Tuesday 9 June 2015 - Estimates Committee A (Ferguson)

LEGISLATIVE COUNCIL

ESTIMATES COMMITTEE A

Tuesday 9 June 2015

MEMBERS

Mr Armstrong
Mr Farrell
Ms Forrest
Mr Gaffney
Mr Hall (Chair)
Mrs Hiscutt
Mr Mulder

IN ATTENDANCE

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

Ministerial Staff

Peter Poggioli, Chief of Staff

Department of Health and Human Services

Michael Pervan, Acting Secretary
David Nicholson, Deputy Secretary, Strategic Control, Workforce and Regulation
Michael Reynolds, Chief Financial Officer
Eleanor Paterson, Deputy Chief Financial Officer
Ross Smith, General Manager, Shared Services
Dominic Morgan, Chief Executive Officer, Ambulance Tasmania
Mark Veitch, Assistant Chief Health Officer
John Ramsey, Chairperson Governing Councils
Craig Watson, Acting Chief Executive Officer, Tasmanian Health Officer
Sonia Purse, Acting Chief Executive Officer, Tasmanian Health Officer
Anne Brand, Acting Chief Executive Officer, Tasmanian Health Officer
Ben Moloney, Director, Royal Hobart Hospital Redevelopment
Matthew Healey, Director, One Health Reform
Lisa Howes, Acting Manager, Executive, Ministerial and Parliamentary Services (supporting role)

Department of Premier and Cabinet

Rebekah Burton, Deputy Secretary
Mitchell Knevett, Director, Office of eGOvernment
Piero Peroni, General Manager TMD, TMD Directorate
Michael Mulley, Commercial Manager TMD
Katie Ault, Commercial Strategy Manager TMD
David Strong, Acting Deputy Director Corporate Services

Department of State Growth - ICT and Innovation

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

The committee mat at 9 a.m.

CHAIR (Mr Hall) - Welcome, minister, to this morning's session. For the purposes of *Hansard* please introduce your people who are at the table.

Mr FERGUSON - Good morning, Chair and ladies and gentlemen. I introduce the Acting Secretary, Mr Michael Pervan, and also Mr David Nicholson, the Deputy Secretary of Strategic Control, Workforce and Regulation.

CHAIR - To kick things off, would you like to give a brief introduction and overview?

Mr FERGUSON - Thank you. It has been a very significant 14 months in health since the election. We have many significant issues to attend to, particularly a number which we addressed to this committee last year. Recent achievements in that area have been announcements as part of health reform, which I might come back to. Importantly, the work of the Royal Hobart Hospital redevelopment rescue task force, which reported late last year and following which the Government responded to provide certainty to that project.

With the upcoming 1 July commencement of the Tasmanian Health Service, we have, since the last Estimates, announced Mr John Ramsay as the inaugural Chair of the Tasmanian Health Service; he is current chair of the three Tasmanian health organisations, THOs. Late last week we also announced the composition of the new governing council for the Tasmanian Health Service. As part of health reform, one of the most important elements of that is the planning of the statewide delivery of health services. The white paper was released in late March as an exposure draft and we have been consulting with the Tasmanian community around the proposals outlined in that document. That document will be finalised at the end of June, and we will have a platform upon which to genuinely put patients at the forefront of all our decisions in health to ensure that we have strong and robust clinical services that are planned around the state, all in the environment where we have made a commitment that hospitals will not close, but we want each hospital to have a defined and clear purpose, to work more closely together. To ensure that where

those supports are required, such as patient transport and accommodation, that we work on fashioning better policies to support Tasmanians who need access to our health system.

Briefly, I will touch on some highlights from the Budget. We again see a record investment in health over the four-year Budget period, we tip over $6 million for the first time. We see an additional $100 million as a significant additional funding component to health, with $25 million per year over each of the four years. We have seen additional investment in patient transport and accommodation of $24 million, which includes $10 million for hard infrastructure.

We have also seen, for the first time, the funding of the North-West Cancer Centre on an operational basis. We have also budgeted for the $4.8 million as part of our response to ice and other drugs issues around in Tasmania. Importantly as well, while the Budget does not reflect these initiatives, I will just mention that after the Budget was finalised, we did secure continued federal funding of the John L Groves Centre in Launceston and we reached agreement with the Commonwealth on the Mersey. All of which I am sure we will have detailed discussions about today.

I welcome the opportunity to appear before the committee and submit myself now to you, Chair.

CHAIR - Are there any general overview questions someone would like to ask before we start?

Mrs ARMITAGE - Thank you. I do not see anywhere else that is right to ask this: you were talking about the change from THOs and THS. Can you advise, or provide later on, what is the predicted budget outcomes for each THO? Can you indicate which THO has actually received additional funding in 2014-15? That is my first part of it. I am happy for you to table it later, if that is easier.

Is there a risk that the additional $25 million funding will be absorbed to deal with structural deficits that the THS will inherit, and the recurrent savings targets embedded in the Budget?

Mr FERGUSON - I would say that from the outset, each of the THOs have operated in different ways, certainly with different historical funding arrangements. As we discussed last year, we have significant financial pressures on the THOs, particularly in the North-West and South. That has been well documented and well known. The estimated outcomes were highlighted in the revised Estimates report which the Treasurer released in January or February. They indicated that broadly the outcomes expected for the three THOs were: THO North, balanced budget; THO North-West, an $8.9 million predicted deficit for 2014-15; and for THO South, an $18.6 million deficit forecasted. Those are the current expected outcomes, which are actually an improvement of about $2.5 million on the predicted outcomes in the RER at the beginning of this year. That is the expected outcomes for 2014-15.

CHAIR - I think you are looking at overview questions. We will deal with THO further down the track.

Mrs ARMITAGE - That was the only area to ask that.

CHAIR - Any other overview questions?

Ms FORREST - The new funding model from the Commonwealth, it would have an impact on provision of growth funding as I see it. There is information in budget paper number 1 and volume 2. Under the new funding model for the Commonwealth, how would the new funding streams actually work? Who will fund what? How much is specifically allocated towards preventative health in dollars terms as well as a percentage of all funding for both state and Australian governments?

Mr FERGUSON - Shortly, I will ask the Acting Secretary to assist me with the answer. Broadly, there is significant change proposed at the Commonwealth level for the funding of hospital services to the states and territories.

It has been the case under the National Health Reform Agreement that we had funding guarantees provided. We also had a 50 per cent growth funding, which was part of that agreement, and it was effectively through that activity-based funding model.

The Commonwealth, in last year's Federal Budget in May, had announced a decision that they would change the funding methodology across a whole range of factors that will influence what future funding looks like. The announcement by the Commonwealth was that we would move to more of a block-funded grant arrangement from 1 July 2017.

It is not yet clear to me what methodology will be put in place to set our baseline funding from 1 July 2017. It is expected at this point that something around population or a per capita share might be the method used, but that is not assured.

Ms FORREST - Is that raising alarm bells for you if that is the case? It is not nailed down; I can see that in the budget papers. It is really unclear. This is a huge issue for Tasmania and the way we deliver health services. I want you to inform me on this.

Mr FERGUSON - It is a very significant issue and all state and territory ministers and indeed premiers and treasurers are acutely aware of this. Our Government is acutely aware of it. It does change substantially the way in which states and territories will see the Commonwealth co-contributing to the cost of hospital services. We are watching this space very closely. We are not agreeing to anything at this point in time. As we approach that 2017 change in funding methodology, naturally we will be fighting for the best possible outcome for Tasmania.

I point out as well, without trying to gild the lily too much, there is something to be said for a greater sense of certainty year on year as to what quantum of funding will be received. Under the current model it has been notoriously difficult for the state Department of Health to be able to adequately and predictably plan its health funding from the Commonwealth because it has always floated on activities, some of which is not easy to predict. You have also asked me about preventive health.

Ms FORREST - Before you go on to preventive health and the growth funding aspect, on page 17 of budget paper 1, it does say, and maybe this is not right then from what you have said, 'From 1 July 2017, the Australian Government will index its contribution for public hospitals funding by the Consumer Price Index' - I assume Hobart's, maybe it is somewhere else, I do not know - 'and population growth,' - again, this is a concern for Tasmania if it is part of the Premier's ambitious target for population growth - 'a level of indexation significantly less than that applying under the previous arrangements.' This is what it says is going to happen. You are saying that it is not certain yet?

Mr FERGUSON - No, I stand by what I have already said. What you have just read out is further information that adds to that.

That would be growth after 2017. It would be based on population growth and CPI. What I said earlier in my answer was that it is not yet clear exactly how the baseline would be settled by 2017. That is what your starting figure would be based on.

Ms FORREST - It is an area of concern. How is the growth funding being funded and what is the percentage of preventive health funding?

Mr FERGUSON - On preventive health, I am going to probably shortly come to the Acting Secretary to add to my answer. Preventive health is more of a state responsibility in terms of how we fashion up the hospital arrangements. There has been a national partnership agreement with the Commonwealth around preventative health which ceased 30 June last year. That has meant a significant withdrawal of effort by the Commonwealth in that space.

It therefore falls increasingly to the state to manage its policies around preventive health. I am sure, Ms Forrest, you are aware we are working very closely with our Health Council of Tasmania and its committee, the Healthy Tasmania committee on the long-term policy settings that we need to secure in this space so that we can help Tasmanians make healthy life decisions to stay well and to stay out of hospital.

Ms FORREST - Do you agree there should be an ongoing commitment from the Commonwealth in this area, because they, allegedly, fund primary health and other aspects of health promotion and illness prevention.

Mr FERGUSON - Yes, both governments have a responsibility in this area. With the cessation of the national partnership agreement some of those initiatives immediately fell to the state to make decisions whether to continue, and the extent to which we were willing to fund them. Both governments maintain that responsibility, as you say. The Commonwealth is primarily responsible for primary health and through the Medicare system they are facing significant questions themselves, as a government, about sustainability of that system. It is very wise for them to have a strong preventative focus of their own for all Australians.

CHAIR - A follow on with Ruth, on that line. Minister, you are probably aware of the UK model, where - it is probably not comparing apples with apples - but it is linked every year to CPI and that is it - regardless of how much health costs inflate, which can be quite substantial. That puts rigour and discipline into the system, and they have rationalised a lot of services. Is that something your Government would consider, bearing in mind that you are contingent on Commonwealth funding and other matters as well? It seems to me that is the way they have gone. They have said, 'Right, we cannot provide everything for everybody and we have to go down this track.'

Mr FERGUSON - I am not particularly aware of the funding arrangements in the UK, with the NHS. If they are locked into CPI that is interesting. It is certainly the approach of the Commonwealth - from 2017, not yet. From 2017 that is the announced plan by that level of government as to how they will fund it into the future.

CHAIR - When you answered Ruth, you were talking about that component plus population growth as well. As you say, you have the two dimensions. Is that what you are saying?

Mr FERGUSON - That's right - CPI and adjusted as well for population growth. The Commonwealth is moving to make it more predictable, more planned, but it has to also be said, less in total. Last year's Federal Budget saw a significant winding back, not of absolute funding, but of future projected growth in funding.

CHAIR - I suppose by making it the UK model - if you put that rigour in the system - it puts some discipline into where you spend your money. You have to spend it wisely, I suppose.

Mr FERGUSON - There is a lot to be said for the outcomes you are talking about, Chair. We are saying we want rigour in the system and as we move to a single THS, we want a governing council and an executive team that are very mindful of the need to work within their budgets and to responsibly plan the health services they know they can afford. It has been one of the errors of the past, with our policy settings, that we have not always had a disciplined and accountable rigorous approach, despite the best efforts of individuals. As a system, it has not delivered those outcomes.

Acting Secretary, could I invite you to add to my answer on preventative health?

Mr PERVAN - Certainly, minister. While the quote in Budget Paper No.1 comes directly from the Federal Treasurer's budget speech from last year, there is no further detail in terms of the Commonwealth's commitment to fund preventative health or other health funding issues. But with the Reform of the Federation green paper, we have a very live discussion at the moment about how the Commonwealth and the states can work together to improve health outcomes, and the delivery of health services. That has led almost immediately to a very robust discussion about sharing the risk with care coordination.

That does not inherently mean a focus on hospital outputs - it is more a discussion about the two spheres of government working together on secondary and tertiary prevention. While the NPA that funded a lot of projects in primary prevention has now lapsed, the system, as it does, is adapting to a new direction, which goes to meeting or anticipating care needs, in particular the needs of people with chronic and complex conditions, through a coordinated care approach.

While there are no dollars on the table yet from the Commonwealth, there is discussion of that being the direction of the reform in federation work.

Ms FORREST - In the policy and parameter statement on page 59, budget paper 1, there is a mere $36.5 million under national partnership payments for healthcare. Is that the preventive health funding we are no longer getting, or are we expecting it this year? You said it lapsed last year, so what is the $36.5 million there?

Mr FERGUSON - We might need to take that on notice and come back to you.

Ms FORREST - We know some of this block grant funding, which is the way the Commonwealth may be headed, but currently and for the next 12 months, what is funded by the Commonwealth in our health services and what is the State funding?

Mr FERGUSON - In dollar amounts?

Ms FORREST - Yes.

Mr FERGUSON - We would have to take that on notice and bring it back to you. It would be in the budget papers; it will not be far away. The Commonwealth's funding for the budget is about $330 million …

Ms FORREST - You have, on page 25.5, $116 [million?].

Mr FERGUSON - The budget papers provide for 2014-15. We estimate the outcome to be $333 million for health reform funding, which is effectively hospital funding, from the Commonwealth. It is called Health ...

Ms FORREST - That is for the major hospitals or the rural hospitals?

Mr FERGUSON - All together. The Commonwealth's contribution is effectively hospital funding and is branded up as national health reform funding because of the health reform agreement several years ago. For 2015-16, that is estimated to rise to $348.5 million and over the forward Estimates it grows to $388 million. That is only predicted or estimated at this stage because with the 2017 policy changes I am not yet clear about what the Commonwealth will seek to do in terms of calculation method. You asked about the state contribution. The Budget appropriates from the Consolidated Fund $810 million in 2015-16. You can plainly see that the state is the greatest contributor to the health and hospitals funding in Tasmania.

Ms FORREST - I know we can do this more in output group 2, but the revenue from the Australian Government in terms of activity-based funding, block funding, Mersey Hospital funding, which is a guess at this time, the national partnership funding and the Commonwealth own-purpose expenditure is there, and the activity-based funding continues. I know it is forward Estimates and they are just that, so could we see again another significant change see if we can change to this in the future?

Mr PERVAN - Yes, because the only thing we have to go on at the moment is that one line from last year's Federal Budget speech. As far as we know, activity-based funding will continue. I need to point out the reason why we have done it like that: to change the current system requires federal legislation because the National Health Performance Authority, the Independent Hospital Pricing Authority, the national funding pool, the entire architecture of activity-based funding is actually set up under the National Health Reform Act 2011. To move to block funding, they have to get legislation through the Commonwealth Parliament.

Mr FERGUSON - I would like to add as well, with this lack of clarity, we really only have the Commonwealth's very broad policy ambition to get to a growth method that sits around factors like population and CPI. It is that baseline level of funding, even in that new future policy environment which potentially could work for Tasmania. Until we know the detail of how the baseline will be settled, we are far from committal as a state on being part of or supportive of that. In the end though, we will always have to advocate for Tasmania's interests and get the best possible deal we can that suits our demographics, and suits out future projected needs in health as well.

Ms FORREST - As the Chair said, and you referred to the UK, where it is just the CPI increase, we know that health inflation costs rise at a much greater rate than CPI, or normal

everyday inflation. That could be a risk for Tasmania, particularly if we do get significant population growth.

Mr FERGUSON - Population growth brings additional demand on services as well, so it would only have ever been a recognition of the increased demand you would face as a jurisdiction with a higher population. To me, the population factor is not absolutely pivotal for Tasmania's future because as our population grows we would be recognised under the new method.

To me the bigger policy question for us as a community, and as a state, is how the base line will be set and is CPI acceptable. You mention health inflation. A couple of points, if I may. First, it has been a longstanding concern amongst health managers, not just in Tasmania but around the country and indeed the world, that a health inflation figure around 6 per cent poses a significant risk to any health jurisdiction.

It means health inflation outpaces the growth of other indices in budgeting. You may recall a previous health minister saying if that was left unchecked, the health budget would take up two thirds of the state Budget.

Ms FORREST - By about 2030 was the concern.

Mr FERGUSON - With that said, I also make the point that health inflation of 6 per cent shows we have a growing burden of disease in the community. Technological and pharmaceutical innovations come at a cost, and people are living longer. These realities are reflected in the Commonwealth Government allowing private health insurance premiums to go up by around 6 per cent.

We recognise there are significant pressures in the health system, and we need to make sure the management of our health system is rigorous and accountable. We need to reliably live within our means and provide the best possible services with the budget we have.

Ms FORREST - If our population grows, predominantly with older people retiring to live here, we are more likely to have a higher demand on health services. Is that something you would take up with the Commonwealth, in deciding how to set this base line?

Mr FERGUSON - Absolutely, and we would do that already because we already have a population that is older than the national average.

Ms FORREST - And sicker.

Mr FERGUSON - Older and sicker in several respects.

Ms FORREST - Some of it is self inflicted.

Mr FERGUSON - Indeed, but when you are looking at demands on the health system, whether it is self inflicted is irrelevant.

Ms FORREST - It is a moot point, I suppose. I want to ask another policy and parameters statement question, unless anyone else has another question.

Mr CHAIRMAN - It is overview?

Ms FORREST - Yes, it is overview. It is in the policy and parameters statement.

Mr FERGUSON - To add to an earlier answer, I am advised that the NHS in Britain has a blended model where some funding is activity based - based on performance and outputs - and other parts are block funded, with CPI growth.

Mr CHAIRMAN - That shot my statement down in flames.

Mr FERGUSON - Not at all. It sounds like it is supporting what you said, but you might have individual trusts being given additional funding if they are able to generate more outputs. It is a win/win.

Ms FORREST - With regard to the policy and parameters statement in Budget Paper No. 1, on the revenue side there is the $36.5 million reduction in the national partnership grants and a $4.3 million increase in the specific purpose grants on page 60, which allow for the policy and parameter adjustment. The amount the Australian government grants in this year's Budget is hard to reconcile. I always find this an interesting document, a really important document.

The figures in 2016-17 and 2017-18 are close - not exact but they are close. The figures for 2015-16 - the year we are looking at - are quite a distance out. The forward Estimates last year for the three THOs showed expected federal grants of $439.1 million.

Mr FERGUSON - Sorry, I beg your pardon. Did you say page 60?

Ms FORREST - Page 60 in this year's Budget papers.

Mr FERGUSON - BP number 1, page 60?

Ms FORREST - Yes, budget paper number 1, the Budget - sorry, I have given you the wrong one. The forward Estimates from last year - I had to go back to last year's to look at the three THOs - this is why it has been a bit difficult to figure out what is happening - that showed expected federal grants of $439 million. After policy and parameter reductions of $32.2 million, one would have expected the grants to be $406.9 million. Instead, this year's Budget has grants totalling $473.8 million. How do you account for that difference?

Mr FERGUSON - I am really sorry, I cannot find what you are referring to on page 60.

Ms FORREST - I had to go to last year's budget papers to add up the THOs adjustment in last year's policy.

Mr FERGUSON - I am sorry, are you looking at last year's budget papers?

Ms FORREST - I am looking at this year's now. To make the comparison, what was expected last year and what is in the budget papers this year in your policy and parameter statement, there is a $67 million difference. I can show you the numbers here if you want. There is a significant difference in that. I am unsure as to why that is. Then, if you look at agency revenue, on page 60 for the THOs, they show a healthy increase each year. I am interested in why they are there.

Mr FERGUSON - Ms Forrest, I am going to have to ask to take that on notice. As I have said earlier, we will need to ask for some further analytics on that from Treasury. We tend to work more out of budget paper number 2 for our operational responses and income and expenditure. I am looking at page 60 of BP number 1 and I am not seeing the figures you are quoting.

Ms FORREST - I will give you the information perhaps in a question on notice. It is difficult when we have constant reform in health and other areas. To compare one year to the next is next to impossible. When there is significant change when you go back, which I do, go back and look at what was forecast last year and to what we have this year, the out-years are the same, pretty much.

Mr FERGUSON - Ms Forrest, what I might offer is that we will take that on notice. Secondly, can I make a helpful comment? If you are identifying figures by comparing budget papers from last year with this year and you are seeing fluctuations up or down on anticipated Commonwealth funding, it may have been reflective of the comment I made earlier today, that it has been very difficult to predict future federal funding even within the financial year, because a lot of it - not all - sits around activity. It has meant that if the THOs are not able to reliably predict their activity in advance, even the Commonwealth budget papers will be wrong in the end. At the end of the financial year, when all of the maths is done and all of the activity converted to national weighted units and sent off to the national funding body -

Ms FORREST - With all due respect, I am talking about national partnership payments here. I would not think there would be that level of discrepancy. We are not talking about activity-based funding; we are talking about the national partnership funding. I am happy to provide the question.

Mr FERGUSON - Please.

Ms FORREST - These should be figures that are known as opposed to unknown.

Mr FERGUSON - With respect, the numbers you are quoting are not on page 60 of the BP number 1 that I have.

Mr MULDER - She is deducting this year's budget paper number 1 from last year's budget paper number 1. That is what you are doing? You are comparing last year's budget papers number 1 statements to this year's budget paper number 1 statements, and asking for the discrepancy.

Ms FORREST - Yes, I am saying in the forward Estimates the out-years are the same. It is this year there is quite a significant difference.

Mr FERGUSON - If you could forward that information across, we would be most happy to be helpful on that.

CHAIR - You can take it on notice.

Ms FORREST - Another overview one. Again this does not really fit anywhere with the change in the way the budget papers are set out. What is happening with the e-health initiative? I understand the funding has ended as far as the Commonwealth is concerned with that. I did see

recently, in the media I believe, that they are still calling for input into the e-health process at a Commonwealth level. It is a pretty important aspect for ongoing delivery of health care.

Mr FERGUSON - It is very important and I will ask the Acting Secretary who sits on the Transition Task Force to add to my answer in a moment. Is that the name of your group, or the Transition Authority?

Broadly, Ms Forrest you are right. This is very important for all health jurisdictions and especially the Commonwealth. The initiative by the Commonwealth four years ago around Health, has been a spectacular failure. It has been very expensive and it has failed to deliver and very few Australian's are even signed up to it. There is a whole range of reasons for that, which I will ask the Acting Secretary to speak to. There have been technological challenges, there have been data matching problems and one of the key recommendations from last year's review which made a strong recommendation around having an opt out system, as opposed to an opt in system, is something that the Commonwealth has now said they will adopt.

From my recollection, this year's Federal budget announced some additional half a billion dollars to go into to what was known as the personally controlled electronic health record. It will now be known as My Health Record and it will be an opt-out process.

Ms FORREST - People will have to make a decision to not have it.

Mr FERGUSON - Correct. People will automatically be part of that unless they have a reason that they do not wish to be part of it. I see that as promising.

At the same time, we need to keep a very close eye on the Australian taxpayers, should it pose concern about this in the future and make sure that the system works for health consumers and that it is functional for health jurisdictions like Tasmania.

Mr PERVAN - Thank you, minister. The personally controlled e-health record, while it was a great leap forward for the Australian health system, suffered as many things do, from having been designed by a very large committee. As a consequence, it was a massive engine. Even people with IT qualifications found it very cumbersome to work with, to enrol in, and there was a great problem getting GPs to use it and to load data onto it.

Most general practitioners in Australia use software called Medical Director and the owners of the software are yet to reach agreement with the Commonwealth to provide any kind of bridging or connectivity between medical director and the PCHR. As a consequence, even in Tasmania where we were given a financial incentive under the Tasmanian Health Assistance package to enrol people onto the PCHR, once enrolled, very little data was included and up-loaded. It was not used by people managing their own journey through the health system and it was not being used by the general practitioners.

We did manage to get some achievements along the way. Tasmania is the only jurisdiction where your hospital pharmacy record is loaded on to your PCHR if you have one. We did manage to make it work, although once again that proved very testing for the national e-health transition authority.

Ms FORREST - Only a narrow field though, you are saying. Just with their pharmacy record.

Mr PERVAN - For their pharmacy record.

Ms FORREST - Which is helpful to know what drugs you are on.

Mr PERVAN - It took us many months to negotiate that, even with all the technical requirements having been met, simply because the e-health record was not designed to integrate with other data sources. It was a very complex procedure.

As the minister said, the PCHR was then reviewed during 2013 and only recently are we starting to learn the detail of how that review will be responded to, with a change to the governance model. The National E-health Transition Authority or NETA, will be wound up as a company. It will be replaced by something slightly less cumbersome, as a public company, to deal with.

We are going for an opt-out model rather than opt in and the design of the e-health record will be considerably leaned out, so that it will be clinically driven and will contain the information which those consulted with, the clinicians, and by clinicians I mean everyone who is delivering health care, deemed to be the essential information to guide someone on their journey through the health system rather than every single record from every single contact.

I know from personal experience when we have tried to do something similar locally, there is always going to be a difference of opinion between surgeons, for example, who would not think that all the theatre notes should be in someone's e-health record, and what a GP needs to see, which is the outcome of the surgery, not everything that happened in theatre.

Ms FORREST - They probably feel it makes their role insignificant.

Just one other question relating to IT. It leads into that, even though it is separate to e-health. The Auditor-General recently released a report about the security of ICT infrastructure and information. Obviously, security of information is particularly important in health because a lot of personal data is collected. How is ICT information and constructive security managed within - that is, right across - the department? Is there actually a line item that we could identify those costs from? Is it funded separately? Is the Budget adequate to address the recommendations made by the Auditor-General recently in regard to this?

Mr FERGUSON - There is no particular line item for ICT in the Budget itself, but it is, of course, a corporate overhead of the department. The department is responsible for a whole range of matters in IT, so it has staff of its own to provide IT services to itself and to the THOs. Additionally, it purchases from TND, which is part of DPAC, for a range of services. The Auditor-General's report was an audit into a range of departments and their IT systems.

The report made a number of recommendations. It also showed there were areas where improvements could be made. I know that the department is responding to that. Additionally a view was expressed that IT needs to be approached on a risk-management basis. If you started again and looked at your IT security arrangements, you would see that some hardware and software security can be more relaxed in some areas, while it needs to be absolutely rigorous in others - for example, patient records. The department is working through that and responding to the Auditor-General's report. If you ask me this later on the day, during the IT Estimates, I will also say that other departments are doing likewise.

Ms FORREST - Is it funded from within your allocated budget? Do you believe it is adequate to deal with all those challenges? Because there were a number -

Mr FERGUSON - Yes, there are. It has not been raised with me as a risk area at all for the department in being able to provide for the improvements that might be required.

Mr MULDER - You mentioned earlier, I think in response to an answer for the member for Murchison, that the hospitals would basically be funded under the NPP. When you were talking about the Commonwealth funding, you were talking about it basically being hospital funding?

Mr FERGUSON - A contribution to it, yes.

Mr MULDER - Which of the hospitals are funded? Is it just the major four? Or is it the regional hospitals?

Mr FERGUSON - It is to all of them.

Mr MULDER - All of the four?

Mr FERGUSON - All of our hospitals where hospital services - acute, sub-acute - are provided. The Commonwealth's share is determined, obviously, through its activity-based funding model. As to how those funds are disaggregated or spent around the state, that is a state responsibility.

Mr MULDER - Let me be clear: all the hospitals the funding is talking about are those that deliver those services? Those services, the acute and sub-acute, are only delivered at the four major ones. Is that what you are saying?

Mr FERGUSON - We have sub-acute services in regional centres, as well as we have sub-acute services in our four majors.

Mr MULDER - So it is more than the four hospitals? Which other ones are there? I cannot quite hear.

Mr FERGUSON - He is speaking to me. I will come back to you, Mr Mulder.

Thank you, Mr Mulder. The Commonwealth Fund activity that is performed by the state and that includes acute and sub-acute which qualifies for activity-based funding. In answer to your questions, all the four major hospitals, the Royal Hobart, the Mersey Community Hospital, the North-west Regional and the LGH. It equally applies in our rural sites. I could give you some examples where hospitals provide services, often sub-acute services - Smithton, Scottsdale, Tasman, New Norfolk, Queenstown, where those equally apply. The state provides the services, reports to the Commonwealth and qualifies for activity based funding from the Commonwealth, having reported what the work performed consisted of.

Mr MULDER - I am sure you will want to take this on notice. It would be nice to know in the last financial year what level of funding each of the regional hospitals received for sub-acute services.

Mr FERGUSON - I think we can provide something to you on that, bearing in mind that some services we provide would be state-funded as well, or something that the state has assumed as something that it should do.

Mr MULDER - That is fine. My next overview is the total of the public health budget - just how much of it is funded by the Commonwealth and how much is funded by the state?

Mr FERGUSON - Working off my memory, of the $1.6 billion in the coming financial year, which is total spending, of that approximately $389 million is provided by the Commonwealth. That is in 2015-16.

Mr MULDER - Do you know what the private health sector is doing?

Mr FERGUSON - No.

Mr MULDER - I am interested to know how much of a burden of Tasmania's health is carried privately. The other question that relates to that, is how do the GP Super Clinics fit in to that?

Mr FERGUSON - GP Super Clinics is a branded program by the former federal Labor government. I am not trying to be flippant when I say this but it is often said to me that the GP Super Clinics are not that super. It is a branded program that allowed some primary health GP medical centres to qualify for capital funding, and maybe some operational funding, for an expanded service to their local communities. We have a number in Tasmania, and they are all doing a terrific job in their own way. What is not that super about it is the way that the former Labor government talked them up and made innuendo about what kind of service the community would end up with.

A lot of people expected they would have, for example, 24-hour first aid-type services provided around the clock, bulk-billed, and those were not things that were insisted upon or even assured through that funding program. Like all of our GP clinics in the state, the people working in them are doing a terrific job and working hard, but the GP Super Clinics, to be fair, sit within the mainstream of GP clinics around the state.

Mr MULDER - Community GP services. The rest can wait for line items.

Ms FORREST - Can I talk about the policy and plan of this state at this time on page 65. The parameter adjustments in agency expenditure and the reason I am asking now is because it is going to apply to Health and Human Services and the THS, formerly the Tasmanian Health Organisations. I do enjoy reading budget paper number 1.

When you are looking at the expenditure there, you have Health and Human Services, then further down the Tasmanian Health Service. If you need to take that on notice, that is fine, but if I ask the Treasurer these sorts of things, he says ask the Health minister. How much of the DHHS line items relate to Health as opposed to Human Services, the adjustments there, and what do they actually relate to? I am wondering if this adjustment includes the ambulance officer wage increases.

Further down, for the Tasmanian Health Organisations, the expenditure increases regarding parameter changes are quite large at $109.2 million, then less than $50 million the following year,

and just over $50 million the following. What do those increases actually relate to, as they are parameter changes? I am not certain. They are not policy decisions; they are parameter changes.

Mr FERGUSON - I ask if I could take that on notice. It sits with your earlier questions and I am seeing now the figures that you were referring to earlier as well. Forgive me, I thought you said page 60 earlier and I am on page 65.

Ms FORREST - There is some detail on page 60 but now it is page 65. It goes right across, the policy and parameter statement.

Mr FERGUSON - I am happy to take that on notice and even come back to you immediately after lunch with some better clarity on that. It may be a technical accounting treatment that I can explain. However, the initiatives and key deliverables that I work to are more outlined in budget paper 2 volumes 1 and 2. If I can be helpful on that, I will be.

Ms FORREST - The Treasurer is often not keen to answer those ones either.

1.1 - Health Services System Management

Mr CHAIRMAN - Okay. We are done with those then we should move perhaps into 1.1, which is Health Services System Management.

Ms FORREST - Minister, what is the $32.5 million for the apparently one-off payment that cross-border obligations refers to? If it is services delivery to Tasmanian mainland hospitals, I will have a perfect question, but I need to understand what it is to start with.

Mr FERGUSON - Can you give us a reference?

Ms FORREST - Yes, I am sorry. I thought I had written all these down.

Mr FERGUSON - I am not avoiding the question in any way. Often these things are an accounting treatment. I do not want to start answering the question without the information. The budget papers obviously meet accounting standards that require Treasury and the department to explain variances and update figures.

Ms FORREST - Here it is. There is a footnote on page 122, Budget Paper No. 2 - Volume 2. It says -

> The increase in grants and subsidies in 2015-16 reflects the expenditure of funds carried forward from 2014-15 of $32.5 million for THO cross-border obligations to other jurisdictions for 2013-14 and 2014-15. At the time of publication, Tasmania has not received data from other jurisdictions to enable the payment of this obligation.

What does this obligation refer to? Obviously we have to pay someone $32.5 million.

Mr PERVAN - Thank you for your assistance there. That reference is specifically to services received by people with a Tasmanian residential address in interstate hospitals. It is a very complex process that goes through the national funding pool administrator. We get an invoice from the national funding pool for that amount. There will be a data file with it, which

tells us this is for these patients. We receive those on a fairly regular basis - at least annually. There is discussion underway with the national funding pool administrator to make it more frequent than that, say three monthly or six monthly.

Ms FORREST - Is this an annual $32.5 million account?

Mr PERVAN - This one is, yes. These budget papers are referring to $32.5 million.

Ms FORREST - That is from the last couple of years?

Mr PERVAN - Yes. It can be.

Ms FORREST - Do we have a list of patients, or a number of patients, who have had treatment on the mainland, and for what procedures? Why were those procedures carried out on the mainland? Because they could not be done in Tasmania or because they have been waiting an extended time? If this money is being spent on an annual basis, what are we paying for and why we are paying it?

Mr PERVAN - It is an interesting issue you raise and it is a discussion I have had with the Victorian secretary of the Department of Human Services only last week. At the moment, all we get is a bill, so we do not know -

Ms FORREST - Really?

Mr PERVAN - Really, and it is the way it has always occurred. We do not know who has been treated, or how they are being referred, or who is referring them. Frequently we do not know if they are tourists - if they have fallen over, or if they are visiting someone and they have become ill and gone to hospital, or if they are part of a formal pathway of referral to the mainland.

Ms FORREST - Do we do the same to Victorians?

Mr PERVAN - Yes.

Ms FORREST - How much do we get from the Victorians?

Mr PERVAN - I would have to ask. We also treat a number of people - mostly tourists. Every cruise ship that pulls in usually puts three or four patients into the Royal Hobart Hospital.

Ms FORREST - I am just trying to understand. Are we paying a net amount? We are paying $32.5 million annually, or thereabouts - maybe more if some of our hospitals and health services treat people from other places. I am really interested in why we do not know who these people are and what is happening. If we get a bill, do we send a bill or is it just the net amount? Is that what you are saying?

Mr PERVAN - The data file goes to the national funding pool administrator that specifies the residential address of people outside Tasmania who have been treated in our public hospitals. That information is then used by the funding pool to invoice the residential state for the state's contribution, and they also invoice the Commonwealth for their contribution. It goes back to the home state of the individual.

Ms FORREST - If I was in Brisbane and I fell ill and I went to a hospital there, they would charge that back to Tasmania?

Mr PERVAN -Yes.

Mr FERGUSON - Can I add that it relates to 2013-14 - a figure of $12.4 million for that financial year - and in 2014-15 $20 million, carried forward to 2015-16. A total of $32.5 million total. That is in fact two years' worth.

Ms FORREST - It is not that much extra a year then.

Mr FERGUSON - Second, to add to what the Acting Secretary said, this is something we have discussed in our project team for the one health system reforms. As a state, we want to have greater certainty and clarity about patient pathways. As you know, there are a range of services our state does not attempt to provide within our own health facilities. Patients predictably need to be managed and treated in an interstate hospital. Organ transplant would be one example, and paediatric surgery another. This is the mechanism by which the state fund patients that receive care in another jurisdiction.

Ms FORREST - I am concerned about that because obviously those Tasmanians need to travel. But it is the other bit we do not seem to know about.

Mr FERGUSON - My understanding is that there is not always clarity about patient pathways and the way in which it is determined that people should receive treatment interstate. We know that in some cases patients have, in the past, been referred for treatment interstate that we believe we could offer here in Tasmania. The question has to be asked - on what basis is a referring specialist sending their patient interstate, when our network of hospitals and facilities is able to provide the necessary service here?

There may be a good reason, and it might be a legitimate clinical decision, but I do not believe there is adequate clarity with that. It is one thing we have said, as part of our White Paper reform - it deserves clarity, and a more defined patient pathway. If a patient requires a service interstate, it ought to be predictably determined. That is, we ought to know, based on their indications, that they would need to be looked after interstate. This is an area of opportunity for our state. A number of people have raised opinions on the merits of sending patients interstate, for example, with our elective surgery purchasing on short-term Commonwealth funds. That has raised the question more broadly about interstate treatment.

While that mechanism always need to be available, it has raised the question of opportunity. Can we be treating more of our own patients in our own state? The answer to that is 'yes'. We are working to establish clearer patient pathways so we can have less of an opinion-based, or an individual, preference being exercised, and much more certainty about what our own health system can adequately provide. On the other side of the coin, we should support those services that can be better provided interstate.

Ms FORREST - So you will be seeking more information about the type of surgery being done, and the reasons people are going to the mainland for particular types of surgery? How are you assured it is provided at a cost to the state that is not inflated?

Mr FERGUSON - I will ask the Acting Secretary to address the matter of cost.

I have asked the one health system project team to examine this for the future. It is not a short-term strategy, however, because the white paper process and the role delineation framework is our immediate focus. In the medium term we also want to look at ways in which patients are managed, and their care is managed and coordinated. There is a fair body of work yet to be done. We want our referring specialists to be able to look after their patients, and remain confident about the care of their patients, but if we are serious about a role delineation framework for our state that includes external pathways, we need to have those agreed. That is why I would now bring in the role of the clinical advisory groups. This is part of their function, to set out how patients are cared for and where.

Mr PERVAN - The cost is regulated fairly heavily by the National Health Reform Agreement and we are only liable to pay any state our portion of the national efficient price regardless of what the procedure has cost.

Ms FORREST - So there are some controls?

Mr PERVAN - Yes, there are some controls. It is undesirable. We would rather have some of those patients here, as the minister said, and it is why we need to clarify those pathways to see the people who have to go and the people who are going because of a lack of a cemented pathway are retained in Tasmania.

Mr FERGUSON - For example, it has been put to me that of the cohort of patients who are being treated interstate, if we were able to gather them up in some clinical areas, we would have a viable service in Tasmania. This is part of health reform, it is necessary and we need to have more of a controlled arrangement.

Ms FORREST - That is an interesting comment you made, minister, about gathering those up. For a viable service it is generally a significant number. Do you believe there are that many people going to the mainland for surgery and to create a viable service we should gather them all up?

Mr FERGUSON - From memory, it is around 4 000 patients a year who are being treated interstate.

Mr FERGUSON - For the same condition?

Mr FERGUSON - No, that would be total. If you were to gather up the case loads in some areas or procedural groups, you would have enough to add to viability of a service based in Tasmania. There is a lot of work that would remain to be done on that, but we have highlighted it. I have highlighted it and said to the department I would like a greater sense of control to be introduced. We need to walk a fine line between clinical judgment by a specialist and strong state-based services. This is where, again, the clinical advisory groups need to take ownership and will be taking ownership of this kind of planning. There is nothing like being in a room of like-minded, craft group, practitioners. You should be able to defend your decision amongst your peers. The role of clinical advisory groups will include planning what services can be safely provided in Tasmania and agreeing on protocols for how patients are looked after. I think there is opportunity here.

Mrs ARMITAGE - I want to ask a question following on from what the member for Murchison was talking about, surgery going interstate. Can the minister advise how much surgery from the north, north-west and south has been going interstate that could have been done in this state?

Mr FERGUSON - It is an identified area for us as we go through health reform where we want to get a better handle on this. There are two elements to this. First of all, there are the patients who find themselves in a hospital interstate and for which there is a cost to the state that we find out about. We find out about that some 12 months later when it is aggregated up and brought to the national authority and we receive the bill. It is de-identified and we will not necessarily know what the case consisted of. Then there are the state-initiated purchases or referrals. The state-initiated ones we would be aware of because we have -

Mrs ARMITAGE - They are the ones I am referring to, that are referred from doctors in the public hospital system to interstate hospitals that could have been done in Tasmania.

Mr FERGUSON - I think the Acting Secretary said in an earlier answer that we are not fully across those and that it has been a weakness of our system that it has not been adequately defined. We will need to further look into this and examine it, but it is not a very good look for a system that is randomly, or apparently randomly, sending patients interstate for treatment. This is a feature of the old health system that we need to get a better handle on. We will always rely on interstate providers, particularly Victoria, as a very close cousin and a great support to us. We really appreciate what the Victorian health system provides for our state. We need to have a better sense of management of it. As I indicated to Ms Forrest earlier, in some cases we believe that if we were to get a better sense of control and a clear protocol over those patient pathways, we might be able to provide more services here in Tasmania.

Mrs ARMITAGE - As a second part of that, can you advise me if this has been answered already, and apologies. Output group 1.1, the Health System Services System Management in 2014-15 shows a total cost of $144 745 000 in what is to be provided in 2015-16. Could you tell me what was provided in 2014 under 1.1 for the $144 745 000 and what will be provided in 2015-16 for $119 695 000. I do not want actual details. I wonder if I can have a simple north-south split of the amounts for 2014-15 and 2015-16.

Mr FERGUSON - Mrs Armitage, I am not sure I can help you a lot in that area because we are not into the output groups related to the actual THOs. That would be more around the Department of Health and Human Services on the Health side of managing health services generally, so it would be much more of a Department of Health and Human Services management side. Of course there would be a heavy bias to the south in that. I am not sure I can provide any greater clarity on that for you.

Apart from the footnote which explains why there is a change in the figure from $144 million to $119 million, which I know you were not seeking that clarity on, it would be very challenging to be able to provide a north-south split on the department. If I can provide that I will, if you would like to put it on notice.

Mrs ARMITAGE - Yes, I would.

Mr FERGUSON - I imagine the best way I could help you with that would be on actual number of positions in the Health department and where they are located. If I can obtain that information for you, I will. Would that be the kind of information?

Mrs ARMITAGE - That would be good.

Mr FERGUSON - Yes.

Ms FORREST - That is in the department. With regard to that, do you have an idea, or can you provide the staffing numbers for the department under DHHS but in the Department of Health that exist now, prior to 1 July, and how many you expect to employ in the same roles as the roles that Rosemary was talking about? I do not mind where they are based, because they are based where they have to be, most of them. What will the numbers be post-July? I know that the amalgamation of the THOs into a THS is one aspect where we will see some savings, but in the department itself, will we see staff reductions on the back of this change come 1 July?

Mr FERGUSON - I will ask the Acting Secretary to assist me in a moment but first of all, I would not expect to see significant change on the Department Health and Human Services side between 30 June and 1 July other than Cancer Screening and Control Services, which we are shifting from the department into the future THS. I am not sure how many are involved. I will get you a number on that if that is useful.

Broadly, as part of health reform, from the department's point of view, it is going through significant change. It is going through a corporate consolidation. It is having reforms around making sure that its role is more clearly defined as a system manager and purchaser of services. To bluntly answer your question, I would suggest that you will not see significant change in employee numbers between 30 June and 1 July as part of the health reforms.

Ms FORREST - The department is pretty set in what it does in the THS?

Mr FERGUSON - Yes.

Ms FORREST - Seeing as there is savings in the THS.

Mr FERGUSON - I am with you. We said when we made the decision to move from three THOs to one but over a full budget cycle. We believe that efficiencies of approximately $20 000 000 could be achieved over that period. It remains to be seen as to how close we can get to that figure in operational efficiencies. As you know, Ms Forrest, we have also made it clear that Treasury and the Government are not seeking to have that money returned. It remains within Health and therefore gives us the opportunity to get more outcomes for our patients using those resources.

You will see significant change over time, but even to the point of 1 July it is not a fundamental shift in people's operational roles until we have a substantive CEO in place and a governing council which has had the time to come to grips with the options and to make decisions about what its future corporate side needs to look like.

There is a fundamental shift on 1 July in the establishment of the THS, the clear removal of those artificial barriers between the three current THOs and starting to get our hospitals working together more seamlessly. We have come to the point where on 1 July we are ready with a whole

range of decision-making arrangements which are now clear as to how they will operate. I also acknowledge that to a degree that is interim and more substantial change will come during the financial year.

Mrs HISCUTT - I was interested in some clarification, minister, based on what the member for Launceston was talking about, interstate operations. Of the 4 000-odd that go interstate that you are aware of, is there more that go through the private system that the state is not aware of? It is possible that there is more than 4 000-odd that go to the mainland?

Mr FERGUSON - Yes, it is possible and probable that is happening and we would not have, as a provider of public hospital services, any insight into that. That would be private in terms of going to a private hospital but it would also be a private arrangement for that person. I do not believe we would even become aware of the statistics because it is really none of our business.

Yes, it would be happening. There is something to be said for encouraging our private hospitals to keep an eye on that sort of thing to the extent that they can, because in some cases it may, if you had some providers for example, a Healthscope, or a Calvary which are national providers. If they were mindful of these things they might be able to find services in Tasmania which are bolstered to the extent that they can encourage their patients to get their service in Tasmania.

Throughout all these things, as the state has approached these issues, as a state hospital and health provider, our focus has not been on viability, our focus has been on safety and quality entirely. That has been our major focus. As we all know, that has raised some difficult and challenging decisions that remain to be made, as part of the final white paper. In some cases if we can consolidate our services on the grounds of safety, it also is a better use of our resources. Freeing up resources which then means we can provide more services to our community.

Ms FORREST - On this output group, I note it mentions the centralised functions that are provided through this output group to the delivery of statewide mental health services. Can you tell us what centralised functions are provided through this output group in terms of statewide mental health?

Mr FERGUSON - That is the directorate which is mental health and drug and alcohol, so I will ask the Deputy Secretary to answer that. We have a directorate in the sense of management in the Health Department which David will speak to, but also at the future THS on 1 July is a provider of frontline mental health and drug and alcohol services.

Mr REYNOLDS - As you would be aware, we transitioned clinical services to the THOs a little over a year or so ago now. We retained a directorate behind which carries policy functions. It administers and supports the chief psychiatrist. It does purchasing and planning work and priority issues in the mental health and alcohol and drug space. It is a relatively small unit that deals with those functions.

Ms FORREST - Do you know what the funding allocation is for the directorate?

Mr REYNOLDS - It is captured within the general department overview for the secured divisions of the department. We could get that figure for you, but I do not have it in front of me now.

Ms FORREST - To clarify, minister, it is really around policy and the determination of where services are delivered? Is that the role of that directorate? And what level?

Mr REYNOLDS - The actual cost, would be in the order of about $2.8 million for that directorate in total, plus all staffing programs.

Mr FERGUSON - Your earlier question was about determining where services are provided. I think to a degree that would be the case. It would advise the health department in how the system manages and how it purchases from THOs in the service agreement - I should stop talking about THOs and talk more about the THS - and how it purchases from the THS. It is much more than that. It is really about the integrity of the system, the way in which the chief psychiatrist and the chief forensic psychiatrist can maintain a watching brief over the clinical management of our patients in mental health in the different facilities and the way in which they are cared for in the community. It is about strong policy and careful management. Also, at different times I have had to rely on the chief psychiatrist to provide me with advice as well.

Ms FORREST - On the couch?

Mr FERGUSON - It has not quite come to that, but we have not done our nine hours yet. To provide me with advice, for example, when I receive very challenging correspondence from consumers of mental health services who are either happy or very unhappy with the service that has occurred. I think that role properly needs to have some separation from the actual provider, being the THS providers. That is a very useful function for our department to have as a key capability.

Ms FORREST - With regard to - I think it is still on the table - an inpatient adolescent mental health facility -

Mr FERGUSON - Yes. At the Royal?

Ms FORREST - Yes, at the Royal. We will get to that later on perhaps. Does this directorate have some role in progressing that, or is that a separate issue?

Mr REYNOLDS - It is more in the sphere of things. For instance, the Government's recent mental health agenda. It is driving agendas that are system-wide - for example, suicide prevention strategies. Obviously we are moving now to a fully integrated THS model, but where there needed to be statewide perspectives, where there needed to be new reform agendas, where the purchasing of community sector organisation services was also required. All that work happens within that directorate as well as the interface to the national mental health agenda.

2.1 - THS

CHAIR - We are probably ready to move, minister, onto 2.1, which is the big one, THS. We might have a few overview-type questions for the THS, then we will move into the output group 1 segment. We have the six points there, on page 108. It would probably be best to proceed along that line. Overview of THS, to kick it off.

Ms FORREST - We have an additional $100 million over four years, which will be spent in each of the areas across the THS, when you read the footnotes in both volumes. Regarding this

additional $100 million, it says that it will be provided across admitted and non-admitted emergency medicine, community and aged care services and statewide mental health services.

When you think it is over four years and spread across all those areas, what is going to be spent on what in each area? It is $25 million a year basically, spread across five output groups or lines. What is the plan to spend it? Spend more in admitted services, less in non-admitted? Where is it going to flow?

Mr FERGUSON - The frontline service funding of $100 million is going to be very welcome and has been welcomed by our health community. With all the challenges we have been discussing already today in Health funding generally, the growth in demand and the burden of chronic disease, we have seen a growth in demand across these different subsets of services under the anticipated THS. The department and Treasury have concluded the best and anticipated allocation of how those funds can be used across THS activities. It is, however, the case the THS will have to come to terms with the service agreement negotiation with the Department of Health under the THO act. That is how it is done; each year we need to see a service agreement. It is broadly expected as to what number of services will be provided across key areas and the sort of funding the department will pay in return for those services.

Ms FORREST - So we are not looking at an even split? If it is $25 million a year over five areas, which effectively is $5 million each a year, you are not saying that is what it is going to be? I am sure Mental Health would love to have an extra $5 million.

Mr FERGUSON - The best way to explain this is to indicate this is still subject to a service agreement negotiation. In advance of that, the budget papers are prepared. The service agreement is not concluded, but will be. At the time of printing this Budget the service agreement was not concluded. It has been apportioned broadly in line with what would be expected.

Mr REYNOLDS - There may be a slight misreading, too. The $25 million is separate from those actual amounts for the cancer centre and patient transport and child and adolescent mental health services.

Ms FORREST - No, I am talking about the $100 million over four years.

Mr REYNOLDS - That is very much part of the purchasing processes that the minister and secretary described. There are specific allocations for child and adolescent mental health and the cancer centre and patient transport which were identified in addition to those items.

Ms FORREST - The reason I ask is, when you look at the line items in the Tasmanian Health Service - footnote 2, 3, 4, 5 and 6 - they all say 'relates to a range of areas', including this extra money that is coming.

Mr FERGUSON - There are other budget initiatives that are beyond the $100 million, and I will give you one example - the North-West Regional Cancer Centre funding. I would imagine that would sit there with admitted services. It has been apportioned broadly in line with how it would be expected to be used in the domain itself of the provider being the THS. It is reported in Health and Human Services as a key deliverable because this has been funding provided for this purpose and has been reflected in the other volume under the THS chapter to show what it is likely to look like as an accounting treatment in the organisation itself. Unless I am mistaken, it

would still be the case that there might be areas where there could be marginal change here based on the service agreement negotiation.

Ms FORREST - Do you have the current staffing numbers in each of the three THOs that are not directly involved in the delivery of frontline services?

Mr FERGUSON - The numbers of staff in the THOs today, before they are amalgamated, that are not frontline? I could generate that for you. I do not have it to hand.

Ms FORREST - What are your expectations going into the one THO? What do you expect the staff numbers to be as a comparison? I accept there may not be a lot of change initially.

Ms FORREST - I can tell you, and perhaps restate an answer from a couple of questions ago, that this is very much in front of us. The approximately $20 million of savings naturally sits around triplicated administrative structures.

I want to work through this, and I expect the THS and its governing council to work through it, in a way that it is very mindful of the need to treat staff decently and respectfully and to consult, to ensure we arrive at a future structure that is fit for purpose and efficient. Not too fat, and not too thin. It needs to be fit for purpose.

I also open-handedly make the comment that it is not determined and it is an estimate only, based on a business case that was done when the previous government was weighing up whether to do one or three THO organisations. I can get you the numbers, I am confident, for non-frontline staff in THOs. I am not sure entirely how reliable it will be for you as it may be based on business units, or it may be based on awards. I am not sure how reliable that will be in terms of the way you may wish to interpret that information. I can get what I can for you.

Ms FORREST - It would be a good comparison for next year. We can consider comparative staffing levels.

Mr FERGUSON - Indeed.

Ms FORREST - That is your little challenge.

Mr FERGUSON - I accept that. You are saving up your questions for next year are you?

Ms FORREST - Giving you a heads-up.

Mr FERGUSON - You are giving me 12 months notice. It is very generous. I would also like to add - and I said this to the committee last year - that in the first year we expect a small additional cost as we prepare for the consolidation. It is not all shock and awe on 1 July. It is about a measured and responsible approach to amalgamating the THOs.

Ms FORREST - I am going to give you 12 months to get it sorted.

CHAIR - Following on from Ruth, is it going to take a full 12 months to determine the attrition rate of staff? You will have redundancies and all sorts of things to consider.

Mr FERGUSON - There will be a range of matters for the governing council of the THS to consider, bearing in mind they have only just been appointed and they will all be inducted between now and 30 June and ready to go on 1 July.

A lot of very careful consideration will need to be given to this, including how we look after staff in roles that are redundant as a result of the amalgamation - how we treat them decently. Where they should be based and what they should be doing.

There is a considerable body of work here. I am very mindful of that. Mr Chair, I am not saying it will take a full year. It may be less than that.

CHAIR - The new CEO might sort that out quickly? When that occurs?

Mr FERGUSON - I would not like to say, as I do not know. The THS will not be able to waste any time. It will need to quickly turn its attention to this. Apart from all the reforms that are part of the white paper, which are the most important considerations because they concern quality and safety.

At the same time, from a corporate point of view, the THS will need to be working effectively in planning the level of bureaucracy needed to support frontline services. Ensuring that from a workforce management point of view, decisions are made in a prudent way and in ways which are mindful of people's welfare.

CHAIR - I may have missed that from inattention. When will the new CEO be appointed?

Mr FERGUSON - The new CEO is currently being recruited. We have a process underway for that. I do not have a date for you because we are not working to a date. We are working to the person. I am not in a position to give a commentary on how it is going. Applications have closed and I am advised we have a strong field.

Ms FORREST - Following on from that, could you give us the names of the governing council members and also the qualifications that make them fit for that position?

Mr FERGUSON - Before I answer Ms Forrest's question, can I add to my earlier answer to you, Chair. The Government and the Premier have recently announced the appointment of Dr Anne Brand as the interim CEO of the Tasmanian Health Service to take up that position from 1 July, until such time as the substantive CEO is appointed and ready to commence that role. Dr Brand is currently the acting CEO of THO North-West.

Mr MULDER - You are holding your cards close to your chest at this stage.

Mr FERGUSON - In what regard, Mr Mulder? I am missing something.

Ms Forrest, I am happy to provide you with the names of the Governing Council that has been appointed, not just by myself but also by the Treasurer, as we are jointly responsible for Governing Council appointments. As to qualifications, I would be running without notes in front of me, but in my address to Parliament, I have given a range of their qualifications, so I will come back to you with that.

Before I give their names, they have been appointed very much on the basis of the right skills mix for the Tasmanian Health Service. We have not played the parochial politics. We have not played with any notions of trying to have every organisation represented on the Governing Council. We have not even tried to get this hospital, or that hospital in, or not in. It has not been approached from that basis. It has been about skills. I have spoken to them all, and they have all received from me the very clear reminder, in case any of them needed it, that they are working for the whole state. Not just for their local region where they happen to come from, but for the whole state.

The appointments are:

- Mr John Ramsay, who is the Chair of Governing Council. He is currently serving as the Chair of each of the three regional THOs.

- Dr Emil Djakic, a prominent GP from north-west Tasmania with a strong understanding of primary health and health reform, as well as regional issues in north-west Tasmania. He is a current member of Tasmanian Health Organisation North West Governing Council. He is also chair of the Australian General Practice Network.

- Professor Denise Fassett, who is serving as Dean of the Faculty of Health at the University of Tasmania. She was recently appointed the inaugural chair of the Health Council of Tasmania. Professor Fassett has a strong clinical, academic and regulatory background and will help to strengthen the relationship between the university and the Tasmanian Health Service. Professor Fassett is currently a member of THO North Government Council.

- Dr Judith Watson, who is an experienced GP from northern Tasmania. She is the current Chair of Tasmania Medicare Local, and I imagine the future Chair of Primary Health Network Tasmania. Dr Watson has a strong understanding of the disconnects, the patient journey, and the challenges in changing the culture and pursuing new opportunities within the health sector.

- Professor Judith Walker, who has over 20 years experience in senior academic and health leadership positions. Professor Walker is currently a director of the Latrobe Community Health in Victoria, vice president of the Monash Academic Board and board director of the Australian Rural Health Education Network.

Ms FORREST - From here?

Mr FERGUSON - Indeed. I can tell you, Ms Forrest, every one of our Governing Council members are Tasmanians:

- Associate Professor Deborah Wilson, a specialist anaesthetist on the north-west coast. She is currently co-director of the University of Tasmania's Rural Clinical School. Associate Professor Wilson has a deep understanding of the complexities of health services in rural and remote communities and is currently a member of THO North West Governing Council.

- Ms Barbara Hingston, who will bring significant finance, audit and risk experience, and has high level management experience in business, scope and structure in health care

organisations. Ms Hingston was a co-consultant to the commission on delivery of health services in Tasmania, which reported early last year, and is currently a director of General Practice Training Tasmania. Also of headspace, amongst other roles.

- Mr Mark Scanlon, who has more than 20 years of experience in senior management positions. Mr Scanlon is currently the Chairman of Ombudsman Service Limited, a director of MAIB and is independent Chair of the Launceston City Council Audit Committee. Mr Scanlon is currently a member of THO North Governing Council.

- Finally, Mr Martin Wallace, who will bring more than 30 years direct experience in public administration and business and financial management. Mr Wallace is a former secretary of the Department of Treasury and Finance and deputy secretary of the Department of Health and Human Services. In the years between those roles, Mr Wallace was the executive general manager at Aurora Energy.

With your indulgence, even though you have not asked me this question -

Ms FORREST - Can I commend you first?

Mr FERGUSON - I will never interrupt you from doing that.

Ms FORREST - I commend you for meeting your Government's objective of having 50 per cent of women on the board. I sincerely congratulate you for that. I believe it is a great step, and well done. One little concern is that you do not seem to have a legal representative on that board. Where is that skill? You have finance and health covered, but what about the legal?

Mr FERGUSON - I failed in my summary of candidates to mention that Mr John Ramsay, who is the chair, has been a practising lawyer.

CHAIR - Is?

Mr FERGUSON - Has been a practising lawyer.

CHAIR - I have no problem with the mix there, but there has been some criticism that there was perhaps too much academia and - shock, horror - there were not enough people from the south of the state. Do you have a comment to make on that?

Mr FERGUSON - First of all, on the academia, it is about getting the right balance. You see people who might be broadly described as being academics, but if you look at them a little more closely, you will see they are academics in part and that part arises from their clinical background.

Second, we needed strong health management expertise and you certainly see that. You see strong financial acumen as well across the board. The criticism - the 'shock, horror' - you mentioned is misplaced: if you take the eight governing councillors plus the chair, you see a group of three from the south, three from the north and three from the northwest. I would submit in the first year of the THS, that is a confidence boost as well. It is very fortunate we had the mix of skills also being able to demonstrate a genuine connectedness to the regions of Tasmania.

Finally, I am not offended by anyone offering that they wish this or that person was represented on the governing council. In a way that shows an appetite to want to be part of this

exciting organisation that has one of the most important jobs in government, looking after our Tasmanian community's health.

The THS is not there to be a representative body. That is not actually its function. Its function is to run the health service, and run it confidently and with strong financial sustainability. It is to be mindful of all of its responsibilities with legal and audit risk, and, importantly, managing a CEO and demanding accountability and performance. It is not a representative body and it should not be expected to be one. There are other ways for representatives of important stakeholder organisations - and I include in that the Health Council of Tasmania and the clinical advisory groups - where once again there is opportunity and expectation that from a medical, nursing or allied health point of view, that is where we want to see strong representation so we can get craft groups making strong peer-based decisions that are accountable and that we can rely on in the future. The governing council is strong and balanced, and has been comprised from a very strong field of nearly 70 candidates.

CHAIR - In light of that, I presume there will be some supervision and measurement processes that will be established to ensure this single THS produces efficiencies and improves patient outcomes? There will be some measurement?

Mr FERGUSON - It is an expectation that sits within the act as well. The Tasmanian Health Organisation Act requires certain things, and demands and requires performance in a range of areas. One of the instruments that occurs through is with the service agreements, where the Department of Health retains a sense of separation from the THS as a purchaser and as a system manager. But equally, the Treasurer and I, as ministers appointing the governing council, will naturally maintain an interest in its performance. As I have shown in the past, where a THO is not meeting its performance expectations, we will performance-manage them.

Mr MULDER - On that point of north-south, speaking for the south, I am a bit disappointed that it was even introduced to the topic. Speaking as a Tasmanian, which is what the one health service all about, I do not think any regard should be given to the north, west, south rivalries. I would not care if they all came from Launceston. I would not care if the THS was based in Launceston. The bottom line is that to introduce it was a big thing and, minister, the fact that you are across the split of the three, I think was also a bit interesting. However, the real point in this exercise is that these boards need to be skills-based and they need to represent Tasmanians. We are not three different organisations in this place, we are one, and I really would like to make exception from the southern point of view that I do not care where they come from, as long as they can do the job.

CHAIR - Actually, I agree. I read it in the paper and thought I had better ask the question. Also there was criticism from a couple of quarters.

Mr MULDER - I hope you were adequately approved, Mr Chairman.

Mr FERGUSON - I will add that we can only appoint people based on what the applications are.

Ms FORREST - Following on from that, minister, can you advise as to what ministerial advisory groups and other groups, including the lead clinicians groups that are in place now, will continue into the future? If there is a change, what change is there going to be? You did mention

that in broad terms talking about the representation and the nursing and allied health input. Can you give us some information about what the future looks like?

Mr FERGUSON - Broadly, the lead clinicians group, I think that is what it is called, now no longer exists. We wound that up pretty early on in the Government. There were very good people working in that group. For various reasons we discontinued that, however, and rolled its expected outputs into what we are doing with the Health Council of Tasmania and the Clinical Advisory Groups.

The Health Council of Tasmania, which I know Ms Forrest, you are familiar with, is a primary vehicle for high-level and strategic, and indeed, long-term advice to the Health minister of the day - me today, someone else another day. That is deliberately constituted in a way that gets the greatest possible buy-in and suffers the least opportunity for criticism that it is political or union-driven or biased to a government. I think it can generally take the politics out of health policy planning. I would regard that as my primary, outside of government advisory group.

Underneath the Health Council sits the Healthy Tasmania committee. I should mention the Health Council of Tasmania, thankfully led by Professor Denise Fassett, and the other members of that committee, all doing it for the love of Tasmania and not for any remuneration, which is incredibly generous considering the work they are doing.

Ms FORREST - Can you table the list of its members?

Mr FERGUSON - I can and I will. I know we have published it in the green paper, but I will table or I could read them. I am happy to read them out.

Professor Denise Fassett is the Chair; Deputy Chair is Tim Greenaway, who in his other world is the Australian Medical Association's President; and other members -

Ms FORREST - Is that position an Australian Medical Association president position or a person position?

Mr FERGUSON - It is a representative position so it is a dedicated role for the Australian Medical Association. In many cases, not all, you will you see it has been a similar method, so the person arrives by dint of their outside either position or nomination. In all cases, however, they are still appointed by the Minister for Health. If they are nominated by their constituent organisation, they nonetheless still have to be appointed. Other members include the Acting Secretary, Department of Health and Human Services; the chair of the THS, the chair of Tasmania Medicare Local - John Ramsay and Judith Watson - a ministerial representative from my office, Dr Scott McKeown, Emily Shepherd, who is the president of the Australian Nursing and Midwifery Federation - she is the ANMF nominee - Leigh Gorringe, the Health and Community Services Union nominee. We also have Dr Graham Bury, who is the community representative and Nicole Grose, who is the consumer representative, and Dr David Knowles, a general practitioner - he is the medical representative - and Giuliana Murfet, a nurse practitioner at THO North West. She is a nursing representative outside of the ANMF nomination.

Ms FORREST - Not through RCNA then?

Mr FERGUSON - She may well be affiliated with that. Her membership has arisen from the advertising process - she put forward her name. And Tom Simpson, who is the executive

director of Statewide Hospital Pharmacy. He is there as an allied health representative, again not nominated by any particular organisation. That is the membership of the Health Council of Tasmania.

CHAIR - Members, if we have covered the overview on 2.1, we will now get into the nitty-gritty of all those line items. We will adjourn briefly and resume at 11.05 a.m.

The committee suspended from 10.52 a.m. to 11.05 a.m.

Output 1.1 - Admitted Services

CHAIR - Minister, we will now move into the THS under output 1.1, which is admitted services.

Ms FORREST - Minister, with regard to the $74 million for the 2014 election commitment, rebuilding health services elective surgery program, can you inform the committee as to how much was spent last year, how many surgeries were undertaken, what category of surgery, and in which hospital? How much of the funding of this will be provided specifically from this initiative over the coming year?

Mr FERGUSON - Ms Forrest, the Budget was in fact for $76 million last year. That is profiled in last year's Budget, with $16 million in 2014-15 and $20 million per annum over the following three years. Up to 6 May, I can advise that a total of $9 million of that $16 million has been expended, which has delivered surgery to 742 Tasmanian patients. It is expected that a further 95 surgeries will be performed this financial year. Of the $16 million allocation, it is anticipated that $4.4 million would be therefore carried forward into 2015-16.

Ms FORREST - Are you able to give us a breakdown of the sort of surgeries conducted with that funding?

Mr FERGUSON - I can. I am very pleased to do that because it speaks to the way in which we have targeted the use of those funds. As you know, Ms Forrest, this is intended to deal with some of the chronic challenges of managing supply and demand in this area of elective surgery. Last year, targeted cohorts included, first, all children who had waited longer than recommended for surgery; second, all over-boundary urgent adult patients; and third, some of the state's very longest waiting patients as well. Those three discrete target groups were targeted. In addition, funding under the Tasmanian health assistance package is also providing surgery to Tasmanians who otherwise would have remained on the waiting list.

As at 26 March, an additional 382 procedures have been performed during 2014-15, and it is anticipated that around 1 600 will be performed in 2015-16. Of those patients, some will receive their treatment from the local private sector and/or interstate public and private sectors. I am speaking there about the THAP funding.

Ms FORREST - You are talking about the people who were over-boundary, or children who were waiting beyond the recommended time. Do you also have a breakdown of whether they were orthopaedic surgeries, whether they were general surgeries, whether they were vascular surgeries, or what they are?

Mr FERGUSON - I think we can describe each individual case. We have very good access to data on that. If you could tell me what sort of -

Ms FORREST - I do not want names, obviously.

Mr FERGUSON - We are not offering names.

Ms FORREST - Good. What I am interested in -

Mr FERGUSON - Because we purchase on their behalf, we have a very good knowledge base of what we have bought.

Ms FORREST - What I would like to have is the category of surgery, whether it is orthopaedic, gynae, paediatric or whatever it was, and the nature of the surgery, whether it is a joint replacement. When you look at some of the over-boundary cases in category 3, for example, some of them are almost in the category of cosmetics. It has been in the past, and I will get to that shortly, but I am interested in what we are doing. There are some people who may claim that you can easily do 742 cases of cataract surgery and no joint replacements, for example, because they are much quicker, simpler and cheaper.

Mr FERGUSON - I am pleased you asked that extra question, because it has reminded me of something that I should really have added earlier. First of all, if you place that on notice, I will ensure that the committee is provided with whatever information it is appropriate that we can share. Second, in a way to our detriment, regarding apparent performance, we have targeted some of the more complex cases, people who have been waiting the very longest. The cynic in me may suggest that may be in part why they have been waiting for a very long time, because they are more complex and more expensive. We get fewer numbers on a line graph, we get a lower apparent performance for our dollar.

We make no apology for that. We targeted these cohorts of patients not on the basis of their complexity, but on the basis of what was just for them. I believe we cleared the list of all children who were over-boundary, which is, for all of us around this table, extremely satisfying to be able to say. We then targeted the over-boundary urgent adult patients, and then we worked from there from the end of the list to - if I can put it this way - the ones who in many cases might never have seen the light of day in an elective surgery theatre. They might have been, for example, a category 3 - they might have had a longstanding chronic but manageable condition, and potentially, on the numbers you might say, they were never going to get their surgery, even though it was necessary. Unfortunately, the use of the word 'elective' implies that maybe they do not really need it. We have targeted those ones and I have had a look at the numbers, and through our purchasing, they are more expensive on average per case. Our effort is there, and I would have to say that we may need to examine whether or not we can report this in a more fulsome way.

It is not an allegation but it is my suspicion that in the past, purchasing practices have oriented towards the cheaper tick and flicks. You can do them for less per case, for example, and I will not mention any. You can get more apparent outcomes for your money.

Ms FORREST - You can have over 100 cataracts in a week. We used to do them in a private hospital. I know how it works.

Mr FERGUSON - You are onto it, Ms Forrest. My concern has been that, from an equity point of view, we have had people waiting on the list, I think for as long as six and seven years, with long-running, chronic, painful conditions that might not have been category 1 or 2 but they nonetheless were eligible for and deserving of their surgery. For our money, I know it is making a difference because I have met some of those people. Although I would always like to see the best possible numbers, in my heart I know we are getting genuine improved outcomes for our patients. In the fullness of time, I think you will see that I will have a better way of being able to put some definition around that so that we can get some recognition of the weighted outcomes, not just the absolute numbers. I will not have that today though.

Ms FORREST - What is your focus for next year then, if you have cleared the children who are over boundary? What is your focus for the coming year in terms of this? It is $20 million, I think you said, plus the carried-over $4.4 million.

Mr FERGUSON - Correct, so the next financial year for us is $20 million. Of course that sits -

Ms FORREST - $24.4 million?

Mr FERGUSON - Whatever - I have estimated roughly what may be unallocated, but that may change. Certainly $20 million is available. This will be something the Acting Secretary as the system manager role will need to negotiate with the Tasmanian Health Service. When we appeared at Estimates last year, we had already made a fair amount of progress on that because it was at August. I am not sure if the Acting Secretary has anything to add at this point. I have to offer as well that it sits above the Commonwealth investment which is currently being assessed from our request for proposals from the private sector.

Mr PERVAN - I can only confirm everything the minister has just said. While we have the paediatric cases now well under control so that we can maintain them through the normal day-to-day churn of surgical activity, we still have some long-waiting patients to clear and in particular some very complex patients to clear. Part of that will be a clinical assessment, not whether they still need the surgery but if they are well enough to undergo the surgery.

Ms FORREST - So these patients predominately have comorbidities that make it more challenging?

Mr PERVAN - Yes. I am not picking on a particular case now, but we have had cases of people with very advanced diabetes, for whom it is not so much the procedure that is the problem, it is the length of time it takes them to heal afterwards, and their reduced immune capacity such that they get very easily infected, and that produces a very poor outcome for them. We are still focusing on them, and equally trying to come to a better understanding, as the minister indicated, where that additional time and cost is coming from.

Is it that the patients are more complex, such that we need to do more pre-work with them? It is a terrible non-English word, 'prehabilation', that is sneaking into the health vocab at the moment, but we need to start looking at getting people well enough to undergo the surgery as opposed to operating on them when they are probably at their lowest health status.

Ms FORREST - Is it not a fair statement here though, I take you back to the case of a person with advanced diabetes, and I am not making any assumptions about the individual, I do not know who they are, but possibly overweight if not obese, possibly with a range of other comobidities, they may or may not be a smoker, for example. Preventive health is so much more important here in preventing those people getting to that point. If I was that person, surgery would be last thing I would want to have, in many ways.

In preventive health, what are we doing? It is one thing to clear and deal with some of these really complex cases but we need to try to do more to prevent them getting there in the first place, don't we?

Mr FERGUSON - We could both answer this Ms Forrest, which is first of all to say that you are right. From a health purchasing and a system management point of view, we can do a lot to make our health system work better for our patients. There has been many illustrations of this as we have spent nearly the last 12 months discussing health reform and as we are now coming to the point where we are making some substantial changes, both in the architecture of our health system with the THS, as well as the way in which we provide services and structure those services through the clinical services profile.

We need to make sure that our facilities and our services profile are as refined as possible so that we can achieve the most number of the highest quality outcomes. All of that is not to overlook the importance of a strong preventive strategy and we will never dismiss that or belittle it or overlook it because naturally, from a state point of view, it is important to try to reduce demand and to bring down some of those push factors in our health system.

In some cases these will be things that the state can control, meaning they will be things that only the individual can control but the state has an influence. It is with that in mind that we have charged the A Healthy Tasmania committee, led by Dr Tim Greenaway, to propose a five year strategic approach to how government can better lead in this area.

I acknowledge your point which is that we want people who are well to stay well for as long as possible. For people who are unwell we want them to be able to manage their chronic condition as well as possible, even if it is for a deferral to save their episodes of care at hospital if we can avoid those. For our very sick people, who need to be treated and there is no going back, we need to be able to treat them and get them the best possible number and quality about covers.

Mr PERVAN - What we need to do is balance the upstream preventative health effort with more targeted anticipatory and care which brings together prevention of care and cure. When people come through outpatients for their first time, as well as telling them that they need a procedure and that we will book them in and that might be six months or 12 months or whatever the wait is, they also get some clear guidance, if not requirement, that if you want that surgery these are the things you need to do. Or the risk you present is so high we cannot operate. It might be giving up smoking and losing weight or just getting their diabetes under control.

Ms FORREST - They seem to go together. I have a few other questions, unless anyone wants to come in.

Minister, what services are funded through this line item that are provided in an out-of-hospital setting besides cancer screening services, which is classified as a non-admitted service? When you look at what it says about full group covers, it refers to that.

Mr FERGUSON - Are we in 1.1 or 1.2?

Ms FORREST - It says in Tasmanian major public hospitals, patients either admitted to a ward or in an out-of-hospital setting - considering what, under your commentary on 1.1?

Mr FERGUSON - Thank you for your question. Out-of-hospital settings, nonetheless considered funded under admittance services, would include services like hospital in a home, which, I am sure you are aware, is funded in last year's Budget and Forward Estimates and we will have further implementation of that as part of the white paper process.

Ms FORREST - In regard to the performance indicators on page 110 of budget Paper no. 2, volume 2 - I touched on this when we had our earlier discussion about the additional funding for elective surgery - there is a target of 88 days wait for people in category 3 for this year and 71 days for those in category 2. It is admirable to have bold targets in this area, when you look at where we have come from, but to go from an actual in 2013-14 of 490 days for category 3 to 88 days - those targets were set last year so how have you gone in meeting them? They are very ambitious and for people in category 3, particularly, getting their surgery is a pretty remote possibility.

Mr FERGUSON - I have last year's budget papers in front of me and you are quite right about the targets listed. There is a significant differential from actual figures. However, the target is what it is because it is reflective of what was agreed, principally by the previous government, on the national elective surgery target. I presume that was part of the national health reform agreement. They are what the states signed up to, as a specified target. I do not have to tell you, Ms Forrest, that the recommended wait period for category 3 is one year. That would ordinarily be 88 days on top. We are a long way beyond that. The average overdue wait time for those waiting beyond the recommended one year is a long way higher than the target of 88 days.

Ms FORREST - So you are not going to achieve that?

Mr FERGUSON - It is plain it has not been achieved, and it will not be in the near term. That is reflective of our broken health system and the way we are trying to use these reality checks to get some positive reform. You will note that no target been documented in the Budget for 2015-16 and that is a function of not having yet reached agreement with the THS under the service agreement. We should set a target that is achievable without -

Ms FORREST - And somewhat ambitious, to try to encourage performance?

Mr FERGUSON - You are walking a fine line there. You want it to be achievable so the governing council has a realistic opportunity to meet it, but equally you do not want to underestimate its importance by setting it too high. For example, if the actual was 490 at the last reporting date and you made it 400, that is still a very long way past what is clinically recommended - it is over two years.

However, can I give you some good news? If you look at the performance for overdue patients, the average number of days waiting for patients who are overdue has been falling, with the average waiting time for category 3 patients falling from 531 days in March 2014 to 325 in March 2015. That is -

Ms FORREST - Three hundred and twenty-five days over the 365 days?

Mr FERGUSON - Yes, that is right. So it is a significant -

Ms FORREST - Two years rather than one?

Mr FERGUSON - It is under two years as opposed to over not quite three. From nearly 900 days to about 660. We have seen a big turnaround here. I can plainly represent that this is a reflection of the way in which we have targeted our purchasing, which is a good thing.

At the Royal Hobart Hospital, the number of days waiting for those who are overdue has fallen from 1 096 days to 575. At the LGH, it has fallen from 281 days to 246. At the North-West regional, it is pretty static from 205 to 204; and at the Mersey Community Hospital, it has fallen from 106 to 53. That is total time. That is not super to the 365 -

Ms FORREST - That is why more people need to go to the Mersey for their surgery?

Mr FERGUSON - I can only agree with you. I raised that to indicate that, although - to go back to our earlier conversation - we targeted our purchasing at the longer over-boundary patients, they have been more complex cases. They have been, on average, more expensive per case to be done. From a justice point of view, it is quite reasonable that they should get an opportunity. As a result you are seeing those wait periods reducing for the longest wait.

Mr GAFFNEY - I have some questions here that may sound interesting coming from me, but they are from a southern member, Mrs Taylor, who is in the other committee.

These matters relate to questions that some people from the south may have with the elected surgeries that the Mersey Hospital specialises in. While I have put on the record that many of constituents from the west and north-west coast often have to travel elsewhere for their procedures, whether they be lengthy or of a short nature, these are Mrs Taylor's questions, and it would nice to put on record some responses to these.

Mr FERGUSON - Of course.

Mr GAFFNEY - Will patients in the south of the state be transported to the north-west for a specialised procedure? How does the government perceive families will be able to provide support to patients who move to a hospital away from home? That is, where will they stay? Will they have to bear all the costs themselves? I will pass these questions to you because you cannot remember them all.

Mrs Taylor comments that it makes no sense that inpatients from Hobart have to go to the north-west Mersey for day procedures. She points out the following:

- Day procedures usually require a mild anaesthetic. at least. So patients fast overnight and then they will have to travel three to three-and-a-half hours by car or bus for the procedure. Three-and-a-half hours would mean patients could not be treated until 11.30 a.m. unless they were expected to leave Hobart very early in the morning.

Looks like people from the south do not get out of bed until 8 a.m.

Ms FORREST - People from the west coast get up at sparrows' -

Mr GAFFNEY - In fact they do not even go to bed sometimes.

- Most procedures with sedation preclude the person from driving themselves. Therefore, a spouse, partner or friend may have to take the day off work to take them or they have to be transported by bus at a government cost.

- Most procedures with sedation require the patient to have a minimum period of four hours to wake up prior to travelling home.

- After procedure, patients are generally required to have someone accompany and monitor them in case they have any aftereffects.

Flippancy aside, the serious question is: how do we see this working? Will the people from the south accept that they may have to, if they want to have elective surgery, travel to north west or other places for that to happen.

The questions are legitimate from that point of view.

Ms FORREST - To expand slightly so the questions can be answered more broadly, people who have to travel from the west coast, from the east coast, from the islands or even Circular Head, to go to the Mersey - even, if you live out at Marrawah, that is probably a three-hour drive anyway.

In terms of patient transport and accommodation, it does not matter where you come from, if you are going to travel, the issue is the same. Rather than just the south coming north -

Mr GAFFNEY - It is that distance element and how will that be handled.

Mr FERGUSON - Are there other questions as well, or is that a good summary of them?

Mr GAFFNEY - I will pass this over, because there are a few others. She did highlight some issues regarding the percentage of procedures being done at the Royal, the north and north-west. There is a little background there. For the record, it would be handy to address those issues.

Mr FERGUSON - I am very pleased, and thank you for representing the member for Elwick in her questions. I am happy to answer this and for it to be a form of discussion, if that is helpful, however you would like to conduct it.

First of all, here is an opportunity for people, irrespective of where they live, to value the Mersey Community Hospital as an asset for our state. It has not been that really in the past, it has been considered an asset to the local community. As you know, Mr Gaffney, there have been even some people calling for the Mersey to be closed entirely. Those calls have come from the south.

We have resisted those calls. We have said that for health reform to have any chance of success, we need to take the community with us and we need to be able to send a clear message that hospitals will not close. What I have not said is that things will stay the same. What I have

said is that everything needs to be on the table, and that we need to establish a clear and - if I can use the word - special purpose for each hospital, so that each hospital knows exactly what its role in the system is to be. In the case of the Mersey we have made it very clear, even from before the exposure draft was released, that some core services need to be provided locally in all places, for example, access to emergency care.

In other cases we need to give each hospital a role so that it plays a key role for the state. For the Mersey, the exposure draft proposes a special role as a dedicated elective surgery centre. We are still working through that, and as part of the final white paper you will see what we are settling on. I cannot speak to the detail of it until that is released, but I can say that there are options around day surgery, and there is an expanded option around 23-hour surgery, which would require up to one overnight stay.

I also want to point out that we are talking about procedures from surgeries right through down to, for example, a diagnostic colonoscopy, for which people in Tasmania are waiting far too long. I do two things, one is I put myself in the shoes of someone from - let us say - the south of the state, even south of Hobart, and how comfortable are people waiting for months for a procedure that should happen within 30 days, particularly when your GP is concerned that you may have an evolving disease and potentially a terminal one. It needs to be diagnosed and treated early. I do not mean any disrespect when I say that people are literally fearful and waiting and being made to wait for a long time. Having put myself in those shoes, imagine what that would be like.

I have tested this when I spoke at the public forums. People are telling me that they would like all their services in their local area, but if they cannot have them, they are willing to travel. People from the south have told me that faced with a choice between waiting months for something like a diagnostic colonoscopy and being able to be treated and seen to much sooner at the Mersey, then they are very happy to travel. I guess that is revisiting the reality of life for many regional Tasmanians, whether it is on the west coast, the east coast or on Bass Strait islands, that travel is already a fact of life for them in accessing some of those tertiary healthcare services.

With respect to all concerned, we are inviting the Tasmanian community to be part of something that is better in the future than what we currently have. We will never force people to go anywhere for anything. But faced with the opportunity to have something done sooner at the Mersey, I know what people will choose.

Second, our purchasing behaviours as a system, with the THS, will define what services and at what volumes we are willing to buy on behalf of the taxpayer. You will see significant increased purchasing activity out of the Mersey for elective surgeries, subject to the final white paper. The questions that Mrs Taylor also asked were about transport support.

This has been a really strong feature, particularly through the green paper consultations we held in February. I was impressed and amazed at the number of people who told me how difficult it is to navigate the system in getting access to health care. We took that very much to heart. It is not a new problem because of the white paper. In fact, in some ways, the white paper makes it less burdensome in travel, particularly in the north-west coast community where we see the greatest change proposed. You see far less travel required because, as it is, people have to travel out of region for services they should be getting locally.

That said, the Budget provides $24 million, as a genuine show of understanding by the Government that we get this. We recognise that this longstanding weakness in our system has made it difficult for people to access health services. An amount of $14 million is for recurrent activity, and we might need to come back to this later. We are still working through exactly how that will manifest, but it will be for things from emergency transport right through to non-emergency transfers between hospitals, and even maybe making the private transport subsidy that people can get reimbursed for, easier to use.

There is also $10 million for hard health transport infrastructure, and even tele-health solutions. Not just for the north-west coast, but for the whole state. Our tiny little state of 500 000 people can do health in a better and a more reliable way. It will require change, and not just on the north-west coast. It will require change in the south and north for people to have opportunities, for the first time, to get their treatments done.

Mr GAFFNEY - Shall we finish the Mersey? I know the $14 million is over four years and you have targeted $10 million for infrastructure. How will that $10 million be used? People would be interested to find out what infrastructure is proposed for that money, and whether that $10 million is part of the $315 million infrastructure bonanza the Premier has put out there. What is that all about?

You mentioned the white paper. When the federal government negotiated with the Mersey Hospital regarding the services that would be provided at the Mersey, there were certain criteria and targets or areas of expertise contained in the initial funding agreement. It was a good deal - $140 plus million for two years - but certain criteria had to be agreed to as part of the funding arrangement. With the continuation of that arrangement beyond two years, is that going to change dramatically? If we have $70 million a year going to the Mersey for a centre of excellence, such as elective surgery or whatever, how can we ensure the Mersey retains what is in the funding agreement? Could other areas say they can provide a service better and take the money with them?

Mr FERGUSON - That is a very well considered set of question, Mr Gaffney. I would also like to put on record my acknowledgement of - especially for a member who has just been through an election - how incredibly proactive and constructive you have been through this.

Many things are being said about the Mersey and its future role. The Government strongly supports the Mersey Community Hospital as a federal government owned and funded, but state operated, service. We have offered ourselves, as a Government, to the Commonwealth, to continue to operate that federally owned and federally funded hospital.

To the key question: the heads of agreement that you are referring to, refers to a range of core clinical activities. The Commonwealth is maintaining an effort in its funding towards the hospital, as you know, and as the white paper exposure draft outlines, we are proposing significant changes to those clinical activities. Some of which we have said in the exposure draft, are core and should remain as key services to the local area. We propose services that should no longer be potentially provided there. Why? On the basis of quality and safety. As a motivation of the Government, it is not about downgrading. I have heard this lazy use of the word downgrading when it is not a downgrade. It is a change. It is a change to the mix of services that are provided.

My continuing motivation will be to maintain that view and to ensure that the Mersey is as busy tomorrow as it is today - that it is busy. It is about getting the right balance of services that can be provided safely and sustainably. Not relying on a temporary locum workforce, which is very expensive.

The Commonwealth has been part of our consultation. We have been speaking to Tasmanians everywhere, but we have also been speaking to the Commonwealth about the white paper exposure draft. I do not want to speak for the Commonwealth but I will say, that broadly, they are supportive of health reform in Tasmania. I welcome that. They too could have played politics on this but they have not. That is not to say they are carte blanche on this, they are not. They are very much expecting to and are being consulted. They are supporting health reform in Tasmania and broadly as we move to the new two-year funding arrangement, it is yet to be finally determined as to what is worded in the Heads of Agreement.

Such was the importance of this issue that we felt it necessary, jointly with the Commonwealth, to make that announcement two weeks ago so that people could have certainty while the very finer points of formalities are agreed to by the two Cabinets. Until that happens, I could not go into the detail.

Mr GAFFNEY - On the last point, that is comforting for people to think that the Heads of Agreement, the Commonwealth, is comfortable that what may happen on the ground as Mersey changes somewhat, and they will still be supportive of that. There was some concern initially that if they did change what was happening on the ground, that the funding could be suspect. That is helpful. If it is a two-year agreement, the proof will be in the pudding a little bit to do with the statistics that come out of the Mersey. The Mersey operates at a very high level with the number of cases it sees and the clients it deals with. With greater emphasis on more elective surgeries, more day time, there should be an increase in the number of incidences, or the number of operations or whatever, that take place.

Where do you start your next lot? I know you have just finished this one and I was aware of Gavin Austin, having conversations well ahead of schedule regarding the next funding agreement? How does that work?

Mr FERGUSON - Thank you for that question. I would start the next round as soon as the first one is signed. Regarding laying out expectations for the future, sharing with the Commonwealth any changes before they are proposed, before any decisions are made about changes, we should, quite properly, consult with the owner and the funder of the hospital for which it is proposed that those changes should be made.

I was pleased that the Prime Minister, about two months or six weeks ago, made a very clear statement that responsibility for these things does rest with the state government, but as the owner and funder of the hospital, they maintain an active interest. As soon as this current two-year funding agreement is settled, we should take every opportunity to talk about the future. It is a good deal and I am glad to hear you say you agree with that. It is a good deal because it is a lot more than a lot of people were saying should be in the deal. It is good money and we want to make sure we achieve the best possible number and quality of outcomes. We want to show the Commonwealth we can commit.

CHAIR - Mike is asking, have you some sort of strategy in place? If, for example, the federal funding is not continued.

Mr FERGUSON - Yes, but not that I would be willing to go on the *Hansard* record talking about. We would always protect the state's negotiating position very closely. I would not countenance that the Commonwealth do not fund it in the future and I am not aware of any attempt to do that under this agreement

CHAIR - To clarify that, the funding is operational only in nature at the moment, the funding that you are getting from the feds?

Mr FERGUSON - Yes.

Ms FORREST - On the heads of agreement, I understand it has not been finalised yet. Will you make that publicly available so that it is clear what the expectations are in terms of service delivery?

Mr FERGUSON - I am quite confident that the heads of agreement will be publicly released.

Ms FORREST - What is the time frame for that do you think minister?

Mr FERGUSON - It is a Cabinet matter. It is between the two Cabinets. I will not speculate on what is in it.

Ms FORREST - It will not be months away will it?

Mr FERGUSON - It can't be.

Ms FORREST - I am concerned for the community, in particular in the Mersey area but the north-west coast generally, about what services are going to be provided where. If there is an expectation imposed through the heads of agreement that you would provide intensive care at the Mersey which we know is not going to be there. That is the concern for the community. It influences the way they see things up there.

Mr FERGUSON - I appreciate the point and I feel I know the answer but I do not feel empowered to give it because it is not my place to do so when we are in active process with the Commonwealth. It is equally their announcement to make but if I may say to the committee, I feel very pleased with where we sit at the moment both in relation to the Commonwealth being a constructive partner in health reform, trusting us on our assumptions and ambitions and wanting also, from its point of view, to get a good deal for Tasmania.

To go back to the Chair's question about any suggestion that the Commonwealth want to get out of it, I do not support that and I do not want to start a new story about that because there is not one.

CHAIR - I know that you would not countenance this but there is that possibility, who knows?

Mr FERGUSON - I will say this. At the Devonport forum I laid it out pretty bare - how does the community feel about this hospital, every three years, wondering about its future, every federal election? I think that is a poor situation for that community. My challenge to those people

who are actively working against health reform in Tasmania is, what are you doing to provide security for the Mersey into the future?

That is the risk for our state. I do not know in 10 years' time who will be in power, federally or state. I do not know who the two governments will be, who will be the local members for each electorate. I believe it is incumbent on all political leaders, federal, state and local, to be proactive and constructive about securing a role for the Mersey so it is not just a local Mersey asset. It needs to be an asset for the state. That is where I am coming from and all I can do is compliment the Commonwealth in their engagement with because they support health reform but they also support the Mersey.

Ms FORREST - They are not mutually exclusive, are they?

Mr FERGUSON - Some people would say that they could be.

Ms FORREST - You are not saying that.

Mr FERGUSON - Some people are calling on us to close it.

Ms FORREST - Yes, I know, some people are ill-informed.

Mr FERGUSON - We will not do that.

If I may introduce to the committee, at federal Parliament, where they are having Senate Estimates, a similar converse question arose and Ms Anderson was asked this question about the two-year heads of agreement. Ms Anderson said that the state government have their white paper process and are in the middle of a fairly intensive consultations across the island, talking about a new future for public health services across the state. It was considered in discussions at both bureaucratic and political level that, in the context of these fairly significant changes to health services across the island, there may be merit in having a slightly shorter agreement, over which time we would consider the future of the Mersey in the context of other changes which might be undertaken.

That perhaps illustrates that we are at a critical time in Health in Tasmania. We have - I will not say generous, I never would say generous about Commonwealth treatment - but it is a good deal. It is more money than we were being called on to secure and whatever, over the next two years, occurs in health reform, so long as I am Health minister I will be maintaining a posture that the Commonwealth needs to continue to be part of owning this issue.

Ms FORREST - Right at the beginning when you started talking about the Mersey Hospital issues and you talked about core clinical priorities or activities, can you identify what they are?

Mr FERGUSON - In the new heads of agreement or in the old one?

Ms FORREST - We know what they were in the old one.

Mr FERGUSON - No, I cannot in the new one because, as I have said, that will be strictly a matter for Cabinet until it is resolved. After it is resolved and the two governments agree, I understand it has been past practice and I see no reason to deviate from it, it would be available

publicly. I have absolutely no reservation in saying that but until it concluded I could not speak to it.

Ms FORREST - Just going back to the performance information on page 110, as we see often in budget papers the measures keep changing, which makes it impossible to track. With admitted patients, there is a change to the measure, why is there the change? There is some discussion in the footnotes about that. Will we stick with this change but why has it changed in the first place?

Mr FERGUSON - Which one in particular?

Ms FORREST - Admitted patients, under Admitted Services, the first performance indicator, you are now using the inlier units. As opposed to weighted separations it is now weighted inlier units. It talks about that in the footnote but I am just interested why the change has been made. It also notes in the footnote that there are aspects of care excluded under this new measure. Are we expected - in growth, in admitted patients? It seems in the figure that we are not, when you go back and look at the previous, add together the three THOs from last year's budget papers, which are under the table, to get to the figure there. It looks like there is not an expected growth in the number of admitted patients. I am also interested in whether that is the case or not, and why the change in measure.

Mr FERGUSON - That is very good question for the Acting Secretary. I can tell you this much about the previous measure of weighted units: they are notoriously difficult to rely on whenever you are talking about anything involving funding, or negotiating for funding or pushing for funding because it fluctuates but, in the end, they are measured, retrospectively. They are really only readily identifiable retrospectively so if the Acting Secretary could speak to how inlier varies from the previous measures.

Mr PERVAN -The use of the weighted inlier units instead of the old weighted separations is really a refinement that comes out of activity-based funding. It is a national development or evolution, and it also makes us consistent nationally. We are now looking at using a measure that more accurately depicts the complexity of the work coming through. The number of patients being admitted is increasing on average around 2 per cent to 3 per cent a year, every year. In weighted separations, we are seeing the complexity of those patients increase. If we could backcast the use of the weighted inlier units three years, and then forecast them, you will see a continuing trend of increased activity in the hospitals. We expect that and that is certainly what the Budget is addressing. They are also getting older and more complex as they are coming through.

Ms FORREST - This better reflects the amount of resources you use on an individual patient.

Mr PERVAN - Exactly. A cost weight is nothing more than a measure of relative resource allocation. The extent to which we are required to put more resources into people, be those continual costs or labour costs, all get captured under a weighted inlier model.

Ms FORREST - My old favourite bugbear about performance indicators and performance information is that there is a dearth of outcomes-based performance indicators. It is easy to count what goes in, but we really need to count what comes out and the effect it has had. How many patients were readmitted within 28 days of discharge as a result of complications related to their

admission, or the same condition for which they were admitted, in the last year? It should be in the budget papers and I would not have to ask the question.

Mr FERGUSON - Those figures are definitely measured. I am glad you asked the question, because it is not a bad one in contemplating what targets should be in the budget. I stand to be corrected, but I understand those figures are provided in quarterly progress charts.

Ms FORREST - Can we have the last year's figures provided then?

Mr FERGUSON - We have readmissions for mental health in the progress charts. I am searching if there are any others.

Mr PERVAN - Of course we had those figures in the green paper.

Mr FERGUSON - It is in the progress chart - on page 29 of the most recent one. Would you like to know what it says?

Ms FORREST - What date? That is to April, is it, or March?

Mr FERGUSON - Released in March, but it is as at 31 December 2014. I do not know if this is much use to you at the moment, but the most recent progress chart, which was released in March 2015 and relates to the period to 31 December 2014, indicates that in the reporting period there was only one readmission within 28 days for the state.

Ms FORREST - For the whole state? I find it quite staggering - working as a nurse for many years, particularly in maternity services - that there has only been one in the whole state in six months. That is what you are saying?

Mr FERGUSON - I will take that on notice and give you some clarity on that. I would like to further check that before coming back and answering.

Ms FORREST - It would be really good to have that information.

Mr FERGUSON - One of our identified concerns is the unplanned readmission rate. I accept that does seem very low.

Ms FORREST - Particularly as there is a greater focus on getting people out of hospital fairly promptly for lots of reasons, many of them positive reasons. Hospitals are dangerous places to remain in.

Mr FERGUSON - A lot of politics was played on that progress chart and no one asked me that question.

Ms FORREST - I am on performance indicator information still, because there is a range of issues that concerns me in the budget papers this year. Possibly it is because we are going from three health services to one Tasmanian Health Service, but you -

Ms FERGUSON - Ms Forrest, if you do not mind me saying, I would like to take it on notice and further interrogate it. I also make the point that there is very open disclosure on much of this data. We have to report data of that nature to the Commonwealth. You may remember the

Commission on the Delivery of Health Services in Tasmania interim report last April outlined a whole range of data which told us where we are going well and where we are going badly. I accept at face value your point about those things. If we can shed more light on that, we will.

Ms FORREST - Hopefully we will see more of these outcome-based points in the annual report of the department as well. That is still yet to be written, obviously, so there is still time.

Mr FERGUSON - I am not going to do this on the run, but I have just been advised that the one related only to progress on national emergency access target and the national elective surgery target, so it might be very much a subset of the bigger picture. Let us get the full answer. I am sure it will be more than one.

Ms FORREST - I would be surprised if it were only one. I would also like you to provide the infection rates. They are not measured in the budget papers here, but methicillin-resistant Staphylococcus aureus - MRSA - and clostridium difficile are really serious hospital-based infections. Do we have the infection rates for the last two years for these two bugs? Do we have a break-down by region on those?

Mr FERGUSON - We do, and we will have that. I would need to be able to take that on notice. I do not have a brief on that today. We would have ready access to that for you.

Ms FORREST - These are some of the outcomes. People who pick up an infection in hospital are there longer and it costs you more.

Mr FERGUSON - Without splitting hairs, I would say it is an open question as to which measures should be listed as performance outcomes. As I have said repeatedly to this committee today, we want the most number of outcomes, but we also want the highest quality outcomes that we can strive for. Plainly there is a balance there between things like, for example, how many elective surgeries have been performed and on time. Then there are other - if you can put it this way - negative measures that need to be reported. We have to consider what the best mix is of those outputs that help to give us a clear picture about how effective and responsive our health system is.

Ms FORREST - They are not negative measures; they are outcome measures, I hesitate to suggest, minister, because -

Mr FERGUSON - A negative measure would be an MRSA infection. Obviously we are targeting that to be fewer than two per 10 000 patient days. I would say that is a negative measure, but not to split hairs.

Ms FORREST - You have the cost per weighted separation at the end of admitted services. Much of the previous discussion about the difficulty with measuring weighted separations is in terms of the new used weighted inline units. Is this cost going to change as well? You have a patient coming in, have them leave, and this is what the average cost is in the terms of cost per weighted separation? Are you expecting it to go down this coming year?

Mr PERVAN - The cost for weighted separation is projected to be coming down this year, but that is more about what that particular measure is capturing. We are capturing more data in Outpatients and in lower cost settings which brings down the average. Same with community

settings; we are getting more data coming in from the community and through clinics and other issues like that. That will bring down the average.

Ms FORREST - This performance measure does not relate to admitted services, is that what you are saying?

Mr PERVAN - It does but it limits services which can include a day procedure or a procedure that might be chemotherapy, intravenous drugs, something like that. You are still an admitted patient but you are not in the hospital for more than a few hours. We are getting more and more activity coming through like that because it is a safer, more patient-focused way, of delivering service.

In terms of the data that we are referring to at the top with the weighted inlier units, the difference between the two is that some of the services that are delivered through weighted separations is not necessarily going to quality for Commonwealth funding. There is a slight difference between the two measures; one feeds into the other, but they cover slightly different baskets of activity.

Ms FORREST - No wonder it is difficult.

Mr PERVAN - It is incredibly complicated, given that the agenda in 2011 was to create a simple solution.

Ms FORREST - I am not quite sure they succeeded in that.

Mr CHAIRMAN - Are there any more question on 1.1? If not, we will move to 1.2.

Ms FORREST - On page 107, budget paper (2) volume (ii), you talk about the Hospital Alternative Program. A couple of questions in regard to this area. When and where will Hospital in the Home be reinstated? What other hospital avoidance programs will be commenced, and where will they be? What process has been used to progress these initiatives?

Mr FERGUSON - The Hospital in the Home program was provided in Tasmania until around 2011-12, when it was abolished, particularly at the Launceston General Hospital. It was working with a reasonably small total of patients. From a policy point of view, if you think, for example, of a cystic fibrosis patient, some of this caseload is ideally provided out of hospital away from risk of infection, so the Liberal Government has pledged to, and has budgeted to, provide for restoring alternatives to hospital care and that includes potentially Hospital in the Home, exactly as it was before. We are still working through the very best way to deliver this commitment. The money is fully provided for in the Budget. We have not drawn down on that yet.

Implementation of it and providing alternatives to hospital care is a significant feature of the white paper. Until the white paper is concluded and released at the end of this month, I am not in a position to describe it further than that but including alternatives to hospital care will be a key part of the rebuilt health system. It is about providing better care coordination for people with complex chronic conditions, with a focus on reducing avoidable hospitalisations and improving health outcomes. While that funding for 2014-15 is unspent, naturally you would be aware the white paper process has superimposed itself over a number of initiatives, including this one. We want to make sure we get the policies right before we start spending the money. We want to make sure it is targeted.

You also asked about where. I am not in a position to say where. It would naturally be focused on getting the best possible outcomes around the state.

Ms FORREST - We all understand the Hospital from the Home was a program based out of the LGH but obviously there are benefits in every region for that sort of service. People with CF for example, live in all parts of the state.

Mr FERGUSON - I am happy to re-state that our commitment is also about restoring Hospital in the Home at the LGH but I am not going to be doing that on its own. It needs to be as part of a broader statewide agenda. After all, if these initiatives are worthwhile, and they reduce the burden on our acute care settings - acute hospital settings - they are worth doing well and worth doing in as many places as possible.

Ms FORREST - Thank you. With regard to points Mike was raising earlier about patient transport - he mentioned, as you have, the $10 million for capital upgrades. Is there any consideration being given to using some of that infrastructure spending to build accommodation, or is it more likely to be used to support people to access accommodation?

You mentioned the patient travel assistance scheme. We have had some really great people working in that scheme in the north-west - I certainly acknowledge that - but it is cumbersome for people to use. Most of the people who use it regularly because they have chronic illnesses and have to travel to access health services, need to find the funds up front and some of them are in a position where that is very difficult. Some of them choose not to travel for care and perhaps do not have appropriate care because of that.

Will a review of PTAS be included in this, as well as the options for capital upgrades? What might that include? In the budget papers, you also talk about streamlining patient transport between facilities. I would like to go down that path - what you are assuming by that - in a moment as well.

Mr FERGUSON - Sure. As we discussed earlier today, it has been a standout piece of consistent feedback from the forums we held in February. I will not say that I was amazed or surprised by that. In my work and in yours, and no doubt everyone here in the committee, we have all become aware of times where people have wished that the patient transport system was better for them. I was impressed with the reality that people identify transport as a significant barrier to access to health care. Ms Forrest, you have very helpfully pointed out that in some cases it is not just cumbersome, or not that user friendly, but some people choose not to have care because it is too hard.

A couple of points. First, could that $10 million be used for building accommodation? No we are not planning to do that, but at the same time we are looking internally for very careful and strategic investments we can make. I am not dismissing it out of hand but it is not something that we intend to do. That would probably not be where the policy was really coming from.

We want to make sure the transport infrastructure, however, can be improved in such a way as to make those improvements work for people. If you would forgive me on that, we are actively working on this with the project team on health reform, and a range of proposals are currently being examined and considered.

Broadly though, on improving transport and accommodation support, you asked me what might have been thought of in terms of transfers between hospitals.

Ms FORREST - You said streamlining patient transport between facilities. Does this mean bypassing departments of emergency medicine after hours in some cases - that sort of thing - or were you talking about something different?

Mr FERGUSON - No, we are not really talking about that as such because that is happening now, if it is clinically appropriate. We need to make sure, as part of the white paper proposes, that if an ambulance is picking up a 000 case from a person's home or business, we want the paramedics service to take them directly where it can plausibly be predicted. We want them to go first to the facility that will service them because there are instances at the moment of going to one only to be transferred to another. It would be far smarter if our care planning was geared around taking the patient to the place where they will receive their care in the first instance.

Second though, I highlight that the exposure draft of the white paper proposes that emergency patients who are brought by ambulance to the Mersey Community Hospital in some cases will need to be treated as a first response there onsite and then if they require to be admitted, they will need transport. We want to make sure that we have put better effort into making sure that transfer can be made in a timely way, for two reasons: one, it is better for the patient, and two, it frees up a bed at that site to allow the next person to come in and be relieved of being in the waiting area.

We recognise that our additional funding provided for in the Budget is not just limited to that, it will also provide for additional emergency and non-emergency patient transport. I have already mentioned improved utilisation of paramedics to reduce demands on EDs. There are also improved trauma and retrieval services, including for neonatal retrievals, which is another important element of the white paper proposals; and increased transport and accommodation support for families. Also, and importantly, I have ensured there is potential also to provide for initiatives to decrease travel or not need it all by using better well-planned telehealth. We can certainly use video conference facilities better; at the moment we have the hardware but it does not really work for patients or clinicians. We need to explore that better.

Ms FORREST - So that funding could be used for that?

Mr FERGUSON - Yes. I have been quite outspoken about the infrastructure funds of $10 million potentially also taking account of whether we can improve some of that hardware infrastructure.

If I can finalise my answer, Ms Forrest, you also mentioned about how people find it difficult to use our PTAS system. I am not saying this because I have not checked it for myself but I am told that it is one of the best or most generous patient transport assistance schemes in the country.

Ms FORREST - I was not criticising the people who are working there.

Mr FERGUSON - I know you weren't.

Ms FORREST - Kim Miles in Burnie has been fantastic for many of my constituents.

Mr FERGUSON - What I am trying to say is that the financial treatment it provides does not of itself mean that it is easy to use. I do not know the answer to this but I suspect that there is a

technological improvement that could be made to PTAS rather than people, particularly people who are on hard times, having to find the money up front only to be reimbursed a percentage, all or some of it, later on. I would also like to explore whether we can take this clunky system and make it easier to use for our health consumers. I do not know the answer because I do not want to promise something before it has been thought through. I have asked the department and the project team to work in this area because firstly, we could be providing a kinder service to our patients.

Second, if we can make it more user friendly we may in fact help people to get their health care at all which is an important outcome.

Ms FORREST - I can put you on to some key witnesses if you would like of the people who need it.

Mr FERGUSON - I would appreciate that.

Ms FORREST - They are not complaining about it. They are just naming the challenges in actually accessing it for timely access for their -

Mr FERGUSON - I endorse that and also I can say to the committee that I have had very few people complaining to me in writing or email about PTAS. People just work with what they have and they try to make it work. I went to the community and I asked what barriers do you have to access in health care, and this is what they told us.

Ms FORREST - We will sort it out later, we will leave it in our office.

Mr FERGUSON - Is that how it works? That is what people have told us. They told us that it can be very difficult to get access to those health services wherever they are located. We have responded to that.

Ms FORREST - I noticed you will move the cancer screening services to the Tasmanian Health Service on the 1 July. I am interested in how this will increase screening rates, because the target in last year's budget papers for 2014-15 was 32 000. Now the target is only 29 738, and the target is only 30 990 for 2015-16. If this move is going to improve access and services, why have the targets diminished, as we are seeing, in some areas reductions in screening, particularly in breast screening?

Mr FERGUSON - Where are we seeing reductions in breast screening, Ms Forrest?

Ms FORREST - We proved that in another committee forum, that there are reductions.

Mr FERGUSON - I would like their name and number.

Ms FORREST - The budget papers have a target less than was achieved in 2013-14. We do not have actuals for this year, and you will not either, because this year is not finished. I am interested how the move will increase screening rates.

Mr FERGUSON - The move of itself is not particularly about improving.

Ms FORREST - Screen rates.

Mr FERGUSON - Screen rates, no. The move is reflective of some of the health reforms that we announced. One, which was a key point, was the Department of Health and Human Services needs to have a clearer mandate about health management and purchasing behaviours. With the cancer screening and control services, which is provided currently through the department - as far as I am concerned it is a front line service and its proper and best place is in the Tasmanian Health Service, which is a front line service delivery organisation. There is not much more to it than that in policy, but broadly in what is envisaged did you mention breast screen?

Ms FORREST - Yes, the target is less than what was achieved last year. For this year we are currently in and the year coming -

Mr FERGUSON - It is modestly increasing.

Ms FORREST - The numbers?

Mr FERGUSON - Yes.

Ms FORREST - That is the number of eligible women; it does not mean they are all getting screened. That is how many women are eligible.

Mr FERGUSON - Are you talking about the percentage of clients assessed?

Ms FORREST - The number being screened, assessed within 28 days of screening.

Mr FERGUSON - Sorry, I have misunderstood the question. Are you referring to the 94.2 drop into 90?

Ms FORREST - Yes, but also we do not know how many women are screening. We know how many eligible women there are. What I was referring to was that the evidence to another committee suggested the number of women who are being screened has fallen, not the number who are eligible. There are two different figures.

Mr FERGUSON - I do not think I am mis-reading it. The first figure is for eligible women who were screened.

Ms FORREST - Oh is it?

Mr FERGUSON - Yes.

Ms FORREST - That is not how I read it.

Mr FERGUSON - Eligible women screened for breast cancer.

Mr MULDER - Screened as in the past tense.

Mr FERGUSON - Yes. I thought you may have been referring to 94 dropping to 90.

Ms FORREST - Yes, I was. I would like to take you back, minister, before you go on. This is why I said there has been a drop. In the budget papers from last year, the target was 32 000 but only 29 738 were screened. A target is a target, but you have dropped the target. It is not an actual, because you do not have an actual.

Mr FERGUSON - That is a helpful observation and I will take advice on that. If I may also say we are significantly enhancing Breast Screen. Apart from the mechanics of where the services are provided outside of Hobart and Launceston, we have had the bus return to places where it has not been since 2011. Places like Bicheno, and St Marys. So that has happened. That has been quite successful which is pleasing, in terms of take-up. There is additional funding from the Commonwealth and the state for additional screening opportunities. We are looking at the moment at an additional 9 000 appointments being available. I would like to check.

Ms FORREST - On the buses, is that?

Mr FERGUSON - In total across the service.

Ms FORREST - In terms of screening services?

Mr FERGUSON - That is right. Yes, significant extra effort has gone in. We have expanded the eligibility age range from 50 to 69 out to 50 to 74. We have joined a national partnership agreement with the Commonwealth to provide more appointments. Recently - I only announced it to Parliament last week - we secured even further funding to equate to an additional 1 000 appointments.

We are purchasing a new breast screen bus. As soon as that is commissioned and on the road, we will take the first breast screen bus off the road and refurbish it. Our outreach in this area is very strong. It is a credit to a lot of good people who are working in this area.

Ms FORREST - To take you back to that, to your target being less than it was. If you are increasing your eligibility to older women, you would expect that to increase. Once women are diagnosed with breast cancer, they can no longer use the screening service. They have to go back to the diagnostic, so you lose those women straightaway from that service, and the occasional man.

Mr FERGUSON - It has been pointed out to me that key performance indicators require that it is the 90 per cent target, so I suspect that is always a base. I suspect that that is an annual target but we are exceeding it. I am not aware of any risk that we might fall below 90, or deteriorate our current performance. The only caution I will throw on that is that we are putting many more screenings into the community, so naturally it will follow that, sadly, there will be more positives that will need to have further follow up.

Ms FORREST - But those positives do not end up back in the screening service, once they are diagnosed -

Mr FERGUSON - They do in the first instance.

Ms FORREST - Yes, but repeat screens, you cannot; you have to go to -

Mr FERGUSON - The second screen is in the cancer control. The first screening, the mammograms that occur, that happens within BreastScreen. The follow-up appointment, when women are asked to come back for a follow up, they do happen.

Ms FORREST - That one, yes. I was thinking about later on. If they are diagnosed, they do not.

Mr FERGUSON - The health treatment occurs in a THS ward. I will, however, if I may, grab that on notice and report back on the specifics of those numbers and why it is not tracking up higher than it does.

Ms FORREST - The other screening, the bowel screening, is a Commonwealth initiative. There has been some concern about the uptake on that. It is probably a bit more difficult to promote bowel screening in a nice, attractive way, as opposed to breast screening. I am not sure what it is, but is the state Government doing anything, particularly in this area to try to increase the uptake of other screening opportunities?

Mr FERGUSON - Other than breast screening?

Ms FORREST - Yes.

Mr FERGUSON - I was looking for some participation data for you. In the meantime, I will ask the Acting Secretary to speak to what the department currently is doing in this area, bearing in mind that from 1 July it will be a THS.

Mr PERVAN - While we are aware of the program and certainly work with the Commonwealth, the promotion of the bowel cancer screening is very much being driven by the Commonwealth department. They have a social marketing campaign through GP offices and public toilets all over Australia.

Ms FORREST - On the backs of doors?

Mr PERVAN - On the backs of doors and places like that. We access -

Ms FORREST - Men do not often stand and face the door. Therein lies your problem - they do not see it. Are they above urinals as well?

Mr PERVAN - Yes, they certainly are. We are a secondary promoter, so we get their materials and all their resources and promote them through our own community health centres and places such as that. We are a participant in their promotion campaign as opposed to driving it. It is very well resourced from the Commonwealth but unfortunately their participation rates could be better.

Mr GAFFNEY - Participation rates are less than 30 per cent, as was explained to us recently. There was a suggestion that if the state stepped into that space in Tasmania, they could provide a better media campaign to get out to people in Tasmania, the men particularly. That is a space they could probably fill or assist with. That is a very low percentage of men, so it does not appear to be effective - and those percentages are dropping.

Ms FORREST - A lot of money is spent by the kits being thrown out in the rubbish.

Mr GAFFNEY - Yes. It would be wise if there was a discussion. If we have limited money within Health, we need to put it to the best use to encourage screening. There is a different relationship between this state and the federal government because of the ownership of the Mersey Hospital. Using that relationship there could be a way forward, to say we could do this better and provide baseline data about how more effective we could be if we could link these two together.

Mr FERGUSON - A great constructive comment, and I will take that on board. It is a helpful suggestion. In breast screening, we are seeing a participation rate for the target age group of 57 per cent. That was the last figure over the 2013-14 calendar years, two years. The Acting Secretary may have mentioned the latest figure for participation for bowel cancer screening was 37 per cent, so just over one-third. In cervical cancer screening that is up to 57 per cent, so you can draw your own conclusions.

Ms FORREST - With the shift of the cancer screening services, are you moving the whole thing holus-bolus? There is no change to staffing or any other arrangements?

Mr FERGUSON - It is a simple administrative change. They will not even change physical location.

Mr GAFFNEY - How did you come up with the $5.4 million going from the public health service across?

Mr FERGUSON - It would just be a simple matter of taking the organisational recurrent cost of that service and taking it out of one organisation and into the second.

Output group 2 -
Tasmanian Health Service

2.1 Tasmanian Health Service -

Mr MULDER - My question is about the recall of the breast screening patients, which I think is what that second point is saying, the percentage of clients assessed within 28 days of screening. They are the ones that are recalled. I know a fair few might wish to opt out but in 2012-13 there is something like 6 per cent or 7 per cent of people who have had an adverse screening. What are we doing to make sure they are not opting out of further treatment? There would be a target group to look at if they are not coming back for a subsequent screening. Is there something where they really opt out or whether we say you haven't taken advantage of our invitations.

Mr FERGUSON - I am not sure we should assume they are opting out either. They might be opting in late, for example. The figures there relate to the percentage of clients assessed within 28 days at least. We have a target. We want to achieve 90 per cent at least of patients with a positive test in the screening service coming back within 28 days. At the moment we are in the low 90s - 94.2 in 2013-14 - and the missing 5.8 per cent have potentially come in after 28 days. I suppose there will be some who did not come back for their return test, but I know from my experience with breast screening management that they work pretty hard to invite them to come in for follow up assessment and biopsy.

Mr MULDER - I would be interested to know how many are opting out of any further treatment at all, or what measures we take to ensure they come back in.

Mr FERGUSON - Would you like to place it on notice? I would be happy to find out and bring that back to the committee.

Mr MULDER - What I am trying to get at is - if someone does not front up within 28 days, what do you do to get them to come back in? Some positive intervention?

Mr FERGUSON - I would be very happy to report back.

Ms FORREST - To follow on from that - the Breast Bus just does mammograms. It does not do ultrasound, does it? Or does it do ultrasound now, as well? Many women, with the density of their breast tissue, have to have an ultrasound. Some of those women may well go to a radiology service where they can have an ultrasound and a follow up mammogram, as opposed to just going back to the bus because it may not necessarily provide the service they need. This may be a question on notice for you, too - if an ultrasound and a repeat mammogram, or another check, are recommended and the woman goes to a private radiology service, is that picked up in those figures? They could be some of the ones you are not picking up. They could have been followed up, but in another setting.

Mr FERGUSON - These figures are only picking up women who have come to our BreastScreen service. If a woman, for whatever reason - between her and her doctor - went to a private provider for a follow up, they would not be captured, I understand, in these figures. These are follow up figures for our own service. It may explain why one or two do not come back to us for their follow up.

Ms FORREST - You would get straight back in - almost the same day.

Output Group 1.3
Emergency Department Services

CHAIR - Minister, we might move to output group 1.3, which is Emergency Department Services. Mr Mulder, you can kick it off.

Mr MULDER - My question is quite straightforward and is about the number of presentations over the long term. Your target this year expects them to drop - going back to Budget Paper No. 2 volume 2, you have presentations dropping.

Mr FERGUSON - The performance information suggests that 2014-15 numbers will be a reduction from the previous year. I will come back to that in a moment - 'N/A' means we have not yet negotiated our service agreements with the THS governing council.

Mr MULDER - What we are suggesting is that from those previous figures that this year is trending reasonably significantly less than the previous increase. I wonder whether you have some comment to make on either management - throwing the drunks out the door before they register. The question was when was the target set and why? That is a better way of putting it.

Mr FERGUSON - The targets of 2014-15, I understand, would be from last year's, or even earlier years', budget papers. I am happy to give you some further data on what we have in terms of up-to-the-minute presentations for 2014-15.

Mr MULDER - Maybe that plus extrapolations for the years. It would be seasonable trending too, like with the flu season coming upon us and things like that. It would be interesting to know why the wider target was set as it was, whether you are going to meet it and what measures you have in place.

Mr FERGUSON - We more than meet it. I can assure you we will more than meet it. It is high demand on emergency departments and, frankly, it is growing. Mr Mulder, the explanation I can offer here is that what you see in the 2014-15 figures is the target.

If I can take it on notice, I -

Mr MULDER - Perhaps after lunch.

Mr FERGUSON - It is better if we do not waste the committee's time right now.

Mr MULDER - I do have some other questions. What particular facilities are captured within this department of emergency medicine presentation data? I take it, there would be the Royal, the LGH, the Mersey, and the North-West General? Are there any other so-called emergency departments operating throughout the state?

Mr FERGUSON - This is a presentation of data of the four official emergency departments and the four majors.

Mr MULDER - That just about does me on emergency medicine.

Ms FORREST - Again, minister, there is a lack of performance information in looking at the number of people who were admitted, referred or treated, referred for treatment and discharged within four hours. I looked at last year's actual numbers. They were across the three THOs then, so they did vary enormously in 2013-14, from 60 per cent to almost 77 per cent. Obviously a lot lower than 90, which is where the target is.

Do you have figures for across the three regions we currently have for waiting times and patients who were treated within the four-hour time frame? If so, could you provide them, either tabled or read to us?

Mr FERGUSON - First of all, the targets listed in the performance information are directly taken from the National Emergency Access Target, NEAT. Tasmania is a signatory to that. It goes back to 2011 approximately, when we signed up to health reform. They are the targets as agreed. In reality, we are not meeting those targets. What would you like, Ms Forrest, the latest?

Ms FORREST - What your current figures are.

Mr FERGUSON - The latest figures that I have to hand are: national emergency access target, percentage admitted referred to another hospital for treatment or discharged within four hours, for the Royal, 60.4 per cent.

Ms FORREST - What date is this?

Mr FERGUSON - As of 31 March 2015. For LGH, 61.76 per cent; for the North-West Regional, 76.08 per cent; and for the Mersey Community Hospital, 77.5 per cent.

Ms FORREST - Which are almost exactly the figures for the last year, the 2013-14 year. We are not seeing much progress in that regard, in improving that. I know you accepted that we are falling behind what the expectation is, but we do not seem to be progressing either.

Mr FERGUSON - Those numbers are a reflection of what is happening in those EDs, even ours. We are comfortably sitting here while there are people uncomfortably sitting in waiting rooms, no doubt, in our four emergency department waiting areas. I make the point - I know I do not have to make it to you, Ms Forrest, or this committee, but for the broader public - that it is really not even a reflection on the performance of our EDs. It is more a reflection of the system as a whole, and the availability to those EDs of places to admit their patients to. The classic issue of bed access is a limiting factor for their performance.

Ms FORREST - Do you think bed access is still the main issue, do you?

Mr FERGUSON - Without a doubt, absolutely. That has been consistent feedback that I get. We can, if you would like us to, explore that issue, but broadly, that is the problem. Our hospital wards, to which patients would be admitted to, are meeting occupancy, they are meeting capacity.

Ms FORREST - I will come back to this point in the next output group, because I believe there is a connection here I would like to make on those comments regarding bed blockage. In regard to the expense allocation, you are saying how much you are going to expend in this area. I am looking at footnote 4 that relates to the emergency department services, it says the decrease in 2016-17 primarily reflects the finalisation of funding under the Tasmanian Health Assistance Package through the NPA on Improving Health Services in Tasmania, schedule E, Improving Patient Pathways through Clinical and System Redesign, innovating care in emergency departments. That was a federally funded project that is now completed.

How did that improve things? Would it be much worse without that? It seems that we are not really moving ahead in this area, for a range of reasons. It was talking about innovative care and patient pathways. How was that money utilised? Why haven't we seen improvements in the waiting times and progress through the DEM?

Mr FERGUSON - I acknowledge here that this is and has been a longstanding and challenging issue not just for Tasmania but I think for all states and territories. This is not to sound glib or flippant, but it is very easy for practitioners to admit someone to a bed in a hospital because they are sick and they need a bed, but the system is less inclined to discharge that person, either home or into community care. There is a taking up of a resource that is -

Ms FORREST - Once we have you, we do not want to let you go.

Mr FERGUSON - Yes, it is a bit of that, I suppose. It is that we find it hard to let you go. I think most clinicians would love nothing more than for their patient, who no longer really requires an acute care hospital bed in the medical ward and who could be perfectly well suited to a step-down provision of care, to get into that care, but either it is not available to them or not easily -

Ms FORREST - Transport is an issue.

Mr FERGUSON - It might be transport; it might be the lack of a community care opportunity. It might be - I can tell you it is often - a difficulty of having that person cared for in residential aged care, where they would be perfectly happy and able and best suited to be cared for. It is classic bed access issues at play. Insofar as the funding that has been provided through the Tasmanian Health Assistance Package under that NPA, it is these innovative care streams in emergency departments, which have been meritorious in different ways, but they have not of themselves fixed the problem either. The classic comment I hear from the clinical directors of emergency departments is that they just wish they could give their patient a bed.

When there is an empty bed in an emergency department and it is an opportunity for someone to come out of the waiting area into the ED itself, the care they receive is second to none, perfectly good, and no criticism. Once they are in that bed, they are seen to and given their first emergency treatment and it is decided that they can go home, I suppose, it is quite easy to discharge, provided there is some way of getting them cared for outside, like a family connection.

It is not easy if that person requires a bed upstairs in one of the wards. That is the classic feedback I receive and we are working within our white paper reforms. I will ask the acting secretary to come back to this for me, but we are working on continuous improvement on this. The white paper is part of that and, second, we have Health Service Innovation, which is a collaboration between the state Government, the Commonwealth and the University of Tasmania. It is literally getting access to the data, mapping what happened, tracking what length of time patients were spending in different stages of their care and literally putting it on the wall and illustrating it and being able to see -

Ms FORREST - Where the blockages are.

Mr FERGUSON - Exactly. Seeing the wasted times and the wasted footsteps. HSI are providing an evidence-base for future reform, but it will be a long-term issue for us to deal with.

Ms FORREST - I would like to know if you have data on how many patients are discharged from the DEM to home or into the community, following being seen by the doctor - I am not counting those 'did not waits' and there will be a number of those - re-presented to the DEM within 48 hours. Some who have been discharged and then within a reasonably short period of time re-present?

Mr PERVAN - I do not know off the top of my head. We could find that out, but it will take some time. It is not a standard reporting measure.

Mr FERGUSON - I have never seen that data.

CHAIR - Take it on notice, if it can be provided.

Mr FERGUSON - I will not take the question on notice. We will provide what we can, but it may not be what you are asking for because I am not sure we have that figure. I have never seen that.

Ms FORREST - You do not have readmission rates to DEM at all?

Mr PERVAN - No, only to theatre. Unplanned readmissions to theatre. Quite frequently it is going to be hard to determine where someone has come back to the DEM because of their pre-existing condition has deteriorated or if it is a new condition, particularly with some of the mental health presentations, but we will have a look and see what we can do.

Ms FORREST - The reason I ask is because I hear quite a few instances through my office where people have been sent home from DEM and then re-presented for the same condition. Unfortunately, some of them do not re-present, they die before they get there on the odd occasion, which is even worse. I would be surprised if those figures are not kept of people who are discharged because how do you know if they are perhaps being sent out a bit early or a full and proper assessment may not have been conducted, so their condition was not managed well enough. Things like acute injuries related to their diabetes or asthma or some of those conditions that may warrant it and children are the classic example of this. I would be interested in that information being available.

Mr FERGUSON - I can quite openly say I have never seen that kind of data. I am not sure it is collected or easily accessible.

Ms FORREST - Do you think there is some merit in it?

Mr FERGUSON - At the individual level it would be, provided the person who is re-admitted - let us take it on notice.

Mr MULDER - I have one more question exploring the times of presentation that do it through the DEM. I guess there are a fair few who get triaged and kept for a couple of hours for observation and then allowed to leave. Those are the very sorts of services that some of the more regional places used to offer, but do not any more, like the Tasman Medical Centre. As you know that was a critical thing for the community - the security of knowing it was there for minor conditions.

Is it possible to re-examine the provision of those services through aged care centres that provide step down care facilities, which is basically monitoring someone post operation?

In terms of service delivery to some of these regional communities - if it is not important enough to take an ambulance for an hour and a half to Hobart, we are going to provide you with a targeted level of service similar to that provided to people who can self report to the hospital.

Mr FERGUSON - I acknowledge the basic point. It is not unfair - the way you put that. It is not the case that we are withdrawing emergency departments or emergency rooms from regional centres. I acknowledge what you said about Tasman.

If I can briefly reflect on Tasman, and the decision taken by the operator of the service there -

Mr MULDER - We can get to that a bit later on.

Mr FERGUSON - I thought you were inviting me into that one.

Mr MULDER - Not at this point. It is not really relevant to this.

Mr FERGUSON - Only that I would like to say that it was not for any reason other than quality issues.

Your broader point, then, about access. There is a fine line here because when you put out a shingle to offer a service, you need to be able to back it up. It needs to be a quality service.

That is a key issue for health policy makers - to ensure that if you are offering a service, you can back the offer with the kind of service people will be able to rely on. In quite a number of regional centres we offer round the clock emergency care but it has to be weighted against the need for having staff that are competent and current in their practice. Second, we need to make sure the community knows that if it is an emergency, the one thing they should not be doing is going to any hospital. They should be calling triple zero.

Ms FORREST - Who will take them to the hospital, hopefully.

Mr FERGUSON - The paramedic or the ambulance service - the triage system that kicks in behind the 000 service - will get them to the facility that will best suit their needs. Sadly, there have been instances of people with quite severe and emergency life threatening conditions, driving or getting themselves driven to what they think is the nearest appropriate facility and it has not been the best and most appropriate facility for them. They would have been much better off to ring 000. I take your point, and it is a good point.

Mr MULDER - Or GP Assist - suggesting they drive to certain areas. On that issue - it relates to the original issue about presentations, the number of presentations.

What about managing presentations at the emergency department that are clearly a case of, 'Please go home and sober up'? Are these the sorts of people you are triaging and if there is a bed available, giving them a bed and mopping their brow. Or are we parking them, as the previous health minister suggested, in the emergency waiting room to sober up?

Mr FERGUSON - That is a very interesting question, Mr Mulder. I have not heard it put to me like that ever before. People are triaged on the basis of need and in the particular scenario you have highlighted, I do not know what the previous health minister said, but we would always take the patient who most needs the service and it would be as simple as that.

Mr MULDER - I ask in the context of there being a time when we all got on our high horses and said we should decriminalise drunkenness. Suddenly the ancient old practice of the police officer picking you up, taking you to the drunk tank, putting you in a cell where you could be watched, and bailing you to appear in court, was gone. When we got rid of that, we did not create places of safety where you could take drunken people. No - every time they are drunk, they have got a medical condition, and take them to the hospital. It is still happening, isn't it?

Mr FERGUSON - I will explore that. I do know there are some, but not many, limited and designated places of safety - sobering up beds. I can think of a couple.

Mr MULDER - I will get to this in a moment. The Chair has some questions about the ice program. I am wondering whether we could perhaps reactivate the idea that police lock-ups, with a nurse or something, is an appropriate place for some of these people exhibiting inappropriate behaviours, rather than using hospital services.

CHAIR - Minister, bad light stopped play. We are going to retire for one hour. We will resume, if we haven't quite finished questions on the emergency department, we will start again at output 1.4.

The committee suspended from 1.05 p.m. to 2.00 p.m.

DIVISION 3
(Department of Health and Human Services)

Output 1.4
Community and Aged Care Services

CHAIR - We will start the next session, and move now to 1.4, which is community and aged care services. Mr Mulder has the lead.

Mr MULDER - This relates to the Tasman Medical Centre, or the Tasmanian Multi-Purpose Service. The not-for-profit services provider is the Hobart District Nursing Service. When is its current service contract due to expire?

Mr FERGUSON - Mr Mulder, the current funding agreement expires 30 June this year. There is active work underway between the Commonwealth Department of Social Services, and the department through THO South. It is understood that the Commonwealth is currently determining its future funding arrangements for multi-purpose services. However, it is understood that there is no risk of the funding beyond 30 June this year.

Mr MULDER - There is no risk to the funding? Or there is no risk of funding?

Mr FERGUSON - There is no risk to the funding.

Mr MULDER - Thank you. We accept the fact that the community GP service was not actually directly funded as a result of those agreements, but is it a fact that the funding would be for the GPs to service the aged care facility? And that, off the back of that, there is some synergy - if I can use that term - in providing some services to the community?

Mr FERGUSON - That is a pretty good way to put it.

Mr MULDER - A number of threats were made that the Hobart District Nursing Service would pull out. It was suggested that would lead to the loss of 68 jobs in the area. I believe that position was put to the community a few times. As minister, you gave the council a written commitment at some stage that the MPS would not close. My question really is about that threat to extinguish 68 jobs. Given your commitment not to close the facility, is that perhaps a blind threat or a bluff, or an inappropriate threat on the part of the Hobart District Nursing Service?

Mr FERGUSON - So what part of your question are you putting to me?

Mr MULDER - There are a couple of propositions in there which you may or may not agree with, but the first proposition was that the Hobart District Nursing Service had threatened to pull out of the MPS. The result of that would have been the loss of 68 jobs - that was quite adamant.

The other proposition was that you have written to Mayor Heyward, I have a copy of your letter, which says,' is the Government planning to close the MPS, no'. This is your response:

> Please be assured the state Government is committed to the ongoing provision of safe and sustainable health services at the MPS.

Given those two propositions, my question is, was the threat of HDMS to remove 68 jobs a false threat?

Mr FERGUSON - First, my undertaking which I have provided to the community at Tasman Peninsular, via the Mayor in that correspondence, I stand by. It is also the same commitment I have provided to any other community that has raised any concerns. Sometimes that is political prompting from my political opponents. We have provided an assurance that health reform is not about closing down facilities, it is about making sure that we get the best possible outcomes for our investments. That is a message of comfort that I provide to all Tasmanian communities, that we do not need to achieve health reform at the expense of our facilities. We can sustain them, provided we are willing to alter our thinking about what we expect from our funded health services.

In the case of Tasman, the state is the smallest player as a level of government in the provision of those services. There are 17 residential aged care beds at Tasman Multipurpose Service and two sub-acute beds funded by the state. All of which are therefore provided by the non-government organisation to Hobart District Nursing Service. The two beds that we fund are an ongoing commitment by us but two beds on their own do not make a service viable.

Interestingly, what has happened is that the service is under some threat but it is not under any threat because of the actions of the Government. It is not under any threat because of the actions of Hobart District Nurses who have met all the requirements set by their two funding levels of government. The service is under threat because a small number of people have successfully run a campaign to undermine the service providers to successfully circulate a petition that expressly stated a lack of confidence in Hobart District Nursing Services to continue to be the operator of that service. With more than 600 signatories to that petition, out of a population of just over 2 000 people, a very strong percentage, one might say, although a minority, a very strong voice from the community who signed that petition. If anything, the threat to that service is coming from that campaign.

I am very concerned about that to the point that I have involved myself directly and I am hoping that my office and THO South can put oil on those troubled waters to ask people to reflect on their actions, particularly those who have led that campaign. I have urged all concerned to value their service and to review their position in respect of the lack of confidence in that service. There can be no doubt that if Hobart District Nurses exercise what the community is apparently asking me to do, which is to leave, I cannot think of another operator who will set up a facility for 17 aged care residential beds and two sub-acute beds, walking into a situation of a substantial lossmaking business for Hobart District Nursing Service.

Why would any other not-for-profit, non-government organisation go in and offer a service that is going to lose money and assume the clinical risk, only to subject themselves potentially to the very same community campaign? For that reason I felt it was my responsibility to speak very plainly, which I did, at a meeting that I convened with the council.

I urged that council to realise that, as the voice of the community, really it is incumbent upon it to lead the community in a different direction. If they do not, and Hobart District Nursing Service does what the community is asking it to do, then the entire operation is at significant risk and 68 jobs with it. That is the background. I feel very strongly about this, and I feel the community has been very poorly served by a small number of hot-headed activists who have, for reasons I cannot understand, put a successful and positive service at material risk.

Mr MULDER - The major focus of the actual survey, the actual petition that was run around the community, you will have to agree, was seeking a restoration of the so-called emergency room. It was actually a by-line buried about two-thirds of the way, almost in conclusion, that there was a lack of confidence. Although it expressed a lack of confidence in Hobart District Nursing Service, it was in the context of not providing the emergency room, not in relation to the 68 jobs at the nursing centre.

I would like to say that the focus on that one line was maybe distorted, inaccurate and unreasonable and unnecessary as it was. Just in case anyone thinks I had anything to do with that petition, I can say my advice to the community was not to do it. That is neither here nor there.

The point of my question was, it was a side issue about the emergency services, not the running of the aged care facilities where the 68 jobs were. Although I am a great supporter of Hobart District Nursing Service and for reasons they provide in there, there has been this wanting to engage in the battle rather than now quietly letting it go, and continuing to pull the tail the donkey, which does not totally absolve HDNS of blame.

That is the question I ask: are they overreacting with their threat to close 68 jobs, given your assurance that they would not lose their jobs?

Mr FERGUSON - Before I go into the substance, I thank you, Mr Mulder, for your support of Hobart District Nursing Service during what has been a very difficult time for that service provider. I should add that Hobart District Nursing Service provides a range of services to Tasmanians around the state and nowhere have I heard a complaint raised about any of their services that they provide. They are held in very high regard, except in this one pocket of the state where we have seen this occur. I take at face value what you have had to say about Hobart District Nursing Service and I thank you for that.

I have to identify however, that HDNS has suffered significant reputational damage as a result of engagement with media by this group. Things that have been said in social media, particularly to social media which is focused on that area of the Tasman Peninsula and of course the petition itself which, I am lead to understand, even includes people who have signed that petition who are residents at the service, who are actually receiving the care.

Mr Mulder, one thing I do not agree with you on, I know you said you do not have it in front of you, but my recollection is that the petition leads with the words 'we express a lack of confidence' or 'we have no confidence in Hobart District Nurses Service'. That was the opening message and I found that very concerning. I know HDNS did and the question for HDNS was really: do we continue to provide this service to this community even though we accept this is loss making enterprise for us and that we invest more into the service in expenses than we receive in income. Do we continue to do that, while we continue to suffer reputational damage for what we do?

To your point, Mr Mulder, about the emergency room at the service - I do not want what I say to be seen as negative against anyone, but in reality the change to service there was with the agreement of THO South and the Commonwealth. The decision was made to no longer keep that service open because of quality and safety reasons. Earlier during this morning's Estimates hearing, I talked about the issue of putting out the shingle and offering a safe service. Those two are not necessarily the same thing.

It was closed without saving a dollar, I am advised. It did not save any money to do so, but people were turning up to that service who really should have been ringing 000. Second, HDNS was very concerned about the patient throughput.

As anyone who has been involved in clinical governance would know, to maintain currency in your craft - in your skill as a nurse, for example - you have to see a certain number of patients, with a certain level of acuity, over a period of time to maintain your competence. HDNS made the judgment, and the two governments that funded the body accepted their advice, that the numbers were nowhere near enough to provide that assurance.

So as difficult as it is to ever make a change like that, it was considered the responsible thing to do in the interests of patients. I have to place on record again that it was not a cost-saving initiative. The politics of that matter were also complicated by the other issue HDNS was dealing with, which was the GP services it was contracting to provide.

It is unfortunate that these things were all rolled into one big negative - that HDNS was running down our services at Tasman, when what they were doing was entirely within what they were funded to do.

Mr MULDER - We still have not got to the fact that 68 jobs, which basically cover the services HDNS is contracted to provide, were being thrown into the pot as a reason to counteract that particular survey. I understand the reputational damage. We will deal with that later.

One of my issues is that throughout this process the central matter was the GP services. Through some pretty good work, that has been take off the table and other issues have taken prominence as a result. But, had the community been given this information, this could have been nipped in the bud early. I refer particularly to the amount of the retainer that was being asked by the previous GP services. It is in the context of that service that was being provided that people are saying, 'We have been spoilt, and now must face reality'.

I would like to have it on the public record that they cannot go back to what they had, because those service providers were doing two things. They were charging an excessive daily retainer of about $1 500, and there have been suggestions there was a huge amount of labour servicing as well. Having some of that material out in the public domain might have saved us all a lot of angst, trouble and fighting.

Mr FERGUSON - I will respond by suggesting that some of those subject matters are very difficult to talk about in public because they might be prejudicial to those very negotiations that I know were underway between HDNS and providers of medical services, and potentially not helpful to the cause of resolving them. It is fine to know something, but then to choose to say it out loud and put it in the public space potentially can spoil an opportunity to resolve them.

I am not going to say that people were being overserviced, but I will say that HDNS were in a very difficult, in some ways poor, negotiating position because, as a result of the community campaign, they were being expected to continue to pay what I might broadly describe as locum prices for GPs, which is not a sustainable model for a service like that, particularly when HDNS are not expected to provide primary care to the broader community, but they wanted to as a good community thing to be doing as an NGO.

They are expected to provide primary care - that is GP support - to their residents and only their residents. The fact that they were seeking to look after their own residents and the broader community, was very admirable. I feel that a number of them - I keep referring to them as this small group but nonetheless a very potent group - were able to stir up so much community angst around this, under the guise of a downgrade of our health services, which is very unhelpful to that cause. I think that things have come to the point now where we have a perfectly viable - in HDNS's eyes - and a high-quality service at Nubeena which is under threat because, and only because, the operator feels that it is not wanted. And so, if it is not wanted, why would they stay?

They are being invited to leave by the people who signed this petition, certainly by the people who organised the petition. They have been invited to leave. My concern, as Health minister, is not primarily about whether or not HDNS leave. My concern is that there will be no replacement. In all of those things considered, you or I might be able to give HDNS helpful advice about how they could have handled it better, but that is immaterial now because a perfectly viable and safe service is under threat for no other reason than local politics.

Mr MULDER - My suggestion is, minister, had it been made clear that if HDNS was to do what the community wanted, they would have withdrawn from any contribution to GP community services, because they were not contracted to provide them. They could pull out from them any time they liked, and that was about the only threat that I think was viable for the community. To suggest that they were going to walk away from the entire contract and all the other bits and pieces, I think was a little heavy-handed.

Mr FERGUSON - Are you saying that when I said that, that was heavy-handed, or that HDNS -

Mr MULDER - I do not think you said it; I think they said it.

Mr FERGUSON - When I learned about this, yes, I did say it because I thought that people needed to hear it very directly. To put it into plain speak, the petition was telling HDNS to nick off. HDNS was losing significant funds per year on its operations, but as a not-for-profit organisation, it was reasonably okay to do that, it was willing to do that. HDNS, reflecting on that and its reputational risk, said, 'We feel like we have to go'. I have urged them to stay, to reconsider, but I cannot expect them to do that if they continue to be treated so appallingly by this small group of people.

Might I add, Chair, as well, to the people who I know constitute that group, I have told them that I will be making them accountable if the service closes. I will hold them accountable.

Mr MULDER - Is that a threat?

Mr FERGUSON - I think it is the only fair and proper thing to do; you have 2 000 people there who are being appallingly served by this play of politics. I am pleased to tell the committee

as well that since those things have been said and done, I have had a different kind of letter arriving in my office - letters expressing confidence in that service and asking me to do everything I can to retain it, which is very welcome.

Mr MULDER - Minister, speaking to some of the people who have signed that petition and now written you that letter, this is where it has come to because they think that is the only way they are going to save the 68 jobs that belong to the nursing centre which were never in dispute unless HD&S chose to walk away.

Mr FERGUSON - Mr Mulder, I invite you to reflect on whether someone else would be willing to come in and operate a 17-bed aged care residential facility that loses money on its overall service. I have no advice other than that no-one else will do it. If no-one else will do it, then the service closes by itself, not by a government.

Mr MULDER - That brings me to the GP services issue which we have some communication about. I will treat that with some level of confidence. In your response to questions I asked on notice in the Parliament, you have pointed out that for some areas that have experienced market failure -

> The Tasmanian Government contracts with general practice management companies for the provision of medical services to local rural and health facilities. Under such circumstances, those GPs can then also provide private community GP services. These are billed to Medicare and not directly funded by the Tasmanian Government.

I am wondering whether, in trying to separate the HD&S from their not for profit making arm of the GP services into the community, whether any thought has been given - with the withdrawal of the Lauderdale Doctors, and I do not mind naming them as it is no big secret - that what is being experienced is a market failure of GP services. The fact is that HD&S are still paying one full-time GP in that area at locum rates because they are unable to contract one. Maybe it is now time to pull the market failure trick.

Mr FERGUSON - That is an interesting observation. I would not be quite willing to declare surrender on that while you have a service provider that is happy to do it - happy to provide that service and to underwrite the cost.

That is why I can only speak in some defence of HD&S. They are performing a community service at the request of government. They are looking after older vulnerable people. They are supporting the Royal Hobart Hospital with some step-down facility so that people can have part of their treatment and care closer to home. They are doing all of this and in recognition of the medical cover that they are obliged to provide to their residents, they have actively chosen to prefer a model that sees GPs locally, five days a week, as opposed to getting someone to come down one day a week from elsewhere. They have preferenced that model because they understand that it is better for the community to have access to that same GP.

I do not concede market failure because as long as HD&S is there with its current model, as imperfect as it is, there is a GP on site, five days a week. That is good for the community.

Mr MULDER - It is permanent part-time three-day-a-week with the other time being filled up by a locum because they are unable to attract a full-time

Mr FERGUSON - You are right, Mr Mulder, but there is five-day coverage with a GP on site.

Ms FORREST - We would love to have that on parts of the west coast.

Mr FERGUSON - Far from declaring it a market failure, I would say that potentially - and I hope it does not come to this - we have a political failure that as a result of a number of people with grievances, choosing to act in a way that mobilises a large percentage of the community to express no confidence in the provider, has put the whole box and dice at risk. That would be a very regrettable outcome.

Mr MULDER - Minister, I note that some of the issues I have raised have finally been communicated to the millions of Tasman. There was a letter distributed by the mayor as late as last week which finally explained some of these things. My point is, a number of times, had some of this stuff been pulled out at the beginning rather than the HD&S going into defensive mode and going into threatening mode.

I was present at the community meeting where this issue was danced around and was only sorted out inside discussions because no-one was prepared to stand up and say, 'Yes, these people have been charging us an unsustainable daily rate'. You did not have to go into the over-servicing, that was something that cropped up a little later. We would never have got to this situation had people understood from the beginning, rather than waiting until now, when it is all over bar the shouting, to get a letter from the mayor telling them why this was going on. Before you start threatening members of the community who were holding them out, they were expressing their concerns and their opinions, as they have every right to do, minister.

It is our responsibility as their leaders to provide them with the information on which to base decisions.

Mr FERGUSON - Yes, people have the right to complain about a service if they are not happy with it, or if they are not happy with the direction of it. That is quite right. People have that right and they have expressed that right, and now there is a consequence. People signed a petition - and I have had feedback that people were not really aware of the gravity of what they were signing, which is interesting. Nonetheless, the consequence of exercising that right is that they might just get what they asked for - that HDNS leaves. The consequence of that, however, is far graver - that no one else will step in to provide the service, which would be very regrettable.

On the positive side, I have met with the council. I had a very good meeting with the council. Following that meeting, council has rescinded its past motion expressing sympathy with that petition. An altogether different motion was passed unanimously by council to the positive - inviting HDNS to continue to run the service. I do not have the exact wording with me, but that is very positive. I said to the council that I am looking to it to lead the community - to be the community voice, and to bring some stability back into this situation. I understand that council is undertaking more engagements.

I will not be any more specific than that, but I know that council and the mayor, Roseanne Heyward, are taking some carriage of this matter in a positive way. It is my hope and ambition that common sense prevails, and the service can remain. Ultimately that will now be a matter for the HDNS board.

CHAIR - We have given this issue a good airing for about 40 minutes. Anecdotally, minister, I have heard that the number of DoNs in rural hospitals is to be reduced, and they are to be replaced by administrators. Could you comment on that please?

Mr FERGUSON - Chair, you are correct, there has been a trial of a change in the way some rural hospitals are governed. As you know last year, through the Budget, we had to undertake a range of budget repair initiatives to make a contribution to getting government finances back under control. It was my, and the Premier's, and all of our team's ambition that we do our best to quarantine the front line from any service reductions.

One example I can bring to mind is Beaconsfield and George Town. I believe it was Beaconsfield where the position of DoN became vacant. Just over the Batman Bridge is George Town, so THO North asked the DoN at George Town to provide oversight for both locations, which she has done. It is on a trial basis - to investigate it, to see how it goes. My early feedback is that no substantial issues have been raised. I know each site would love to have its own full time DoN, but saving the cost of one senior management position -

CHAIR - In close proximity with other rural hospitals that are -

Mr FERGUSON - I will certainly come to that. I beg your pardon; I am told that the vacancy was in fact at George Town so the Beaconsfield DoN has covered both George Town and Beaconsfield. It has made that saving possible and it has reduced the pressure I needed to make in other savings somewhere else in the THO North. That was for ongoing evaluation to see if it could be done safely and efficiently. I have not had any advice that there are any particular risks to patients as a result of that.

As to your question about whether this might more broadly happen in the health system, I do not know. We need to have leadership in our rural sites. There is no doubt about that. This naturally will be a matter for the new THS to consider as it goes forward. But in all cases we will not be leaving regional sites without quality leadership.

CHAIR - Thank you for that. I have one more question which could be covered in overview. Some statements were made in this morning's press -I think Neroli Ellis made some - about the placement of nursing graduates and the fact that many of them had to move interstate. I can remember my second daughter having to do that 15 years ago; I felt it was deja vu in some respects. Do you have any comments in regard to Neroli's comments about graduate positions being available?

Mr FERGUSON - Yes, you are quite right about that. It is not a new issue; it is not a new problem. It certainly is a problem for a person who has worked hard for three years at university to attain a Bachelor of Nursing degree qualification only to have difficulty obtaining work. My recollection is that approximately 300 nurses per year graduate from the University of Tasmania alone - that is, in Tasmania. Our baseline recruitment each year is 115 nurses. That does not include what the private hospitals are employing, and it does not include what aged care facilities and residential aged care might also be employing.

As a Government we are mindful of this. We want to provide positive pathways and in our Budget we have actually provided $5.4 million over the four years to allow for an extra 85 graduate nursing positions over and above the baseline of 115 per year. So we will maintain the baseline, and over the four years we will gradually ramp up to a bigger recruitment. This year

is the first time this has occurred, with, I am advised, the first of those 85 graduate nurses being recruited. So we have recruited an additional 10 and the total figure this year comes to 125 people.

In the coming years we will also recruit additional graduate nurses. In 2016, we have provided for an extra 15; in 2017, we have provided for an additional 20; and in 2018, we have provided for an additional 40. We have also budgeted for providing an additional clinical nurse educator, which is a key part of that graduate program as well. While I am on it, the Education minister and the Education department are employing 20 nurses as school-based nurses as well, 10 of whom are in the process of being recruited right now.

Finally, we are also undertaking some work with ANMF on the skills portfolio to provide different models of care and recruiting. I think the title of the qualification is a Diploma in Enrolled Nursing. There is that extra opportunity for more positions.

To come back to the beginning, not to be relaxed or cavalier about this, more people are graduating from the university than there are jobs. We are doing our best as a health system in Tasmania to make sure that we have strong graduate opportunities to support our frontline services.

Mrs HISCUTT - Coming back to community nursing, minister, I noticed that the performance information is steady, about 43 per cent of our population. Is that different people or the visits? I presume it includes aged care, postnatal, post-operative care and childhood care, page 111. Would that be right?

Mr FERGUSON - What was that question again?

Mrs HISCUTT - The numbers look like it is 43 per cent of our population. I am wondering is it return visits, or is that the number of people.

Mr FERGUSON - That is the number of occasions of service. The one person may be having five, they might even be having fortnightly or weekly visits.

Mrs HISCUTT - I notice that in the forward Estimates, the money available is going down, whereas they are trying to service so many people.

Mr FERGUSON - As the note to 1.4 shows, over the forward Estimates there is a reduction that has been provided for that is connected to the expiry of the number of NPAs with the Commonwealth and some Commonwealth own-purpose expenditures.

Mrs HISCUTT - So you reckon that is going to be enough money to look after those people? Bearing in mind that community nursing is so valuable. I should imagine they save us more money than by keeping people in hospitals.

Ms FORREST - A follow-on from that one, I noticed that again we are talking about targets here, but the targets are not expected to grow in the occasions of care. I would have thought, if you are trying to actively engage out-of-hospital care and keep people out of the acute setting, wouldn't you expect community nursing occasions of care to increase?

Mr FERGUSON - You certainly might. The white paper is still three weeks away.

Ms FORREST - It is a good shield, that white paper, isn't it?

Mr FERGUSON - If we factored decisions in the future white paper into the Budget, people would say why are you making us wait for the white paper? The white paper is not finished. We are not holding it out to any arbitrary time frame. In fact, it is an ambitious time frame at the moment to keep to 30 June. We will. No, it is not anything other than what it is. Yes, it is a fair point. In what I have had to say in speaking to the exposure draft, I have often reflected on the need to grow stronger linkages with primary and community care, and community nursing is obviously a significant part of that. If we can keep people out of hospital, it is better for the patient, and it is also better for the system. It is a good observation.

Ms FORREST - Can you provide us with the occupancy rates of all the rural hospitals?

Mr FERGUSON - Yes, 55 per cent.

Ms FORREST - Each individually, I mean.

Mr FERGUSON - Of each of them, one at a time.

Ms FORREST - Of each hospital, yes.

Mr FERGUSON - We can, but I do not have those figures with me.

Ms FORREST - Take that one on notice then. The reason I am asking is, I find it is -

Mr FERGUSON - A word of caution, sometimes occupancy is not necessarily reflective of activity. Also, it might be the case that you pick up on a couple of hospitals that have what seems to be very low occupancy, but the hospital might not even be funded for all of the beds that it has in its physical facility. A word of caution when I do get you those figures.

Ms FORREST - Yes, I accept all those nuances with that. What I really want is a benchmark, if you like. Again, with one THS, and you know my views on that, I am right behind you, with that global perspective at this stage, I would have thought there was more opportunity perhaps to use these rural hospitals as dealing with your bed blockage issues. We mentioned before lunch about the bed blockage being a major issue for the DEMs. Are you actively looking at opportunities to use these beds that are there, accepting that some may not be funded? Is that not an opportunity to look at how we can better utilise them, and perhaps where there is plenty of room in these, as long as you have the staff to care for them? We could perhaps expect to see next year, when we are back around this table again, increased occupancy in some of those hospitals.

Mr FERGUSON - It is a good set of points within the question. It is a difficult question to answer specifically because the white paper will certainly be talking about the role of rural and regional services and facilities. As you probably have heard me say a number of times, I often walk through a country hospital, a rural site, and think about the empty bed, and at the same time about the people waiting in an emergency department waiting area. There is that nexus of an opportunity for better patient flow. At the same time you do not get a more efficient system if all you do is open more beds. I do not know the answer at this moment about how we can do it better, but I believe that our rural sites can provide more support for our patients. I will give an

example of a postoperative patient who is perfectly able to recover, maybe in the latter part of their recovery, as an inpatient in a sub-acute bed, like at Scottsdale, after having surgery at the Mersey Community Hospital -

Ms FORREST - They do not do any major surgery. You have to go straight home from the Mersey. Pick somewhere else.

Mr FERGUSON - Nonetheless, you might need some, especially on sub-acute, and to be closer to home. Once again our rural sites need to be part of that equation. There is a fair bit of work yet to do on that.

Ms FORREST - That also helps maintain competencies of your nursing staff, by having access to greater acuity patients; immediate postoperative care, as opposed to some of the more chronic medical conditions they tend to deal with. I guess there is a whole range of opportunities there.

Mr FERGUSON - Yes, you might hypothetically say that you would like to see more rehabilitation patients go to a country site than have a sub-acute bed. The other question for Government would be, do we have the right range of allied health services, and the answer to that may be no. We need to temper that, temper our own enthusiasm, but at the same time seek opportunities. Without wanting to appear that this is deflecting the question, these will be big questions for the THS in the new organisation.

Ms FORREST - Can I take you to oral health, which also comes under this area. There is a predicted decrease in funding from the Australian Government and there is a footnote 12, on page number 2. When will the decision about the Australian Government funding be made? When are you expecting it? Does the reduction in funding concern you, particularly when you look at the performance indicators that indicate an expected significant decline in all levels of care other than children, and when you look at the reduction in adult general care, episodic occurrences for adults and dentures as well. The only one that is increasing is children.

Mr FERGUSON - First, I come to the broad issues. Funding was provided in the federal budget for a one year NPA on Adult Public Dental Services. That was announced recently in the 2015-16 federal budget to replace the expiring National Partnership Agreement on treating more public dental patients. That federal budget allocation for Tasmania is $5.5 million; that is our share in 2015-16. The Australian Government has indicated that funding for dental services beyond then will be subject to the outcomes of the reform of the Federation white paper process.

The Australian Government also announced the voluntary dental graduate year program would not be renewed. However, the adult public dental services, NPA, extension for one year post dates these budget papers.

Ms FORREST - You would expect then occasions of care not to reflect the reality then in your targets, because it is looking quite dire. The Acting Secretary said, 'Yes'.

Mr FERGUSON - When our Budget went to print, that was pre our awareness of that. The new National Partnership Agreement yet to be negotiated. We have seen the dollar amount but the actual NPS or action plan is yet to be agreed. The previous NPA was $4.3 million per year so the new NPA will be $5.5 million - slightly more - and the agreed target will naturally reflect that. It will be upwardly updated.

The funding allocated in the 2015-16 Federal Budget for dental will allow the department to continue to provide the same level of activity in 2015-16.

Ms FORREST - It is a really important issue - socially as well as health related. Any other questions on that output group?

Mr FERGUSON - If the NPA had not been renewed, the downward revision of activity targets would have been what was previously the case before the NPA was in place.

Ms FORREST - Which was when we had long waiting lists and people not getting access to the care they needed, and all the inherent issues that go with that. We hope the federal government might stump up again in this area.

Statewide and mental health services: the performance indicators suggest no growth in in-patient separations from mental health and alcohol and drug services. Why is this the case? Particularly when we know mental illness is not diminishing and another performance indicator shows that only 42.7 per cent to 58.4 per cent of patients in 2013-14 had their needs met by Tasmanian mental health services, depending on the region in which they were located – South, 58.4; North, 42.7 per cent. That is from last year's budget papers.

We only seem to be aiming for a target of 50 per cent of people having their needs met by statewide mental health services. Why are we anticipating no growth in in-patients separations? Are more people being treated in the community, or what is the story? There is no measure there for that.

Mr FERGUSON - That is an absolute stated goal - to have increased provision of resources in the community so they would be, where appropriate for the consumer, preferenced ahead of an in-patient facility.

Ms FORREST - Okay, let us look at the next performance indicator. There is no increase in the targets for community and residential active clients. We are saying that neither of them are going to increase. We know that mental health issues are increasing in the general population, unfortunately. We are saying that there is not going to be any increase in the community and residential clients, or the in-patients separations. Is that because the Budget does not provide for any -

Mr FERGUSON - First, I will point you to the work we are doing in mental health. The Rethink Mental Health project has a stated goal of investigating how we can do mental health better in the community, and in in-patient environments. The focus is on getting better outcomes for consumers and carers from within our existing budgets in mental health, and potentially making recommendations for system reform and strategic investments in service workforces and capital infrastructure.

No doubt there will always be a desire to have more resources and do more in this area. From a budget point of view, it is a reasonably stable environment, but we do have a stated goal of servicing people as close to home as possible, wherever possible. Year to date, to 30 April 2015, we are seeing 7 846 active clients.

Ms FORREST - So there is growth there.

Mr FERGUSON - In the community, and residential active clients. That is plainly in excess of the current financial year target, because we still have two months to go.

Ms FORREST - You would expect, then -

Mr FERGUSON - It is a reasonably stable environment we are working in, as far as government resourcing of mental health goes. We are still waiting for a substantial response from the Commonwealth to its national review that has been undertaken by the mental health commission into its major report. Plainly, we need a balance between community and in-patient or acute settings so we provide as much care as is appropriate to the person as possible and their family and carers.

Ms FORREST - I agree that the majority of mental health care should be in community not in -

Mr FERGUSON - You did not ask me when the re-think will report. We are working towards a release of our work on re-think in October.

Ms FORREST - We could see some changes there?

Mr FERGUSON - We have to see change. One of the key initiators of this work was the very fragmented way in which the system taken as a whole operates. You have public providers, private providers, you have the state Government and the Commonwealth all dabbling in this space and there is a desire, if we can, to make it an easier to navigate system for consumers and their families.

Mr FARRELL - What sort of future role do you see for institutions around the state that currently exist, of the likes of Millbrook Rise and others, that are currently in operation?

Mr FERGUSON - We do not have any change of model envisaged for them. I have heard different suggestions about what could be contemplated for individual facilities but I do not have any fixed view on them. I want to be guided by evidence and I would always look to achieve psychiatrists who also serve as the chief forensic psychiatrists for advice on those kinds of matters. I know in the Derwent Valley region there is a significant interest in Millbrook Rise and I am happy to indicate to you that a number of people have expressed to me all sorts of views about what should happen there.

I am open to looking at evidence and if we can find better models of care to look after people either in the community settings or settings like that one, to provide better arrangements, I am open to that. I would, as you are the upper House member for that area, be very happy to engage with you on that subject. As a general statement, as Health minister I should, and each of us should, be willing to change how we do things but let us be willing to be guided by evidence and focus on how we can do it better for our community.

Ms FORREST - Do you know how many patients have required forensic mental health care over the last 12 months, the last two years, for a comparison? The more difficult one to answer which you may not be able to is, how many of these were successfully treated? It is unfortunately the case that sometimes people in our community end up in forensic mental health care as the only

option when the systems failed them and they end up there and find the extra care they need. Thankfully it seems to be happening a bit less than it used to.

Mr FERGUSON - I would like to take that on notice. I am sure we can get that data; we did not come prepared with it. As for system failure, we want to provide safe and appropriate therapeutic environments for our patients, our consumers, where they need it. The forensic service is definitely a part of that so I would perhaps urge some caution that we do not assume that if someone goes that the system has failed them.

Ms FORREST - I am not making an assumption.

Mr FERGUSON - I have met a family for whom the Wilfred Lopes, they believe, saved their son.

Ms FORREST - I know those people too. The problem is that someone sent them through the system and they ended up calling foul of the law and will sometimes will get into such a difficult place that that was the only place that that could be treated. Early intervention may have prevented that getting to that stage. I guess that is putting in place good systems and it might be the beginning.

Mr FERGUSON - Indeed, so if we could take that on notice.

Ms FORREST - Can you tell me how many people have come into contact with the criminal justice system that require mental health care, specifically forensic mental health care?

Mr FERGUSON - I think that is wrapped up in your earlier question and it may even be something for the Minister for Justice might be more able to provide.

Ms FORREST - It does cross across, I accept that.

Mr GAFFNEY - Are we onto 1.6 yet, forensic medicine service? I thought this was quite a straight line item. It involves a relatively large amount of money. When you look into it, it says that it is to deal with forensic and medical services, forensic pathology and clinical forensic medicine. Then 1.5 also covers forensic mental health services. What exactly does that line item cover when it says 'forensic pathology' and 'clinical forensic medicine'? If you go back to last year's and the year before, it does not get much of a mention. I am interested to know what that is about.

Mr FERGUSON - Mr Gaffney, the funding allocation there is to support the role of the Chief Forensic Pathologist, an office within the THOs.

Ms FORREST - Psychiatrist or pathologist?

Mr FERGUSON - Pathologist, Dr Chris Lawrence. That will be an office within THS from 1 July, supporting the role and the work of the coroner.

Mr PERVAN - And criminal investigation. The work that requires laboratory and anatomical study, basically, of evidence and the production of evidence for criminal prosecution.

Mr GAFFNEY - Similar to the question asked by the member for Murchison, is it possible to get the numbers of people or cases that he has worked with over the last three years? I am asking this question because there has been a 20 per cent reduction in the funding for that position, which is $300 000, which is quite a significant decrease. If there is a decrease, where does that get picked up? Does it get picked up in the management line of 2HS or is it a FTE position? Unless the number of cases has decreased over the last three years, I would be interested to know how you have come to that decision.

Mr FERGUSON - Can we take that on notice? We think we know the answer, but I would like to check it to get it right.

Mr GAFFNEY - That is fine, thank you.

Mr MULDER - Are we still in 1.6, Ruth?

Ms FORREST - Yes, 1.6 and 1.5, they do cover similar things. Forensic mental health is in 1.5 as well as 1.6.

Mr MULDER - Did I miss something, or has forensic science services moved from police back into -

Mr PERVAN - Only the medical component of it. This is Dr Chris Lawrence and his tiny team. At the moment I think there are two people, who are at the Royal Hobart.

Mr MULDER - There is an overlap between the pathologist and crime scene investigation - -

Mr FERGUSON - But quite distinct from the mental health services.

Mr MULDER - That is why I was asking whether we were on to 1.6 now, because this question really relates to that.

I have had a quick look through the policing one but we have not yet reached that. It seemed to me, when the police ones were sent to New Town, to be a strange thing to separate the forensic science criminal stuff from the forensic science medical stuff. Has the government has given any thought to bringing those two back together again? I know they work fairly closely together, but I would have thought that a single system of management in a scientific support area would have been a better proposition than the cross-over of different agencies.

Mr FERGUSON - I will take that on board. That is interesting. The forensic medicine service, though, is a medically oriented field and it is organisationally and physically located at the hospital. That is interesting. I am sure they would be working in tandem with the police. It is exceeding my commission on that one.

Mr MULDER - I have just had a quick look but I cannot find the output group.

Ms FORREST - Picking up from Mike's question about the significant reduction in the line item in this Budget, there is no footnote and that is not the point Mike was making; there is no explanation for that reduction. It is a small number of people involved in this, so how are they

going to maintain the same level of output with so much less money in terms of the percentage of the Budget?

Mr FERGUSON - I need to take advice on that. I want to be reliable in regards to that so I am happy to take the question on notice.

Mr GAFFNEY - Further to that, the forward Estimates then indicate that it puts more funding back into that line item. It is interesting to see how they have decreased it, and then looking at that, that will be helpful.

Ms FORREST - Even in 2018-19, it is not back up to what it is now. There are some cuts there somewhere.

Mr FERGUSON - We have charged the agency heads of each of the four current agencies with the task of making a leaner bureaucracy. There is no apology or defensiveness about that. We have had to; we have needed to, and we have required agency heads to do that in a way that protects as much as possible the front line. I have to say, they have been remarkably successful at doing that. I thank each of the four of them for what they have done in that regard; it has been pretty hard but in this case, on this specific one, I would like the time to get a considered reply.

Mr GAFFNEY - It is the 20 per cent which alerted me to something. It seems significant.

Ms FORREST - It is such a small aspect. The others can contain a whole heap of services and they may have made cuts in some areas but it is harder to identify.

We have about finished the output group we are dealing with now. I think the Tasmanian Health Service, output group 2. One I wanted to ask about and was not sure exactly where it fitted in, is about the North-West Regional Cancer Centre. Can I ask you how this service will be run and will there be a rotation of all medical and service delivery staff, that is medical and nursing staff through both sites, the Launceston Holman Clinic and Burnie? What level of service, what specific services in terms of cancer treatments and diagnostics will be provided at the North-West Regional Cancer Centre? Will there still be some services some patients will be required to travel to access? What services will be required to travel for? It may be connected to the individual patient, I understand that, in some cases, but in broad terms.

Mr FERGUSON - The capital project was commenced in 2012 to build the Regional Cancer Centre; that was a combination of support from the Commonwealth and the state together with private funding. That has enabled the new cancer centre service for communities located in Tasmania's north-west and will accommodate medical oncology, radiation oncology and related services. From an infrastructure point of view, it includes the capital infrastructure, capital equipment, medical equipment, chemotherapy chairs, consulting rooms, teaching facilities, administration offices, and a base for palliative care. The construction of the centre is well underway and we are expecting to complete that by the end of this year. The project is on time to be completed within the funding agreement milestone date of November 2015. Medical oncology services are planned to be transferred into the building late this year, and radiation oncology services are to commence next year.

You have asked about staffing and funding. As you know, funding is in the Budget for the first time ever. The centre was being built without any forward planning of the operational funds that would be required to support it, so it is now up here. Funding of the staffing model is

required to commence radiation oncology services and for other staffing. That model has been funded in this budget for the first time.

You asked me if staff will be rotated around the north and north-west. Broadly my answer is 'yes'. It will be a northern integrated cancer service. It will not be a standalone; it will not be an orphan service. I do not want to dwell on that too much other than to say that would have been a risk if it had been.

Ms FORREST - It was never the plan for it to be like that. There was originally some indication that we would run with Peter MacCallum Cancer Centre in Melbourne.

Mr FERGUSON - Still, the better of all possible outcomes has emerged with a northern integrated service. Being supported across the whole of the north, with a population approximately equal to the south of the state, is a good outcome. It is my advice that over the last number of months, as staff have been recruited to the Holman Clinic in Launceston, their place of work during the recruitment phase has been listed as, not Launceston, but Launceston and/or Burnie. Already the model has started to evolve toward a collaborative approach.

At the operational level, how much staff will rotate around - I cannot not be more specific than that, other than saying staff of the THS dedicated to the northern integrated cancer service will be a corporate body of staff.

Ms FORREST - When you say 'northern', you are not talking in the traditional northern sense of Launceston, you are talking about 'northern' being about the whole north of the state.

Mr FERGUSON - North being the whole north, and north-west. Providing services to Burnie and to Devonport.

Ms FORREST - It is really important. It is something you probably need to explain to the community - when you say northern integrated cancer service, you are talking about the north-west coast and the Burnie centre as well. We call the northern cancer service the one based at the LGH. They still service the north-west coast, because there is nowhere else to get those services. You see the point?

Mr FERGUSON - I accept your comment. I consider the north and north-west as separate regional identities, but I take your point about explaining to the community that the northern integrated cancer service is for the northern half of our state. North of the Blackman River.

Ms FORREST - We have finished the THS. That was my last question unless anyone else has any last questions.

CHAIR - On the THS?

Ms FORREST - Yes, which is output 2. I have finished that.

CHAIR - Anyone else? If not, we will move to Group 3.

Output Group 3
Statewide Services

Output 3.1 Ambulance Services -

Mr FERGUSON - Chair, I introduce the committee to a well-known face, Mr. Dominic Morgan, CEO of Ambulance Tasmania.

CHAIR - Thank you, minister. I will lead with a couple of questions. You have talked about the patient transport system quite extensively so I will not pursue that any further. A quick question - and we did some legislation a year or two ago - how is the private system going at the moment? The provider?

Mr FERGUSON - This is an area where we might be able to offer some commentary but it might be very difficult for us to do so. We might be able to speak about the sector, without referring to individual businesses.

Mr MORGAN - Suffice to say since the legislation was enacted on 1 July 2014 there has been another provider who has been issued a licence. Most specifically, you may recall one of the key points was that to deal with a perceived conflict of interest the authority to grant licensed was removed from the Commissioner of Ambulance Services and provided to the Secretary. That has been a very useful adjunct that came out of the upper House process. Since that time, as we understand it, the commercial market has continued to grow as the commercial market will do.

Ambulance Tasmania has limited itself to dealing with what we describe as government patients only, so transport to, from and between DHHS and THO facilities and into the future the THS. All indications are that there has been a very seamless translation forward through the change in the legislation and the regulations that were foreshadowed in that, will be going forward in the coming months.

CHAIR - Minister, there was a fair bit of media attention on to the recent announcement that the Government would increase ambulance and paramedic services for the Southern Midlands. Budget paper 2, page 65, noted that the cost of this initiative will be met within existing resources. Some of the deckchairs within the Ambulance Services are being arranged, it could be said. It also noted that new services will reduce pressure on the Campbell Town and east coast services. So logic would conclude, that facilities and services will have to be reduced from somewhere else, in the ambulance service to meet this new commitment.

That is the question I have. Can you provide any details of where these changes will be made and impact of services of available in other areas?

Mr FERGUSON - The announcement for the Southern Midlands Paramedic Service is one that is important for the Government and to Ambulance Tasmania. As you have indicated the estimated cost of funding an ambulance service, a paramedic service at Oatlands, is $500 000 per annum. This is a decision that has been welcomed and is quite necessary in the community. We have seen a service there that has been extremely well supported by the community and by a team of volunteers. A modestly sized, a small group of volunteers, but nonetheless very dedicated and many of whom are providing good service, and a subset of which seem to be carrying a greater share of the load. A smaller number are carrying the lion's share of the load. That is a service that is being supported principally with a nursing position at the hospital and at different times with the GPs playing a role.

The concerns we have had, in response to what the community have been sharing with us, has been the extent to which that service is online. There have been times where the service has been notionally offline and it has been necessary in a 000 scenario to send a vehicle, the next nearest vehicle which might often have been from Hobart.

We are building a new service there. I must emphasise that it does not replace the volunteers. What the service effectively does is replace the need for a dedicated nursing position at the site to be the employee of the health system who principally provides the service with the support of the volunteers. We still need our volunteers to see this model. It will be a 24/7 paramedic supported and staffed by volunteers.

Your question is about funding this, and the Budget papers indicated that this will be serviced internally within the department and Ambulance Tasmania. The department is in the process of reviewing its capacity to fund this, through existing budget capacity and existing review sources within Tasmania and the potential for any redistribution of funds across and within the agency. The department has not finalised details on the specific source of funding within its existing budget but it will do so prior to the establishment of this service.

Finally, I can provide the committee with an assurance that the advice to me from the agency is that this is entirely okay and reasonable to achieve.

CHAIR - Thank you for that. Have you had any community feedback at all from this initiative? Bearing in mind I think you had a public meeting of some 500 people up there at one stage, on different issues.

Mr FERGUSON - Standing room only. I think it was back in October last year when a number of people felt the need to raise the issue of their health service in the area. I willingly responded and attended the meeting. It was a big turnout of support from not just Oatlands but the wider community of Southern Midlands. It was one of the highlights of my 14 months as Health minister because it brought it all very quickly home about how much people value their health services. I believe a lot of the issues were doing the rounds were things we were able to explain and to show there was no downgrading taking place. One of the very real concerns was the amount of time the ambulance was offline. I made a commitment to address that.

You have asked me about the feedback I have had: entirely positive both from the Mayor on behalf of the council, very grateful and thankful, together with the local doctors, particularly someone like Raz[Robert?] Simpson, who expressed some relief this decision had been arrived at - all of which, I hasten to add, has happened. The community were not even asking for this. They were not asking for a paramedic service but when I took a good look at what was happening and the concerns I had on advice about the future viability of the existing model, we felt it was necessary as a government to step in and provide an around-the-clock paramedic service. We are not disrespecting the role of volunteers until now but thanking them for their work and asking them to please stay involved because the service, such as we see it in other regional sites, does rely on both the paramedic on standby around the clock and a team of volunteers to provide backup.

CHAIR - I have a separate question; note 7 on table 4.11 indicates a decrease from 2016-17 in depreciation costs in relation to the ambulance fleet. Does that imply the ambulance service is to operate with an ageing fleet of vehicles or is there a continual vehicle replacement program in place? If so, how can depreciation charges be reducing?

Mr FERGUSON - I will ask the CEO to provide an explanation.

Mr MORGAN - That is largely to do with the accrual accounting basis. Essentially, we have a recurrent fleet program which retains and has not been affected. We replace approximately 18 Class 1 vehicles per year. Historically there were some older vehicles that were coming up to end of life. They have been capital-funded for the program going forward and we will be spending approximately $700 000 on new vehicles, of these specialist support vehicles, into next year. It would be dealing with the issue of those ageing and depreciated vehicles going off the books.

CHAIR - Another question I have for the minister which became noticeable in the media hits recently, regarding an ambulance driver who claimed she had been driving while under the influence of ice, the drug. She made some statements, which was a most unfortunate and then claimed that perhaps everyone should be drug-tested before they go on duty. Is that a policy of the department at all, does it happen?

Mr FERGUSON - Naturally I am aware of the media reporting of that issue. The Government and Ambulance Tasmania were appalled at the claims of drug-taking while on duty by that particular ex-employee. I would like the committee to know that I understand that Ambulance Tasmania, or the Government, were not aware of that story before it went to air. I do not think we were given an opportunity to either respond to or refute that. I am willing to stand corrected on that, but my advice is that it was a surprise to us.

Mr MORGAN - The angle of the story is correct, minister.

Mr FERGUSON - As to the use of illicit drugs while on duty, we would have no tolerance for that kind of behaviour and activity. Whether or not it happened, events of this nature, where true and where occurring, will be dealt with in a very strong fashion by our health managers, including Ambulance Tasmania.

Mr MULDER - The question arises, minister, is there any testing regime or integrity testing or anything like that going in there? In other emergency service agencies, where your main one is alcohol, but we also have had some examples of people under the influence of other sorts of drugs. I am wondering what internal procedures you might have to try to nip those things in the bud.

Mr FERGUSON - Mr Morgan shortly will add to what I have to say on this, but to Mr Mulder and to the committee, I can assure you that we take a zero tolerance approach to this. Wherever it is identified it will be dealt on that basis, zero tolerance, because the safety of our patients, both in the health service and in the department, through Ambulance Tasmania, is our highest priority. Ambulance Tasmania has been turning its mind to this and Mr Morgan can add to what I have to say on that.

Mr MORGAN - Yes, this is an issue that Department of Police and Emergency Management and we have been discussing for approximately 12 months, before this particular example arrived. Stefan had been looking at going down a pathway of not just doing random testing, but doing drug testing for people who identified as having a health care problem as well. We went for the position that we will treat it predominantly as a health condition. We are not only talking about methamphetamine, if that were to become an issue -

Mr MULDER - Targeted versus random.

Mr MORGAN - Correct, that is where we landed. We made an assessment at the time that there was no greater evidence that there was any illicit drug taking higher than the normal population in Ambulance Tasmania. Ambulance Tasmania staff are as accountable for random drug testing by Tasmania Police, as any other group in society. However, if we do have someone who is identified as having a problem with illicit drugs, primarily that is treated as a health problem. Sometimes that can result in a return-to-work plan with some random testing that we set up with an external company.

Mr MULDER - The first one is the contracted hours for the helicopter. How many hours were they contracted for in this recording period, and what sort of services were they used for?

Mr FERGUSON - Mr Mulder, in 2014 the helicopter was despatched for 125 hours on ambulance-related tasks. As you know, this service is provided through a contracted helicopter service. It is principally provided by Department of Police and Emergency Management. Ambulance Tasmania takes 30 per cent of the contract. It is involving the use of a single helicopter based at Hobart airport. That is available to us on a stand-by basis.

You asked about the number of cases and 125 is the answer in 2014. Was there something else?

Mr MULDER - No, I was trying to get hold of how many hours you are contracted for. I take it that is roughly 40 hours, as a third of 125.

Mr MORGAN - No. The contracted hours for Tasmania Police, which is the principal to the contract, is 300 hours plus 60 hours - that was my last understanding. The 125 hours and the 125 cases was our share of that which, if you do the maths, is roughly 30 per cent, and that is what we paid to DPEM.

Mr MULDER - Of the 125 hours, how many have you used?

Mr MORGAN - We will always deploy to the number of cases required. We do not use a cap on the number. We contribute to a 30 per cent standing charge arrangement, which we pay whether we use it or not, and then we pay an hourly rate for the hours of utilisation. For example, if DPEM were to go over their contracted 300 hours for operation, then we would contribute to that as well.

Mr MULDER - How many hours of operation were they used for?

Mr MORGAN - It was 125 hours for 2014.

Mr MULDER - For the full 125 hours?

Mr MORGAN - Correct. It is not a set amount. The standing charge was calculated on 30 per cent. That is the cost of just having the machine there, and that is what we paid, and then a notional historical 30 per cent of the hours were assigned to Ambulance Tasmania, but we paid for each of those hours.

Mr MULDER - You pay for the bulk of the hours - you said you paid an hourly rate when you deploy them.

Mr MORGAN - Correct.

Mr MULDER - You pay 30 per cent of the standing charge?

Mr MORGAN - Correct.

Mr MULDER - Which entitles you to 125 hours.

Mr MORGAN - Correct.

Mr MULDER - If you use more than 125 hours, do you then pay additional charges?

Mr MORGAN - We pay either way. If we used 130 hours we would pay 130 hours; if we used 110 -

Mr MULDER - That goes to my question. Did you use 125, 130 or 110 hours?

Mr MORGAN – One hundred and twenty-five hours is exactly what was used.

Mr MULDER - That is really good forecasting, isn't it.

Mr MORGAN - It was based on historical utilisation - on previous years.

Mr MULDER - There has been no increase in the hours worked over recent years?

Mr MORGAN - No. Historically, as you are well aware, it made no particular difference other than for internal reporting - what was a police job, what was an ambulance job. DPEM got much more diligent in determining medical cases from search and rescue.

Mr MULDER - Going back to your Oatlands experience and trying to extrapolate that, what is the model you use for deciding how many permanent paramedics you have on site, how many volunteers you need in the community, and how many ambulance vehicles you have for each community? How does that work?

Mr MORGAN - The model we use in rural Tasmania is what is referred to as a branch station model. Historically that is a single paramedic working four shifts of approximately 11.5 hours over four days -

Mr MULDER - At a station?

Mr MORGAN - Not necessarily. For example, at Queenstown, which is also how we intend to commence the Oatlands model, the paramedic and the volunteer work from the hospital to start with. Oatlands was the last of the historical hospital base services to transition over to us. The model pretty much everywhere is this same model that we intend to put into Oatlands, which is a paramedic working 365 days a year - one for four days, one for another four days - and then on call with a volunteer overnight.

Mr MULDER - You rotate two paramedics through the station, if you like?

Mr MORGAN - Correct - or their base.

Mr MULDER - Then that is backed up by volunteers?

Mr MORGAN - Correct. Most of the time, with the bigger volunteer centres, the volunteer will be on station with the paramedic during the daytime and of an evening they will do a deployment from home on call.

Mr MULDER - They work the day shift and then they are on call?

Mr MORGAN - Correct.

Mr MULDER - That is both the volunteer and the paramedic? I gather the volunteer would probably drive and the paramedic would be in the back if the patient required -

Mr MORGAN - It will always depend on the circumstances.

Mr MULDER - But you would want two up, wouldn't you?

Mr MORGAN - Yes, that is right. The advantage of the model the Government has chosen to go with will also mean we will forward place a second vehicle into a community. It also gives us the opportunity - if, for example the paramedic is called out on a case - to grow the volunteer numbers, and be able to turn out a second volunteer crew, backed up by a paramedic from further away.

Mr MULDER - You have two people actually living in the community doing four-on, four-off or something?

Mr MORGAN - Correct.

Mr MULDER - That is how it would work? Four days on, four days off, then relief from town or a larger station when someone took some leave?

Mr MORGAN - That is exactly right.

Mr MULDER - That is two paramedics, or a paramedic and a volunteer? If you put on a fully trained-up paramedic you certainly would want to be giving them some days off and some leave. You would need two permanent paramedics.

Mr MORGAN - Two minimum to get the 365 days a year.

Mr MULDER - To get one FTE? Yes?

Mr MORGAN - Well no, not to get one FTE. It is two FTE because they work four days in a block and then one will go off -

Mr MULDER - Sorry, 365 by 24.

Mr MORGAN - Then your annual leave, training, et cetera, is covered by a relief officer who is recruited specifically for that purpose from town.

Mr MULDER - That is the model you have at Tasman.

Mr MORGAN - Absolutely everywhere - Nubeena, Triabunna, Scottsdale, Queenstown.

Mr MULDER - I would like to put the two together and ask you about the future when we get a helipad on the top of the emergency department. You were previously in a New South Wales organisation that conducted a study that indicated that medivac by helicopter was a more efficient method, both by cost and quality response over rural roads.

Has any thought been put into substituting some of these local services with what is obviously a more efficient response time from a helicopter rather than a locally based paramedic who could be called out of the area?

Mr FERGUSON - You might be thinking of trauma cases. That is a useful observation. We obviously will come to the Royal, of course, but the Royal, as now scoped, will include a helipad. It will be available by the end of 2018. Plainly we want to make sure that we have infrastructure that supports what we have been talking about these last 12 months - genuinely linking up our hospitals and providing opportunity for the retrieval of patients who genuinely need to be, for example, at the Royal Hobart Hospital can get there in the best and most appropriate way.

In some cases that will be by road, but in others the best and most appropriate form of transport may well be a helicopter. We are providing for that. Although we will always have to keep our eye on options for the nature of helicopter service to support that in the future, at this stage we are about making sure our infrastructure is future-proofed. I cannot imagine anyone wanting to build a hospital tower in the capital city that does not have a helipad. We have remedied that.

Mr MULDER - We will not ask why you are building it. We might ask it another time. I was trying to get to that point about the linkage of the helipad and that New South Wales study. I am sure your commissioner would be more than in a great position to provide to.

Mr FERGUSON - You said from a previous job? I thought you said from a previous job.

Mr MULDER - I was making reference to a study by the New South Wales Ambulance Service that was put out to a consultancy. It came back with some figures about quantity and quality and the efficiency of a helicopter both in cost times and in road-based transport for emergency patient transport. My question was predicated on the helipad being on the top of the emergency department so that there would be none of this nonsense that we get now with packaging and unpackaging on the domain. There are some efficiencies to be gained here, particularly with all the small rural communities. Tasman is a classic. Why would you have an ambulance there that takes an hour-and-a-half to travel on the road when you can fly 20 minutes on a chopper? That would reduce the -

Mr FERGUSON - I am happy to invite Mr Morgan to respond to that. I would suggest in the first instance that I am discussing your earlier question. There was a Tasmanian report done into those issues. I am not sure about New South Wales. I do not know about that. We had a study done under the previous government in AT. I invite Mr Morgan to speak to the general

point about the role of road versus air. While there is nothing like travelling by air and getting a 20-minute transfer organised from a remote location, in many cases road would be the more appropriate choice.

Mr MORGAN - Helicopters are very useful platforms for certain cohorts of patients. Predominantly trauma patients, neurological patients and cardiac patients will benefit from the rapid retrieval time back to a centre of definitive excellence. The other side that is often overlooked is the speed with which we can deploy a registered medical practitioner, and these are important things to remember. There are skills and attributes a traumatologist will have that they can deploy out in the field, perhaps even on the Midlands Highway, that as paramedics we are unable to do.

They have a very useful place but they will never be able to replace the predominant role paramedics have, which is to deal with immediately life threatening conditions where you need to have someone on site rapidly, with high levels of skill, being backed up by higher levels of clinical practice - being a doctor on an air frame. The other important thing to remember is that rotary wing platforms are weather contingent, and some machines deal with weather a lot better than others.

I have just come back from Canada where they are using precisely the same machine that we have previously been considering for cold weather.

All of these things bring together a picture of an holistic system; they are not mutually exclusive. That was backed up by the study we did in 2010.

Ms FORREST - Minister, has the wage increase for ambulance officers been included in the Budget, and if it has where is it?

Mr FERGUSON - Ms Forrest, the outcome of the paramedics work value case was not known at the time of finalisation of the 2015-16 Budget Estimates. The estimated cost of the paramedics work value case for 2015-16 is $2.9 million. The department is actively reviewing its capacity and the methodology to fund this amount in the first year and considers it will have short-term savings available that can be redirected to fund this cost in 2015-16.

Ms FORREST - Short term savings within ambulance?

Mr FERGUSON - In the department.

Ms FORREST - Can you give us an indication of where those savings will be? It is not an insignificant amount - nearly $3 million.

Mr FERGUSON - First, with the agreement that has been reached between Government and the union representing paramedics, it is good for our state to have been able to resolve that long running issue. I am sure the committee will agree it has been a good outcome for all concerned, particularly when you consider that members of our workforce have been willing to accept a staged implementation of the work value decision of the TIC, which we were disagreeing about at court. Nonetheless, when you consider the range of possibilities, it is a good outcome.

Ms FORREST - Did the staged implementation result in the $2.9 million for this next year?

Mr FERGUSON - That is right.

Ms FORREST - So it would have been more without the staged implementation?

Mr FERGUSON - Yes.

Ms FORREST - Back to my question though, where are the savings going to be found?

Mr FERGUSON - This would be an example of where I would expect the department to examine its various options over the course of the year - examine any savings capability it might already have. It would be closely looking at revenue that is already being attracted by Ambulance Tasmania, because in some cases its work attracts revenue from external sources other than the Tasmanian Government.

Ms FORREST - So you might see some of the costs go up for some of the services that Ambulance Tasmania provides to the community to fund it, is that what you are saying?

Mr MORGAN - They are two different questions.

Mr FERGUSON - First of all, one is MAIB, another is the Department of Veterans' Affairs. The point I was looking to make earlier is that a number of those sources of revenue will be on a defined basis. That is, defined by the external insurance company or organisation like DVA. In other cases we charge full cost attribution. The ambulance regulations, which do change from time to time, will reflect full cost attribution for external purchases of ambulance services.

Ms FORREST - Are you confident then that in the hospital system where you have patients who are privately insured using the public hospital, they are given the option of going in as private patients and their health fund is funding some, if not all, of their care - the proportion which the health fund does? They are not always picked up, or they have not been historically. Are you maybe getting better with that?

Mr FERGUSON - I understand that is the case, that the department and Ambulance Tasmania are getting pretty good systems, ensuring they are receiving full opportunity for income as we are eligible to claim. I make the broader point that in regard to meeting the cost of the additional paramedic work value case in 2015-16, we have identified what the cost is, $2.9 million. That is something I believe and am advised the department can manage within its resources. Exactly how and which sources it may choose to use is something for the agency head and not something that has been determined today.

Ms FORREST - The cynic in me, and it doesn't come out very often as you would imagine, says that because of the pretty harsh cuts inflicted across most of the public sector last year in terms of positions being lost and staff cuts, that there would not be much fat left. Otherwise it would have already been trimmed away to meet the pretty significant budget savings that were achieved in the last 12 months. That is why I am struggling with this quantity, finding another effectively $3 million in this year to fund this. I acknowledge it was not known until the Budget was framed but I would not have thought there was that much fat.

Mr FERGUSON - We always want to be lean but not too lean. We are trying to find the right balance here. Also, the $2.9 million figure is $1.7 million above the level of funding provided to the department under government wages policy. One might say the differential that

needs to be found within existing resources is $1.7 million. In an agency the size of the Department of Health and Human Services, not being glib about this, my advice from prior to today's Estimates committee meeting is that the department is comfortable it will be able to manage that.

Mr MULDER - So there will be no RAF?

Mr FERGUSON - That is exactly what I am saying. The department has advised me it is comfortable being able to meet that additional cost burden. I am not in a position to guess what the future holds, Mr Mulder, but we had a RAF last year and that is historical now. The department did not have a RAF; the two THOs did.

Ms FORREST - Minister, looking at the performance information on page 76, one thing I think is not there and is probably helpful to know, is how many calls made did not require an ambulance service? I note last year you had the Save 000 for Saving Lives campaign. Did that result in an observable reduction in these calls, and do you have a record of how many calls fit into that category?

Mr MORGAN - For community education programs, it is notoriously difficult to measure their impact because essentially you do not know what the demand would have been in the absence of the program. We are doing is a whole raft of things to reduce the number of instances of transport to emergency departments. You can imagine the challenge with our business is that invariably, whether it is or not an emergency is not known until such time as the person is assessed. A lot of our focus is currently looking at things like alternative referral pathways, secondary phone triage, extended care paramedics and the like, so that we can minimise the number of observable instances of patients being transported to emergency departments who may have been able to be dealt with by alternative pathways, such as community nurses, such as by extended care paramedics, or quite frankly, just by referring to their doctor the next day.

Ms FORREST - Or ringing up their mother, perhaps, heaven knows?

Mr MORGAN - Absolutely. Historically the logic has always been 'call an ambulance and you will be transported to hospital' - that is not unique to Tasmania. But the transition of the paramedics into the tertiary sector and being able to make informed clinical decisions that are based on the risk matrix allows us to divert a significant number of patients away. A good example is our non-transport rate already is around 21 to 23 per cent across the state, so that is one in five 000 patients who are already referred to an alternative referral pathway.

Ms FORREST - There was another question here about the number, how many cases do you have where the patient was not transported as opposed to where they were treated at the scene or whatever? I am looking for those numbers when you have finished your other comprehensive answer.

Mr MORGAN - That 21 per cent is our non-transport rate across the number of patients who we were called to. That would not be -

Ms FORREST - So 21 per cent of 79 000.

Mr MORGAN - Correct, is generally what we are not transporting. It is a fairly substantial number. You can imagine if we were taking arguably - I am going off the max now - 14 000 more patients to an emergency department, what a burden that would be on the system.

Ms FORREST - Can you tell me how many calls were made that ended up not being of a nature that would warrant a 000 call?

Mr MORGAN - No. The reason you cannot directly answer that is, again, you do not know that it is not an emergency until proven otherwise, because the one thing that we always know is when the person dials 000, of course it is an emergency to them, until such time as we triage otherwise.

Ms FORREST - What was the outcome of the extended care paramedic trial that was introduced in Launceston?

Mr MORGAN - The extended care paramedic trial was funded through Health Workforce Australia when it existed. It was a very successful trial for Ambulance Tasmania. There were five sites around the country, four states. The model that we incorporated into the northern part of the state - bearing in mind they were targeted calls, so it was not all 000 calls - resulted in a 65 per cent non-transport rate. Interestingly, other jurisdictions had similar outcomes to targeted levels. It was assessed and evaluated by the University of Wollongong.

It was only a trial funded by the Commonwealth. As you know, Health Workforce Australia does not exist anymore, but in the suite of programs that I was referring to that Ambulance Tasmania is very interested in looking at for further diversion away from ED pathways, extended care paramedics is very much on the list. I think it is fair to say the minister has quite a degree of interest in this area too.

Ms FORREST - Minister, on that point then, clearly it is not something that is offered at the moment, but from the trial it appeared to be quite successful. Is this part of the white paper consideration? How is this being considered? Is it an option for diverting people away from the acute service?

Mr FERGUSON - It is not specifically being examined as part of the white paper, which does not have a deliberate spearhead into that. The trial produced some promising outcomes on, however, of course, short-term funding. We will always accept more funding when it is available.

Ms FORREST - The trial is just a trial.

Mr FERGUSON - There is a risk of taking on board short-term funding and we have seen that time and time again. When the funding ends, as it inevitably does with short-term funding, we have difficult decisions to make. We need to be careful about that. But if the additional resource is there - I'm not sure if Mr Morgan mentioned that the extended care paramedic going out as a first responder in those cases was as a result of a triage unit. It would have happened back at the operations centre.

Mr MORGAN - Yes, primarily that is the case, but we also provide them with web access so that the ECP who was best qualified to determine what might be an ECP case was also able to see and have input.

Mr FERGUSON - The point being it was a somewhat selected sample. Cases that are more likely than not to require transport, receive that service in the first place.

Ms FORREST - It would have been cost effective overall. That was what they found in Wollongong. That it was cost effective in the conditions

Mr FERGUSON - Where you have the resources, it would be a good use of resources. If you do not have the resources, would you take on an ECP at the expense of a paramedic service? Our position at the moment is, no you do not.

Ms FORREST - How many volunteer ambulance officers do we currently have and how does this compare with recent years?

Mr FERGUSON - It is up, and successfully up. I should be paying tribute here to a range of people including the volunteer ambulance association, Ambulance Tasmania itself under the stewardship of Mr Morgan, as well as a number of community leaders that have got behind it. It is up 25 per cent from five years ago, to 600 volunteers around the state.

Ms FORREST - Are there any areas where we are particularly short of volunteers?

Mr FERGUSON - There certainly would be a number of instances. I have mentioned one already today - a small but very confident group of volunteers at Southern Midlands. Even though they were small in number - around eight or so at the time of the public meeting - the number of volunteers was not the limiting factor, it was the availability of paid professionals. But there are a number of locations around the state where volunteer numbers are quite concerning, and one of those would be the west coast. We are always looking to get community leaders involved. People like you, Ms Forrest, who use the opportunities we have as members of parliament and local government to encourage people to consider the option of volunteering. Full training is provided and all the support and backup you would require. It makes it possible for people to enjoy the quality of life regional Tasmania has to offer. But we also need to maintain a strong compact between Ambulance Tasmania and the general community.

Ms FORREST - What are your chances on the west coast? Because there is limited mining activity in the area at the moment, have you found that volunteer numbers have increased? Particularly in Queenstown and Zeehan? It is a double edged sword, that one.

The program you ran last year - Join, Learn and Be Ready - to encourage the recruitment of volunteers, that and other initiatives the minister mentioned saw a 5 per cent increase over five years. What was the cost of running that program?

Mr FERGUSON - Can we take that on notice? It was a Commonwealth initiative announced jointly by minister Abetz and the Premier, Will Hodgman. I do not know the final figure but we can get it for you. It will be in the vicinity of $50 000.

Ms FORREST - So, it was relatively cost effective if you recruited extra volunteers.

Mr MORGAN - Yes. The nature of volunteering, and it is experienced by all agencies with volunteers, is that every unit has a lifecycle. Whilst this year this particular town is really strong, vibrant and healthy, within two years it can be down to two or three people just trying to hold it together. The Fire Service refers to it as going through a period of renewal.

Ms FORREST - Like a football team really, needing a new coach.

Mr MORGAN - Yes. It really is and so the view that we have to take to volunteerism is, there is never a point where we would say we have enough volunteers. It is all that front-of-mind stuff and people knowing that there is a role and a need. We will always, in our language, say there is a place for anyone, including non-operational volunteers, who have something to contribute within the community.

Mr GAFFNEY - Have there been any standout models used by communities which seem to be more sustainable? I know that some groups might link with their fire service, where they just need a home base instead of being stuck in someone's shed or office as their base. Have there been any studies that you have been able to do to indicate if a community group was thinking about setting up a base, what would they aspire to, or what is one that has shown to be beneficial and long-lasting?

Mr MORGAN - The answer to that is, there is no panacea for volunteer groups. The reasons people volunteer, the types of people are absolutely different in every location and historically I think the real successes come out of sitting down with those communities and pretty much asking 'What are you looking for?'. The model that we brought in a few years ago of what we refer to as community emergency response teams, which was a model that we brought in from South Australia and Victoria, has proven to be very successful and exceedingly cost-effective. It has allowed us to really target those remote communities with only a few hundred people. We provide them with the same training as any other volunteer ambulance officer but we provide them with a sedan rather than an ambulance station and rather than providing them with a fully marked-up ambulance class 1 vehicle, and we back them up with paramedics from around the surrounding areas. That model seems to have worked very well because they are in locations now where we have never been able to put them had we had to put out a million dollars worth of infrastructure. The reasons why particular volunteers come to it - the lifecycle definitely changes over time. You might get an older group of people, say, on the west coast, but that might quickly turn to a younger group of people, and it just depends on the group dynamic.

Mr MULDER - Are we the only jurisdiction that does not have an ambulance levy yet?

Mr FERGUSON - Tasmania certainly does not, and I understand Queensland is another state that does not have such a levy.

Mr MULDER - Given the budget pressures and issues, is it time to bite the bullet and perhaps reintroduce the idea? If so, I guess MAIB pays for the ambulance services, do they not? I am just wondering if there is some sort of insurance scheme or something like you have through local government, the fire service levy, which they use to fund some of their operations by spreading it across the ratepayer base. Which also of course captures rent because rents reflects those sorts of charges. I am just wondering if it is time for a cash-strapped government to perhaps revisit this in a less politically charged environment, because the days of Tasmania pleading special case exemption when it comes to why we will not collect certain taxes when everyone else does, probably needs revisiting.

Mr FERGUSON - The simple answer to that is no.

Mr MULDER - You are not considering it?

Mr FERGUSON - We are not considering it.

Mrs HISCUTT - Does OH&S, do they pay -

Mr MULDER - Workers comp.

Mr MORGAN - Workers compensation pay - yes, the insurance companies.

CHAIR - Thank you very much.

Output Group 3
Statewide Services

Output 3.2 - Public Health Services

Mr FERGUSON - I invite Dr Mark Veitch, the acting Director of Public Health.

Mr GAFFNEY - Thank you. I know other members would like to ask questions regarding this line item which I will now put through. I would like to set some groundwork. On page 94 in budget paper 2, volume 1 - I do not want to misinterpret the information - it says '3.2 Public Health Services'. This is why I earlier came up with the figure of $5.359 million. The reason for that decrease this year is attributed to the public health service and reflects the transfer of cancer screening services, which we have dealt with. Let us say that is $5 million. If you then go to page 72 of that same book, where it says 'Output Group 3', it shows a decrease in public health services between 2014-15 and 2015-16 of about $8 million. The reason for that is in footnote number 4, which says that it reflects the cancer screening services.

If we take the $5 million out, we are left with $3 million. That is explained by the expiry of national partnership agreements, including Preventative Health, and revised arrangements for the Essential Vaccines program. Is the remainder of the money after this year's decrease in that funding because of those two programs? If so, what is that amount? Over the next two budgeted forward Estimates, there is another decrease of approximately another $6 million or $7 million. Over that three-year period in this output line item, there is a decrease from $40 million last year down to $25 million in 2017-18. Only $5 million of that is attributed to the BreastScreen services. I assume the other $10 million over that time is a result of the MPAs and the revised arrangements for Essential Vaccines program. How has that been extrapolated for that time?

Mr FERGUSON - Mr Gaffney, I hope this is of assistance. The 2015-16 estimate for this output has decreased by approximately $5.5 million. That primarily reflects the transfer of responsibility for cancer screening - the $5.8 million from this output to the THS, which we have already discussed today - and additional savings of $112 000 as a result of the pay pause not proceeding, offset by updates to departmental overheads and accruals of $472 000. From an accounting trim point of view.

Mr GAFFNEY - Did you say $5.8 million?

Mr FERGUSON - Yes. The transfer of responsibility for cancer screening, $5.8 million from this output to the THS.

Mr GAFFNEY - That doesn't add up to the figures on page 94.

Mr FERGUSON - Two other figures are at play here to get to the $5.5 million. So we are starting with the $5.8 million, being the transfer of responsibility for cancer screening, but there are two other factors. One is the additional savings of $112 000 as a result of pay pause. You would add that to the $5.8 million. That gets you to just over $5.9 million. That is then offset by updates to departmental overheads and accruals of $472 000, which brings you down to $5.35 million.

I have a little bit more information to assist you and the committee. The movement in expenditure for this output in 2015-16 has decreased by $7.9 million from the 2014-15 Budget to this Budget. This primarily reflects the finalisation of the breast screen digital mammography and other cancer screening and control services national partnership agreements and reduction in the essential vaccines and preventative health NPAs of $2.2 million. The transfer of the cancer screening to the THS -

Mr GAFFNEY - Thank you. I am interested in why between 2015-16 and 2016-17 and 2017-18 you have assessed probably about $6.8 million worth of decreases in funding. If the screening has already gone across, the NPAs have gone, and the essential vaccine program. You obviously have information that shows a decrease in expenditure for the forward Estimates. Could you explain that figure?

Mr FERGUSON - Mr Gaffney, to assist you further, I can shine some light on the adjustments against each of those financial years. I have already mentioned the reasons for them. If I can give you some indication of the amounts, and in what years, it will help. The national partnership agreements in particular - of that amount $2.2 million relates to 2015-16. In 2016-17 - $1.1 million, but in 2017-18 - $5.1 million. In the fourth year, 2018-19 - $245 000. That goes a long way towards explaining the differential between 2016-17 and 2017-18.

Mr GAFFNEY - Yes, it does, thank you. Page 94 again, where we have in this year's Budget $13.7 million for public health services. It says in the preamble that is for two major things. First, it is for Public and Environmental Health Services, which monitors the health of the Tasmanian population and implements programs to protect and promote health. The second one is Population and Health Priorities, which implements programs to prevent or reduce risk factors that lead to chronic conditions. The explanatory notes give some details about the immunisation of our children.

What is the overall cost, out of that $13.7 million, for the immunisation budget? What are some of the other preventive health programs and how much are they afforded for that financial year, whether it is to do with chronic illness or preventive health programs? Do we have a breakdown of where the funding goes for other health programs - preventive health programs particularly?

Mr FERGUSON - Mr Gaffney, I believe you are reading from page 94, table 4.12. That is a revenue table. That is indicating, by output, what revenue is attracted from the appropriation. I cannot answer your question at the moment, but I can have that analysed in terms of the different areas you are asking about. I can provide that to you if you pop the question on notice.

Mrs HISCUTT - Excuse me, Chair, can I add to that? Is it possible to find out how those programs are advertised and accessed?

Ms FORREST - To add to that, making it a comprehensive question. We particularly know what you plan to do in terms of obesity. We have had recent media coverage and commentary from experts in the field that obesity is going to present more of a risk to public health and health budgets than smoking. It would be really good to know what is happening in that area.

Mr FERGUSON - Plainly, we have a significant issue on our hands here. We have an increase in the burden of overweight and obesity in children, which is a warning sign of further demographic change.

We already know that around two-thirds of the Tasmanian adult population is either overweight or obese. That is a significant push factor on chronic disease-growing burden and that will naturally have consequence later on in life when illness presents and health deteriorates.

At this point in time, the Government, being mindful of this and not being overwhelmed by it but wanting to be proactive, we have engaged the Healthy Tasmania committee to work with us to develop a longer-term and strategic approach to how we can address this.

From my point of view, I hasten to add that this cannot be a government at the centre remedy. It has been tried before and failed. For us to be able to see the sorts of changes that we would all like to see in the community with a healthier population, it will need to be a partnership between government as the principal leader of thinking in the community but families, schools and in particular parents, taking significant responsibility for the life decisions that they make and addressing risk factors. We cannot expect them to do that if they are not informed. We need to work with them to inform Tasmanian families about the best way to make healthy choices.

With all of that in mind, we are awaiting the report of the Healthy Tasmania committee. I am looking forward to hearing from them in phase 1 of their work by the end of this month. It is my intention to basically provide that to the community as well at the same time before we then go into a more detailed consideration of specific responses.

Ms FORREST - I understand that in terms of infrastructure in hospitals, beds, operating tables, those sorts of things, even trolleys for transporting patients, has required additional capital investment on the basis of being able to cater for some of these particularly obese patients. Do you have a figure of how much it is costing in terms of that sort of infrastructure?

Mr FERGUSON - I doubt we would have a cost. In every new redevelopment or new upgrade of a ward, there are always one or two rooms in those wards that need to be bariatrically engineered. It is also part of ambulance as well. Across the board we are having to make these additional investments to take account of that number of the population for whom standard operating equipment is not safe.

Ms FORREST - The problem is when someone rings 000, they do not tell you how much they weigh, do they?

Mr FERGUSON - I have not thought of that. I do not think we have a figure on it, but naturally it is one of the many costs that a government is faced with when this change has happened in the community in the level of health.

CHAIR - Minister, in the key deliverable statement, budget paper 2, page 63, you talked about the Ice and Other Drugs Strategy and $4.8 million. That sounds pretty good, but it says

over four years so the actual spending for 2015-16 is $1.35 million and then that drops off in future years.

I have another proposition I want to put to you in a minute. Given the significant commentary released recently on the rise and use of ice particularly, it seems doubtful this level of expenditure could be expected to have any significant impact. In any event, are you aware what evidence other than anecdotal is available to support the facts as to the extent of the drug problem? I have four questions so I had better not overload you, had I?

Mr FERGUSON - Please don't. First of, I all acknowledge the anecdotal evidence. The anecdotal evidence is actually worth something and I cannot ignore it and we have never ignored that anecdotal evidence. Throughout the time that I have been minister, now 14 months, it is to be acknowledged that it became much more of an issue around the middle of last year than it had ever been before. There is a range of evidences around the use and abuse of drugs including ice - and I try not to focus on ice, I try to remember to use the words 'and other drugs' when I refer to ice. Unfortunately it can be an unhelpful distraction away from some of the very big drug abuse issues that we have in the state including alcohol, tobacco and cannabis and non-ice methamphetamines, which are all real problems for us. The abuse of prescription drugs is another.

There is certainly the anecdotal evidence. I do not mind saying that some of that anecdotal evidence I do not think was very constructive but some was constructive. The Government and my office sought to get the best possible measure of the degree of the problem in the community. We commissioned our Alcohol and Drug Service and our Clinical Director, Dr Reynolds, to look into this in some detail. I am pleased to say that the report that he provided, while lengthy and quite comprehensive and not focusing on ice but focusing as much as possible on the range of drug abuse issues in the state, gave us 11 recommendations to consider, one of which reflected the fact that we do not have a very good evidence base often and we need to improve our information gathering systems, which is one of the things that would be funded out of this $5.8 million that is listed as one of the key deliverables.

What we want to do from here is address the service gap that has been identified on the north-west coast. That does not single out the north-west coast for special criticism or stigma about being a greater or lesser community in terms of the use and abuse of drugs. It does recognise that it is the one region of Tasmania that has not had the residential rehabilitation services that other parts of the state have. By investing in this, it will not just provide a better service in that community, it will also help to carry some of the load for the rest of the state.

CHAIR - I entirely accept what you say about the abuse of other drugs and including prescription drugs but, as we are aware, ice is perhaps the flavour of the month in some cases. If you talk to police, law enforcement officers and people in Health, particularly in some of the rural areas, it is the one that is causing many problems. Having spoken to quite a few of those people, I did say in the budget reply that I would put that proposition and I will ask your response on this. When or not when an ice addict arrested on the spot, instead of them being put on bail and sent back into the community, they may take some months to get into a rehab unit, by then they may have lost that will to go there and they are back in that same community and are using again straightaway. The proposition is that, if you get the right, with the discretion of a senior police officer, then those people should be put straight away into a rehab facility so that they are given the best chance. Obviously that would be reasonably costly but maybe it is a better proposition than what we have at the moment. Would you care to comment on that?

Mr FERGUSON - I would be happy to respond and it would be a reasonably reflective response because I know that this has been suggested not just by you but by a number of others who are deeply concerned about providing the sort of support that we think people will need. This is an area I would want to tread very carefully; not just this minister but other ministers would need to be persuaded as well about the merits of considering such a course of action. At this point in time, no, we are not.

CHAIR - Are other ministers being able to help in this?

Mr FERGUSON - For example, I was thinking of my colleagues the ministers for police and justice.

Mr CHAIRMAN - You have great sway in Cabinet, don't you?

Mr FERGUSON - I was about to say flattery will get you nowhere, Mr Chair, but that would be reflecting on the Chair.

This would not be a health matter, it would be a justice and law and order matter. The evidence I have taken from visiting a number of the rehabilitation centres is that the successful outcomes were with people who had met a crisis in their life and they made a resolution to change. In one young man's case at Missiondale, he had nothing left to live for. He had done an enormous amount of damage to other people's lives before he made the decision to turn himself in for voluntary rehabilitation. The model provided at a facility like that is one where the person is always free to leave. They are always free to fail the program.

Those who make it are the ones who have resolved to do so. That comes with an acceptance it is not a 100 per cent success rate. The alternative may be - and I am now speculating, this is not the Government's position - a mandatory or enforced model may also be a complete failure. If the personal motivation is absent, it may well be that you can dry them out after a period but as soon as they are free to go, you have not had the therapeutic or emotional and social training that comes with successful residential rehabilitation. The person may go on to live a catastrophic life. To come back to the point, I would need, and the Government would want, to see some strong legal, health and psychological evidence that would sustain that argument. At the moment I have not seen that argument or that evidence.

Mrs HISCUTT - You talk about a priority to establish a residential rehabilitation program for clients based in the north-west and more beds. Have you advertised yet for service providers? If you have, where are these 12 beds going to go?

Mr FERGUSON - The advertisements were placed in the last week in May. The request for proposals was advertised on 23 May and remains open until 29 June. As I earlier mentioned, the initiative is not about ice, it is about ice and other drugs. It includes funding for 12 new residential rehabilitation beds for clients across the state, but with a priority on establishing a residential rehabilitation program in the north-west coast. That is our ambition and our aim. We are hoping that providers will come forward with strong proposals to achieve that outcome.

It is not just hope. I am at some arm's length from the procurement process, but nonetheless I am encouraging collaboration - and I say this quite openly - between all the service providers offering different services to different cohorts of Tasmanian people wanting to escape the drug

abuse cycle. I am encouraging them to talk to each other. I am encouraging whoever or whatever organisations in the end put in formal proposals, to look internally to see if they can find better ways of working with each other in those different parts of the state. The request for proposals is for a 24-hour, seven-days-a-week residential rehabilitation treatment service or services for men and women, including support for families and carers.

Mrs HISCUTT - Were you hoping to get something up in the Burnie-Smithton way, central, on the coast or Launceston?

Mr FERGUSON - The very strong inducement is for a service physically located on the north-west coast. That is the strong message that sits with the RFPs. There are existing providers - I can name Serenity House at Sulphur Creek, which is provided by the Launceson City Mission. I visited there, I think, with you, Mrs Hiscutt. We are all impressed with their hard work and professionalism. We want to support our various services. The RFP - after it closes, I can indicate to the committee that the criteria will include the demonstrated ability and experience to provide a resi-rehab treatment service to people with a drug or alcohol dependence, the demonstrated ability to recruit and maintain appropriately qualified, skilled and experienced staff, and the commitment to developing and supporting the alcohol and other drug sector workforce development needs, and demonstration of sound organisational governance and financial structures, including professional practice accountability processes.

I might close on this point, unless there are more questions, by saying that respondents are encouraged to identify options for residential facilities that could be used to provide the residential treatment service. Really, we are quite open minded to innovative proposals, including whether it should be at Penguin or Burnie or Ulverstone or Wynyard or Smithton. We are open to those and we will be assessing it in line with the criteria I have outlined. Further to that, the department is willing to work with the successful respondents to identify appropriate facilities for the provision of services, should that be necessary.

Mr MULDER - I see where you are coming from with the Ice and Other Drugs initiatives, but some ice users - and this is very important to know - exhibit extreme aggressive behaviour or psychotic reactions. It is those particular ones we are noticing. Along with rehab beds, isn't there also a need for an emergency dry-out facility for the protection, not only of the individual concerned, but of the broader community? I do not see any program to deal with these people we see on the television being dragged into emergency departments, where it is quite clear they do not belong.

Mr FERGUSON - Yes, Mr Mulder. I also draw your attention to the national task force, which is led by Ken Lay. The Tasmanian Government is supporting that and has been part of discussions and part of the consultations, including one as recently as Wednesday 27 May, when we were part of a consultation session held in Hobart. Government representatives from the Department of Health and Human Services, Justice, DPEM, Education and DPAC attended the session, along with representatives from a range of service providers.

The major points raised from the consultation so far include the need for joined-up service delivery, the importance of family engagement, workforce concerns, in terms of employers' capability to intervene, and short term funding challenges. The task force will prepare an interim report for consideration at COAG on 23 July. I feel certain that matters such as the short term security of the person and the people around them -

Mr MULDER - Emergency response is what we are talking about, not long-term programs. What is the initial emergency response?

Mr FERGUSON - Indeed. Short-term security of the person and the people around them, for example when there is an episode of heightened aggression, naturally will form part of Tasmania Police's response and that of the national task force.

Mr MULDER - You are putting 12 beds into the program, but that does not deal with the immediate problem. I am also deeply concerned about the message coming out - and even the Prime Minister has done the same thing - almost suggesting that if you walk past someone who has once used it you will suddenly become a raging addict who is going to go head-butting clinicians in emergency departments. My warning to you is that we have been down this path 100 times before. The bottom line is, as the Tasmanian Ambulance Service has worked out, there are some very high functioning people out there using ice, for whom this message will mean nothing.

You are right to deal with ice and other drugs, but there are some things about ice we need to understand. We need emergency intervention. Clearly, these people do not belong, in the first instance, in a DEM. They are only there because we have nowhere else to take them.

CHAIR - You have taken it all onboard?

Mr FERGUSON - I have taken it all onboard.

Mrs ARMITAGE - Page 76, table 4.4, Public Health Services. Given the minister' stated objective of Tasmania having the best health outcomes by 2025, which is a laudable objective, why is there only one performance measure? Surely there are a host of other measures that should be included to ensure we meet the 2025 target. Can you please advise? The only measure I see there is about vaccine coverage.

Mr FERGUSON - We have been discussing, during the course of the day, a range of the performance indicators for various outputs and there are many that you could list. The key ones are selected here and if the committee would like to recommend other ones be added, then I would be happy to do that.

Mrs ARMITAGE - I just thought it was interesting that you had vaccines there, that was all.

Mr FERGUSON - Of course no-one, least of all me, would be suggesting that is all public services are doing. That is one of the key measures of the success of the work of Public Health Services and their engagement with the community.

Mrs ARMITAGE - So in the report next year there should be a few more listed? It just seems under Public Health Services there might have been more performance measure listed.

Ms FORREST - Some outcomes-based ones perhaps as opposed to output, not just output measures.

Mrs ARMITAGE - Yes as opposed to vaccines.

Ms FORREST - Just going down that path, my favourite topic of outcome-based performance indicators. On the theme of vaccines, we are falling behind the national average on fully vaccinated children except in one age bracket. What is being done to improve the immunisation rates, the rates of full immunisation for children across all age groups?

Mr FERGUSON - I was actually studying these figures last week and in many areas nationally we want to keep a close eye on the proportion of children in particular who are getting vaccination coverage. When you compare Tasmania with the Australian average, in a number of cases we are tracking on par and in a couple we are below. You were asking what is the department or the Government doing in this area. I will ask Dr Veitch in a moment to speak to this, but I will also gently draw the committee's attention to the reality that a number of families think that vaccination is bad for their children. I do not know that that fully explains the one in eight or the one in 10 who are not listed as having vaccination coverage.

Ms FORREST - There are some people who, on medical advice, are not, and that is fine, but they are very small in number.

Mr FERGUSON - I understand that is a very small percentage.

Ms FORREST - Yes, very small.

Mr FERGUSON - I do not just want to scare people into taking their children to be vaccinated. I would like them to be informed and want to have it done. I have seen a number of things that are said about vaccines that suggest that they are not to be trusted, when in fact it is one of them most effective public health responses with one of the best rates of return, if I can put it that way, in the community that we can offer.

Dr VEITCH - First, I would add there is probably less cause for alarm than you might think from the dip in the rates in the information that is in the table.

Ms FORREST - In the 12- to 15-month cohort.

Dr VEITCH - Over the last 10 years we have had probably a doubling of a number of vaccines that have been included in childhood schedules. When a new vaccine is added to the schedule, there is a lag of a couple of years before they are included in the measurement of vaccination coverage. Usually for the first two years after new vaccines are included in vaccine coverage there is a dip in vaccination rate.

Ms FORREST - In that particular new vaccine as opposed to all of them?

Dr VEITCH - Just because of people who will not have had the new vaccines or the new vaccine has not been adequately documented by general practitioners reporting through to the national register. What we typically see is two things; first, the vaccination coverage in the cohort getting the new vaccines picks up in the next two or three years; second, as that cohort ages we see them catch up that new vaccine they may have missed out as they get older.

Ms FORREST - When they present for other boosters and things like that?

Dr VEITCH - Yes, when they get to the last benchmark which is at five years. We would expect that to happen. What are we doing about it? There are extensive interactions between the

vaccination section of Public Health Services and general practitioners who are the principal providers of childhood vaccinations. They work with general practitioners to remind them of the new vaccine schedules, the importance of reporting and so on.

The other important fact to bear in mind is that of the slightly fewer than 10 per cent of children who are usually incompletely vaccinated there are only about two per cent who are children whose parents completely decline vaccinations on their child's behalf or children who have medical indications for not being vaccinated. Most of the rest of the gap, 6 per cent or 7 per cent or so, comprises families who have access difficulties or things get in the way of receiving a dose of vaccine. They are the ones who generally catch up vaccines by the later landmarks. The other fact to bear in mind is the new national strategies relating to withholding of tax benefits. We anticipate this will act as a fairly strong incentive for people to catch up their delayed or late vaccinations.

Ms FORREST - On the back of that, minister, can you tell me how many children have been diagnosed with any of these illnesses: diphtheria, tetanus, pertussis, polio, Haemophilus influenzae type B, influenza type B, hepatitis B, measles, mumps, rubella, pneumococcal, meningococcal C, and varicella infections in the last 12 months?

Dr VEITCH - Diphtheria, tetanus, polio, some of the vaccine preventable diseases you mention, none of those diseases have occurred in Tasmania for, in some cases, decades. There are other vaccine-preventable diseases such as **(TBC....inaudible...4.43.05...HIB (Haemophilus influenzae type B??)** has now become exceptionally rare in vaccinated children. We only see one or two of them a year. We have had about four cases of measles, not in young children but in adults in three small outbreaks that occurred about two years ago. Measles has become very rare.

Pertussis happens in cycles. The last substantial cycle was around two to three years ago when we had around 1 000 cases spread over two years. Pertussis, or whooping cough, is now at the trough of the cycle. We have only had 10 cases so far this year. We anticipate that count will pick up over the next two or three years. Pertussis is a very difficult disease to eradicate completely. The vaccine does not completely prevent circulation in the population. What we particularly emphasise, the minister may wish to comment on this, is vaccination that protects infants and the initiative Tasmania is now adopting is the vaccination of pregnant women in the third trimester. It is a strong protective strategy to protect the newborn infant in the first few weeks of life.

Ms FORREST - With the 10 cases of pertussis in this last year, how many of those are children with the infection?

Dr VEITCH - I cannot tell you off the top of my head if they were children. They were a mix of children and adults.

Ms FORREST - Do we know whether those individuals had been vaccinated? Were they people who had not been vaccinated?

Dr VEITCH - I cannot tell you case by case. We do not follow up all cases of pertussis vaccination history. However, there is the slightly paradoxical occurrence that when you look at pertussis cases you will often see that quite a proportion of them are people that have had vaccine and they represent waning immunity despite vaccination. It does not mean the vaccine is ineffective because there would be many more cases if there were not being vaccinated.

Ms FORREST - So what about Varicella? Varicella has not been around that long but are we are starting to see a decline in the infection rate?

Dr VEITCH - Varicella or chicken pox is a difficult disease to understand from surveillance data but there are some indications in the national data that the incidence of disease has declined.

Ms FORREST - These are all reportable diseases, so do we have figures for Tasmania?

Dr VEITCH - We do have figures and there are around 100 to 150 notifications of Varicella, I think, per year. One of the difficulties is we did not have surveillance for Varicella before the vaccination program came into place so it is difficult to see a before and after effect.

Ms FORREST - That has been in place now for a number of years though. Would it be up to 10 years?

Dr VEITCH - It is. We still see cases of Varicella. Often people who have been vaccinated generally have a modified illness so less severe than chicken pox in days gone by. We still see people who get shingles, the late reactivation of chicken pox, in older people. There is a national working party looking to try to vet surveillance to better understand transient varicella.

Ms FORREST - What about meningococcal C?

Dr VEITCH - I do not think we have had a case in the vaccinated population for three or four years. We had a case a couple of years ago in a person who was too old to have been vaccinated but it has dramatically reduced meningococcal C disease in Tasmania. At the height of the epidemic, about 10 years ago, we had the highest rate in Australia.

Ms FORREST - In Public Health, I wanted to go to water quality issues? Can I ask what targeted testing is done in the state for lead levels in drinking water?

Mr FERGUSON - Ms Forrest, is your question specifically on lead?

Ms FORREST - Yes.

Mr FERGUSON - The responsibility for this sits in legislation including the Public Health Act 1997. It provides the powers to regulate for safety drinking water which must be managed in accordance with the Tasmanian Drinking Water Quality Guidelines and the Australian Drinking Water Guidelines. The responsibility rests with TasWater, which is required to undertake risk assessments in accordance with the guidelines to determine the monitoring frequency of water supply parameters. Different suppliers will vary in their risk profile and that might influence the regime of testing and monitoring for non-microbial indicators like heavy metals and pesticides.

TasWater, if there is an exceedence, are required to notify public health services of any test results that indicate non-compliance with those health-related guideline limits. Information from TasWater, including summarised notifications of non-compliance, is included in the publicy available Public Health Services Annual Drinking Water Quality Report.

Ms FORREST - This is a concern to you, as Minister for Health. TasWater has to do their bit but you would be aware that the township of Pioneer has had a lead alert since November

2012. Are you aware of what testing has been done there? What are the results of levels in the water, and also the human blood lead levels of residents in that area?

Mr FERGUSON - I will ask Dr Veitch to assist me in a moment. First, I showed a personal interest in the water quality testing regime that TasWater had on file. From my working memory, that information was available as far back as TasWater have owned the water. I would need to check if that included any data relating to the Dorset Council's responsibility for it when it was a council asset.

In broad terms, there were fluctuating measures of lead in the supply, that is, in the water at the tap. There were also different levels back in the supply and at different points along the pipeline. I asked for that information to be provided and Dr Veitch gave it to a number of members of the community at Pioneer. It is being released publicly, even though the nature of it requires a little bit of interpretation because different sources for the testing have influenced the level of lead in the water.

As soon as the exceedences have been identified, TasWater has to advise Public Health Services. The Director of Public Health then issues the 'do not consume' notice which is in force currently for Pioneer.

You have asked me about whether or not there is an awareness of lead in blood levels currently. I did also show an interest in this. Although the brief in front of me does not address this - and I will ask Dr Veitch to add to my answer - I am advised that there is no evidence of members of the local community having high lead levels in their blood. Dr Veitch, I will ask you to fill in any gaps that I may have left.

Dr VEITCH - Not many gaps, minister. It is correct that lead levels fluctuated around and a bit above the regulatory limit up until the time that we decided to put a 'do not consume' notice on the supply at Pioneer. That means that the lead levels were a bit above 10, which is the regulatory limit. It is not actually at a level where we would expect harm to come from drinking that water. However, it was at a level that you where you wanted to stop people drinking that water in case you get sustained elevations when people drink it for a very long time.

The public health intervention occurred before we would expect people to have accumulated lead in their body at a level that could cause any harm.

Ms FORREST - So have serum lead levels been done?

Dr VEITCH - We have not recommended it. There was no evidence that the exposure was of such a magnitude or sufficiently sustained to give rise to harm to people. If there were, we would have recommended people get tested.

The other consideration is that elevated blood lead levels is a notifiable disease in Tasmania and we have never had a notification of someone with elevated blood lead levels, at least in the last four or five years, from the north-east of Tasmania.

Ms FORREST - Assuming they have been tested at all.

Dr VEITCH - I am inclined to believe that because of the signficant publicity around the event, some people would have gone and got tested. I take some reassurance from that.

More particularly, I take reassurance from the fact that the intervention to stop people drinking the water occurred before they could be exposed to a high dose for a long time.

Ms FORREST - The member for Apsley has a particular interest in this area. She is on another committee so I am taking up some of the concerns that she has raised. It appears that the lead contamination is not from natural sources but from water infrastructure owned by TasWater. That is the information that has been received. I am not sure whether that has been confirmed or otherwise. You may know.

The question I would like to ask on behalf of the member for Apsley is: are you aware that TasWater has taken 24 months to have only nine water tanks installed for residents? The work to install these nine tanks happened over a seven-day period. So it took 24 months to do seven days' work. Would you agree that the situation is unacceptable and that TasWater needs to be held to account for the lack of timely action for this community?

Mr FERGUSON - First of all, thank you for the question, and vicariously to the member for Apsley for asking you to ask that question. I want to make the point that we do, as a public health authority, pay very close attention to the concerns and the needs of people, not just from Pioneer, but from other communities who are affected with similar 'do not consume' notices. Our first response has been a conservative precautionary one to protect people and to insist that they not drink something that is not meeting guidelines.

I am aware, broadly, of the response by TasWater to provide at its cost, on-site rain water tanks for collection, and then to provide it internally to the house. I am very well aware of the impatience that a lot of people are experiencing as a result of the time delays in getting that next work underway. I know that the Treasurer, the local government minister and the minister with responsibility for the TasWater app, the Deputy Premier, have all expressed - as I have - to TasWater the importance of providing a solution which is as timely as possible. I do not cast judgment on TasWater, but I do know that there are frustrations that might be being experienced on both sides of that equation because of the deed that I think TasWater is asking people to sign before they are then willing to do the on-site works.

I do make any judgment either against TasWater or the people who perhaps have not yet signed that agreement, but I see it as an area that has caused the process to slow down.

Ms FORREST - Is the water quality testing information that TasWater carries out made available to the public?

Mr FERGUSON - I do not believe it is routinely made available. In this case, I gained access to that information and I asked the Acting Director of Public Health to provide it to the community that was asking for it.

Ms FORREST - That was done.

Mr FERGUSON - It was done, maybe four to six weeks ago. Just a cautionary note here - some of the data has been collected not with the intention that it be released. Some of the data has been collected at different points in the catchment - in the reservoir, in the mains lines, and then finally at the end of the tap at different premises. In some cases, there are variables at play. A reading of the data, at first glance, may make it seem better or worse than perhaps it really is.

This is so particularly where the water has been still and not flowing for a long time. Naturally, that is going to have a very high reading.

With all of that in mind, I nonetheless asked for the relevant data to be released, particularly the exceedances, and that has been done. TasWater, as I understand it, principally collects this information to satisfy its own requirements under the Act. Where there are exceedences that are relevant to the water quality guidelines, they must - and do - inform public health services to allow those services to make informed decisions around 'do not consume' or 'boil water' alerts.

Ms FORREST - Clearly, a response generally would be to issue a 'do not consume' notice. It would have to be publicly notified, otherwise how would people know not to drink the water if you do not publicly notify it? Are all exceedences notified publicly, on the public health website, for example? How is it managed?

Dr VEITCH - The imposition of a 'do not consume' notice will normally occur after two consecutive elevations of water.

Ms FORREST - Under what timeframe?

Dr VEITCH - It depends upon the monitoring schedule. If they were around about a week apart, it would probably give us an indication that there was a sustained elevation. It also depends on the context of the testing - whether or not interventions have been put in place in between the first and the second test, and the history of the system. It is difficult to provide a single answer because it does depend upon the circumstances. A single exceedance can occur, for example, when someone takes a sample from a tap without flushing it or cleaning it. We have to be a little bit careful not to put out 'do not consume' or 'boil water' notice on the basis of a single test, because it could put people to significant inconvenience when there is no public health threat to them. That requires an understanding of the history.

CHAIR - On the same issue, from a public health perspective, many Tasmanians, like me, are not hooked up to a reticulated TasWater supply. Are there any issues you are finding with water out of sync with Australian water guidelines in tank water? Do you get any indication of that?

Dr VEITCH - A strictly personal water supply will not necessarily be drawn to the attention of public health services.

CHAIR - Do you get any feedback through DPIPWE? DPIPWE does quite a lot of testing. Obviously they do rivers and streams and everything else, but they also do quite a lot of private water suppliers. Do you get any feedback through them?

Dr VEITCH - I am not sure about the answer to that question. There are private water suppliers - people who have their own registered private water supply - and that may be people who run accommodations, for example, in remote places. They need to provide water for their patrons and they need to have a private water supply. They are subject to the same testing requirements as a public water supply, but we do not hear about problems with them very often. They are mostly managed through local government.

Ms FORREST - A closing one, if that is all right, Chair. Someone made a comment about this being not just about vaccination, although the budget papers would make you think it is.

What other areas does Public Health Services now cover? You are taking cancer screening out of it. It used to be called Population Health - what is the significance of the change of name? Would like to explain that? What other areas are covered, particularly under this output group?

Mr FERGUSON - I will invite the Acting Secretary to outline the structural change that has taken place, then Dr Veitch can articulate the full range of services provided.

Mr PERVAN - With the cessation of the Commonwealth funding, we had to remodel and reprioritise, if you like, a lot of the activities of the population health division. The decision was made to change its name to Public Health for two reasons. First, because we were aware of the expectation in the community, in education and in local government, that the division now had the capacity and capability to keep delivering at that level. Second, in recognition of some particular interest coming from the Health Council of Tasmania and other sources, in the UK model. Population Health, as an organisational title, is uniquely Australian. In the UK, everything we would call Population Health is done in a traditional Public Health unit.

We have two basic functions under Public Health. We have health protection, which are the traditional public health services largely governed by statute and overseen by a Director of Public Health, who is a public health physician, and health improvement, which is where the remodelled population health programs like Move Well, Eat Well and those areas that focus on primary prevention like Go for 2 and 5 and Find 30 - those sorts of programs. That is where we are at with the structure.

In another discussion in this room recently we went through how Move Well, Eat Well is now being delivered. Part of it is being normalised through the school curriculum for adolescents. The primary school-aged children program is still being largely driven by us, and there are other programs with that. There are instances where we have now amalgamated functions like men's health and women's health, so a single policy officer is now doing multiple portfolios. We are still doing all the work, just not quite so much of it as we did over the three years when we had the benefit of that substantial increase in funding.

Dr VEITCH - I think the acting secretary has covered the health improvement side well. The nutrition and exercise aspects; some policy positions around tobacco and nutrition. The other side - the more statutory side, the health protection side - covers some other areas worth mentioning. We have talked about vaccination; there is also communicable disease control, outbreak management and case follow up. There is also some blood-borne virus work, with partners in preventive measures around blood-borne virus transmission. There is food safety, toxicology environmental health assessment, and regulatory roles in the tobacco space. There is the State Water Officer and a number of other regulatory roles -

Ms FORREST - How does the State Water Officer work with TasWater?

Dr VEITCH - The State Water Officer works with population services and obviously has close collegial support with his colleagues in TasWater. He is the regulator.

CHAIR - Thank you. If we are all done, we might move to CIP.

DIVISION 3
(Capital Investment Program)

[5.06 p.m.]

CHAIR - Do you need to change your guard at all?

Mr FERGUSON - I will keep the team at the table, but we do have the new project director for the redevelopment, Mr Ben Maloney, who is on hand if required.

CHAIR - My question is the hoary old chestnut: given the RHH, given the hospital taskforce report, what degree of confidence do you have as minister that the redevelopment project can now proceed on time and within budget?

Mr FERGUSON - Chair, I am pleased to say that we are confident again that the redevelopment of the Royal Hobart Hospital will be a success. This time last year I was not able to say that - regrettably what should have been something of significant enthusiasm and good news for the state really had deteriorated to the point that we were concerned that the project might never actually happen.

Significant risks were identified connected with the project, some of which related to financials, where we saw something in the order of a $70 million unfunded expected blow-out. We saw a significant matter around time, and the very concerning twofold areas of project governance and patient care. The methodology of construction together with the way in which patients would be managed through a demolition and rebuild process was my biggest concern. It should not need to be said, but it is self-evident that removing patients from the hospital while construction works are underway poses an immediate dilemma.

On the one hand, you cannot demolish a building that has people in it; on the other hand, taking people -

Ms FORREST - Not at the same time, anyway.

Mr FERGUSON - Indeed, that is really my point. We can afford to be a little bit humorous about it now, but at the time it was greatly concerning. The idea of taking a patient away from the core services that required them to be in hospital in the first place was identified as a major risk. People - for example, the Department of Psychiatry staff - were far from happy, and consumer groups were naturally concerned.

With all of that said, in the time since I was last before this committee, the rescue taskforce then headed by Mr John Ramsey was appointed and has reported back, together with a remarkable project team over a period of around six months. They worked assiduously to get the project understood, to have a review of the building methodology, to re-examine the financial management and governance arrangements around the project, and even to the point of reviewing the project and improving it.

I can speak to those improvements briefly but the biggest and most significant game changer that was achieved was the safe and achievable decant plan to look after our patients. While that has been remarkable in that we will see the construction of the temporary facility on site at the Liverpool Street forecourt, providing us with a temporary facility which allows us to keep our vulnerable patients on site, I understand the Hobart City Council is actively considering that, so I will not in any way prejudice what is happening at local government level but we are awaiting planning approval on that and are hopeful of securing it.

The project is also improved, as we have heard already today. It will include a helipad, as it always should have, at significant extra cost. That has been able to be achieved within the already identified financial blow-out. It will have better and more contemporary standards as well as greater outdoor areas for mental health services. There will be the accelerated replacement of the hyperbaric chamber which is approaching the end of its service. Fortunately, during the work of the task force, it was identified as a potential construction risk that had not been picked up by the former government. We are really pleased that the project is now alive again. There are currently what you might call early works and minor demolition works. Pending council approval, then the first stages of the decant plan can actually begin to be delivered, including the temporary facility.

We are pitching for an end-of-2018 completion date. I have no doubt that along the way in the next three and a half years, we will have challenges that emerge. We believe we have substantially de-risked the project. We have a competent team in place, strong governance arrangements and a clear vision for the future to the point that the master contractors and subcontractors locally have every reason to be optimistic about being involved in the project and giving Tasmania the redevelopment that it should have and deserves.

CHAIR - Given some past experiences with significant government projects, quite a few projects of any sort, what measures will be in place to monitor the progress of the project to control the variations and avoid those cost blow-outs which seem to plague most major government projects?

Mr FERGUSON - We have a range of new initiatives in place. I will ask Mr Moloney to step forward and provide that extra advice. We have substantially improved governance arrangements which have been signed off by me and the Premier.

Mr Moloney might be able to take detailed questions on that. We also have a strong level of planning, which has now been achieved and is now an asset of the project, which frankly was not all there this time last year. If you want to explain the governance arrangements and how the QA of the project came forward.

Mr MOLONEY - I guess building it up from the ground up, essentially in staffing the actual contract itself between the state Government and the contractor is a managing contractor model so in proceeding with that approach, there is a guaranteed contract sum, a limit to which the value of the contract can get up to with sharing the savings that are obtained should the project be delivered below that. If the cost of the project exceeds that guaranteed contract sum, the managing contractor actually incurs those costs. That is the starting basis of the contract.

[5.15 p.m.]

Then, through that there may be other variations that occur through the life of a project. You would imagine that in a project of this complexity, there may need to be changes in response to changing service requirements of the hospital and the like, so we have appropriate governance structure around managing those. It is about making the decisions in a timely and effective way, depending on the complexity of the issue being resolved. The first layer is approvals being made by myself as project director if they are within my delegated authority, but that is generally the day-to-day business of the project to keep it moving. We have a large resource happening on site and there are substantial costs for delays. The general business decisions are made by the executive project manager and myself. Matters more substantial are elevated through the governance structure.

The first step beyond myself is to the project control group. That has a number of members, including the CEO of the hospital and other similar members. They deal with middle-range issues wherein it is necessary for quick decisions to be made in order to ensure the operational needs of the hospital are met. If there are larger issues, they are elevated to the executive steering committee. That executive steering committee consists of representation across government. We have the Secretary of the Department of Health. We also have the CEO of the hospital, whatever the title may be in the new arrangements. It also has the Secretary of Treasury; an independent chair - Dan Norton, who was a member of the task force; an independent project hospital specialist; a project director - Jo Thorley, who was also the other member of the task force. All of that representation is on the executive steering committee. They make more of the high-level decisions and refer those beyond their delegated authority to the minister.

CHAIR - That is something we will watch with interest, minister. Did your Government consider, like other major infrastructure projects and particularly hospitals in other states, a PPP-type arrangement? Is this something you have considered within Cabinet for this redevelopment?

Mr FERGUSON - Bearing in mind the Government made a commitment that we would bring this thing back into a healthy condition to proceed with it, along the course of the work of the task force a well-publicised proposal did emerge for an altogether different model. It is the well-known proposal to build a new hospital at the Cenotaph on the Domain. It was a very exciting proposal. It was very interesting and attractive in lots of ways; there are lots of good things one could say about it. I do not want to be dismissive of that idea. We did give it proper examination as a rival, you could say, to the project we were seeking to rescue on site. The very clear advice Cabinet received was that it was not a viable option for us.

CHAIR - It is easy in hindsight. I remember being on the various Public Works Committees where we went in and did a retrofit here and another retrofit there. That is water under the bridge; it is done now and we are where we are.

Mrs ARMITAGE - Can the minister explain how a $3 million allocation to the Launceston General Hospital, when compared to existing $71.9 million of state funding, bringing this to a total allocation of $657 million for the Royal Hobart Hospital redevelopment, is a fair and reasonable allocation. LGH patients will still be treated in wards not air-conditioned. Many are over 30 years old. There are predominantly shared four-bed wards, including mixed gender and total strangers. There is an absence of palliative care capacity to allow patients who cannot be moved to dedicated palliative care facilities and their families to spend their last days with dignity. Northside patients are treated in accommodation that does not reflect the needs of these most vulnerable patients.

Mr FERGUSON - Mrs Armitage, it is reasonable to ask the question, particularly when you are aware of individual areas of capital infrastructure at the LGH you have identified that you would like to be improved. If you could provide the details you read, that would appreciated. I might be able to give it a further response as well.

I would like to answer that in two parts. First, the project is not for Hobart; it is a project for the state. It is physically based in Hobart, but as a person who lives in Launceston I regard the Royal Hobart Hospital as my hospital as well as the Launceston General Hospital. I need it and my family needs it when they require treatment of a nature that cannot be provided at our local hospital.

Mrs ARMITAGE - I am not criticising the Royal Hobart Hospital. What I am asking is whether $3 million is reasonable for the Launceston General Hospital, given the aged -

Mr FERGUSON - I would love to take you on a walk around the Royal. It is a very tired hospital.

Mrs ARMITAGE - I am not criticising the money for the Royal Hobart Hospital; I am asking about the money for the Launceston General Hospital in comparison.

Mr FERGUSON - That is my point. You did ask me that question in the context of comparison with the Royal Hobart Hospital, so I have to give a balanced answer as well. The Royal is a very tired hospital; its oldest parts go back to the Depression era. It has been stretched in many ways and it has really required that type of redevelopment. Establishment of the new K Block will in some ways liberate that hospital to grow into it and take the strain off a number of other service areas, as well as provide a more modern environment, including services that only the Royal provides.

To bring it back to the Launceston General Hospital, it was built in the early 1980s, I think 1983, and it is a much newer building. Even though it is over 30 years old it does not face the engineering challenges that the Royal Hobart Hospital does. In a way it is really unhelpful to even mention the two hospitals in one sentence in relation to their physical environment. They are very different.

If there are shortcomings at the Launceston General Hospital then I would like you to tell me more about those sometime. I am aware that one of the areas in most need of an upgrade is the Allied Health clinic. That was not going to happen until this Budget. The Government saw fit to provide $3 million to make that upgrade happen. It is not just an upgrade but a more modern and expanded service. It is, I am sure you are aware, down on level 2. It is in need of those funds and that upgrade. I am very proud to say we secured those funds. It will be really well appreciated by our staff and patients. If there are other shortcomings at the site you can make me aware of, I would be happy to receive them.

Mrs ARMITAGE - I hope you are already aware of them.

Mr FERGUSON - This is not to dismiss the issue you raised with me; air-conditioning was one. The Launceston General Hospital has had over $100 million spent on it in the last five years. What matters is not what each hospital got or what each community feels they received out of this. I have to take off my parochial hat now I am a minister. What matters to me is that we have a hospital system which works for the whole state and is focused on the needs of their local area and how they fit in as part of a statewide family of hospitals. That is what the message of health reform has been all about. Take a walk through the Launceston General Hospital. It is a lot more supportive, comfortable and professional environment than Royal Hobart Hospital staff have to put up with.

Mrs ARMITAGE - I am not criticising the Launceston General Hospital. Regarding the $100 million, could you outline where it went? Does it include the integrated care centre? I am talking about actual patient care. That is all. I am hoping we can have a discussion later, minister.

Mr FERGUSON - I hold great affection for the Launceston General Hospital. I am also concerned about all our health infrastructure, and making sure it is fit for purpose. If I can -

Mrs ARMITAGE - But there are concerns about people in shared wards - male and female shared wards. There are a lot of issues, and I have had a lot of them raised with me, particularly with elderly people. Elderly people who go into hospital, and they are sharing with men and women together. There are some concerns, and it is responsible for me to bring up my constituent's concerns with you in this environment.

Mr FERGUSON - I also have people raise the very same issue with me and I acknowledge that it is a legitimate concern.

CHAIR - Any more on CIPs? If not we will then move to 3.1, which is all about ICT. Do you need to replace anyone at the table at this stage?

The committee suspended at 5.26 p.m. to 5.30 p.m.

DIVISION 7
(Premier and Cabinet)

Output Group 3
3.1 Electronic Services for Government Agencies and the Community

Mr FERGUSON - Chair, I introduce to my left Ms Rebekah Burton, Deputy Secretary of Department of Premier and Cabinet as well as Mr Mitchell Knevett, Director of the Office of eGovernment.

For the first part of this Estimates hearing may I recommend to your committee that you might approach this by doing DPAC outputs 3.1 and 3.3 in any order of your preference, and Department of State Growth output 1.2. That is what the budget papers tell me I am addressing.

If I may explain, in my ministry for IT and Innovation I have two departments working to that ministry. The first is the Department of Premier and Cabinet, for which I have introduced these two witnesses, and I also have responsibility for a part of the Department of State Growth and those people are waiting on the side.

Ms FORREST - Are you representing State Growth, minister? Is that yours?

Mr FERGUSON - No, it is Matthew Groom's output. My work in State Growth is a subset of 1.2.

Ms FORREST - I have a similar questions for Mr Groom on this output 1.2 for State Growth. How do we know who to direct them to?

Mr FERGUSON - If it is IT-related to me, and if it not to Mr Groom. This is last year's approach.

Mr MULDER - Sounds very joined up.

Mr CHAIRMAN - Yes, not quite the way we had things planned anyway. We will bat on.

Mr FERGUSON - I am at your service and whether or not you wish to go to 1.2 today is entirely up to you. I am here.

CHAIR - What do you think? We may leave that for Mr Groom?

Ms FORREST - Let us go through the first bit and I will have a quick look.

CHAIR - See how we go?

Mrs HISCUTT - Minister, you have your e-government advisers which is really good. I find this quite fantastic and amazingly a Tasmanian cloud. Can you give me an overview on that and how the move is going to the cloud and how long you anticipate this to take?

Mr FERGUSON - I might provide a bit of an overview of the portfolio as it regards Premier and Cabinet.

Output 3.1 is about coordination, development and implementation of whole-of-government information systems. Telecommunications, information management strategies and policies and this is aimed at improving and modernising the ICT operations and statistical capability of government.

This output 3.1 is primarily provided by the Office of e-Government. The major activities of that office during the year included progressing the development of the Tasmanian government's open data policy. It includes working with TMD to address the future requirements of the Tasmanian cloud and working with the department of Treasury and Finance to streamline the government's current approach to ICT procurement as well as developing a contemporary ICT security framework to address the ICT security risks faced by government.

Output 3.3, delivers contemporary information and communications technology services to agencies across government in a one government context. This output is delivered by the government's technology arm TMD and includes initiatives such as the government's proposed Tasmanian cloud. From this will emerge the next generation of managed ICT services developed in close consultation with the local ICT sector leading both to better service delivery by government and a stronger ICT sector. TMD operates off budget and cost recovery is achieved by invoicing of agency customers for the managed services that they consume.

By consolidating overall demand for ICT services across government, TMD obtains improved tariffs and economies of scale as well as high service functionality from the market. This translates into lower cost for government and a more integrated standards-based ICT environment. Many of the services established by TMD are available to and used by, not only inner budget agencies but also a wide range of other service providers in Tasmania such as private hospitals, private schools and GBE's and local councils.

Mrs HISCUTT - Minister, you mentioned the open data policy. How does that meld with security concerns? One sounds open and one sounds closed. How do you marry them?

Mr FERGUSON - The government is committed to improving the open data agenda in Tasmania. There is an interface from a policy point of view with privacy and personal information being secured and we are very conscious of that. At the same time there is great opportunity if we are willing to open up community access.

Even corporate access to government data, where that is appropriate. By first of all ensuring that data is only ever published in a way that is mindful of Tasmanian's private information and ensuring that such data is published with minimal limitations on its re-use transformation and re-distribution provides opportunity.

It has the opportunity to create public value by allowing the re-use of government data for commercial innovation and community benefit. For example, last year we supported an initiative called GovHack which is in the community. It is not run by government, but we co-sponsored it as a government. It is about releasing government information that we sit on, that we have, which is largely only accessible by government. But by being willing to release it to the developer community, at GovHack we saw two or three entrants submit their app for your phone which turns Metro timetable information into a useable app so you can plan your journey. That is just one illustration of a situation where releasing government data, which government owns on behalf of the Tasmanian community, can be used for better services.

We also believe that open data can increase government service efficiency through sharing data within and between governments. Many governments around the world have found that they are amongst the greatest users of their own open data. Plainly, as you have indicated, we need a clear policy in place that supports privacy, but also to support the publication of quality open data across agencies and that way, who knows what value-adding can be done in the wider community with that government information.

Mrs HISCUTT - How is the IT framework going?

Mr FERGUSON - The policy framework?

Mrs HISCUTT - Developing a contemporary ICT security framework. Obviously it is under Development.

Ms FORREST - This is the one the Auditor-General referred to in his report, is that the one you are talking about?

Mrs HISCUTT - Yes. 'The ICT Policy Board has recognised that these current whole-of-government arrangements can be advanced, and is developing a contemporary ICT security framework.'

Mr FERGUSON - The Government Information Security Policy provides a framework to focus on and coordinate information security planning and management by all agencies. This is a service that is conducted across Government. The Information Security Policy Manual gives guidance to agencies exactly on securing information, including governance, risk management, record security, physical security, which was something that the Auditor-General also raised, ICT security and incident reporting, and business continuity planning.

In response to that, the ICT policy board - which operates across Government, chaired by the Secretary of the Department of Premier and Cabinet, Mr Greg Johannes - is currently reviewing

the information security policy, taking into account the need for a strategic and coordinated approach to address changes to the way that government agencies use and share information and ICT resources. The Government broadly agrees with the view that was expressed in the Auditor-General's report that we do need that kind of focus. Generally, the five agencies that were part of that audit are now following a risk-based approach to implementing ICT security recommendations as part of their own policy implementation.

Mrs HISCUTT - There is just one thing that I was not quite sure about. It talks about the transport inquiry service.

> 'A project is currently underway to transfer the TEC from the Department of State Growth. This new service will be fully operational from 1 July 2015 and is expected to receive approximately 130 calls per annum.'

In the transport inquiry, what sort of things would people be -

Ms BURTON - That comes under output 3.2, which is the Premier's output, but if you are happy for me to respond to your query, it is under the Service Tasmania output, for which the minister is not responsible. The transport inquiry service, if you have ever rung up previously - you may not have - to find out how many points you have on your driver's licence, you have rung a small group in what was the Department of Infrastructure, Energy and Resources. Now, that is a little call centre which is part of an initiative that Service Tasmania, over the phone, is undertaking. They are consolidating all of the call centres across Government, and the transport enquiry service is one of those call centres that is going into Service Tasmania, under that umbrella.

Mrs HISCUTT - So it is not part of the cloud.

Ms BURTON - No.

Mr FERGUSON - But we can talk to the cloud if you wish us to.

Mrs HISCUTT - I am very interested in the cloud and how it is going. I can see it is going to cost a wee bit of money to get over there, that is fair enough. How is progress going in the cloud?

Mr FERGUSON - Rebekah and Mitch are both well placed to help explain this. We call it the Tasmanian Cloud Project. It is about establishing the next generation of data network and related ICT provision of services. I am speaking here of services to government. Services that government requires to provide education, health and other services to the Tasmanian community. This is about what kind of architecture we have for ICT that is operated by the Tasmanian Government for its own agencies. This is an iteration of previous projects that have carried the name of Networking Tasmania I and Networking Tasmania II. We think the name 'Tasmanian Cloud' is less important that what it will do. The name speaks of having a whole-of-government, one government, multi-agency approach to ICT.

At the moment, ICT services are broken up into different silos by different agencies. We want to redesign that architecture within a single environment. There will be some benefits that flow from this. Can you imagine, for example, the value of having teachers and students being able to access learning resources and submit information from any location, not just physically

within a school? If you look at, for example, courts - judges, prosecutors, defence counsel and court staff require access to shared resources. Currently some of those services are very difficult to arrange. Child services like staff from health, education, justice and police, need to be able to access each other's networks. At the moment that is either not possible or very difficult to do even though they are working on the same case - maybe the same child or the same family.

Mrs HISCUTT - Do you have to ask permission to access someone else's information like that?

Mr FERGUSON - You do. If you are working in different agencies it may not even be possible, or very difficult, to achieve.

Mr KNEVETT - A key aspect we talked about before was the Government's ICT security framework. That is a premised very much on people having access to information they are authorised to access.

Mrs HISCUTT - So do you authorise the person or does the person have to seek authorisation?

Mr KNEVETT - The person will be authorised as part of their role so it is basically premised on the notion that where you are in the organisation defines what type and what level of information you can access.

Mr FERGUSON - Broadly, this project commenced last year, in the middle of the year. One of the first things we did after forming some of the broad background and the ambition of the project was take it to the industry in Tasmania. In November last year, we presented industry with a substantial document outlining what the shape and form of the Tasmanian Cloud could look like. We asked industry something they have never been asked before, at least that is what they said - how can they improve it before we go to tender? How can they contribute to it or address any of the weaknesses they might identify in our work, before we seek formal procurement? That was warmly received - we had around 100 people.

Ms BURTON - The commercial strategy manager in TMD, Katie Ault, who is running the NT III project - the numbers can come from her.

Mr FERGUSON - The implementation of this will happen over stages with different core services being achieved in a sequential manner.

Mrs HISCUTT - The people from whom you are going to procure services, are they mainly locals or did you have to go elsewhere for services?

Ms BURTON - Basically the way the contract works is that we go out to tender. We are progressively looking at aspects of the program. Depending on which aspect, it tends to be international players that are most interested, but they very often have a local component. Katie has day to day contact with the industry and runs this program.

Ms AULT - At the moment, we have six NT suppliers and five of them are local. The only one of our suppliers who is not a local is a specialist providing internet services to the Department of Education. You can imagine it is in the nature of the services because they involve local infrastructure and a lot of local service delivery so the chances of the successful suppliers not

being local suppliers are usually pretty slim. Certainly, the very strong interest in this market consultation process that the minister has started is very significantly from local suppliers. National suppliers do have perhaps a small local presence and they are interested in increasing that.

Mr FERGUSON - I might just add that part of this shift to the Tasmanian cloud recognises that we need to vacate somewhat end-of-life data centre services, including the one that we have owned by the Tasmanian Government at Bathurst Street. We need to vacate that and progressively migrate our agency services into more modern, robust premises with much better security infrastructure around them. We are growing into that as we progress through the Tasmanian cloud by going to market.

Mr GAFFNEY - How do you evaluate or measure the effectiveness or otherwise of what you are trying to introduce. Where are the timelines that say, 'What are we doing? What are we achieving, and are we on the right path?' I am not saying we are not on the right path but how do you actually provide back into that where the weaknesses are, or for the future growth of it, I suppose?

Ms BURTON - In looking at the strategy, as the minister described, we have been over two decades and unfortunately I can speak to both decades. We have been through an issue of process of NT1, which was bundling up all of the government's wide area network. NT2 - improving the technology available, and now we have NT3. So in terms of evaluation, we evaluate by asking how usable and useful the approach is. We certainly also go to external consultants on occasion to provide us with a sanity check. The Auditor-General provided a bit of a sanity check in terms of his ICT security report recently. One of things that we are doing which the minister has just talked about, directly addresses one of the Auditor-General's concerns around security.

I think we have a 'belt and braces' approach. We talk to the suppliers; we talk to our stakeholders in Government agencies; we look at what is happening nationally and internationally. It is this interim process and we have built up quite a bit of expertise over the past two decades. We were the first jurisdiction in Australia to go to this joined-up model because we have one approach to widening the network across Government.

Mr GAFFNEY - The same thing with NT3?

Ms BURTON - Yes, in fact, hopefully it is in continuous improvement.

Ms AULT - There are some outputs which are simple to measure whether or not you have delivered them - for example, the request for tender for internet services, connection services, panel and so on; so there is a program of requests for tender. There are some supporting policies that is a time-liner and, most particularly, the new ICT security framework which will specifically be about modernising that framework to support this greater collaboration between agencies. Measuring around the outcomes around whether people who are engaged in Government can access the resources that they are authorised and approved to access by their agencies through the technology - that is going to be an evolutionary process because there are a large number of applications and agencies and people involved in that.

The proof will be in how easy it is to roll out those whole-of-government services in the future. There are things that are difficult like delivering IT into Service Tasmania shops, service

hubs and some of those sorts of those locations. Even small improvements in the convenience of making that stuff work will be quite obvious.

Mr GAFFNEY - You said that you have had some contractors or some tenders going out. What time frame is that tender available for, and when do they have to then prove that they are doing - so involved in your tender process, when do you analyse that what they have said they are going to do, they are actually doing. Is there some sort of back gate, if they are not supplying us with what we want them to do; or we now want them to go further into another area; or are some issues with what they are supplying? I suppose it is that safety mechanism.

Ms BURTON - What we need to recognise is that these are substantial contracts in the multi-millions of dollars. We put a substantial amount of work in at the outset, in terms of defining what services we would expect. Because of the nature of the telco business, it is quite easy to determine if there is a default or if there are problems in terms of delivery. I am not answering your question directly but I think that we have the checks and balances right. It is pretty obvious if somebody does not have a service, they are in breach. I have to say that over the 20 years that I have been involved with this there has been very little of that. The telcos are very adept at delivering into a service level agreement and we have in place very robust service level agreements, with whomsoever we contract with.

Ms AULT - Again under 2.3, one of many aspects there is that our service level agreements will be more standardised so that it will be easier to stack these services on top of each other and compare them.

Ms FORREST - In terms of 3.3, I know there has been a significant shift towards using VOIP, as opposed to fixed line. What sort of savings have you been able to generate through that.

Mr FERGUSON - I will ask Ms Burton to find some numbers if they are available. One of the compelling issues there with the move to VOIP, which was initiated by the previous government, was really the existing what we call 'spectrum service'. It is what we have all been using up until recent times. Just a few agencies are still using it but are progressing out; it has actually come to the end of its life. It is a Telstra solution, is it not?

Ms BURTON - Spectrum was a Telstra product

Mr FERGUSON - It is literally coming to the end of its workable life and we are quite, by necessity, having to move into the new technology. Importantly, whatever financial benefits it provides, or does not provide - Rebekah will shortly tell us and Piero Peroni who joins us from TMD - can speak to this as a solution for government agencies. It is not just about the cost as a push factor, or even the expiring old infrastructure; it actually provides us with quite an exciting opportunity for innovation across government. It is not just a telephony service; in fact it is a platform for a range of services that could sit on top of it. One obvious one is, of course, video conferencing from your desk phone, which a number people are now doing as an everyday part of their work. Equally, in hospital situation, the same platform can be used, for example, for security, for red buttons in rooms for alerts on infrastructure that might be temperature sensitive. They are all on the same platform, providing us with a real opportunity to really integrate some of the clever solutions with the way in which people are doing their daily work. So Rebekah or Piero.

Ms BURTON - I will hand over to Piero, to talk about the costing, but I think the minister has really adequately covered the opportunities that arrive. It was a burning platform and we had to move and then we have taken the opportunity. Piero do you want to speak?

Mr PERONI - Yes, the primary cost saving is the call rates. So in moving to VOIP we also gave the government business for carriage to a new service provider and we are already seeing a cost reduction in the calls. Calls are across the board are cheaper. I think also there is a potential cost saving that is not being seen right now but will be seen over time which is in the extra robustness being built around the current systems and backups to make sure that this telephony platform continues, particularly in the critical services in police and health. As the minister said, I think it is in the functionality. So for a similar price to what we had before, we actually had a whole range of opportunities open to us around innovation, and utilising the platform for a whole lot more than simple voice communication.

Ms BURTON - How we sold the new approach, it certainly was not on the basis of an efficiency because we saw that we needed to embed -

Ms FORREST - You had no choice.

Ms BURTON - - something robust. So that is what we went for - a robust solution. As Piero described, lots of interesting opportunities have come from this. We have gone with a Cisco backend, which means we have a lot of opportunities on that platform. We also had a few comprehensive audits with agencies on their number fixed phone lines, which seen a substantial reduction in those lines. Agencies had phonelines that were not being used but there was a monthly charge -

Ms FORREST - There must be a lot less hard infrastructure too. I know it is not just about cost, but my question was around the cost savings. I understand that there is a need and also opportunity, but hopefully the cost savings will be fed back into developing those opportunities.

Ms BURTON - TMD is very focused on those cost savings. We could talk at length about the cost savings we have been able to make with mobile phones by negotiating fairly tough terms with telco providers. There are aspects to this business when it is very much about taking advantage of the opportunity that arises by this, yes, closing off all those fixed lines, moving to VOIP - you might need a mobile, you might need a different solution. It is about a solution-focused approach, and that is what TMD has been doing.

In terms of evaluation: we are still rolling out the model comms programs. We are about to go to THO North in the next three weeks. The majority of agencies have moved, but we still have the three THOs to transition as well. It is all one system; it is all provided under one umbrella, so that is irrelevant. It is necessary for us to work very closely with the hospitals because they have been the most difficult entities to transition because it of the, as the minister described, the high-level integration of telephony with their day-to-day business, which has been a surprise to some of us. We have worked with Cisco and the THOs to develop a plan to attack this.

Mr BURTON - I have a little information about the Tasmanian cloud, if you would like to have it for your committee.

CHAIR - Thank you.

Mr FERGUSON - Can I make a suggestion, Chair? If the committee would like to go into 1.2, I will bring a different advisory team to the table.

Ms FORREST - I would like to ask about the Digital-Ready Business program and how it is progressing. It is one of those things that ...

Mr FERGUSON - I am keen, I am here. Thanks to our Department of Premier and Cabinet team of TMD.

Thank you, Chair and committee. Obviously you already know Mr Bob Brotherford, Deputy Secretary in the Department of State Growth, and Mark McGee, to my right, Executive Director of Invest Tasmania and Client Services. I am quite happy to talk to a question about digital-ready

Mrs HISCUTT - I had the pleasure of undertaking the digital-ready course with another business I ran. I found it very, very successful, but I have heard that the uptake on the latest offerings have not been that successful. Do you have a comment on that?

Mr FERGUSON - I sure do. First of all, thank you for the question. One of the commitments the Liberal Party made in opposition was that we would continue digital-ready and that we would support it digital ready continuing, because it was a limited-term funding, with $800 000 over four years. It was to provide Tasmanian retailers and the wider small business community with the know how to take their business into the digital community and on-line world. On coming to government, I looked at the digital ready program and reflected that it was quite a quality product in terms of the hand holding and coaching that it can provide.

I felt that it needed greater penetration into the Tasmanian community with a wider net of influence to give more businesses the opportunity. That is why we have taken the Digital Ready for Business program through some evolution. It ran last year virtually under the similar model as previous years, but this year it has changed. For 2015 we have commenced a different approach. In this one year alone there will be a total of 80 coaching groups, workshops and public seminars. We have structured this in four different geographic regions. The first is Hobart and the south, the second is the north-west, the third is Launceston and the fourth is the west coast.

For the first time we have given the west coast different treatment from the broader north-west. For the first program registrations for this year we had 15 registrations for Hobart, 15 for Ulverstone and 10 for Queenstown. They were all at capacity. As at 20 May, when we last looked at this, only four places were open at Launceston. The second coaching program will commence on 22 June. Registrations are progressing well with Hobart already at capacity, Ulverstone close to capacity and more spaces available in Launceston and Queenstown.

There will be a number of ways in which businesses and individuals can get involved. They do not have to be involved in the coaching program, they can also attend an open-seminar approach as well, so that they do not necessarily have to be committed to the full coaching program. If we can learn from our 2015 round, we will, and if in future rounds it requires a different way of marketing the opportunity to businesses we will certainly do that.

Mrs HISCUTT - That is good to hear. I found it very helpful.

Ms FORREST - Do you do any follow up or an effectiveness measure with the people who have been through the program?

Mr FERGUSON - Like an evaluation?

Ms FORREST - Yes, it is obviously well subscribed but what about outcomes from the people who have undertaken the program?

Mr McGEE - We do look at - as a general rule in our program delivery - post evaluation processes. I do not have information on this particular program, but it may be something we could get that information for you.

Ms FORREST - You have conducted a formal evaluation; that is what you are saying?

Mr McGEE - That is generally what we do with our programs. I am not entirely sure what is happening with this Digital Radio Business Program. I can certainly find that out for you.

Mr FERGUSON - If I may add to that, Chair, when we launched and announced the four new coaches to deliver the program in each of the regions, I had a discussion with a number of those coaches. There was a shared view that after the early stages of the new model have progressed, we should really have a review and examine whether or not the best mix of businesses were aware of the program and the sort of commitment and eligibility that would sit around it so that we can make sure that in future offerings we have taken account of that. The answer is yes, we will be constantly evaluating this.

It is a big investment by Government. With all respect to the previous way it had run, my message was that we want to have greater penetration into the business community and as much opportunity as possible. One of the outcomes of that message has been that the materials are now online. We have tried to find as many modes of delivery as possible rather than the pure coaching model we had before.

Ms FORREST - So you will provide that information, the evaluation?

Mr FERGUSON - If you would like to place it on notice we will absolutely respond to that. It will be important that we do keep a watching evaluation on this program. We see it as a very important one and a good way to encourage Tasmanian businesses to not lose their market share, given that so many Tasmanian consumers are opting for online purchasing. We want to encourage Tasmanian businesses to not be left behind by that.

Ms FORREST - Thank you.

CHAIR - Any further questions? If not, thank you very much minister. We appreciate your time and thank you for the entire day. We appreciate your frankness and the way you have answered the questions.

Mr FERGUSON - Thank you to you, Mr Chair and your committee. It has been a good exercise. I look forward to responding to those questions on notice.

The committee adjourned at 6.12 p.m.