a lesser rate than what they would be doing now?

Ms EGAN - The answer is probably yes, but in this State, whatever we do, we have to abide by Treasurer's instructions.

Mr WILKINSON - Treasurer's instructions can always be changed, can't they?

Ms EGAN - That would be good. Perhaps that might be useful at times.

Mr HARRISS - They are driving this agenda.

Ms EGAN - So yes, we can go to the mainland and we have been given advice from Treasury that we cannot hook into a contract that is already in place but yes, we can be part of a tender process out of Victoria or New South Wales that might be going out for particular goods or services. Once again, the restriction is that we still have to abide by our own TIs at this stage.

Mr WILKINSON - How has that got to change, the TIs, to enable you to do that - to hook in with, as you say, the bigger purchaser to become an even bigger purchaser to get the better price?

Ms EGAN - The TI is all around value for money and they have not been value for money in transparency so as long as we could still do that and hook into a Commonwealth contract and still meet the TI, that would beat the problem. It is where we go outside of the TIs, that will always be an issue.

We already have a whole range of State contracts or whole-of-agency contracts - we have about 23 in place. There are about three ready to be finalised this year, another three in train, so we have quite a few in place already. We would like to do more and I am sure the area health services have a number of areas that they would like to progress as well. It is quite a big task.

The opportunities to do things differently are there, whether we can link with the private sector on some, but from Treasury's perspective they absolutely say to us whatever we do we must abide by those TIs. The THOs, when they form from 1 July next year, will also have to abide by those Treasurer's instructions.

Mr WILKINSON - If you could still carry out the same intentions of the Treasurer's instructions, change those Treasurer's instructions to enable you to do that, that to me would be an obvious solution, would it not?

Mr JOHANNES - At the moment, Mr Wilkinson, we are really focusing on trying to find opportunities to aggregate demand within the State so that we can drive a better price based on aggregating volume and then the next step is to look at what opportunities there might be to work with other States to even further aggregate.

We will also be guided fairly strongly in that by the fact that we are going to have independent THOs or a THO with independent boards. We will have to work with them on this issue too because it will be very much in the THO's interest and in the boards' interests to reduce the cost of things such as consumer goods so that they can get closer to or even under the efficient price as part of health reform.

CHAIR - We want to get some idea what we are talking about here. How much do you believe could be saved if you could ignore the Treasurer's instructions - not that you can, but if that was changed - such that you could more easily go to tender or seek funding with another agency -

Mr JOHANNES - Via somebody else's contract.

CHAIR - Yes, via somebody else's contract or however it could be achieved, what sort of figures are we talking about? How much could we potentially save?

Ms EGAN - That is a really hard figure to determine but, I suppose, how long is a piece of string if the TIs were not there? It is also hard to understand, or sometimes to know whether you are actually always getting a better price.

For example, we have just finished a tender on gloves and we know that we are getting a better price than Victoria so you would have thought automatically we should have gone and joined the Victoria tender but we have actually achieved a better outcome. You do not know that, of course, when you are in the process of doing tenders so I do not know what that figure would be. We could probably look into those.

CHAIR - Would you say it would be significant?

Ms EGAN - It would have to be significant I would have thought across the board if you did not have TIs but there is also the importance of whether you have each area doing their own thing or whether you still try to do it collectively within the State. There are a few decisions I think around at the moment.

Mr KIRWAN - Can I just exercise some caution - and I appreciate these are not accrual figures so one has to be careful - 75 per cent of our operating cost is workforce. The next biggest is pharmaceuticals, which is around 6 or 7 per cent. Then you start talking about the others so when we are talking about supply and others, yes, there are savings to be made and I agree with everything that the CFO said, but they are not going to make the 100-plus units of savings.

CHAIR - No, I am not suggesting that they would.

Mr KIRWAN - I just want -

CHAIR - In the pharmaceutical area too though, John, is there capacity because pharmaceuticals are quite -

Mr KIRWAN - We have recently had that question asked, in fact by some of Penny's people and we have had a look at that through the pharmacy. We run a statewide pharmacy service now, as you are aware, and they have come back and said, 'No, we are getting a price', and they have justified how that was the case. We are confident with that.

CHAIR - You do not think there would be a lot of savings in pharmaceuticals, is that what you are saying?

Mr KIRWAN - No. Where there is the potential savings is our high-cost drugs and pharmaceuticals for high-cost patients, which is what we call exceptional episodes - how we deal with those patients, is that appropriate care, are these appropriate procedures. That gets into clinical decision-making realms and that becomes an interesting discussion when talking about blood products, pharmaceuticals and other interventions.

Mr WILKINSON - John, you said earlier that you were mixed up with a cost cutting exercise, for want another phrase, in Western Australia. Was that successful?

Mr KIRWAN - No. In Western Australia when I left there was a structural $60 million deficit and it didn't matter what we did that was what was there every year. Every year Treasury said, 'If you go over that you'll get all sorts of trouble' and in March every year they bailed us out.

CHAIR - The same happens here.

Mr KIRWAN - And I have to say the result of that was when I was in the department you would talk tough with the hospitals and then we would get to March and the money would come, they would take the money out and you would start the next year with that. That happened for three years in a row and you end up with the inevitable result.

Mr WILKINSON - What about a situation in relation to private patients in the public system? Has that been asked as yet?

CHAIR - No, we haven't asked about that. That was one of the revenue strategies I was going to ask and I am sure you have read strategies for increasing revenue.

Mr WILKINSON - Can I ask about the situation in relation to that? There is a question I put on the Notice Paper a couple of weeks ago in relation to it.

Mr JOHANNES - I will talk broadly about it. Obviously we love all those people who have private health care to avail themselves of private health care when they have an episode of care. When they roll into a hospital my understanding is we will ask them whether they have private cover or not, but it is really up to them whether they wish to exercise their right under their private cover to reclaim privately or to be treated on the public credits. We can't treat them inequitably based on their having private cover and then choosing not to avail themselves of that. You would like to think that in the current environment people might reduce the burden on the public system if they have private

cover by using that private cover so that is the broad comment I would make. But John, Gavin and Jane can speak far more articulately to the issue than I can.

Mr WILKINSON - I would like to look at the numbers, the percentages, the costing and if the private patients had to avail themselves of the private cover what would be the savings because, to me, that is an area that should be investigated and investigated strongly.

CHAIR - For services that could be provided in a private setting but some things can't be.

Mr WILKINSON - Yes, I understand that.

Mr KIRWAN - I am fairly outspoken on this one so I might go first, if Jane doesn't mind. The current agreement does not allow us. It is an election of choice, as Greg has indicated. If people choose not to elect they will be treated as a public patient even if they are privately insured. What we try to do now is not define them as private or public patients, but as non-public patients because the whole suite needs to pick up MAIB, DVA, sporting, self-paying as some do, and so we pick up people from overseas. There is a whole range of people in those suite of areas where they should be paying and we should be making sure that if we can access the funds we access everything possible. As I indicated earlier, that is where we are focused on first because it is not necessarily easy but the more we increase in revenue the less we have to cut in costs from staff and services. It is a no-brainer.

There are some structural impediments including the COAG agreement where we have signed up to areas. I know Professor Einoder has argued, and I would agree with him, that we should consider means-testing because the group that also cause us grief are those who can afford or could afford private insurance but who do not and who are then using the system because of the perception that it is free. This whole discussion is testimony to the fact that it is not a free service, someone pays or someone is going to get less. It is as simple as that.

There is a whole range of areas and we are maximising that but I do need to say, certainly in Launceston - and I won't comment on the other regions as I don't know their areas well enough - we have a good relationship with the Little Company of Mary at Calvary. We have a very close relationship, we need the private sector, and it is one of those models where if they start getting into trouble because we chase private work to their detriment that will not help anyone. We have a good balance between private and public. As I said, all but one surgeon in Launceston works in both and that is a very good move to have for all sorts of reasons.

We will chase the work but only for those who come to us because there is no other choice. We would still prefer them to go to the private sector. We have more than enough patients, more than enough work so we are not exactly afraid of that sharing, I can tell you, but for those who have to come to us for high acuity, intensive care, the procedures that are covered we can deal with so they have to come to us. But we do need to become more aggressive, which we are, and we probably need to test the boundaries a bit which the minister and the Premier have probably said that we should be looking at.

Mr WILKINSON - Are you able to say the percentage of people at any one time in your hospital.

Mr KIRWAN - We can say how many have declared and used, because we do not know the other information. If they choose not to, we do not know. All you can do is go to the background information that says how many in the community have private insurance, because you would really have to then take out the frequent users and others. We do quite well with DVA but of course DVA in itself is going in one direction, without upsetting the member for Western Tiers.

CHAIR - His days are numbered he said.

Mr HALL - My days are numbered.

Mr KIRWAN - That is not quite what I said.

Mr WILKINSON - If you are talking about his age I can understand it.

Mr KIRWAN - We are having active discussions with the department on this because some of it probably requires legislative change and some of it would have an impact on the private insurers and others. Again, we need to be careful. It is a complex system and we need to get the balance right. That is a challenge.

Mr WILKINSON - Are you able to give us the numbers though.

Mr KIRWAN - The numbers that use it and pay, yes, but we don't know is how many don't declare.

Mr WILKINSON - I understand that. You have not got those numbers now.

Mr KIRWAN - I think we just answered a question on notice though.

Mr WILKINSON - You have, have you?

CHAIR - You will get it today.

Mr AUSTIN - Similarly we do everything we can to maximise private insurance but at the end of the day it is a choice for the individual to not declare.

Ms HOLDEN - In the south as well we are chasing any compensable patient, who includes the MAIB or the DVA or self-insured or overseas, as John said. So there is a broad view of chasing where you really can. In our records we can tell every day who is a compensable patient who is holding a bed , but if they decline to use their insurance we do not record that. They just come in as a public patient. So we do not record the ones who are privately insured that decline our ability to treat them as a private patient and therefore charge their insurer. From our point of view, I agree a really healthy health service is one that has a healthy public and a healthy private sector. In the Royal almost all DMOs work both in the public and the private sector and it is important to ask that we keep those going because I think the reality is that Tasmania actually has a relatively limited access to private options and that means that it does put more pressure on the

public health service. Where there is an opportunity to get revenue from compensable patients we are tracking it down quite aggressively. But we are not, and I think quite appropriately, running out to compete for the private market because we need to address the patients who are also on our list that are not compensable.

Mr WILKINSON - Jane, it is a double-edged sword though isn't it, because not only do you get recompensed for the people that you treat, if they are able to obtain private insurance or if they have it, but also you allow there to be more beds to assist with the waiting list if these people that have private cover are treated in private hospitals or alternatively if need be in the public hospitals. It seems to me you are not only going to get some money but you are also going to have more beds available and therefore fewer on your waiting lists.

Ms HOLDEN - Well, yes, I am not quite sure I follow that. The reality is if they are compensable and they declare that to us we get more money for having them in our beds. If they are insured and they go privately, clearly they are not in our beds although there is a complex arrangement in the south between Calvary and Hobart Private where actually the Royal does contribute to some of those services, so it is a little more complex.

For those patients who require services only available at the Royal, and they are covered by insurance, it would be great if they declared that and then we could claim on their insurance. We can't force them to do that but it would be great if they did. We have to not discourage people from going to a private hospital if they have private insurance because when they do that we have a bed ready to take on a public patient. That's why we need a strongly collaborative market not a strongly competitive one.

CHAIR - While we are talking about trying to increase revenues, Penny, I think you mentioned you have strategies for trying to increase revenues. What do they involve?

Ms EGAN - Some of them we have already publicly announced, which I think are on the list. Certainly compensable patients is one around the MAIB, for example, to make sure they pay the full facility fee for having people in the beds. That has been looked at for some time. Some of the others are more with the CEOs themselves around ensuring that we recover all the costs associated with services that we deliver or charges that we are allowed to charge under the legislation, ensuring that we fully charge out what we can. There is a whole range of work at the moment looking at pieces of legislation and ensuring that all the notices that are out there for a whole range of services are correct. We are allowed to charge for things like full-cost contribution. There are number of things we're looking at.

CHAIR - What sort of dollar figure are we looking at, potentially, for additional revenue if all these things were chased up?

Ms EGAN - I could work that out for you from what we've put in place. There are a number of strategies that the areas are working on that wouldn't be part of the savings strategy; it is just part of what they are working on day to day.

Mr HARRISS - Penny, you mentioned the MAIB facility fee - and I had that tagged for a question - you are looking at $2.5 million. What is the detail around that?

Ms EGAN - That's just looking at the number of patients that we currently have under MAIB who frequent the hospital, unfortunately. I think it is a bed fee that we charge. We still always charge the costs of pharmacy, surgery et cetera, but there is a bed fee charge, which has been set in stone with a CPI adjustment for the past several years. We are now looking at increasing that to what is the real cost for that.

CHAIR - It hasn't kept pace with the cost of the bed day?

Ms EGAN - No. There is a differential there, so we are in discussions with MAIB about whether we can increase that fee. That should assist the three health organisations with their efficient price. For example, they are getting full recovery for the real cost of that bed.

CHAIR - That's not just the initial admission obviously? They come back for removal of screws from their fracture and things like that.

Ms EGAN - That's right.

CHAIR - I turn to he areas of payroll and HR, that sit outside of clinical services. Have there been cuts in these areas? What measures have been taken to increase the efficiencies, particularly with payroll, that projected pay that seems to cost a lot of money? Can you give us some idea about those costs and how that could be changed and savings made?

Ms EGAN - We pay approximately 12 500 people fortnightly. There are about 8 000 manual time sheets that are processed every fortnight. Until we can get manual time sheets out of the system the ability to reduce numbers significantly, either in payroll or within the areas, won't happen. We have a project on that that will automate rostering, which will filter straight into the payroll system. When that happens there should be a minimum of 20-25 people somewhere in the system that we can take out. Our objective is to have that in place by June next year, so we should start to see those efficiencies flow.

CHAIR - So 25 positions will go out of the system?

Ms EGAN - Within the system - that's our estimate at that stage. There will always be some manual time sheets in the system because of where people work and how, but if we can get away from the predictive pay, which is currently under discussions with the nurses, and we will be looking at the HASA award for the same thing. I think that should take away a percentage of those time sheets. As I say, we process 8 000 a fortnight but probably 3 000 of those are changes from the prior period because rosters have changed therefore you have to change.

Mr JOHANNES - And therefore predict a week ahead.

Ms EGAN - If we can take away that predictive period and pay people retrospectively for the hours that they work, I think there is a substantial amount of change. That gives us some opportunity, I believe.

CHAIR - Twenty-five positions and certainly greater efficiencies, what sort of dollar figures are we talking about in savings there?

Ms EGAN - They are probably $60 000 or $70 000 positions in those areas. There is a whole range of things that we need to work around that.

Mr WILKINSON - Can I ask you in relation to overtime. I have heard of examples where a person has worked in a ward as a nurse and he believed that he was going to finish at a certain time, because he was rostered on for that time, and had to work a bit of overtime because of a situation, and this was just a case study. I am wondering how often, if at all, it goes on. He said, 'I have got to be back at work at 8 a.m.' and they said, 'No, you are on the afternoon shift.' He said, 'No, I am on the morning shift.' 'No, you are on the afternoon shift.' Come two-and-a-half hours into the next shift that he worked overtime on they said, 'You are right, you are working in the morning, and not the afternoon shift. So you have eight hours, going back in the morning shift, not the eight hours and worked the morning shift. He finished up getting paid one, for the shift that he was on; two, for the overtime, the two and a half hours overtime, but because of that mistake in relation to the information obviously not getting through that he was working the morning shift, finished up getting double time again for the following morning. If that occurs at a regular interval that is money that did not have to be paid. Could that be because of lack of middle management perhaps, that normally put those fires out? Does that happen, does it happen regularly, and could it happen in the future?

Ms BURCHILL - I was just going to come in to say that we are monitoring overtime and the overtime rate has actually stayed quite static over the past six months. We were expecting as the number of staffing was reduced then it would push up agency extras and overtime but it hasn't. That has stayed firmly static, but in terms of what happens on the ground anecdotally you could hear stories of that but actually proving it and investigating it is very, very difficult. I would imagine that the chief executives and the middle managers have got quite strong controls in place where overtime has to be signed off by the middle managers and countersigned before it gets to payroll.

Mr WILKINSON - But this was a situation, it would seem, where there was a belief that it would not be overtime but because of the mistake when the person suggested that they were working in the morning, the people he had to report to stated, no, that was not the case. They then found out that it was the case. He then got paid the double time for the following morning.

Ms BURCHILL - And investigating that through is very difficult.

Ms AUSTIN - That would be an unusual circumstance. The rosters are done four weeks in advance so normally speaking that would not occur. I receive daily reports of bed activity, double shifts, so if there is any upward trends, anything happening, I could respond daily.

CHAIR - So all overtime has to be approved still, doesn't it?

Mr AUSTIN - Yes.

Ms BURCHILL - We do critical incident monitoring on any nurses' actions prior to working double shifts. So double shifts being eight hours and then another eights hours. We monitor that on a daily basis.

Mr KIRWAN - And we now all have a double shift report, which we actually table with the unions, indicating the number and reason. So if it is something like that I can assure you the unions will be sorting it out pretty quickly and rightly so.

Ms HOLDEN - Similarly on the staff it is a well documented protocol that needs to be followed and that protocol was reported and work the forecast rosters costing applied to those. I agree that sounds like one that we would be picking up.

CHAIR - We are pretty much out of time. I know I have asked for a few bits of information and follow-up and the secretary has a list. You said that the submission would be coming on Friday.

Mr JOHANNES - I think the due date is 25 November. We will try to pick up as much of this as we can and talk to the secretary. We will try to pick up as much of this in the context of the Friday submission as we can, even if it's just an attachment.

CHAIR - We will wait until we get that and if there are things we still need we will contact you. With regard to the information from the budget control team, could you let us know about what is available including reports, briefing notes and that sort of thing. Anything that is relevant to the advice.

Mr HALL - Obviously we have, something I'm not advocating, a lot of smaller regional and country hospitals and healthcare centres. Is there any agenda, at this stage, to close or rationalise any of those to achieve cost savings?

Mr JOHANNES - There is no agenda at this stage; there is no list. As we go forward opportunities will arise to deliver health care differently in regional areas as a result of things such as the introduction of the national broadband network. That might change the nature of service delivery but any change to the model of care in those more regional centres will be done carefully in consultation with communities. There is no list, no plan currently anywhere within the system.

CHAIR - Thank you very much for your time, everyone. We appreciate the time you've given today and the information you have provided.

THE WITNESSES WITHDREW.