**CHAIR** - We now have a quorum and so we will get going, Minister. As the health output is a very large portfolio -

**Ms O'BYRNE** - We will try to restrict our answers as much as possible.

**CHAIR** - Yes and if there are things we can table, great heaps of statistics and everything else, are much better tabled rather than having to soak up a huge amount of time listening to all of those. I know that they are frightfully important but we need to -

**Ms O'BYRNE** - I know that you know that.

**Ms FORREST** - The National Health and Hospitals Network reform, NHHN - I accept you cannot answer this in a really brief, succinct manner because I have a few questions relating to it. Can you explain how the funding is to be administered and how you see this rollout, overlaying our area health services and do you see any threats to the work that has already been done in the establishment of our area health services with these reforms.

**Ms O'BYRNE** - Can I ask you two things? Are you talking about the money that we have provided on a transitional basis now to assist us or from operation when we are on 40/60?

**Ms FORREST** - We need to look at both. The transitional arrangements because that is obviously very important but also then the ongoing arrangements.

**Ms O'BYRNE** - Sure that is fine. I will give you a sort of general overview and then you can go anywhere else that you wish to after that.

We signed up to the national performance part of COAG. We will actually get an additional $102.8 million in additional capital on recurrent funding of hospitals over the next four years. Not all of that is currently included in the State budget papers that you would have because some of them were still within Treasury to be drawn down; it was not all available so that includes some funding for multipurpose mental health and longer stay older patients. In the budget paper, you will probably be able to find it yourself if you add it up probably about $88.9 million rather than the full amount. We then have to distribute that, particularly for the elements provided for which are elective surgery and emergency care. I don't have the list of everything in front of me. They will be divided between the work allocation that will be required in the hospitals. I do not think we have actually allocated what is going to each of the area health services at this time but we do have the global figures and where they will be divided into. Can somebody magically hand me the list - thank you. There are allocations for the specific areas of emergency departments, elective and sub-acute contained in the $102.8 million. In addition to that, under the new system of national health reform, for primary care the Commonwealth will take 100 per cent responsibility. There is a debate at the moment about what constitutes primary care. Clearly, it constitutes GPs. We have yet to find where to negotiate with the Commonwealth - the States will negotiate with the Commonwealth on what else will come into primary care. In Tasmania, when we say primary care, we mean our regional hospitals, we mean a lot of the allied community services that we provide so, somewhere between what we provide and GPs is where we imagine they will end up.

**Ms FORREST** - What time frame are we looking at for the Federal Government to fund that 100 per cent?

**Ms O'BYRNE** - I think that starts from 1 July of next year, Des?

**Mr GRAHAM** - I am Des Graham, the Executive Director of Policy, Information and Commissioning within the department. As the minister mentioned, the definitions around primary care and what it constitutes is not yet defined so there is still a discussion about the introduction of the 100 per cent ownership, if you like, by the Commonwealth.

**Ms O'BYRNE** - A nominal target.

**Mr GRAHAM** - The nominal target is around the year 2012.

**Ms O'BYRNE** - So that would then happen. From that point, after the transition work goes through - when we are dealing with their taking 100 per cent of primary health care and 60 per cent of those things are private funding health care, whatever the boundary might be - the State will become a purchaser of services. We will purchase services from local health networks. A local health network will then provide that service. They will then come back to us and say, 'On the activity-based funding, here is exactly what we have done and this is what it has cost.' We will then verify that; we will pay our 40 per cent; we will advise the Commonwealth that the 40 per cent has been paid; they will then pay the 60 per cent directly to the LHN. That is the absolute edited version.

The key for us, though, is that area health services have worked very well and the integration that is provided has worked very well so whatever model we do has to support the integration of services in Tasmania.

**Ms FORREST** - So then how do you see the area health service working with primary health, possibly called Medicare local, and local hospital network or a number of them, not in any way pulling apart the area health service model?

**Ms O'BYRNE** - That is part of the discussion that we still need to resolve. We know that Medicare local will be a GP; we absolute know; that is the only thing that we know will be part of that. It might be that that is where it ends. It might be that it extends beyond that. The key, when we get to the point of having decided what an LHN structure might look like, we can only do so on the basis of understanding what all those things are going to be. That is our time issue at the moment. They are negotiations that are ongoing with the Commonwealth. I spoke to the Commonwealth and the Australian Government minister again last night about where we might end up and we have not managed to solidify a position that says, 'What else needs to be dealt with'.

**Ms FORREST** - There seems to be some confusion here then because the Primary Health Services are not within the local hospital network, or are they?

**Ms O'BYRNE** - Their definition of Primary Health Services is not and I think the problem is that when we talk primary health services in Tasmania, we mean George Town Hospital, we mean St Marys District - they are primary health facilities for us. When the Commonwealth says primary health it absolutely means GPs, which it has always funded, and it is going to mean some other things.

I do not think it will necessarily end up being regional hospitals - I think that would be unlikely - but it might include some other allied services and community services - we just do not know what they are yet.

So whatever model we do really has to work predominantly with the fact that Medicare local will exist in whatever form it exists - and I understand the General Practitioners Associations have done quite a bit of research and I understand that will be released extremely quickly - about where they see their picture. But they see their picture from a GP perspective and the Commonwealth have yet to determine what those other things are. This makes it very difficult for us to determine how seamless integration is going to work with all of our statewide health services.

**Ms FORREST** - So in your local hospital network then, as you informed us previously, by 31 December you have to have a plan to the Federal Government about how the local hospital networks will look in Tasmania?

**Ms O'BYRNE** - We have to have a draft plan or a nominated plan on the basis that there is always the risk that the Commonwealth might not have resolved some of those other issues and that we might need to work around that.

At this stage, we have a target of delivering to the Commonwealth a draft position of what Tasmania might look like by 31 December and yet a number of States are looking at different models. One of the things that we want to do is make sure that we have as much information as possible and can consult to make sure that what we do is actually delivering a) what the Commonwealth wants, b) what the community wants, and c) is also consistent with our Tasmanian Health Plan, because we have worked really hard to make sure that we do have an across -the -board agenda that makes that we can meet the needs of our health into the future and we don't want to unpick that.

When the Commonwealth sets national agendas, they do so recognising that every State is probably at a slightly different level and a slightly different structure. So our area health service structure is quite developed in terms of integration, which is not necessarily the case elsewhere.

**Ms FORREST** - But how will you ensure in Tasmania that the model that we end up with will not see a continuation of the cost shift and blame game that has gone on and has been the problem? This is a reform that is making some in-roads at the moment.

**Ms O'BYRNE** - We are going down this process to ensure that there is a lot more clarity about what is done and the department itself will be quite a different body than to what it is now. We will have regulatory responsibilities, we will have, I guess, accreditation and standings of quality roles, but we will also the purchaser of the services.

What will then happen is that we will fund $40 million, they will fund $60 million to make up $100 million.

**Ms FORREST** - So how do we stop the cost shifting?

**Ms O'BYRNE** - I am not sure where the cost shifting would then occur because that is going to be ex-procedure. Procedure might cost whatever dollars and there will be 40/60.

**Ms FORREST** - The Federal Government will pay the efficient cost of a procedure and there is also reward or incentive payments.

**Ms O'BYRNE** - Incentives if you meet particular targets, yes.

**Ms FORREST** - Yes. Tasmania is one of the worst performers in the nation as far as achieving those sorts of benchmarks in ED and in elective surgery so we are starting from a very low base. The Treasurer informed me that the reward payments are factored into the budget already. So how are we, in Tasmania, ever going to get a reward payment if we are starting from such a low base and if they are already factored in the forward Estimates, how could that impact on your funding into the future if we are relying on those for the funding model?

**Ms O'BYRNE** - We are also engaged in a bilateral discussion with the Australian Government based on the fact that Tasmania does have a significant challenge in order to meet those sorts of benchmarks. So we are currently negotiating with the Australian Government additional support to allow us to get to that point because we are starting -

**Ms FORREST** - So why wasn't that negotiated at the time when the deal was signed? Tasmania signed up before anybody else.

**Ms O'BYRNE** - We are working with the Australian Government on it now.

**Ms FORREST** - So what are you seeking in that regard?

**Ms O'BYRNE** - We have a business case that has gone to the Australian Government - $124 million is what we are asking the Australian Government for to assist us, particularly because we have a large number of over-boundary patients, particularly because of the chronic liability issues that we do have -

**Ms FORREST** - So why wasn't this argued at the time before the deal was signed?

**Ms O'BYRNE** - These discussions were commenced at that time. There is just a process of being able to then create a business case around it.

**Ms FORREST** - So we didn't hold out at the time, we signed up early in the hope that we could now go to the Federal Government and ask for more money.

**Ms O'BYRNE** - No, it is not, 'Now we are going to ask'. The Premier had bilateral discussions at the time. It is not unusual for States to have bilateral arrangements with the Australian Government outside of the Commonwealth funding arrangements. It is not unusual at all and this was a process that was commenced then.

**Ms FORREST** - So how confident are you of getting that extra money? Does that depend on achieving target as well?

**Ms O'BYRNE** - No, that money is to assist us to meet the targets that currently exist. They are in recognition of the challenge of the target that we have, given the nature of some of our waiting lists and some our particular patient needs. I had further conversation with the Health minister last night and the Premier has, I believe, spoken to the office of the new Prime Minister and has written to her to confirm the arrangements.

**Ms FORREST** - It is fair to say though, that the agreement was signed with no guarantee this extra $124 million, did you say it was?

**Ms O'BYRNE** - But there is a bilateral negotiation that commenced at the same time with some parameters around it that the Premier was involved in.

**Ms FORREST** - But there is no guarantee we are going to get it?

**Ms O'BYRNE** - I would anticipate that we would be extremely fortunate to get it.

**Ms FORREST** - How will we know when that has been provided? Will there be a media release?

**Ms O'BYRNE** - Once we sign off on the contract negotiations, then it would be public.

**Ms FORREST** - In your view, Minister, how will the activity based funding model impact on each major hospital in terms of administrative time and cost and impact on the Budget and the reliability of predictions of activity?

**Ms O'BYRNE** - I think the activity based funding is an area that we need to be extremely aware of. For the information of other members, who probably have not lived and breathed this as much as you, Ms Forrest. Activity based funding is a different way to way that we fund. When people have been talking about local health networks they have assumed community boards and a bucket of money. What we will have is local governance and activity based funding which means we might say, to the North West Regional Hospital, 'We would like you to do 100 hip operations and that is what we are contracting you to do.' They will do 100 hip operations, they will come back, we will pay 40 per cent of 100 and the Commonwealth will pay 60 per cent of 100. The question is what the quantum will be. We are in negotiations with the Australian Government about what the price setting of the activity based funding will be and that is a pretty crucial discussion for us to have because there are great variances across Australia in the cost of providing particular medical procedures.

What we do not want to do is make life way to complex for one LHN, three LHNs, four LHNs, whatever the LHN structure might be, we do not want to overlay ridiculously large numbers of problems for them. So one of the things that we have always maintained in our discussions is the need to develop our IT system to a point that we can track activities in a better way than we track them now. Three area health services probably all do them slightly differently now, as it is and we do need a consistent service to allow us to do that. The question does come back to 40 and 60 per cent of what.

**Ms FORREST** - That is the question and, as far as the cost shifting goes, the hip is a good example. It is a major procedure, it often requires a blood transfusion afterwards, which may be the person's own blood - they may have already provided that earlier. But there is always a series of diagnostic tests carried out before and after the surgery. So when we are talking about the activity based funding being for that person, is that funding going to be attached to the person so that everything that person has, whether it be a blood test, whether it be an x-ray or whether it be surgery, whether it be the anaesthetist or whether it be whatever, is included in that? So the Commonwealth will pay 60 per cent of that, regardless of where that test occurs? It could be in the pre-admission clinic, it could be with their GP. What are we talking about here?

**Mr ROBERTS** - Yes, you are quite right, the costs upon which the ABF will be calculated will the full costs of providing care to a patient in that hospital setting. So it will take account of any tests and diagnosis that they have, any inpatient stay they have, any operation that they may or may not have. It may also include some of the ongoing care-type of issues. I think there was a journey to be had around that community based funding. The costs that we initially calculate and the ones that we end up with as a State and Commonwealth in 10 years time may well be different. We may, and hopefully we will, get to the point where we are buying things with an outcome attached to them rather than a series of inputs, which is where we are at the moment. But we do fully expect for the initial activity based funding to reflect all the input costs that our hospitals currently have in delivering a process or a procedure of care for somebody. Of course activity-based funding is only going to apply, in large part, to in-patient care and of course not everything that we do in hospitals is in-patient care.

**Ms FORREST** - That is my point.

**Ms O'BYRNE** - Whether or not it is a GP-initiated treatment.

**Ms FORREST** - Like you would have a blood test beforehand to check your HB and a whole range of other things.

**Ms O'BYRNE** - The question is does that come in as part of the 100 per cent -

**Ms FORREST** - Yes, because this is where the cost-shifting has occurred in the past. For instance, the State could push you out to the GP to have your test done before and then the Commonwealth paid, but if you went into hospital and then had your blood test done before the surgery, it would be State-paid.

**Mr ROBERTS** - There is a clearer differentiation that will occur. It has not occurred yet but it will occur in terms of determining the 100 per cent funding of general practice, primary care or community care and those three things are important for the committee to understand. The Commonwealth has not yet determined where that line will actually fit. Some debate has taken place that it should be everything that is not non-in-patient care, so the boundary of that line has yet to be drawn. Assuming it is drawn in a place that is acceptable generally to all, then the Commonwealth will pick up 100 per cent of those costs. If it is not, then clearly the hospital system will have to pick up some more and, by dint of that, the State will pick up 40 per cent of those costs which, under the new system, are uncapped costs.

**Ms O'BYRNE** - Your point is well made and it is something we are quite aware of but we are still in the process of negotiation. I would also point out, of course, that West Australia has yet to sign up anyway.

**Ms FORREST** - Yes; they are not signing up until they get what they want, which is different from what Tasmania did. We were hoping to get -

**Ms O'BYRNE** - We have a bilateral process so it's a different way of achieving what we want.

**Ms FORREST** - We have a Labor government here and a Liberal government in West Australia. Perhaps that is the reason.

**Ms O'BYRNE** - I wouldn't like to comment.

**Ms FORREST** - Otherwise it becomes a political discussion. When is it planned, then, for these changes to be implemented such that we are then working under the new funding arrangement, the new model?

**Ms O'BYRNE** - The entire model, as we said, comes into play 2012 but we will be moving to some of it from 1 July, I understand.

**Mr ROBERTS** - Minister, there are a lot of things undecided at the moment. With the implementation for activity-based funding we will start to work through what activity-based funding means for us next year. The agreement where the Commonwealth takes on this large responsibility for primary health and the growth and assistance is actually not until 2015-16, so there is some while to go yet. We believe the date is 2013-14 for the implementation of ABF so there is a couple of years to go, and it will take us every bit of that two years to actually develop the systems that are going to be required for us to operate what is quite a sophisticated means of funding our health care system, even though it will only fund a proportion of the current system.

**Ms FORREST** - Obviously, one of the big issues with the activity-based funding is the record-keeping; the coding, the really high importance of nursing and medical staff, and accurate reporting and recording everything that happens or doesn't happen.

**Ms O'BYRNE** - Absolutely crucial.

**Ms FORREST** - What sort of impact is that going to have? That is paperwork that potentially takes nurses and doctors away from the bedside.

**Ms O'BYRNE** - Not necessarily. I am hopeful it will be done by a far more sophisticated mechanism than that.

**Ms FORREST** - Well, nurses still have to enter the data. If it is going to be recorded so that it can be coded, it has to be recorded by the person who provides the care.

**Ms O'BYRNE** - But the data would be recorded anyway and care is still recorded. The problem we have is that it is not recorded in a consistent manner, so this is about implementing a system that is consistent across the spectrum so that we get all of that information. It is not that technology does not exist around that; Victoria is quite good at tracking its particular procedures. There is also technology and I saw a model of what is occurring in South Australia at the moment where the television you have when you are in hospital at the end of your bed is actually linked to your medical data, so you, as a consumer, as the patient, will use it to change channels and order your food and things like that, but your nurse or doctor or whichever attending clinician you may have, will come and swipe their card and instead of filling in a chart at the end of the bed, they will fill in one update of five.

**Ms FORREST** - They are still entering the data but it is in a way that is electronic.

**Ms O'BYRNE** - It is just about making sure that the data entered is useable and retrievable and we currently enter data in different ways in different places and we need a system that allows us to track all of that. The key to that is the patient identification system that we are

implementing. For those who do not know, at the moment when you present to a hospital they will probably start a new file for you, but what we will have, and we will be the first one across Australia that we have - very exciting - is that you will have one patient identification number. So whether you present to get your blood work done, whether you present at the North-West Regional in Burnie, whether you present at Hobart, one file will exist.

**Ms FORREST** - But not for the private hospitals. It won't encompass the private facilities?

**Ms O'BYRNE** - I think there are conversations about how that would be best transited but I am not sure that we have -

**Mr ROBERTS** - The minister is correct. We already have a unique Tasmanian health identifier. The new patients administration system, which we have just finalised going live with at the Royal Hobart Hospital will enable us to have one health record per citizen in Tasmania. That is excellent. The private hospitals in Tasmania also use the same system as we do, or certainly Calvary does. So it would be possible for us to work together to get a common identifier shared. Of course, there is now a national health identifier, which went through Senate just last week and we will be able to map onto a unique identifier for every citizen in Australia.

**Ms FORREST** - Is this the thing that Tony Abbott was going to rid of if he was elected?

**Mr ROBERTS** - I don't know whether he was going to get rid of it, however -

**Ms FORREST** - Or not continue to fund it.

**Mr ROBERTS** - No, I don't believe that was what he was referring to. This is the unique health identifier, which is part of the national health transitional authority project. This is really important because it does mean that we can actually track the health and wellbeing of patients who turn up in any of our health facilities. Of course, you are quite right, the sooner we can get that number used across primary health, community health and private, the better.

It is an excellent option for us who have cancer patients and patients with chronic diseases. General practice is very keen to integrate their computer systems and data with the hospitals or, I should say, we are with them. I think that begins then to build a very clear picture of how we look after the health and wellbeing of our citizens.

**Ms O'BYRNE** - One of the issues is that if you are discharged from the hospital and you present to your GP or you need your GP to present to the hospital, as a patient, you assume that all these doctors talk together but, of course, that information does not transfer.

**Ms FORREST** - They don't.

**Ms O'BYRNE** - The other thing it will allow us to deal with is the schedule 8 drug use. We have a lot of issues with people accessing drugs. What tends to happen is that they make a number of appointments with GPs with a condition; they 'doctor-shop'. They get eight prescriptions and fill them at eight different pharmacies. At the moment it takes some time before you get that back through pharmacies nationally to be able to identify that it has occurred. That would not be able to occur if these systems were all operating as we would anticipate they would.

**Ms FORREST** - If we go to the data collection, at the hospital level as well as eventually across primary health and the whole area, will that be a State cost? I assume this will happen under the local hospital networks. I assume we do not know what they are going to look like in entirety but the data collection, as far as coding and such, to set up and establish that infrastructure and to maintain it; will that be a State responsibility and will it be funded by the State?

**Ms O'BYRNE** - Certainly, we would want to have it set up before it all occurs; that is the ultimate aim. The reality for local health networks is that they are the statutory organisations responsible for their own budget and costs but we would see this is a statewide thing - and we have always seen this as a statewide thing. It would not work unless it is statewide.

**Ms FORREST** - Yes but is it something that is funded entirely by the State or does the Commonwealth provide some funding for that?

**Mr ROBERTS** - No, it is entirely to be funded by the states so the infrastructure that is required in order to move to how ever many LHNs we finally move to and to activity based funding is a State requirement. We do have a small amount of money that has been given to us under the activity based funding project but it will not enable us to actually bill all of the IT structure required for us to run under this system in the future. That is a State cost. It is the subject of propositions and proposals that we need to put to government over the next few years to actually seek the local investment that we require.

**Ms FORREST** - State Government?

**Mr ROBERTS** - State Government.

**Ms FORREST** - You have already mentioned IT. Will human resources and those sorts of areas be State-funded activities?

**Ms O'BYRNE** - In terms of setting up the system, we still have some time before we actually hand over to an LHN statutory body, whatever it might look like, but that is part of the discussions that we need to have and they are part of the things that need to be considered in the establishment of LHNs. One thing you do not want to do is set up an LHN with so many cost burdens that it is impossible for them to manage. That is a real concern that we have. By the same token, you want to make sure that you guarantee autonomy and local clinical decision making.

So the conversations that we need to have between now and December are, 'How do we provide the absolute best care for patients,' and, 'How do we minimise the cost and burden on organisations and still meet all the requirements that we have?' They are the conversations we still need to have. To be absolutely honest, we have not pulled together yet the sorts of models that will show what they would look like, but the key is that we need to make sure that we are not overburdening anybody with administration. In fact, one of the requirements of the national agreement is that we do not employ any more people in bureaucracy, which is always a nice easy thing to say but then you might have multiple LHN opportunities and you need to make sure that they are resourced in an appropriate way to deal with that. So they are the conversations that we need to have.

[2.00 p.m.]

**Ms FORREST** - We do not want a bureaucracy laden set-up, though.

**Ms O'BYRNE** - No. It is not fair, particularly, for instance, with the model of three which has been put up. If there were just three in Tassie, I would be extremely concerned about the administrative burden placed on the LHN. So you would need to look at a model that supported that. Or, if you had four, I understand that there is one model design for one particular hospital and one particular town that has been put forward.

**Ms FORREST** - Let me guess.

**Ms O'BYRNE** - I do not think you need to.

**CHAIR** - Sorry, I was focusing on something else. You were talking about local hospital networks, were you?

**Ms O'BYRNE** - It is all part of the national throughput but yes, we can.

**Ms FORREST** - If anyone wants to go down that path, I will leave that for now but I have information I wanted from the local hospital networks.

**CHAIR** - So when will the final decision be made on the -

**Ms O'BYRNE** - We have to advise a preliminary position for the Commonwealth by 31 December, bearing in mind -

**CHAIR** - I think you told us about the meeting in Launceston -

**Ms O'BYRNE** - Yes. The problem is that there are a number of things we still need to know from the Commonwealth side of things in terms of Medicare, local and other structures around that, but we need to have community conversations. The overarching thing is that we need to create an efficient system that meets the needs of patients. That has to be the focus.

**CHAIR** - Given that former Prime Minister Rudd is now gone and his preference was for three, do you think that will change the perspective at all?

**Ms O'BYRNE** - I am not sure that he actually ever said his preference was for three.

**CHAIR** - Okay. Maybe I read that in the media.

**Ms FORREST** - He said his preference was for 150 in Australia. That is what he said.

**Ms O'BYRNE** - But they also made it extremely clear that that was something for States to work out internally and every State is looking at different models. I understand the Northern Territory is probably looking at one. The ACT is probably looking at one. South Australia was looking at two but I have heard three as well. But these will change as well, as individual negotiations take place in States. We have not come to a position -

**CHAIR** - We will wait and see.

**Ms O'BYRNE** - But the really important thing is making sure you have local clinical decision making. That is really important. That is what we have in the majority of the services. That is what we need to support, but you also do not want to overlay absolutely unmanageable

administrative frameworks around those communities, so we need to work with the clinicians in hospitals. We need to work with nurses, we need to work with the community, but we also need to be very mindful of whatever comes out of the Medicare local model because we need to be able to work really well with that and we do not know yet whether Medicare local is GPs, as its current Commonwealth structure is, or GPs plus something all the way through to what? Our definition of primary health is of course much different.

**CHAIR** - I want to go back to administration. As with the question I asked with tourism, obviously 25 per cent - as the Premier said - could not deliver on those promises. What happened in health? Was there 25 per cent that health did not get -

**Ms O'BYRNE** - I can give you a couple of things on that. You would be aware that we committed $130 million over five years for 260 more doctors, nurses and allied health professionals and support staff at the LGH. We will have $61 million over four years and, as I said, we are hopeful of increasing our commitments. We have met 75 per cent of our commitments. We would like to meet 100 per cent over the four years, but this is how it currently stands. There was the four million for palliative care services in the north and we have $2½ million over four years.

There is, of course, another half a million in cancer services payable. I think the only other one that is probably worth some discussion is the money around the Royal Hobart purchase. I do not know whether you want to deal with that in an output group or just a general discussion around it now.

**CHAIR** - We might as well clean it up now as well.

**Ms O'BYRNE** - We announced that there would be money to buy back the Hobart Private to redevelop the Royal and build the new Queen Alexandra women's and children's hospital with a mixture of State and Commonwealth funding. We do not have line items necessarily as part of that in the Budget yet, other than the $100 million that we have already committed for the Royal Hobart Hospital. There will, of course, be additional money required as a result of these negotiations when we undertake the new Hobart Private. The Commonwealth will then be looking to supplement other building work there. So that is why the line does not necessarily exist at the moment. That is still a commitment, but I thought I would point it out that it is not a line item.

**CHAIR** - And then, as I asked before, the agency cost reduction requirement; where have we ended up with that?

**Ms O'BYRNE** - With the savings that we have made?

**CHAIR** - Yes.

**Ms O'BYRNE** - Give me a moment.

**CHAIR** - Early age retirement?

**Ms O'BYRNE** - Yes, we have made some savings, which is very difficult in Health. It is a challenge. One of the problems is that in some places we have made savings but you will not necessarily see that as an outcome because, by making savings, we have actually increased access

and then you increase demand on a particular area. So there are some areas from a clinical perspective that a savings might be made that you cannot necessarily track.

As an agency, we have had reductions in non front-line employees of approximately 73, including and inclusive of 48 FTESAs and five SES positions. We have reduced the T-plated motor vehicle fleet by 68 vehicles and that is probably saving around $100 million and there was a halt on the number of people who can access rental vehicles. We have had reductions in staff travel and we have six new statewide procurement contracts, which are currently being finalised, which allow us to make savings in purchasing.

We have had increased demand pressures in the system, which have masked other areas. For example, Royal Hobart has made some changes that have resulted in a reduction in cost and additional facilities. So, for instance, they have put strategies around employment freezes and slowdowns as well as some of their closures to reduce activity over the Christmas holidays. Some of the things that they have done is that they have improved the tracking and recouping of compensable costs of prosthetics. They have had a reduction in energy costs through negotiations with Aurora and the nonrenewal of some maintenance contracts that they have been able to manage. I think we have saved about $6 million to $8 million in staff reductions and vacancy control, $1.5 million in motor vehicles, $0.6 million in travel and $4 million in maintenance. We have reduced some contractual arrangements, which has saved $700 000, $4 million in indexation and $5 million in hospital efficiency savings.

**CHAIR** - There is a lot written on that little document. Is it possible to table that?

**Ms O'BYRNE** - I can probably get you one that is a little clearer to read, actually.

**CHAIR** - Is it? Could you do that for us?

**Ms O'BYRNE** - Yes, I am happy to do that.

**CHAIR** - That would be fine, thank you.

**Ms O'BYRNE** - I think where we are with Health is that it is very difficult to find savings within Health, and partially because if you decide to wind down a service, it actually takes you a while to do it. If you decide to grow something, it takes you a while to do it as well and we do not want to impact on services. So we have to try to find savings everywhere else we can except in the front-line positions that we provide. Whilst we have had significant savings in positions that are outside of the hospital infrastructure, we have actually employed more staff in the Health Budget overall. I think we have an additional 323.

**CHAIR** - Yes, even if you could table staffing levels - what are the staffing levels and a comparison with previous years.

**Ms O'BYRNE** - I am happy to do that but can I also say that, whilst we have employed 323, it effectively is only an extra 60 positions, because you do not have to replace one person with one person. A new position is effectively five people, because you need to run it 24-7, 365 days a year.

We employ 323 additional front-line staff, but they effectively equate to around 60 positions because you have to part with them all of the time. We have done that and at the same time we

have made significant savings elsewhere because we had to get smarter with the way we do it because we need to provide services as efficiently as possible. At the same time, we have obligations to the community to meet services and we have to continue to do that. So it is a challenge for Health.

**CHAIR** - Any asset disposals at all sold off in hospitals?

**Ms FORREST** - They bought one.

**Ms O'BYRNE** - We have just bought one for $29 million on the north-west coast.

**Ms FORREST** - Are we talking about the $29 million for the North West Regional?

**Ms O'BYRNE** - No, no major asset sales.

**Ms FORREST** - Can I move on to the purchase, or do you want to move on to that later - the purchase of the North West Regional?

**CHAIR** - We can do that later, yes. Do you want to do it now?

**Ms O'BYRNE** - I do not know whether or not you might need something, so I am comfortable either way.

**Ms FORREST** - With regard to the $29 million, that is the only funding, except for the car park. There is some money for the car park at Burnie as well.

**Ms O'BYRNE** - There is the additional money for cancer care as well.

**Ms FORREST** - For the hospital I am talking about, the hospital itself. Demand pressures would suggest that work needs to be done on the hospital itself, not just the car park. So $29 million is a significant investment in the hospital, and no-one denies that, but at the moment there is nothing in the forward Estimates that I can see for further upgrade of that hospital. So when extra work is needed - capital works particularly I am talking about, not so much staffing and recurrent costs -

**Ms O'BYRNE** - There is for the cancer care facility. There is additional money for that. As I understand, and I will seek to gain advice if this is necessary, where we will extend for the additional cancer care beds we will create enough load bearing capacity within that infrastructure in order to build up if demand needs it to. So it is a little bit about positioning in case the needs increase, yes.

**Ms FORREST** - So where will the cancer care facility be built?

**Ms O'BYRNE** - It might be better if we got Jane here and she could -

**Ms FORREST** - Maybe we should leave that until -

**Ms O'BYRNE** - We can get her down now. We can do it in the output group and actually go through it, if that is -

**Ms FORREST** - It will come up in another output group.

**Ms O'BYRNE** - I am happy either way. It is effectively an infill, one of the courtyards as I understand. As I understand, it is an extension into an infill within one of the courtyards, and there are a few courtyards. I could not stop here and tell you which one it is, but I am sure Ms Holden will be able to do so when she is down here.

**Ms FORREST** - Maybe it would be best to wait for Jane.

**Ms O'BYRNE** - Yes, and she will be able to describe it in a way that you as a local would immediately understand. She pointed it out to me when we walked around -

**Ms FORREST** - It concerns me that the cancer centre is going to be in the middle of a hospital, but anyway.

**Ms O'BYRNE** - From my visit around the hospital I have that comment on it as well, but I will let you go first.

**Mr ROBERTS** - The North West have actually undertaken a strategic plan for the hospital. They, as you quite rightly say, recognise there are a number of things that they need to do. The purchase of the North West Regional was a really important strategic step for us because it enables us now to invest in our property as opposed to somebody else's, which had quite a confusing and complicated contractual arrangement associated with it. So the North West Regional team have actually put together a strategy for that campus. The cancer plan was included in that strategy that they produced. Yes, there is a combination of infill, but the CEO is actually also looking to move some of the internal pieces around to enable them to get a better flow with cancer as the infill building - for instance, some of the imaging technologies that she is trying to move around. They have investment proposals that they have already submitted to the Department for ongoing investments which will have to be the subject of submissions to Treasury for Budget where that is appropriate.

**Ms FORREST** - Because they do not appear in the forward Estimates at this stage.

**Mr ROBERTS** - They were only received by the department a few weeks ago. I would not have expected them to appear in this round. It is actually going to be subsequent rounds of budgets.

**Ms FORREST** - Okay.

**Ms O'BYRNE** - My discussion with the Australian Government minister about capital funding for hospitals is that of course where States have plans and States are able to keep their 40 per cent they are very keen to work on the 60 per cent, and that is a challenge for some other States I think because it is hard to come forward with that money. But certainly we will continue to work with the Australian Government on any future capital developments under the national reform as well.

**Ms FORREST** - So are you saying that the Federal Government will pay 60 per cent of capital expenditure?

**Ms O'BYRNE** - Long term that is their formula. If all goes to plan, we will be looking at significant capital investment in hospitals from the Commonwealth. So that is part of the plan.

**Ms FORREST** - So 60 per cent is paid by the Commonwealth.

**Mr ROBERTS** - The proposals under the national reform do make provision for capital as well as the operating costs. What is yet undecided or undetermined is what is the process to actually get hold of that 60 per cent. Of course the Commonwealth will want to have a say in the strategic importance or appropriateness of any investment that we choose to make. As we sit here today, yes, the proposition is that capital will also be the subject of that formula, the details of which are untested.

**Ms FORREST** - But States will own the infrastructure.

**Mr ROBERTS** - I do not believe that has been resolved. That is another important issue. Not least of all, it has not been decided at this point how capital or the cost of capital will flow through the activity based funding formula. Again, those two things are inextricably linked and we have the act to work that through.

**Ms FORREST** - But they are quite separate arguments.

**Mr ROBERTS** - They are conjoined arguments. Technically, you would be absolutely correct in saying that they are separate arguments, but we need to make sure that we recover the full cost of a hip operation including the cost of capital employed in providing that hip operation through the tariff payment, and the formula and the means by which we do that is yet to be determined.

[2.15 p.m.]

**Ms FORREST** - Nothing like a complicated system, is there?

**Ms O'BYRNE** - I am sure it is going to work beautifully in the end. We just have quite a difficult journey to go through. That is all.

**Ms FORREST** - We will keep watching. One question you skirted around previously when we got on to the discussion of the extra -

**Ms O'BYRNE** - I do not think I am into skirting around, so I apologise if I did.

**Ms FORREST** - $124 million that you are working on getting out of the Commonwealth to assist us to get up to speed -

**Ms O'BYRNE** - With the over boundary cases.

**Ms FORREST** - Yes, with the over boundary cases. The reward funding is attached to achievements of certain benchmarks and will only be paid, as I understand it, if those benchmarks are achieved.

**Ms O'BYRNE** - We are anticipating meeting those benchmarks. We have no choice but to meet those benchmarks.

**Ms FORREST** - Why do you have no choice?

**Ms O'BYRNE** - We want to meet those benchmarks. Those benchmarks are not only requirements but about getting the care levels that we want to sign up to.

**Ms FORREST** - I put it to you that you have to meet the benchmarks because the Treasurer has already factored those payments into the forward Estimates.

**Ms O'BYRNE** - Yes, that would be true, too.

**Ms FORREST** - So we are relying on meeting them. If we do not because of the fact that we start from a low base, the Budget is going to be in trouble to start with.

**Ms O'BYRNE** - Hence, the need for the bilateral agreement, yes, which has always been part of our discussions with the Commonwealth.

**Ms FORREST** - Again, this may be one that you want the CEO to be around for.

**Ms O'BYRNE** - I am happy with whatever level of comfort you have with that, Ms Forrest.

**Ms FORREST** - As far as the funding of Mersey Community Hospital is concerned - the Federal Government owns the infrastructure in Tasmania - it is now operated by the State.

**Ms O'BYRNE** - It is a model that stands alone in Australia.

**Ms FORREST** - I know, as crazy as it is.

**Ms O'BYRNE** - It is not a pathway we planned.

**Ms FORREST** - That arrangement runs out in 2011-12.

**Ms O'BYRNE** - We are having conversations with the Commonwealth at the moment about continuing the agreement and there is no intention at this stage. We have not received any advice that would indicate that that is going to be a problem. It is June 2011.

**Ms FORREST** - June 2011 is when the current agreement expires?

**Ms O'BYRNE** - Yes.

**Ms FORREST** - Last year we had $60 million in the budget papers identified as providing that funding for the Mersey, because it is a separate bucket of money.

**Ms O'BYRNE** - Yes.

**Ms FORREST** - I cannot find it anywhere in this year's budget papers. So what has happened to the Mersey funding?

**Ms O'BYRNE** - I will just seek some advice on that. Where in last year's budget papers did you see the $60 million?

**Ms FORREST** - I did not bring them with me.

**Mr ROBERTS** - It is in the Con Fund. It is not separated out.

**Ms FORREST** - It was mentioned in a couple of places in last year's budget papers. The $60 million was in footnotes. It was everywhere as an explanation for the money, because it is a separate bucket.

**Ms O'BYRNE** - We are happy to find that and come back to you on that one. We will answer that before we move on.

**Mr WILKINSON** - I notice when you look at the forward Estimates in relation to all of the line items in relation to health - going back to 2008-09, then going to 2009-10, then going to this year - you can see that we are always well under what they finish up being.

**Ms O'BYRNE** - I am not quite sure -

**Mr WILKINSON** - What I am saying is that if you look at -

**Ms O'BYRNE** - Can you point me to a particular table? That would be useful.

**Mr WILKINSON** - You probably have not got the 2008-09 budget papers with you, but what I am saying is that when you look at 2010-11 in relation to clinical support services you will see a figure of $41 902 000; in 2011-12, it is $41 168 000; in 2012-13, it is $43 452 000. When you look at the previous years, they are a lot lower than that.

**Ms O'BYRNE** - There are probably a couple of things. There is one issue that occurred last year which was the twenty-seventh pay. I am not sure, without looking at the particular figures you are looking at -

**Mr WILKINSON** - All of them.

**Ms O'BYRNE** - That changed the structure of the Budget for that year because there is an extra $30 million.

**Mr ROBERTS** - I do not know what table you are referring to. May I ask the table number?

**Mr WILKINSON** - It is all of them. When you look at Output group 1, Acute Health Services, all I am saying is that, going back through 2008-09 and through 2009-10 and then 2010-11—

**Ms O'BYRNE** - If you look at previous ones, you see fluctuations.

**Mr WILKINSON** - When you look at the forward Estimates—

**Ms O'BYRNE** - Okay.

**Mr WILKINSON** - The forward Estimates as we look at this Budget are always quite an increase on where the figures we believed were back in 2008-09, when we look at where they would have been in 2011-12 or 2012-13.

**Ms O'BYRNE** - So what you are saying is that in 2008-09, for instance, it was $100 million and that we expected it should go to $110 million or $120 million, and instead we have gone to $130 million or $140 million.

**Mr WILKINSON** - It is an increase of $10 million or $15 million.

**Ms O'BYRNE** - There are a couple of things that specifically skew that and part of that is the Mersey itself. The money we got for the Mersey does skew the budgets for that one year. You will notice that the targets as well within those forward Estimates have a spike within that period and that is predominantly because of the work we were able to do as a result of the Mersey investment. I think we have gone from 8 000 elective surgery procedures to something like 23 000. I will get those figures checked before I allow you to keep them in the record. That actually changes the cost structures around things. There are also the issues of things such as the twenty-seventh pay, which means that for one year there is a $30 million difference on what we would have anticipated. I am not quite sure if I am answering the question though. I am hoping I am.

**Mr WILKINSON** - Not at the moment. All I am saying is that when you compare let us say Output Group 1 from 2008-09 and you go for the five years of what the forward Estimates would be and then you do the same with 2009-10 and the same with 2010-11, each one of them is a significant amount more. For the year of, say, 2011-12, they are a significant amount more this year in the forward Estimates than what they were back in 2008-09 and 2009-10.

**Ms O'BYRNE** - Because they are estimates of what costs would be if they remained at the current level of that 2008-09 level. When you make estimates, they are based on a certain projection and those projections would change as you travel through.

**Mr ROBERTS** - There will be things like additional funds that we would have got from the Commonwealth, which would affect those numbers. Indexation will have changed over those periods. We would have to look at specific numbers for you and take them apart to show you.

**Mr WILKINSON** - It is probably not a question you can answer here.

**Mr ROBERTS** - Possibly not.

**Mr WILKINSON** - It is probably best that I sit down with somebody and try to understand what is going on.

**Ms O'BYRNE** - And we are happy to provide that.

**Mr WILKINSON** - Especially when you look at Budgets in years to come and say, 'We are going to be a surplus Budget in 2013' -

**Ms O'BYRNE** - Budgets do not remain stagnant, particularly within Health, because costs of procedures change and therefore funding allocated for those kinds of procedures change as well. We get Commonwealth own-purpose payments, we get national partnership agreement money, we get special purpose payments and at the moment we have national health reform money. The moneys change in terms of Commonwealth contributions that we get. Also the cost of things that we do changes and the way that we do things changes.

I do not see anything particularly disturbing about the fact that the costs continue to rise. I do not think anyone would be surprised that health costs continue to rise, particularly with health inflation. I think the other thing to remember is that, often by getting better at something, by investing in a State-wide clinical model that is supported by doctors that means they can do things more efficiently, it actually means you end up doing more of something and that can change the cost as well. We are happy to have someone sit down and go through that with you if that would be more useful.

**Mr WILKINSON** - Probably.

**Mr ROBERTS** - I would add that table 4.10 on page 4.33 of Budget Paper 1 does go through all the changes to each of the individual numbers. I am not confident that that answers your question.

**Ms O'BYRNE** - No, I think we probably need to sit down.

**Mr ROBERTS** - I think it is probably a bit more subtle than that. All of the changes between the forward Estimates are detailed down here.

**Ms FORREST** - Are you looking at the Policy and Parameter Statement?

**Mr ROBERTS** - Yes. I am not sure that is what you were trying to get at.

**Mr WILKINSON** - Not really. What I am looking at is that you look at this year and you say in 2013-14 we are going to be in surplus, yet when you look at what has been happening in the past we cannot really say that.

**Ms O'BYRNE** - Part of that also is health inflation is variable as well and there are things that we cannot control within that.

**Mr WILKINSON** - Especially in Health. I am focusing on Health because of the huge area that it is.

**Ms O'BYRNE** - And it is an extremely large part of the Budget.

**Mr WILKINSON** - Can I just ask a more general question if I might, and a few people will ask it at some later stage, but it is an area that I have been thinking about for a couple of years and that is obesity. What are we doing in relation to obesity? Looking at the figures, it is increasing. It is obviously a cost to the community and is going to be an increasing cost unless something is done in relation to it. Do you want me to ask that in another line item?

**Ms O'BYRNE** - I am happy to address that generally here. If there are further areas that you want to go to within the line item, I am happy to deal with that as well. I will talk generally about it, as we manage that.

**Mr WILKINSON** - What are the latest figures in terms of how much we are spending in total to directly combat the problem of obesity?

**Ms O'BYRNE** - This sort of partly comes from my previous portfolios as well involved in sport and recreation and the work with the Premier's Physical Activity Council. We are investing in particularly the early years to change patterns of behaviour. It is no secret that we do have significant obesity issues in Tasmania. It is no secret that that leads to a number of significant risk factors. It is a risk factor for significant conditions: type 2 diabetes, hypertension, cardiovascular disease, strokes, some forms of cancer have links to overweight and obese issues, psychosocial disorders, musculoskeletal disorders and gall bladder disease. We have seen significant increases across Australia - it is not predominantly a Tasmanian thing - but I think we do recognise that Tasmanian figures are extremely disturbing.

A lot of the work that we are doing is very much around about how we invest in change in the early years. So it is about making sure that we are supporting parents and supporting schools. So that is the canteen accreditation work that we do, the Eat Well Tasmania, the Family Food Patch, the Get Active Program. They are about giving children healthy choices to make, but we are still, of course, relying on their family structures and education structures to support them as well.

One of the other things that we have done, and that is through the Premier's Physical Activity Council which we contribute to, is we market that you should exercise 30 minutes a day. Now, we all know that you should exercise more than that but 30 minutes is pretty much the point whereby you change behaviours. You can say to somebody '30 minutes' and that sounds like a reasonable investment for them to make, it does not sound too scary. We then know if they do 30 minutes they are more likely to then do 40, 50 and add upwards to the sort of numbers that they should be doing - that Mr Hall regularly does.

**CHAIR** - Not as regularly this week.

**Ms O'BYRNE** - Not as regularly this week, no. So it is predominantly behavioural change. We have to be extremely careful in the language and the work that we do not to blame parents. We want them to be able to provide healthy choices but we need to support them to be able to do that. It is not an issue of blaming parents for children's obesity issues. We have been supporting some other national approaches in relation to restrictions on food and soft drink beverage advertising that takes place, particularly in its marketing to children and those television time slots where we know children are watching. You do see, as a parent, that preponderance of ads for things that you do not necessarily want to be involved with.

Look, I must say, conversations I have had with Roscoe Taylor - and feel free to have this conversation with him when we get to the line item - is that if you do not get progress you have to start thinking about what else you do. If you continue to educate and provide information and provide support, what is then your next point if you cannot change behaviours. I know that a lot of GPs are implementing some really good programs where you front to a doctor with an illness and they will actually say, 'Here is your prescription that says you have to walk for 45 minutes on Tuesday, Thursday and Saturday.' They are actually good behavioural changes as well, but the conversation that eventually we may get to if we do not make changes is, 'Well, what exists for us - under the Public Health Act what can we do - that actually starts putting some rigour behind some of the programs that we implement?' Because we not only want healthier people but we do need to take pressure long term off the health system and we will not be able to do that if we do not continue to support healthy living.

It is not necessarily about being fit. I know obesity is the thing to think about, but we want people to be healthy. For some people they do not need to be extremely thin to be healthy. You

can be quite healthy and have a larger frame. So it is about making sure that people are intrinsically healthy. It has got to be about positive health measures.

**CHAIR** - Like Mr Wilkinson.

**Ms FORREST** - You can be thin and not fit, too.

**Ms O'BYRNE** - True. You can be someone who is naturally thin and be completely unhealthy. I know people who do great amounts of exercise and who eat really well and who are big framed. It is not necessarily about being thin or fat; it is about being healthy and that is a really important message that we need to send. We are putting a lot of work in education and engagement and opportunities for people with bike tracks, making it simpler for people to engage, but at some stage I think we need to consider the option of using the Public Health Act. Maybe there are some things that we need to start enforcing, because this is unsustainable in its current trend.

**Mr WILKINSON** - Are we able to say how much we are spending in relation to it, if there is any set figure?

**Ms O'BYRNE** - It would be across a number of departments. We could certainly give you some of the work that we have done, but you would also need to get some out of Sport and Recreation, from out of Premier and Cabinet.

**Ms FORREST** - And the cost to the Health Department, you were talking about, weren't you?

**Mr WILKINSON** - Yes.

**Ms O'BYRNE** - Yes, but bearing in mind that that is only the cost of obesity.

**Mr WILKINSON** - No, the first -

**Ms O'BYRNE** - No, the cost of engagement.

**Mr WILKINSON** - The first one is what are we spending on education to combat obesity and, secondly, if I might, how much is it costing us?

[2.30 p.m.]

**Ms O'BYRNE** - I am really happy to look at getting that figure, but the reality is that I am not sure that we will be able to do it in the confines of this time, because we would need to go to other agencies. There is money that is within the Education budget, money within DPAC and money within Sport and Recreation. There are a number of buckets of money that we use as we target different things. We are also part of a number of national collaborative programs that are about engagement.

**Mr WILKINSON** - I hear what you are saying in relation to that.

**Ms O'BYRNE** - But we will see what we can get within the time frame. I do not want to overcommit on information that we might be able to provide. In terms of cost to the health system -

**Mr WILKINSON** - Cost to the health system.

**Ms FORREST** - Just while you are looking for that information, can I just ask about bariatric surgery?

**Ms O'BYRNE** - Yes.

**Ms FORREST** - There was some discussion in the past about whether the State would provide funding for that. Where are we with that? I do not see it as the option for obese people generally.

**Ms O'BYRNE** - No. Can I just say that bariatric surgery is not an easy out for anyone. It is a risky, complex piece of surgery that should only be undertaken on strong clinical advice. And that advice is not provided by social policymakers; that advice -

**Ms FORREST** - And in the context of a lifestyle change.

**Ms O'BYRNE** - Putting all of that - I know that you agree with that - on the record, we have done quite a bit of work under the Health Plan about managing the public provision of bariatric surgery, because it is clearly part of that State-wide plan about how we manage increased morbidity and obesity. In 2008 there was a review of the scope and operational arrangements for public bariatric surgical services. That went through to 2009 and early this year the expert advisory group recommended a service delivery model to the Tasmanian Government, improving access to public bariatric surgical services delivered within a multidisciplinary framework. We are currently considering the recommendations of that group and the implementation of the bariatric surgery model within Tasmania's public health system.

The reality is that this is only something that people should undertake under a clinician's advice and a number of clinicians, I understand, are actually requiring their clients to go under a particular dietary and behavioural regime prior to surgery as well, which does decrease the risk.

**Ms FORREST** - Of crushing up Mars bars and sucking them down a straw.

**Ms O'BYRNE** - That is a risk, but it is -

**Ms FORREST** - That is what they do.

**Ms O'BYRNE** - It sounds gross. I am just trying to work through it.

**Ms FORREST** - We do not have to use Mars bars; there are other things you can use.

**Ms O'BYRNE** - I got the idea about the straw.

**Mr WILKINSON** - Better than a Rocky Road.

**Ms FORREST** - A bit lumpy.

**Ms O'BYRNE** - But I have to say that it really is important that we recognise that bariatric surgery is the clinical response to a really chronically severe problem. It should not be in any way

ever construed as an option for people who do not choose to make other life choices. Where there are other life choices available, we must always encourage and support people to make them.

**Ms FORREST** - But are we providing a public bariatric surgery service?

**Ms O'BYRNE** - Yes, we are.

**Ms FORREST** - Do you have any idea how many procedures have been undertaken in the past 12 months?

**Ms O'BYRNE** - There would not have been many.

**Ms FORREST** - As public patients, I mean.

**Ms O'BYRNE** - As public patients. There would not have been many. There has been a debate about bariatric surgery for young people as well. That is a national debate. Bariatric surgery for an older person with chronic morbidity issues that they have been living with for a long time is possibly something that you would view differently from that of a 13- or 14-year-old child, for instance. So there is that issue to take into consideration as well.

**Ms FORREST** - So can we get that figure?

**Ms O'BYRNE** - Yes. When we get to the output group, Mike Pervan might be able to help you.

**Ms FORREST** - Okay.

**Mr WILKINSON** - We were looking at the figures. How much do you believe obesity costs the health system?

**Ms O'BYRNE** - We will have to get that for you. I do not have the figure on me.

**Mr ROBERTS** - Again, perhaps under the other group we could ask Roscoe to tell you about how much is currently being spent on prevention programs which is when we could do that. I doubt that we will be able to provide you with a figure of how much we spent for obesity.

**Ms O'BYRNE** - It would be quite difficult.

**Mr ROBERTS** - Health systems do from time to time look at things like diabetes, because that is a substantial agenda. But obesity would be quite a tricky one. It would require some research to be done, I think, in order for us to determine an obesity figure.

**Mr WILKINSON** - Because of the Tasmanian issue - when you look at the statistics compared to other States - should we be doing more in relation to it?

**Ms O'BYRNE** - Certainly we are working at a national level as well as doing the things that we do, and that was my point before. We might even bring Roscoe to the table now to talk about the new prevention unit that we are setting up. While he is getting here, some of the things that we have looked at are that it is not just about physical behaviours. It is not about eating the wrong foods; it is about eating the right foods as well. There is really disturbing information on the lack

of fresh fruits and vegetables that are being consumed, and it ranges from different age groups. In reality, people over the age of 65 are far better at eating fresh fruit and vegetables than those who are younger. Young people between 15 and 24 are probably the group that do not do it, that do not eat enough. So it is not only about what not to eat and about what behaviours you do; it is also about encouraging information about what you should eat.

**Dr GOODWIN** - It can be a social inclusion issue as well, can't it, about getting access to fruit and vegetables and things through some of the programs that are now being funded?

**Ms O'BYRNE** - Some of the community garden programs, exactly. I remember a program I was involved in - I probably will not name it - that was doing a program for grade 5 children and roughly 68 per cent of the grade 5 children involved in the community garden program were the primary meal preparers in their home. So we are talking about 11-year-olds being the people who cooked. Some 68 per cent of the kids in this program were the ones who cooked the meals for the family every night, and of course that meant that they were picking what was easy. What the garden program worked on was growing vegetables so that they could chop them up and take them for soup packs, and almost all of the soup packs would be used because otherwise they have not been given another model - another educative model - about what to eat. So we are dealing with more than just a decision not to do something; we are dealing with an absolute dearth of knowledge. Social inclusion and inclusion in those sorts of communities is crucial to build that capacity and support. We assume knowledge is handed down, and it just is not.

**Ms FORREST** - I am all for 11-year-olds cooking the evening meal.

**Ms O'BYRNE** - My daughter is nine, so I will go home and strap the new rules as of next week.

**Mr WILKINSON** - Two years time.

**Ms O'BYRNE** - Looking forward to sitting back.

**CHAIR** - We have one more question on the overview.

**Ms O'BYRNE** - Roscoe just had that final answer on preventative health to give and then we will not necessarily need to cover it then.

**Dr TAYLOR** - First of all on the numbers, we have got retrospective figures on what we spent in 2009-10 on tobacco control and I have prospective spending that is coming to population health where we are going to support a new national partnership agreement on preventative health. We can get further figures if you require them on the other parts of our Budget for prevention. But in tobacco control in 2009-10 the Department allocated $1.458 million in recurrent funding for tobacco control activities which was a sizeable increase on previous years. That includes $442 000 to QUIT and $260 000 on top of that specifically for additional social marketing activities and an additional counsellor. We also were able to fund an additional $90 000 for pregnancy support services in relation to smoking, bringing the total funding last year to $792 000.

For the national partnership agreement on preventative health, there is some money coming to Tasmania from the COAG allocations - the national partnership agreement - and last year that was $58 000. This coming year it is $198 000, a sizeable increase, and the Department has been

able to reallocate funding from within its Budget towards prevention, so there is an additional $1.6 million commencing in this coming financial year recurring to help us address the national partnership agreement and hopefully give us a better chance at meeting the requirements that we need to get the award payments under the way the COAG framework was established. If we reach certain decreases in smoking rates or improvements in fruit and vegetable consumption in adults and in children and physical activity -

**Ms FORREST** - They should give bonuses when pregnant women give up.

**Dr TAYLOR** - Bonus payments?

**Ms FORREST** - I think you should push for bonus payments when pregnant women give up in the first trimester.

**Ms O'BYRNE** - How would you audit it?

**Ms FORREST** - That is not my worry. But seriously -

**Ms O'BYRNE** - I think that sort of thing works well. I was just wondering how you would actually monitor it.

**Ms FORREST** - You would have to monitor the women who may take it up again. Midwives do that. We do it all the time. When a woman who smokes comes to you pregnant you ask them every visit, 'How are you going with it? How are you going with it?' You see them afterwards. There are two people there. Also, some of the problems we are having with our children's wellbeing and health is because of abuse they receive during pregnancy.

**Dr GOODWIN** - There is the alcohol consumption problem as well with foetal alcohol syndrome.

**Ms FORREST** - Yes, exactly. So if you can fix some of those -

**Ms O'BYRNE** - I think nurses and particularly the midwives who you might see at the midwife clinic in these programs are the less threatening mechanism by which to have those conversations. I think child health nurses are the same. You will go to them with a degree of comfort and I think they are one of the better mechanisms by which to have that conversation.

**Ms FORREST** - They are more likely to tell you the truth. They do tell you the truth, because you can tell if they do not.

**Ms O'BYRNE** - Yes.

**Mr WILKINSON** - Do you want me to ask you later on what obesity is costing us as a State?

**Dr TAYLOR** - We do not have State specific data for that, I am sorry. We do have national estimates.

**Mr WILKINSON** - We have it in relation to smoking, haven't we?

**Dr TAYLOR** - Yes.

**Mr WILKINSON** - Do we believe that by keeping the figures it does assist us to combat the problem?

**Dr TAYLOR** - By keeping?

**Mr WILKINSON** - Figures, costs, outcomes, inputs.

**Dr TAYLOR** - The cost-benefit analyses are yet to convert policy into practice or principles into practice. In my opinion the allocation of funding towards prevention has not followed the actual costs of the preventable conditions that we try to do something about.

**CHAIR** - I am wondering, Minister, while we have Dr Taylor at the table, whether public health issues fit in any of the line items.

**Ms FORREST** - The line item is 2.3.

**Ms O'BYRNE** - I am very flexible. If you want to deal with it while Dr Taylor is at the table, I am fine.

**CHAIR** - We will leave that until 2.3.

**Ms O'BYRNE** - I am flexible with however you wish to deal with it.

**CHAIR** - Are there any other matters?

**Ms FORREST** - I have one on overview. Minister, this is probably something you can table. I would like the number and name of consultants and consultancies that have been used by the department, the dollar value of those consultancies and what they were for.

**Ms O'BYRNE** - While we are grabbing that, this is the answer to the issue in terms of the overdue accounts. I will give you the names of the consultants. I will just state for the record that our consultancies are not necessarily consultancies in terms of people coming in and telling us how to better do business.

**Ms FORREST** - No, no.

**Ms O'BYRNE** - They can be construction consultants. They also include medical programs, medical purchases, construction and those things. I am happy to table it on the basis that everyone understands that the total figure is inclusive of construction, medical purchases and a whole host of other things.

**Ms FORREST** - It tells us what they are for though?

**Ms O'BYRNE** - It is a list of who it is and how much they got.

**Ms FORREST** - Thank you. The tabled document as far as the overdue accounts are concerned does not break it down to those that were 30, 45 and 60 days beyond term. It just gives you an overall figure. We would like that information as well - those beyond 30, 45 and 60 days.

**Ms EGAN** - We will provide you with something to (*inaudible*)

**Output group 1**
**Acute Health Services**

**1.1 Clinical support services -**

**Ms FORREST** - I have a quick question on this output group. I notice there is an extra $4 million in funding reflecting additional expenditure in front-line services. Can you give us any details about unfilled positions in those allied health areas—physio, occupational therapy, speech therapy and the like?

**Ms O'BYRNE** - Does anybody want to be a physio at St Helens right now? It is a fantastic job.

**Ms FORREST** - That is one that is empty obviously. I am interested in unfilled positions. Can you table the information about unfilled positions?

**Ms O'BYRNE** - For allied health, I have one. We had 1 057 paid allied health professionals as at April 2010. For the corresponding pay period in 2009, we had 982 so we in fact have an increase of 58.29 full-time equivalents. There are currently four allied health positions advertised in Health. What was the other one you wanted?

[2.45 p.m.]
**Ms FORREST** - Where is the extra $4 million to be targeted? Is it any particular area? I am interested in positions - that is, whether it is a physio, OT, et cetera - and regions.

**Ms O'BYRNE** - We probably cannot give you that right now but if we can get it I will get it. I have just checked and, no, we do not have that yet. We would not have got to the allocation stage, from what I understand. Once we do have it, I am happy to share the information.

**Ms FORREST** - Are you saying that you do not have any plans for extra staffing in any areas at this stage?

**Ms O'BYRNE** - I just do not think we have got it broken down at this stage. That is the advice I am receiving.

**Ms FORREST** - You have an extra $4 million though. Surely you must have an idea of where the need is.

**Ms O'BYRNE** - We have not yet finalised the allocations. We are just trying to source where your $4 million is coming from. Can you refer us to which piece of paper you are at?

**Ms FORREST** - It is just from last year's budget figures, the line item. There is $4 million more than last year.

**Ms O'BYRNE** - We had a wage increase for allied health professionals.

**Ms FORREST** - Would that eat up all of that increase?

**Ms O'BYRNE** - Possibly, $4 million is not a lot in wages for that many staff.

**Ms FORREST** - I appreciate that.

**Ms O'BYRNE** - We do have, as I said, the additional positions we have in allied health as well to come out this year. There are a whole lot of things that make up that $4 million.

**Ms FORREST** - So we are not seeing an increase in any particular area then?

**Ms O'BYRNE** - We have increased allied health positions. As I said, in allied health we have actually grown the amount of positions from 982 to 1 057, which is a net increase of 58.29 full-time equivalents from April 2009 to April 2010.

**Ms FORREST** - Do you have a breakdown of the professions? That covers quite a range of professions. Do you also know what geographical areas the increases have been provided to?

**Ms O'BYRNE** - We could probably get that. I do not have it with me at the moment but there have also been the pay increases that they have received -

**Ms FORREST** - I appreciate that. There was a comment in the budget paper that there was an increase in front-line services. I am interested in which positions they were and which part of the State they were in.

**Ms O'BYRNE** - Sure. We can probably do that.

**Mr ROBERTS** - We can give you where the money was distributed but we cannot give you the posts associated with that.

**Ms FORREST** - So you can give us the regional information but not the professions.

**Ms O'BYRNE** - Yes.

**Mr WILKINSON** - In relation to the physiotherapists and occupational therapists, my understanding is the positions are hard to fill in some areas. It certainly is in private practice - that is, the positions are hard to fill. Are you having difficulties filling them?

**Ms O'BYRNE** - When I was in St Helens, they were still attempting to get a physio at that point, although other places have not had troubles at all. I think that is a variable outcome. I am not sure that we are noticing any difference to the normal challenges in attracting allied health professionals.

**Mr ROBERTS** - It waxes and wanes in terms of our ability to recruit. Allied health professionals have been more easy to recruit more recently - more difficult on the north-west coast. The changes that have been put in place through the Royal around a training school for physiotherapists are going to help and are helping. So there are a number of strategies that have been employed to try to enable us to recruit those numbers, but we still do have places where it is difficult to get allied health professionals.

**Mr WILKINSON** - Years ago you had to go to Melbourne to do physiotherapy. You cannot do it here. You would do it in Melbourne, Adelaide, Queensland.

**Mr ROBERTS** - Not here.

**Ms O'BYRNE** - If I can introduce Fiona Stoker to the table.

**Mr WILKINSON** - Do I understand you are saying that there is going to be a physiotherapy school within Tasmania?

**Ms STOKER** - Yes.

**Mr WILKINSON** - We knew that you were coming in for that comment.

**Ms FORREST** - So glad you can walk and listen.

**Ms STOKER** - We have commenced - it is not a whole school for physiotherapy; it is an adjunct to the Bachelor of Health lines which is being done through the Rural Clinical School in the north-west. So, we are starting off with about eight places in Tasmania at present and this is being done in collaboration with the University of South Australia.

**Mr WILKINSON** - Therefore these people who want to leave the State to do physiotherapy can now do it here in Tasmania?

**Ms STOKER** - They can, Minister, but may I elaborate a little bit? It is a postgraduate course. What we are actually doing is taking students from Monash as well. So we are taking undergraduate physiotherapy students from Monash and they are being supported through the Launceston General Hospital and also through the Royal Hobart Hospital. The course that is going through the Rural Clinical School is a postgraduate course.

**Ms O'BYRNE** - Which, of course, does allow people to reconnect with communities. I did meet a few of the students when I was touring in Burnie. Jane introduced me to a couple of the people who were involved in that program. It does sound like an extremely promising opportunity.

**Mr WILKINSON** - Years ago your normal physio course was three years. You got a diploma then. Then it became a bachelor and it was four years. The postgraduate course is going to be how many?

**Ms STOKER** - It is going to be three years for the normal degree. I think that is actually going to be four years as well.

**1.2 Medical services** -

**Ms FORREST** - This one, Minister, crosses a bit over some of the discussion we have had in relation to the national reforms. There is $11.1 million being allocated to create a new four-hour national access target in the DEMs. How much of that will be spent in common or shared infrastructure or services and how much will be allocated to each DEM?

**Ms O'BYRNE** - The key to remember with the four-hour targets is that it is four hours as long as it is clinically appropriate to do so. So, clinicians in the emergency unit will preserve that right to determine that it might take more than four hours if it needs to. We are not going to intervene in that.

**Ms FORREST** - They will not be sitting there waiting for four hours before assessment.

**Ms O'BYRNE** - It does say 'four hours where clinically appropriate'. If I turn up with my ripped toenail, I would not be complaining if I waited five.

**Ms FORREST** - Is the $11.1 million allocated to create the national targets?

**Ms O'BYRNE** - You want to know which places it goes to?

**Ms FORREST** - Is there some being spent on shared infrastructure or shared services or is it being distributed to the DEMs and how is it to be used there?

**Ms O'BYRNE** - We have not actually allocated it to each of the DEMs yet, but I understand the general practice will be about their level of presentation.

**Ms FORREST** - So we could see it all sucked to the LGH, then? Is that right?

**Mr ROBERTS** - No. There will be an appropriate distribution. The way the numbers have been calculated initially for the $102 million work are based on formulas derived by the Commonwealth. As the minister has already said, we believed that, in order to meet those national health reform targets, we needed a sum greater than that, which is where the $124 million bilateral agreement comes from. The combination of those numbers has been derived from what each of the area health services believes they need in order to implement the national targets. So the bilateral discussion is really generated from the amount of money that the hospitals think they need to, over the four-year period, actually achieve that target, and that is why -

**Ms FORREST** - So how they spend it is up to them?

**Mr ROBERTS** - No, not strictly speaking. Yes in many ways, because we are placing accountability back to areas to actually find the solutions to these issues and manage these challenges. But we do have a reform team, which is work that is happening under the care reform to try to standardise the approaches for each of the hospitals to learn for themselves in terms of how they will actually implement the reforms. It is not just the ED target; it is also the elective target. As we know from the ED performance regimes that other countries have experienced, it is much more actually about the way the systems of care operate across the whole organisation rather than just what is happening in the ED.

In answer to your question about the sums of money, they have yet to be finally allocated. The bilateral sum of money of $124 million is absolutely essential to the targets being achieved, and of course we already have an investment going into the north in terms of the LGH capital scheme which will also contribute very positively to that. The North West is also spending some money on an upgrade to the Mersey DEM, and that will again contribute to how they achieve the target.

**Ms FORREST** - Of the $37.3 million allocated to operate the new subacute beds, does that money include the staffing costs of those beds, or is that more capital expenditure in relation to that?

**Mr ROBERTS** - Yes. Again, this is an allocation which is split into two. Part of it is for the staffing costs associated with this and part of it is for the construction of any new beds. The Commonwealth will then aggregate them together to give a number. We are at this point not certain how that money is to be spent, whether it is to be given to the State and then distributed to individual areas or whether the Commonwealth will expect us to bid or tender against that sum of money. So that is one of the undecided features at this particular point in time.

**Ms FORREST** - So how will the determination be made at a State government level, then? I am sure that the three or four major hospitals could equally claim that they need subacute beds.

**Mr ROBERTS** - Correct.

**Ms FORREST** - So how is it to be determined?

**Mr ROBERTS** - Through the normal budgeting process that it would go through and the needs of each of the areas will be weighed up. I am sure it will not buy the total number of beds that the individual area wants to see, but it will certainly go a long way to giving them capacity which they currently do not have.

**Ms FORREST** - In terms of the additional $61 million for the LGH to improve staffing, what category of staff are the extra staff referred to in the Treasurer's Budget speech to help patients in the acute medical unit and the IC and HDU?

**Ms O'BYRNE** - In terms of the $61 million, which is the commitment over the four years, they will actually be everything from the clinicians through to the cleaning staff that will be needed. It will be the whole range. By the time we get the full $260 million, which will be in the fourth year, we would be looking at 121 nursing, 54 allied health professionals, eight medical specialists and 50 support staff for the ED, the A&E, the day procedure unit, infusion and desensitisation service which is the whole project.

**Ms FORREST** - So does the support staff -

**Ms O'BYRNE** - So that will be everything from orderlies to cleaners to technicians and, I would imagine, technical staff.

**Ms FORREST** - Are we talking about AINs, assistants in nursing, or any of that sort of group of people?

**Ms O'BYRNE** - I would assume they would form part of the 50.

**Mr ROBERTS** - I do not believe this has got assistants in nursing in it, but we can actually seek some advice for you.

**Ms O'BYRNE** - We can seek some advice on that.

**Ms FORREST** - Yes, if you would not mind.

**Ms O'BYRNE** - So if you could ask the next question while he is on that one.

**Ms FORREST** - Yes. Can you also provide us - and this is something that you might be able to table, too - the numbers and costs associated with agency nursing staff and locum medical staff across the hospital sector?

**Ms O'BYRNE** - Agency nursing staff?

**Ms FORREST** - And the locum medical staff.

**Ms O'BYRNE** - And the locum medical staff

**Ms FORREST** - Numbers and cost in each jurisdiction.

**Ms O'BYRNE** - The agency worker cost to the health services was, as at May 2010, $23 988 140. In May 2009, the cost was $21 622 111. So there has been an increase of just over $2.3 million in agency worker costs.

[3.00 p.m.]

**Ms FORREST** - Is that broken down into regions?

**Ms O'BYRNE** - No, I do not think that I have any regions with me. Once again, it is something that I could get for you.

**Ms FORREST** - Yes, I think we need it for each of the hospitals.

**Ms O'BYRNE** - Yes, I can give that to you. Do you want me to read it in?

**Ms FORREST** - No, table it, if you would not mind - and the locum medical staff as well.

**Mr ROBERTS** - No provision has been made in those forward numbers for assistance in nursing at the LGH in their current model, but they have made some provision for an increase in enrolled nurses relative to registered nurses.

**Ms FORREST** - Where are you going to get them?

**Ms O'BYRNE** - We have four years.

**Ms FORREST** - Four years. You have time to move in that time.

**Ms O'BYRNE** - Sorry, can we correct the final number that we are negotiating for the bilateral with the Commonwealth. We have been saying 124. It is actually 125.1, just for the record.

**Ms FORREST** - Can I just clarify, Minister, this information that was tabled. The agency workers' costs -

**Ms O'BYRNE** - Yes.

**Ms FORREST** - Is this nursing staff?

**Ms O'BYRNE** - Can I just take that figure on notice?

**Ms FORREST** - Agency nursing staff? The way this reads is that it is the agency, not the nurses who are employed through an agency process. I do not think that we have the right information here.

**Ms O'BYRNE** - That would give you the total figures for agency staff - agency staff employed by agency.

**Ms FORREST** - Right.

**Ms O'BYRNE** - Yes. So you actually want a breakdown of agency nurses.

**Ms FORREST** - Yes.

**Ms O'BYRNE** - We are just taking that one now.

**Ms FORREST** - And by region.

**Ms O'BYRNE** - That is agency staff holistically by agency?

**Ms FORREST** - Yes, we need that - agency nurses, locum medical staff by region, by number and cost.

**Ms O'BYRNE** - Yes, we are on the case.

**Ms FORREST** - Good. Can I just suggest one issue in relation to productivity and outputs? I know that in the outpatient clinics many patients return for follow-up consultations and the like and often their medical reports are not available - their recent pathology or radiology reports are not available. The consultant is the one who appears to be running around looking for this stuff. That must reduce productivity considerably and waiting times for patients and the like. Is there a process in place to deal with this sort of problem? It has been ongoing. It is something that I have raised with the Department more than once.

**Ms O'BYRNE** - Yes, part of it is the patient identification number, which means that there will be one record that will be easily accessible rather than people trying to find multiple records.

**Ms FORREST** - It is a lack of efficiency in the system, because these people have one unit record in this regard, because it is all provided within one hospital. It is a problem only at the LGH, with people from my region going to the LGH and having to wait for 15, 20 minutes during their consultation while their consultant goes and looks for results.

**Mr ROBERTS** - It is a detailed operation in question -

**Ms O'BYRNE** - That does not answer the question. We do believe that new IT system is going to make it a lot easier because they will be accessible. I think we might ask John Kirwan, the CEO of the Launceston General Hospital - who has come all the way from the not-so-sunny

north, because it was bucketing down when I left yesterday - to join us and he might be able to address that.

**Mr KIRWAN** - Just a specific response, because I am aware that there is a specific issue that has been raised recently by the member, in respect of oncology areas, we did have some confusion. We had some new staff starting and there was some confusion about the north and north-west by some of our staff, because they were new to Australia, as to where they were coming from and where they could best get some of their pre and post treatment. That has now been resolved since they have been there.

In the Holman Clinic, we are moving to a new information system called Aria. For all of our oncology patients, all of their records will be able to be found electronically, as well as all of their tests and others. So that is now in the process of being rolled out.

**Ms FORREST** - When these consultants travel to the north-west to follow up their patients there, will that system travel with them?

**Mr KIRWAN** - Yes.

**Ms FORREST** - Thank goodness.

**Mr KIRWAN** - In the Holman Clinic, that will be the new Aria system which has been recognised across Australia as being one of the first and most innovative. It is in the process of being rolled out now. So we accept there have been problems both with new staff and with paper based systems in the past.

In our other specialist clinic in other areas, one is the new patient information system. As Mr Roberts referred to earlier, as I understand from listening to him, if I listened correctly, the new unique identifier actually allows matching of the data where previously that was not available. That improves things significantly. Our new patient information system changes areas like our outpatient areas, which were previously paper based, not electronically based. Once we work through the systems and the scheduling - and there have been some implementation issues, but they have all been resolved - that will allow us to do that.

The other issue is we have a tender that is in evaluation with the shared e-health foundation which will allow us to move ahead and start digitally and stay digitally with our medical records, except in some areas where there will still be scanned and variations given because of both the significant amount of paper base we have and our significant legacy systems. The end result is - and this is what we are pursuing for the Integrated Care Centre and our Acute Medical Unit - a start-digital, stays-digital medical record on an online system that is linked to the general practice with appropriate privacy and other protocols. We can then actually see the tests, see what has been done, avoid duplication and make sure the specialist or specialist clinic has all of the appointments and all of the tests there and available. At the moment, there is duplication and there are a number of paper based systems. Given the volume of the work we are seeing, it is not surprising that on occasions there are errors. We are getting most of those out of the system now. We are very confident that the systems we are seeing come on in the future will actually eliminate those. Unique identifier is very important to that, and moving to a digital base model is very important to that.

**Ms FORREST** - So it will link to the North West Regional Hospital?

**Mr KIRWAN** - It will be transferable amongst all of the government systems. We have seen the technology that allows us, with appropriate approvals, to actually link with the GP practices, particularly through Medical Director. If you go to a number of GP practices now, they can order your tests and receive your tests electronically, not paper based. You can in fact go and have your blood tests in the morning -

**Ms FORREST** - And the doctor can email your result to you.

**Mr KIRWAN** - Exactly. We would see those tests, in the best model, to then be available. For example, if I was at my GP last week getting my blood tests and I was then in the hospital the following week - touch wood, hopefully I am not - they would be able to look up those blood tests, with appropriate approvals, and not have to reorder and duplicate them. They would also know it then and there, particularly if you are coming into the emergency department. So they would not have to do after-hours tests if the tests were only done a week ago and if that efficacy is there.

**Ms FORREST** - You may not be able to answer this, but how many GP practices use Medical Director?

**Mr KIRWAN** - I would not know. You would probably have to ask Dr White or Dr Cerchez that. They use Medical Director or another version. The take-up rates are now quite high, and in many ways they are probably ahead of us in that at the moment.

**CHAIR** - Are there any more questions on 1.2, Medical services? If not, we will move to 1.3, Surgical services.

**1.3 Surgical services -**

**Ms O'BYRNE** - Can I advise that, on the issue of how many bariatric cases we have done, there were 20 cases treated in the public system. I thought I saw an estimate somewhere that 50 would be a statewide figure that might be needed to be done, but that would include the private sector potentially.

**Ms FORREST** - With regard to surgical services, the progress charts provide a degree of information about elective surgery and waiting times. Can you table for the committee data showing waiting times for various categories of surgery?

**Ms O'BYRNE** - Can we provide that?

**Ms FORREST** - We have got it in other years.

**Ms O'BYRNE** - Okay, I was not sure. I am operating on 10 weeks of accrued knowledge here. We can in category 1 and category 2, or do you want to know the type of surgical procedure?

**Ms FORREST** - Yes, whether it is orthopaedic, gynaecological or neurological.

**Ms O'BYRNE** - What I have for you now is that I can break it down into categories. You have been able to get that information before based on whether it is orthopaedic, whether it is a cardiac -

**Ms FORREST** - Yes.

**Mr ROBERTS** - You would like it by specialty?

**Ms FORREST** - Yes, by specialty.

**Ms O'BYRNE** - Yes, we are getting that for you.

**Mr ROBERTS** - We have it at a summary level.

**Ms FORREST** - Yes.

**Ms O'BYRNE** - I can tell you that the State-wide waiting list in march 2010 was 7 792, which is a nine per cent reduction from the 8 534 in March 2009, but we will get you the break up.

**Ms FORREST** - So when you look at the waiting list and also the waiting times - which is, in my mind, somewhat a more important measure than the list itself - at the LGH there have been challenges and I think there will be more challenges. Why are public patients who are awaiting surgery at LGH not transferred to North West Regional Hospital, which appears to have a greater capacity, to try to clear their list? Maybe the CEO of the Mersey might not want them there. I do not know. I assume that some of the surgery or procedures carried out at the Mersey, for example, are also carried out at the LGH.

**Ms O'BYRNE** - For elective surgery?

**Ms FORREST** - Yes.

**Ms O'BYRNE** - The median waiting times for the LGH are 43 to 39 days; the Royal Hobart Hospital, 50 to 45; the North West Regional Hospital, 56 to 40; and the Mersey, 25.

**Ms FORREST** - Mersey focus predominantly on day surgery and less complex cases. Is there any thought—without the information it is hard to know where they fit - being given to the less complex cases perhaps being sent through to the Mersey?

**Mr ROBERTS** - I can answer the question. In the sense of can it be done, yes, of course it can be done. Assuming that the individual patient is happy to transfer to that location and they are content that the care can be provided, then there is in reality no reason whatsoever why that cannot occur. I do believe it will require a greater level of cooperation between the various hospitals, the two areas. I think it would need to be ensured that appropriate systems were in place to provide due care and attention, getting records across to them. Of course that will be easier under the -

**Ms FORREST** - One unit record number.

**Mr ROBERTS** - It would be much easier under the one unit record. This may well be a philosophical barrier rather than an actual practical barrier.

**Ms FORREST** - When you think about the distance that people from that region have to travel and the distance that people from Circular Head on the west coast have to travel, they would actually get there quicker.

**Mr ROBERTS** - Yes.

**Ms O'BYRNE** - It is also a decision for individuals as well. Some individuals may not wish to be further away from their family. I think there will always be that element of humanity that impacts on decision-making.

**Mr ROBERTS** - I think it is also important to reflect here that it is only now that we are just starting to see the substantial benefits accruing from the inclusion of the Mersey back into the North West Regional. The tightness of that system is becoming very evident, and the ability of the Mersey/Burnie hospitals to perform a much wider and greater statewide role is again only just emerging. I think some of this is cultural and some of this is real. There are certain procedures that we would not want to be undertaken at the Mersey hospital. But I think the CEO and her team now have pretty much sorted out what is right and wrong, and I believe she is open for business if anyone else wishes to go there.

**Ms FORREST** - That is what I have heard.

**Ms O'BYRNE** - I see.

**Ms FORREST** - It is interesting though, when you look at the DEM presentations as well, when you add together the North West Regional Hospital and the Mersey Community Hospital there are actually more people seen there than there are at the LGH.

**Mr ROBERTS** - There may be a complexity issue.

**Ms FORREST** - I am sure there is and I am sure it is not as simple as that.

**Ms O'BYRNE** - Most figures tend not to give true pictures of these sorts of things.

**Ms FORREST** - Why do we publish them if they do not give true pictures?

**Ms O'BYRNE** - Because there are bigger pictures that you can get.

**Ms FORREST** - Can you also provide the number of over-boundary cases that you have in each hospital for the various categories of surgery? I did not ask for that, did I?

**Mr ROBERTS** - We can. Can we add that to the analysis that you have just asked us for, which we will get for you hopefully by close?

**Ms FORREST** - Yes. Can you also provide information about how many services and what services are being contracted to the private sector and at what cost?

**Ms O'BYRNE** - We can add that to that as well.

**Mr ROBERTS** - We will go get that for you.

**Ms FORREST** - Can I ask now again perhaps about the Mersey funding issue? Is it an appropriate time to ask that now?

**Ms O'BYRNE** - You can ask now, yes.

**Ms FORREST** - About where it has disappeared to. I know it is where it is - in the Mersey hospital.

**Mr ROBERTS** - I reassure you that it has not disappeared.

**Ms FORREST** - I hope it has not, because there is a $60 million hole if it has.

**Ms O'BYRNE** - I will call Penny Egan to the table. Penny Egan is the Chief Financial Officer.

**Ms EGAN** - There was a note about the Mersey in both budget papers 1 and 2. In budget paper 2 it is on table 5.2 under the income statement. It is included in the sales of goods and services and there is a notation at note 5. So it will be table 5.12.

**Ms FORREST** - Under supplies and consumables?

**Ms EGAN** - Sales of goods and services. If you look at the notes below, over the page at note 5 it will mention Mersey.

**Ms FORREST** - Note 5 relates to supplies and consumables. That is where the confusion lies.

**Ms EGAN** - Sales of goods and services. In budget paper 1 there is also a mention, which is under table 4.4. It is also just a notation. There is an extra $5 million that we received this year.

**Ms FORREST** - $65 million. Why did the Feds get so generous, do we know?

**Mr ROBERTS** - Sorry, I missed that?

**Ms FORREST** - The extra $5 million, $65 million this year. Not that you can tell from the Budget Papers how much it is; it is not there at all, as far as an identifiable amount to the Mersey.

**Ms O'BYRNE** - As to the generosity of the Commonwealth, let's leave that. We are in the process of renegotiating another five-year contract. We have commenced that process.

**Ms FORREST** - So is there any suggestion, plan, intention, great hope, that the Mersey might actually be taken into the fold and not be this little stand-alone Federally-funded hospital?

**Ms O'BYRNE** - I think it is within the fold in terms of its general operation. I think that the north-west region works very well in the arrangement there. The Commonwealth arrangements and fundings are what they are.

**Ms FORREST** - Doesn't it in some respect though duplicate some of your administrative roles and things like that? You have got to meet these Federal Government requirements for the arrangements around that hospital. It could be more efficient. You might not get the same amount of money, I guess, and that is always going to be a trade-off.

**Ms O'BYRNE** - This is not an arrangement that we ever - this is not where we sought to be in terms of the operation of the Mersey hospital, but it is where we are and we need to continue to sustain the investment.

**Ms FORREST** - As far as when that arrangement expires -

**Ms O'BYRNE** - It will be interesting to see where we go by the time we get to 2015-16 as part of the national health reform.

**Mr ROBERTS** - May I?

**Ms O'BYRNE** - Please do.

**Mr ROBERTS** - I think your comments are worthy of note and to be taken on board, particularly if it is possible to have an option which perhaps is less burdensome on both parties. However, I would say that the North West Area Health Service has made a very good job of integrating the Mersey Hospital into the operations of all of the health service - primary, community and acute - and we are entirely comfortable with where it is at the moment. The Commonwealth is funding us to the level we believe is required to ensure that the patients in the north-west, and particularly at the Mersey, get the care that they require and we, through the renegotiation with the contract, will take the opportunity to present to them where we think further benefits can be derived from either an easing of some of the terms of that agreement or some ideas that we may well have for greater integration across the State, because there are State functions that we want to see take place in the north-west as well as in other areas and we think it can play an even greater role than it is currently playing. So we see that as an opportunity through the negotiations, which will be starting very soon actually, in terms of negotiating a position for the coming period of time - whatever it is.

**Ms FORREST** - Seeing how it has been run, I think there could be greater efficiencies, I believe.

**Mr ROBERTS** - Yes.

**Ms FORREST** - Thank you.

**CHAIR** - Anybody else for more on 1.3?

**Mr HARRISS** - Just with regard to the use of private hospitals, has there been any increase in the utilisation of private hospitals for surgery procedures in the last 12 months?

**Ms O'BYRNE** - We regularly purchase surgical services for public patients in private hospitals. We have some formal arrangements that exist. The Launceston General Hospital, for instance, purchases cataract surgery from the Launceston Eye Hospital or on a case-by-case basis. We also purchase surgical services for public patients to reduce the backlog of patients waiting on

elective surgery. I do not think that we have the figures. I can tell you from 2007-08 and 2008-09, but I do not actually have 2009-10 with me yet. I am not sure we would have it yet.

**Mr ROBERTS** - I am sorry, I am not sure of the question. Are you asking our utilisation of private or -

**Ms O'BYRNE** - Yes, how many people, how many we have sent?

**Mr HARRISS** - Your utilisation.

**Ms O'BYRNE** - Yes, so for instance, the LGH paid for six public patients to have surgical procedures undertaken in a private hospital in 2007-08 and the same amount in 2008-09, but I do not have the 2009-10 figure yet. That would include people who came to the LGH but then were sent off for postoperative care.

**Mr HARRISS** - Okay. So that is the LGH. Across-the-board? Do you have any information?

**Ms O'BYRNE** - For the North West Regional - once again, I have only 2008-09, but I am happy to give you those if that is of use to you?

**Mr HARRISS** - That is an indication.

**Ms O'BYRNE** - In 2007-08, the North West Regional Hospital had 270 public patients who had their procedures undertaken in a private hospital. In 2008-09, it was 363. Therefore they are patients from the north-west coast, including eye surgery performed at the North West Regional Hospital and the Eye Hospital and the lithotripsy at the Calvary in Launceston. The Royal Hobart Hospital had 70 in 2007-08. In 2008-09, it was 596, and they include the cataract surgery which is purchased from the Hobart Day Surgery.

It is probably interesting to note, of course, that Tasmania is clearly getting more people who are choosing to have a different level of choice in terms of private health insurance. About half of the people who have private health insurance who present at hospitals choose to be treated as a public patient. So 11.8 per cent would be privately insured patients. The proportion of privately insured patients in Tasmania's public hospitals - the second highest nationally - grew by 144 per cent between 1997-98 and 2007-08 to 18.3 per cent of the total, but I do not have, I am afraid, the 2009-10. I am not sure that we to have those - we do.

We had 21 per 1 000 of weighted population for private patients admitted to public hospitals. That is not a figure that you want. You want public patients treated in a private hospital, so that is the other way around. We will have to get the 2009-10 figures for you, but that gives you the question by 2007-08 and 2008-09. It is not an unusual thing to do, and I guess one of the ways that we are going to have to look at how we meet the targets for clearing our backlog as well is to look at where we might need to have partnerships with the private sector.

**Ms FORREST** - So arguably you could suggest that the LGH should look at that more too, because it was only a small number of public patients being treated -

**Ms O'BYRNE** - Some of that also comes down to what clinical treatments might be provided in the private system as well, and they do differ in different private hospitals which is a crucial difference. In terms of the Little Company of Mary, the services that you might be able to

access in Hobart in the private system with Calvary are not the ones that you would necessarily be able to operate in Launceston, and that is a significant difference between the types of service and does have to do with their engagement of clinicians and arrangements around that. So I do not think that is necessarily an LGH issue.

**Mr HARRISS** - So from a more strategic position, you have indicated that you do purchase, and by the figures you have proved that you do. But from a more strategic position, what is the Government's direction I suppose in terms of building a stronger relationship if there is a need? The first question would be is there a need to build stronger relationships?

**Ms O'BYRNE** - I think we have very strong relationships with the private sector, and certainly there have been a number of arrangements made in the past. I think the reality is that if we are looking at purchasing services or if we are looking, for instance, at trying to clear our backlog, we need to do that in a way that is sustainable. If we are going to ask the private sector to support some of our work, we need to do it in a way that allows them not to burn out staff, and the reality is that a lot of the staff who work for us do shifts for them. We need to be conscious of the fact that whatever work we might ask the private sector to do, they can actually manage it within their forward structures and ramp up staff to an appropriate level over a period of time rather than a really quick one.

So I think we absolutely need to have a good relationship with the private sector and I think that there are a lot of conversations that we need to have. But once again, it does come down to the variances in what they are able to offer as well that might meet our clinical needs, and they are different depending on where you go. Certainly the eye surgery ones have been a reasonably valuable contractual arrangement.

**Mr HARRISS** - With regard to resignations of particularly surgeons in our public hospital system, have we got unfilled gaps as a result of resignations over the last 12 months?

**Ms O'BYRNE** - Our three CEOs are all shaking their heads, so I am assuming it is not a significant issue.

**Ms FORREST** - Must be keeping the doctors happy, are they?

**Ms O'BYRNE** - We are happy to have a look at that. If there is a relationship between resignations and unfilled positions, then we are more than happy to look at that, Mr Harriss. While we are getting that information, this is hopefully the data that Ms Forrest requires - and I am hoping that it is because it is our third attempt - in relation to the payment of invoices. Mr Harriss, to go back to your earlier question while we are seeking some information on that one, we do not have the Royal figures yet. But in terms of private services that are purchased, the North West Regional for up to 31 May was $1.22 million worth of services which was 103 procedures. The Northern Area Health Service was 522 procedures at $1.794 million, predominantly ophthalmology. So that is the relationship we have with the Launceston Eye Hospital which, as you would be aware, is reasonably closely located. Sorry, we are just getting the information on resignations, Mr Harriss. We are happy to come back to that. In terms of the locum staff for nurses, medical practitioners and VMOs, I will just check. That is the agency for procurement of nurses, doctors and visiting medical officers.

**Mr HARRISS** - I have a final question with regard to surgery matters. It is a broad question which has two components I suspect - that is, whether there have been any inappropriate

procedures or mishaps which in turn might have brought any legal claims against the system for negligence.

[3.30 p.m.]

**Ms O'BYRNE** - While we are searching for that, here is the by region demand pressures for $30.3 million - the Southern Area Health Service amount, the Northern Area Health Service amount, the North West Area Health Service amount, oral health, the swine flu process and out-of-home care, adding up to $30.3 million. The total medical liability claims settled from the combined area health services in 2008-09 was $1 279 435, including legal fees. To 27 May 2010, it was $864 767.83 from the combined area health services. They are a combination of legal costs and settlement costs. Is that the information that you require or did you want it in a more detailed way?

**Mr HARRISS** - That is a dollar figure.

**Ms O'BYRNE** - I have costs. I do not know that I have numbers.

**Mr HARRISS** - The number of claims which have brought about that -

**Mr ROBERTS** - The number of new claims or the number of claims in the system? Some can take years.

**Mr HARRISS** - Yes, they do, I understand.

**Ms O'BYRNE** - So do you want newer claims that have presented in the last 12 months?

**Mr HARRISS** - Yes, please.

**Mr ROBERTS** - We would have to go to our external provider of our risk payments, which is Marsh, to get those. We can do that.

**Ms O'BYRNE** - We would not be able to provide it by close of business today. We could report back to you.

**Mr ROBERTS** - We would take it on notice, yes.

**Mr HARRISS** - Thank you.

**Ms O'BYRNE** - So that is the number of new claims in the last 12 months. We will need to take that on notice and provide answers later.

**CHAIR** - I think we have just finished 1.3. We will adjourn and come back in about 10 minutes to start on 1.4, Women's and children's services.

**The committee suspended from 3.32 p.m. to 3.54 p.m.**

**CHAIR** - Order. Thank you. We will now resume the session.

**Ms O'BYRNE** - Mr Chair, may I provide the information supplied for the over-boundary by specialities for the month ending May 2010 and over-boundaries by specialty and by category.

In an answer to a question about obesity we did get some figures. The Australia-wide figure for the cost of obesity is $58.2 billion and growing. In direct health costs that is 8.8238. That is the national direct cost of that and 39.9 when you consider the indirect cost which, of course, is also including costs of wellbeing, loss of life, loss of productivity and all of those areas. Now, for Tasmania, direct and indirect, we anticipate that it is probably a cost of $1.455 billion.

**Mr WILKINSON** - Each year?

**Ms O'BYRNE** - Yes, I believe. I can check. Yes, each year. That is including loss of life. That is including reduction in productivity. It is including all the issues that impact on wellbeing. That is the whole figure that we would anticipate.

**Mr WILKINSON** - Compared to smoking? You probably have not got the figures but somebody might have them at the tip of their tongue. But compared to smoking?

**Ms O'BYRNE** - When we get to population and health, I am sure we will. Can I just let you know though, and I did not touch on it before, but I think that you would be interested in the fact that Victoria announced yesterday that in relation to food advertising, all fast food chains are going to have to include a kilojoule count. That is part of the education. I actually think that there are really good reasons that we should do that here. We will be examining the Victorian model with a view to adopting in Tasmania stricter advertising for fast food chains. That is part of the education, but that is also where you can actually use regulation to bolster some of the education work that you do. That would probably not be the under Public Health Act, I imagine that might end up being under the Food Act. I am very happy to continue conversations with members who may have an interest in that because I really think that not only should we be telling people, but putting in structures that have a level of compliance around it.

**Mr WILKINSON** - Thanks for that.

**Ms O'BYRNE** - I knew that you had an interest in that.

**CHAIR** - Ms Forrest, you had another question before we move on to Output group 1.4?

**Ms FORREST** - I wanted to go back to a question I asked earlier when the CEOs were not here. I was asking whether all units operated within their allocations; if not, which had not; and what were their projections and were they to be over budget in this financial year? I was wondering if we could have an answer now.

**Ms O'BYRNE** - As I said, we do not have the final figures.

**Ms FORREST** - No, but to date.

**Ms O'BYRNE** - I just want to preface the fact that the amount of money given at the beginning of the year will generally be different to the amount of money that they have ended up with at the end of the year and keeping budgets on target is a mammoth task for hospitals.

**Ms FORREST** - There is a requirement, the Treasurer keeps telling us, that they will work within their allocations. He says it every time.

**Ms O'BYRNE** - The comment from my finance operator was it is 30 June; she can tell you soon.

**Ms FORREST** - But the projections for where they are headed?

**Ms O'BYRNE** - Yes.

**Ms FORREST** - Can we have that?

**Ms O'BYRNE** - Yes, we are just getting it for you.

**1.4 Women's and children's services** -

**Ms FORREST** - With regard to Women's and children's services, can I ask how the upgrades to the antenatal clinic at the Royal Hobart Hospital have been going and has there been any reduction in that with the shifting of the funding to the Royal?

**Ms O'BYRNE** - The shifting of the funding? By that you mean the $100 million?

**Ms FORREST** - That seems to have moved around a little bit.

**Ms O'BYRNE** - For the committee's record, can I state that Treasury gave us an allocation that it believed we would spend within the financial year, which is why the money went down to $10 million, but we have an absolute guarantee that should additional moneys be required then it will be brought forward. I think we are on target for the women's and children's area. We are absolutely on target. There is no delay as a result of that.

**Ms FORREST** - I notice there is an increase in funding from last year's Budget to this, as you would expect in this area. I do not know that the birth rate is increasing though.

**Ms O'BYRNE** - Yes, it has.

**Ms FORREST** - For the next forward predictions over the next year? In light of the global financial crisis I thought there might have been a bit of a slowdown, or are we doing things for comfort these days perhaps and not having a negative impact?

[4.00 p.m.]

**Ms O'BYRNE** - There certainly has been an increase.

**Ms FORREST** - Either way, the question is: are there extra services being provided, such as antenatal services and support for pregnant women? I go back to that point I made about a bonus for women who give up smoking, drinking and other things which we know can be harmful to the unborn baby during pregnancy.

**Ms O'BYRNE** - And your point you have made previously about dental care as well.

**Ms FORREST** - Yes, and antenatal dental care. I was going to get to that in the dental line.

**Ms O'BYRNE** - For the LGH, we have seen a birthrate increase from 1 400 to 1 700 per annum since 2004. That clearly means an increased demand in services, particularly for those complex clinical needs. We are in the process, although it does not have it in here, of changing the physical area there as well in order to better cater for those needs.

**Ms FORREST** - So are we looking at enhancing antenatal services into the community? I know down in the south we are looking at that. I am just checking that MSOAP is still operating on the north-west coast. Is there any suggestion that that will be expanded to the east coast?

**Ms O'BYRNE** - I might ask Michael Pervan to join us. He is the CEO of the Royal Hobart Hospital and he has been doing a bit of work in this area. While Mr Pervan settles himself, we have the median waiting times by specialty by hospital for July 2009 to May 2010, and the median waiting times by hospital. Michael, the question was in regard to antenatal services and the growth in both the demand because of the increased birthrate that we have and also the services within the community.

**Mr PERVAN** - Thank you, Minister. The Royal actually began a process some 18 months ago of putting antenatal services for the projected low-risk pregnancies out into the community in Kingston, Glenorchy and Clarence. Those clinics are incredibly successful. In particular, the midwives who are delivering them cannot imagine delivering services any other way now.

**Ms FORREST** - I could have told you so, but anyway.

**Mr PERVAN** - And so you may well do. That service has been very successful. It has reduced some of the pressure on the clinics in the Royal that effectively are in a converted corridor space. The issue we have at the moment is that there is an increasing number of predictable complex births coming through, particularly with young women who are pregnant and who may have other issues around their health, particularly drug and alcohol problems and even dental problems. We have a lot of teenage mums who have none of their own teeth and that actually carries a risk for premature birth and all sorts of other things.

**Ms O'BYRNE** - That is something which Ms Forrest actually raised with me in my first meeting with her, and we are going to have to address that.

**Mr PERVAN** - We are coping at the moment but we are going through what appears to be an unpredicted baby boom. That is very much in conflict with the projections that were done for the new Royal project, which had births declining sharply across Tasmania and particularly in the south. It is actually increasing all the time.

**Mr WILKINSON** - It is nothing to do with the wet, cold winter last year?

**Mr PERVAN** - There are two spikes in the deliveries.

**Ms O'BYRNE** - Isn't it September, after New Year's?

**Mr PERVAN** - No. The last two spikes were around nine months after the two benefits to the community from the former Prime Minister.

**Ms FORREST** - The national stimulus funding.

**Mr PERVAN** - They are referred to in the Royal by the midwives as Rudd bucks babies. I am sure it is a complete coincidence that both of the spikes occurred nine months after that.

**Ms O'BYRNE** - It probably just had people thinking more about the family planning issues.

**Mr PERVAN** - Or not thinking about them.

**Ms FORREST** - They could afford to buy the condoms and obviously failed to.

**DEPUTY CHAIR** - I think we are getting a bit off point.

**Ms FORREST** - Sorry.

**Mr PERVAN** - So there is pressure. I am aware that Launceston has similar pressure to do with younger mums and an increasing number of complex births. We are very lucky in that we have managed to recently recruit additional obstetric staff and some additional nursing staff. We have got some workforce challenges around the midwives because none of them are very young and it is a vocation within nursing and within health care that seems to be quite hard to attract people to. We are actually looking now at how to get young people into training in midwifery.

**Ms FORREST** - The question then is what action has been taken to progress the case load midwifery model of care throughout the State?

**Mr PERVAN** - Throughout the State -

**Ms O'BYRNE** - That is possibly not one that we need to put to Michael. Just before we get to that, can we ask John, the CEO of the Launceston Hospital, to swap places, because extensions have been made to the services at the Launceston Hospital and he might be able to update you on that.

**Mr KIRWAN** - As the Minister has said, out birthrates have increased by just over 1 700.

**Ms FORREST** - Do yours relate to the -

**Mr KIRWAN** - An element of that. What some of our staff are now also reporting is that women are now having babies younger. So there is a bit of a generational change, where before they waited some time but now it would seem that some are actually going back to probably a baby boomer type of mentality of having children somewhat younger.

**Ms FORREST** - When you say 'somewhat younger', what age group are you talking about?

**Mr KIRWAN** - In their teens and 20s rather than waiting quite some time. But that is more anecdotal than evidence based. What has occurred is that the increase has actually put some significant pressure on paediatric services, particularly for changing models of care from an inpatient to an outpatient model. That has put some pressure on that we are having some difficulties in our outpatient paediatric clinic actually addressing. We have plans for that, that is, it is part of our restructuring to move our paediatric outpatient area so that they could actually move into one of the areas that are currently being occupied in some of our decanting so that we can do the other capital works. So that is actually coming together. The time is probably not quite right

for us. We will have to do something earlier than that. What is also occurring with using the hospital infrastructure funding money from the Commonwealth is that we are about to upgrade our neonatal unit and totally rebuild it, that is, gut it and expand it.

**Ms FORREST** - As a former user of that facility, I endorse that.

**Mr KIRWAN** - It is an area now that - because of the number of neonatals that we are dealing with and the younger age group that we can maintain, as opposed to moving to Hobart or the mainland. That redesign is just about to be completed and signed off and we are relatively confident, assuming building prices and contractors' availability, that that can be refurbished and opened by the end of this current year.

**Ms FORREST** - So how many beds will that have?

**Mr KIRWAN** - You have got me there. I think it is probably around 15 or 16.

**Ms FORREST** - So what level would it be when it is completed?

**Mr KIRWAN** - Two, three.

**Ms FORREST** - So babies from the north-west will still need to go to Hobart if they need to?

**Mr KIRWAN** - For the advanced areas, yes, or to the mainland, which tends to occur.

**Ms O'BYRNE** - I can ask Jane Holden to come up, because she is doing the case load midwifery work in the north-west at the moment. So she can talk you through that element of your question. While she is coming, can I let you know - and Mr Harriss is not here - for the record the number of surgeons who have resigned and the number of resulting vacancies. In the Northern Area Health Service we have had no surgeon resignations and no vacancies at the moment. In the North West Area Health Service, we have had one orthopaedic surgeon resignation. We have one vacancy from a previous year resignation. We have one gynaecologist effective mid-June at Mersey who we are currently recruiting for. In the Southern Tasmania Area Health Service we have one person who has not resigned but retired and we are constantly recruiting and filling as part of normal vacancy management. That is for Mr Harriss when he returns and I will hand over to Ms Holden. This is about the case load midwifery.

**Ms HOLDEN** - As a result of the maternity review that has been undertaken in the north-west over the past 12 months, we have committed to roll out case load midwifery at the Mersey and that is a balance against the Know Your Midwife scheme up at the North West Private, which is a similar sort of scheme, although I think case load midwifery is more comprehensive in its application. So we have the required number of midwives in the Mersey who are keen to take on a case load of about half our beds - about 250 at the moment at Mersey - and a case is about 50 births per midwife, roughly that sort of number.

**Ms FORREST** - Full time?

**Ms HOLDEN** - Full time, yes. We are working now, having rolled out a number of policies, a number of standards - those sorts of things - in terms of working as a case load midwife and the

industrial processes commencing now with the ANU on a State-wide basis to introduce how we would remunerate case load midwives.

**Ms FORREST** - So looking at it annually like salary?

**Ms HOLDEN** - Yes.

**Ms FORREST** - Looking, then, at the contract with Healthe Care for maternity services in the Burnie region, do you believe that is a value-for-money contract? Has consideration been given, now that the Government will own the North West Regional Hospital Burnie campus, to providing public maternity services within that facility? I know it would require work to do it, but is there a long-term plan?

**Ms O'BYRNE** - Sorry, I missed the question. I hate to ask you to repeat it, but I did not hear it.

**Ms FORREST** - I was saying that with regard to maternity services provided at Burnie under contract to Healthe Care, do you consider that a value-for-money contract? Will consideration be given, now that the Government owns, or will own shortly, the North West Regional Hospital Burnie campus, to providing public maternity services from that site?

**Ms HOLDEN** - In terms of the first part of that question, clearly Healthe Care is a private organisation and there is some investment for them and some profit out of that. So the level at which you answer that is around what is a reasonable profit for a private hospital to make from that service. The short answer is: I am constantly watching that this is good use of taxpayers' dollars and to that extent have taken over the chairing of the maternity committee that works with the private sector on behalf of DHHS and the North West and we look at both their costs and their income. I require them to satisfy the committee that their numbers of midwives per birth are reasonable and relative to other providers. I also require them to report on equipment and whether they have enough. Any issues in terms of what we would look at in the public sector I require that committee to look at in the private sector.

So increasingly I think we can be comfortable that we are seeing the sorts of standards in place that we would expect in the public sector and that we also have changed a woman's pathway in the private sector so it more reflects a contemporary pathway you would expect of a woman accessing maternity services in the public sector to get, and that is a more comprehensive pathway with greater access to midwives, greater antenatal access and those sorts of things. So I think in that regard it is an increasingly cost-effective service. I think maternity is a core public service and I think we constantly look at the model and whether or not the model is giving the best return for the taxpayer. With regard to your second question, the contract is in effect in perpetuity at the moment, but we do need to look at that on at least an annual basis and we do.

**Ms FORREST** - So no plans at this stage to take it back into the public facility -

**Ms HOLDEN** - Contractually there is not that opportunity at this point, nor any reason for us to believe that they are in default of their contract at this point, but we watch that. As I say, I have a meeting every month and then every year we do a thorough review of that.

**Ms FORREST** - One of the problems in the past has been reporting.

**Ms HOLDEN** - Yes.

**Ms FORREST** - So now that you say that you have asked for a whole range of reporting, which is great, how are they recorded and are these available to the public?

**Ms HOLDEN** - They are recorded in the minutes of that meeting and also we have now just brought the North West Private Hospital on to the perinatal database for the DHHS so all births are recorded as well. We require a monthly report before we will pay any accounts with regard to their work. So we require those reports.

**Ms FORREST** - So will we see a summary, then, of the recording and reporting that you refer to?

**Ms HOLDEN** - Where?

**Ms FORREST** - Yes. Is there a summary produced at the end of the financial year with regard to the number of births, the midwife to women ratios and all those other matters that you raised?

**Ms HOLDEN** - We can report that. As you know, we have a north-west area advising committee and we have shortly got our annual report to that committee. Numbers of births and those sorts of things we will include in that. No, there is not a public disclosure of the number of midwives to women, but I do not think that is any secret from the general manager of the North West Private either if one was to ask him.

**Ms FORREST** - It has always been a difficulty to get that sort of information out of that setting in the past. Will you actually publish this data anywhere?

**Ms HOLDEN** - No, we just report on the number of births like we report on the number of surgical patients and the number of medical patients and outpatients we see. We report at that level of output for the public in terms of the investment made in the north-west.

[4.15 p.m.]

**Ms FORREST** - But you could report the number of caesareans, the number of inductions -

**Ms HOLDEN** - Yes. That is public information.

**Ms FORREST** - I did ask - I think it was skipped over a little bit - about outreach services. Are maternity services to Circular Head and the west coast still going on?

**Ms HOLDEN** - Yes, they are. Via MSOAP funding?

**Ms FORREST** - Yes.

**Ms HOLDEN** - Yes, they are. There is some change in the kinds of services that we want from that MSOAP funding. MSOAP has been extended to include midwives now. Previously it was only for doctors. So that has changed how we want things to work in that regard. We have done a lot of consultation through the review with the GPs working on the west coast in particular to see what they think they need as well as what women receiving those services need. Yes, that is a robust service that will change just because that is what the client group who are using those

services need as a change. They do not just need to see an obstetrician; they need a multidisciplinary consultative meeting, midwives, and we need plans for what they are going to do when we want them to leave the area—where are they going to stay, how are they going to get there, who is looking after their children? So we are taking a much more comprehensive approach. But we are still using MSOAP funds to do that.

**Ms FORREST** - Is that sort of program going to grow out like on the east coast at St Helens or anywhere like that?

**Ms HOLDEN** - I do not know. John could speak to that. What I can tell you is that we have an opportunity within MSOAP funding because this round ceases on 30 June 2011. I know, as an area CEO, that I have been asked to pull together what I am looking for in MSOAP funding for the next round. So I am sure that is probably something that is happening across the board.

**Ms O'BYRNE** - I am advised that we are looking to roll it out into other communities.

**Dr GOODWIN** - I have a question that flows on from the discussion earlier about babies born with complex needs as a result of drug and/or alcohol issues. Is there any benchmarking of that and do we know whether it is becoming more common?

**Ms O'BYRNE** - If there is a higher prevalence of it?

**Dr GOODWIN** - Yes.

**Ms O'BYRNE** - I do not know whether we can provide that for you. We are not sure that we have the data. If we do have it, I am really happy to provide it to you. Anecdotally of course and in general conversation, I am extremely concerned about issues such as foetal alcohol syndrome. We have had to take measures under other portfolio areas to manage babies who are born to mothers who may be habitual drug users. So it is something I think we have had to put measures around. I think, under the Attorney-General's portfolio, we would have done that two years ago.

**Ms FORREST** - Minister for children.

**Ms O'BYRNE** - We did not have a minister for children. I think Lara would have done it either as health minister or as Attorney-General. There are some serious issues for children's care as a result of that. Whether or not we are able to get the figures, I am happy to see whether that data is available and, if so, provide it to you. I am not sure whether it is going to be within the time structure of the committee if it is data that we have to search from somewhere else. It really is a significant issue. We can save babies now that we could not save before. There are whole lot of things around that in terms of the infrastructure and support that we need to provide.

**Dr GOODWIN** - Thank you.

**CHAIR** - If there are no more questions on that output, we now move to 1.5, Diagnostic and pharmacy services -

**1.5 Diagnostic and pharmacy services** -

**Ms FORREST** - No. I have not got anything on that. It is an expensive area, I know. The allocation has increased. I expect it will be enough.

**CHAIR** - So we will move to 1.6, Ambulance services.

**1.6 Ambulance services** -

**Ms FORREST** - Just one area that I wanted to look at with ambulance services. When ambulance services are required for patients on the Bass Strait islands, and I refer to particularly King Island, because I know more about what happens there -

**Ms O'BYRNE** - So the fixed-wing service?

**Ms FORREST** - Yes. When a patient has been treated and requires to be treated in Victoria, even though the particular service they require may be Tasmania, there is a huge discrepancy between the cost of the Victorian ambulance service and the Tasmanian ambulance service. Unfortunately, they do not get to choose, so the patient ends up paying a huge amount for air ambulance services to go to Victoria. It is double the amount. It is thousands of dollars we are talking about here.

**Ms O'BYRNE** - That would be on the basis that they actually have an insurance system that they participate in in Victoria; would that be the reason?

**Ms FORREST** - What was that, sorry?

**Ms O'BYRNE** - I am just going to check with Dominic Morgan. Can I ask Dominic from Ambulance Tasmania to join us. Dominic, I am wondering whether or not the difference would be in relation to the fact that if a patient is on King Island and they are picked up by the fixed-wing service the cost of that transport to Victoria is much higher than the cost of our transport here.

**Ms FORREST** - No, no, it depends which service they are transported with. The example that was brought to my attention - I cannot remember the exact figures - was that it was something like $2 000 to go to Victoria with Victorian Air Ambulance. With the Tasmanian air ambulance the cost was nearly $5 000. The Patient Travel Assistance Scheme does not cover it because they went to Victoria because of complexity of their co-morbidities. But the surgery they had could have been provided in Tasmania.

**Ms O'BYRNE** - It could have been.

**Ms FORREST** - Yes, but because of their co-morbidities they needed to be in Melbourne with the surgeon that had provided the original surgery. I am just interested in how this sort of situation arises. A patient cannot make that choice, I guess. The only reason they got the Victorian ambulance was because the Tasmanian air ambulance was tied up.

**Ms O'BYRNE** - I will ask Mr Morgan to take this one.

**Mr MORGAN** - That is probably the situation, without knowing the specific case. I am aware that, where our resources are tied up on whatever they may be tied up on, we do from time to time engage the Victorians to assist us with that type of work. The notion of the funding arrangements or how they happen to have the cheaper flight would have been a factor of how they actually structure their pricing for their services.

**Ms FORREST** - Then it begs the question that if a patient, even though the surgery could have been provided here -

**Ms O'BYRNE** - As to why the decision was made to transfer? I suppose it is the co-morbidity issue.

**Ms FORREST** - Well, they went to Victoria because that was the most appropriate place for that person. Why was patient travel assistance not provided for them?

**Ms O'BYRNE** - I am honestly happy to have a look at that issue.

**Mr MORGAN** - The Patient Travel Assistance Scheme is not one of the things that Ambulance Tasmania is across.

**Ms O'BYRNE** - I am happy to have a look at that issue for you, Ms Forrest. Can I just add to another answer before Mr Harriss starts? On the issue of the data that we collect about babies with foetal alcohol syndrome or who may be born with a drug dependency issue, because it is clinical information the information has been quite hard to collate so we do not have pre-existing data. But we have just purchased a perinatal database, so from now on that information will be tracked and we will be in a position, particularly when we are here next year or if there is a stage during the year you wish to discuss it, to be able to give you that information.

**Mr HARRISS** - I always try to get a bit of a grab on my own assessment of cost per call-out, I suppose, of the ambulance service. I do a bit of my own extrapolation just from the performance information with the total ambulance responses and the emergency ambulance services and get a bit of a percentage from what the emergency is compared to the total.

**Ms O'BYRNE** - You mean in terms of those that might be a transport medical issue as opposed to an emergency medical response?

**Mr HARRISS** - No, that is all there. I just want to try to understand what the cost of an emergency response is, on average, and what the average cost of a non-emergency response might be. I can do some rough numbers, but I do not know that it is that simplistic, is it?

**Ms O'BYRNE** - Which is why I would immediately say, 'So, Dominic.'

**Mr MORGAN** - Thank you. That is entirely right. The cost of ambulance services is complex. If you are in a major metropolitan city and you have lots of ambulances that are responding on emergencies all the time, you can get some sense of how much a callout will cost, but if you think about a rural and remote setting where it is not actually the workload of the ambulance that is the driver of the service, on face value it would appear to be a very expensive service to have a branch station where there is only a single paramedic sitting there who might only work two jobs a week. It is a factor of response and it is a factor of coverage and that is why they are not immediately transferrable. Generally speaking, we try to look at things in a sense of them being rural and remote.

**Mr HARRISS** - Would you be able to provide an average - I know it is only a bit of a loose grab - of the cost per urban, rural and remote response?

**Mr MORGAN** - No. We do not break it down in terms of that because it is not actually a good indicator of the cost of your services. If you look at remote, in Tasmania we are perhaps talking about Queenstown. If you extrapolate that out to the mainland, we are talking about Broken Hill. To try to work out whether they are valuable indicators or not is really not helpful. What is helpful is when we look at populations and the amounts of money we invest as a State in ambulance services generally by the population we have. There are some rough qualifiers around the fact that this is a small State and we do not have efficiencies of scale that any of the major services do, but it is not a bad indicator of how we are tracking and the services we are providing. All of the States provide intensive care paramedics now and that has a higher level of training. How do you benchmark whether that is good value for money? Generally speaking, against peers is the best way to do it.

**Mr HARRISS** - Are there any ambulance staff on stress or related leave?

**Ms O'BYRNE** - We do have a figure for that.

**Mr HARRISS** - I do not think I want to go into the details as to why.

**Ms O'BYRNE** - No. We can give you a number and most of us could possibly extrapolate from that.

**Mr HARRISS** - While you are looking for that, there might be a simple answer to the next question. There has been plenty of publicity over the years around ramping at emergency departments at hospitals, particularly the Royal. Has there been a reduction in those occurrences?

**Ms O'BYRNE** - I can give you stress leave. There is one Ambulance Tasmania staff member on stress leave at the moment.

**Mr HARRISS** - Is that long-term stress leave or are we talking a shorter time frame?

**Mr MORGAN** - My understanding is, if it is the case I am thinking of, that it is a long-term issue.

**Mr HARRISS** - Is there any potential for a return to work?

**Mr MORGAN** - I am not particularly familiar with the details of the case.

**Ms O'BYRNE** - And I would be loath to give anything that might be an identifier.

**Mr HARRISS** - I understand that. It is just a broad question of whether there is a potential for a return to work. That does not identify anybody in particular.

**Ms O'BYRNE** - I think it might be an unknown.

**Mr MORGAN** - In relation to that case, it is an ongoing rehabilitation issue as I understand it. I can say that we do have exceptionally good critical incident management processes within the organisation. They consist of a tiered approach to dealing with stress which most effectively involves peer briefing and officers who are experienced in talking with other officers and it is across the emergency services. There are protocols in place that ensure that, even if staff do not

self-present to the critical incident stress program, where we are aware of it, we will proactively follow up on people and make sure that they have got some assistance if they need it.

[4.30 p.m.]

**Ms O'BYRNE** - On the issue of ramping - and I am sure Dominic may have some comments to make as well - we have introduced some measures particularly in relation to the Royal Hobart Hospital in order to deal with that issue. The new inpatient protocol that has been developed could be used when admitted patients, without being allocated a bed, are awaiting only an inpatient medical review and are essentially stable whereby the emergency department senior doctor, with the knowledge of the admitting team, can generate a four-hour management plan outlining the management needs of the patient for the next four hours in terms of whether the patient is allocated a bed to await inpatient review. They have introduced a standard 10 am discharge time across all inpatient wards, which improves the patient movement. That then expedites patient transfer out of emergency.

Ambulance Tasmania has initiated a practice of varying roster start times for some patient transport crews to best manage the transport of long distance cases which then, I understand, lessens the ramping as well. The trend figures that I have indicate that they are going down. I could not necessarily give you a figure for them at the moment, though. I do not know if Dominic has anything that he would like to add, but the data that we have here indicates that, since August 2007, the trend line is going down, primarily because of the things that the Royal has implemented internally and the work that it has already done.

**Mr MORGAN** - Correct. I think first and foremost you would probably have to acknowledge that ramping is a challenge to all health services. It is not unique to Tasmania. The one thing I think it is fair to say is that my area health service colleagues and I will absolutely strive to have no ramping. Where that does occur, we have very good relationships in place to ensure that they are minimised to the extent that it is at all possible. Given the increases in demand that both the ambulance service and the area health service have been experiencing, the strategies that have been put in place collectively to have kept it down to the level that they have has been quite a considerable discipline.

**Ms FORREST** - Can I just follow on from that? There has been some comment or concern raised that the Federal Government target of the four-hour emergency department stay - and I am not sure exactly at what point that starts; one would assume it is when the patient arrives through the doors -

**Ms O'BYRNE** - Yes.

**Ms FORREST** - That can potentially have an impact on ramping, because if there is a bit of a backlog you do not bring them in through the doors until the ED staff are pretty confident that they can deal with them in four hours. Now, that may be painting a pretty bleak picture, but do you feel that there is any pressure that that target will impose on the service not to bring the patient through the door, so that when the clock starts ticking it could impact negatively on the ramping of ambulances?

**Ms O'BYRNE** - Certainly, one of the issues that we are aware of in terms of meeting the four-hour targets and one of the reasons that we clinically approached the four-hour targets is to provide doctors with that clinical protection as well so that they are not in a position of saying, 'Hang on, I have my four-hour target to meet.' Emergency departments will treat patients when

they need to be treated. We do not want to see anybody in an ambulance for a longer time than they need to. Of course, that is no reflection on the paramedic staff. Whilst I think that is one of the more negative outcomes that might come from the four hours, we are aware of it. We would be endeavouring to ensure that that is not the case and I am sure that our emergency departments would not be wanting that to be the decision - that they decide whether they are treating somebody in an appropriate time frame.

**Ms FORREST** - I guess time will tell. If ramping starts increasing after those targets have been imposed -

**Ms O'BYRNE** - Then we would have to manage that, yes.

**CHAIR** - Any more matters there?

**Mr HARRISS** - In the past I have often asked about the core business of the ambulance service. I refer to non-urgent patient transfer as opposed to emergency response staffed by paramedics. My observation and that of plenty of others in the past has been that you have ramped up your non-urgent patient transfer service. The contention, of course, in the past has been that that may not necessarily be core business, whereas there are private sector providers of such a service. Minister, is there a policy position that you would want to move out of too much non-urgent patient transfer? I accept the difference between emergency ambulance responses and total ambulance responses. Non-urgent patient transfer is a different matter altogether.

**Ms O'BYRNE** - In order to operate under the Ambulance Service Act, ambulance operators are required to provide a consent to the director of ambulance services, who is also the secretary of the Department of Health and Human Services. There are currently two private commercial operators, Ambulance Private and St John Ambulance, that are licensed to provide non-urgent transfers of stable patients and they are also licensed to provide safety coverage at a range of low and medium risk sporting events. There are public hospital operated non-urgent ambulance providers in the north and north-west of the State which have operated for many years and, as you said, Ambulance Tasmania operates a non-urgent ambulance patient transport service in the south of the State. These providers transport stable stretcher patients, they handle other patient movements and coordinate health deliberations.

We have previously made public our decision not to outsource routine patient transport services for public sector work and to charge full cost attribution charges where there is competition in the public sector. I guess the only other question will relate to how the patient transport service is set up as a unit within Ambulance Tasmania. That might be worth commentary on. I think part of that will be how the transport is booked as well, and it is going to be booked centrally rather than individual wards. That should create some efficiencies within that as well, I would imagine, and a reasonably fair deal out of the non-urgent work as well.

**Mr MORGAN** - Yes, exactly. Some of the key findings out of the Banscott review that was endorsed by the Government in 2008 were that there were efficiencies that could be gained for the Department in the moving of what are loosely described as patients in their care between the health facilities. Two of the things that are achieved by that are by having one single statewide service we can actually improve the efficiencies. A good example would be a patient travelling from Launceston to Hobart under a separate patient transport service versus one going up from Hobart to Launceston and then coming back empty. These are the sorts of things that we can stop through having a centralised statewide system, and that work is well in train.

In terms of the other question about whether it is core business, I would put the position that at the end of the day we are an ambulance service. An ambulance service is a service that is there for the transport of the sick and injured, of which they are not all emergencies. So I am quite comfortable with the direction that we are heading in relation to transport generally. Additionally, a side benefit of this is that we are a small State and it does actually provide us with some opportunity in the event of major incidents to have vehicles available that can assist in the event of a major incident. So there are lots of layers to the non-emergency patient transport question and it fits quite neatly with the business that we are in.

**Mr HARRISS** - Minister, have you had meetings with the two private providers to assure yourself that everything is okay?

**Ms O'BYRNE** - In my 10 weeks not yet, but I am on a constant progression of meetings with a whole lot of our private sector partners in the health services line. I am very happy to sit down with them. But you will understand that in my slightly under 10 weeks of being a minister we have had five weeks of Parliament and we have had five weeks now of being here, so I am a little behind the schedule that I would have liked in terms of having met everyone.

**Mr HARRISS** - Can I address a matter of personnel management and ask what the regime currently is with regard to the incidence of overtime within the ambulance service?

**Ms O'BYRNE** - Overtime costs in 2008-09 for Ambulance Tasmania were $3 million - just a little over $3 million - and $3.8 million, with a difference of some $766 000 during that period.

**Mr MORGAN** - The challenge of getting qualified paramedics in the State is ongoing. The State had a period of growth pre my arrival where they significantly enhanced the number of paramedics on the road. To organically train those within a small system is a big challenge. We have now entered a partnership with UTas for a pre-employment degree. What is really useful is that they will be able to increase their numbers on a two-year lead-in to actually meet our future workforce demands. Levels of overtime within the ambulance service are invariably corollary to the growth in positions that we have and the positions that we have available. So we have those strategies and we are under virtually recurring recruitment now to fill positions. In fact, I signed on another three intensive care paramedics for the State last Thursday. We finished another recruitment and we will be putting on hopefully another five general paramedic standards. We are about to go to the mainland to do a recruitment at Monash University on 20 July to attempt to attract mainland graduates to the State. So it is ongoing. We are hopeful that our partnership with UTas will put us into a good position to grow our workforce into the future.

**Mr HARRISS** - With regard to overtime, Minister, are there any instances - and, if so, can you quantify them - of staff on leave who are subsequently called back in for an overtime shift?

**Ms O'BYRNE** - I would have to seek advice. I would imagine that that is not unheard of.

**Mr MORGAN** - Yes, that is correct. On occasions staff members will make themselves available. This is a situation which is, in my opinion, historically perhaps untidy. We have put in place a new process - I believe a trial computer program has just been constructed and made available to us - where staff nominate their availability. I think it is important that staff when they are on leave or away from the workplace are not unnecessarily disrupted. Some members of staff are very glad to be disrupted and to have the opportunity to have the overtime. What we are trying

to find out is what proportion of the workforce wish to be notified and we have ways and means around allocating hours within this, and we hope that that will come on board shortly.

**Mr HARRISS** - In that mix - and Dominic has just indicated that you have implemented a new process where people can identify their willingness, if you like - in the past or even with the current system, does that involve people who have been required to take annual leave?

**Ms O'BYRNE** - Do you mean where there is a level of compulsion for leave - so leave that might be about to expire?

**Mr HARRISS** - No. They have actually been required to take leave because the accumulation might be at a level which management has decided is a little too high. So they have been required to take leave but then you bring them back in on overtime. Are there any instances of that?

**Ms O'BYRNE** - We would probably have to look at that.

**Mr MORGAN** - We would, Minister. It would probably be within the context of specific cases. But what I can say is that annual leave within the ambulance service is preprogrammed 12 months in advance. Is it likely that leave was allocated to an employee, they were required to proceed on that leave and during the time that they were otherwise anticipated to have adequate staffing numbers to cover that leave things changed and that employee was asked to undertake overtime? That is possible.

**Ms O'BYRNE** - We would not have compelled them to take overtime while they were on leave. We might not be able to get hold of them anyway.

**Mr HARRISS** - No, but it could be the reverse. You might have compelled them to take ordinary leave and then previously, without this new system, you might have contacted to them to invite them in to take overtime. They would jump at that chance probably.

**Mr MORGAN** - Quite possibly, because of the length of time that we actually preplan annual leave. But I probably should qualify that our new system is under development. So it is not as though it is coming in tomorrow. I should be entirely clear on that.

**Mr HARRISS** - How many instances of a one-person response have there been over the year, if you like? Is that a matter that you would monitor? I suppose you would. You would have figures on that.

[4.45 p.m.]

**Mr MORGAN** - Not direct figures, because it can actually change from hour to hour. On that point, Tasmania has a really unique system that is actually a strength. We have more response points in this State per capita than any other State or Territory in Australia. The reason we do this is that we are flexible in the model that we can deliver.

I can say that in the jurisdiction I came from we basically did not have volunteers. The line was that if we could not sustain a permanent service then we would not have one. Tasmania is flexible in its approach in that we have the volunteers who willingly give of their time for the community. In between the full volunteer stations and the permanent salaried stations, we have another hybrid model which is a salaried paramedic and a volunteer. From time to time, it is

entirely correct that volunteers cannot attend to give that service and our protocol is that we immediately back those officers up. But the cost of having a salaried service across the State and being able to recruit and retain in those positions would make it almost untenable. Yes, there are single officer responses.

**CHAIR** - We will move to 1.7, Forensic medicine services.

**1.7 Forensic medicine services** -

**Dr GOODWIN** - Minister, I am interested in getting a bit of an overview of this output because it is not an area I am overly familiar with. Can you give us a breakdown of the Budget and what it covers?

**Ms O'BYRNE** - Unfortunately, Mr Lawrence is not here with us today. We were hoping that he would be able to step forward magically.

**Dr GOODWIN** - Do you have a budget breakdown at all?

**Ms O'BYRNE** - Yes, we can provide a budget breakdown.

**Dr GOODWIN** - Are there any particular issues?

**Mr ROBERTS** - We are in the process of trying to run the sexual assault service through this service. It is the interaction of where we have all of our Coroner's work undertaken and it dovetails across the State - all of the Coroner's work and all of the dead and deceased and how we support the psychological effects of all of that.

**Ms O'BYRNE** - It would be the other side of the business that you dealt with from your police side.

**Dr GOODWIN** - The budget looks fairly static.

**Mr ROBERTS** - Sorry, what was the question?

**Dr GOODWIN** - Can you give us a bit of a budget breakdown of what that nearly $2 million is for?

**Ms O'BYRNE** - The bulk of it of course is staff and employee entitlements. It is mainly staffing really. There is some money on consumables, there are medical surgical costs and there are some IT and communication costs, but predominantly it is staff who are employed in forensic medicine services.

**Mr ROBERTS** - We could provide you on notice with the types of people in now. I do not know off the top of my head who they are in terms of the numbers of people.

**Dr GOODWIN** - That would be useful. Then next year we might be able to come up with some more questions.

**Ms O'BYRNE** - Okay. We partner with other services, so it is in effect a support facility for other services as well. We have 6.1 staff employed in that area.

**Mr WILKINSON** - It seems pretty well a flat line as far as the budget is concerned when you look at it for four or five years.

**Ms O'BYRNE** - That is kind of what it is. Nothing changes there. Oh, flat line, I did not get that. I missed that entirely. It must be getting late.

**Mr ROBERTS** - It is a stable service in that the volume of work that it has to cope with is growing but it is a fairly stable service in that regard. They do a fantastic job. These are rare people. We struggle to find them. We have a great service director at the moment but it is a small service compared to the State. They have been involved in international work required of them.

**Mr WILKINSON** - And the forward Estimates are only going up $30 000 over the next four years.

**Mr ROBERTS** - Which will be an indexation on the staff.

**CHAIR** - Are there any more questions on 1.7? If not, I am mindful of the time, Minister.

**Ms O'BYRNE** - I will try not to waffle.

**CHAIR** - I think we are going to slither past 5 o'clock. We will now move to Output Group 2, Community Health Services.

**Output Group 2**
**Community Health Services**

**CHAIR** - Minister, do you need to change any staff at the table?

**Ms O'BYRNE** - I think most people are in the room and we can grab them as we need them. I am pretty sure we will have everybody here who we need.

**Ms FORREST** - We did ask that question about cancer services with the hospital.

**Ms O'BYRNE** - Sorry.

**Ms FORREST** - I am just wondering whether we need to do that before we move out of this area.

**Ms O'BYRNE** - Why don't I ask Jane to step forward. Jane Holden is the CEO of the North West Area Health Service.

**Ms FORREST** - It does not really fit under primary health.

**Ms O'BYRNE -** This was just explaining where in Burnie the new cancer facility was going to sit. I clearly did not explain it in a way that Ruth could understand. That is probably because I am not as familiar with the site as the pair of you.

**Ms HOLDEN** - It is actually as the Minister and Mr Roberts did explain. We are looking at the moment at building into one of the interior courtyards and then creating an environment with

enough structural supports that we can stack up wards to get better co-locations in the hospital. Those are the plans at the moment. That is the basis on which we have submitted a capital request to the Department over the next five to 10 years.

In mid-July we have a planning session and we are bringing some hospital developers from the mainland over to work through the number of projects. We think we have to try to get actually a really sensible site development plan, including the cancer services. What is included in the cancer services are a place for chemotherapy - an additional 12 chairs in that regard. We have got treatment centres, we have got some alternative therapy rooms, we have outpatient centres, the potential for including a self-contained day-stay area for palliative patients if, for instance, someone wants to get their hair done and just make sure that the person can be cared for, and a range of other services all linked by IT through to the rest of the network or the regional network for cancer in the north-west. There is the capacity for a bunker and also to implement an MRI.

**Ms FORREST** - An MRI scanner that might appear one day eventually, possibly.

**Ms HOLDEN** - Planning is under way right now.

**Ms FORREST** - So we will get it?

**Ms HOLDEN** - Yes. We are planning to put that scanner in. I have an understanding with the secretary. The time line is that he wants something on paper very clear by the end of this calendar year. So we are planning in terms of not only the where but also what sort of machine and the how.

**Ms FORREST** - Will all these services you have just described essentially be within the same location within the hospital; it is not going to be a bit here and a bit there?

**Ms HOLDEN** - No, it is not. That is why we are taking time to plan it, because co-locating services makes very good sense in terms of patient flow. The North West Regional Hospital currently is not as fit for purpose in a brand-new built hospital as we would like and that is why we are taking the time to make sure that we get it right. The kinds of co-locations you are looking for are emergency to X-ray to CT scanning to theatres, as they are to ICUs and HDUs and surgical wards - those kinds of things. That is the planning that we are looking at.

**Ms FORREST** - You are looking at a broadscale plan rather than just a cancer services plan?

**Ms HOLDEN** - Yes, we are looking at the whole campus.

**Output 2**
**Community health services**

**2.1 Primary health services -**

**CHAIR** - In monetary terms, primary health is a substantial expenditure. I have had a look through the explanatory notes and they explain those budget breakdowns quite well. What I would be interested in is the rural hospital occupancy rate. I notice it has an average of around 63 per cent.

**Ms O'BYRNE** - You would like a breakdown for each hospital?

**CHAIR** - Yes. Could you provide a list of the rural hospitals and how many beds they have got and their occupancy rate for the past three years, please?

**Ms O'BYRNE** - We might need to take that on notice.

**CHAIR** - You can take that on notice, that is fine.

**Ms O'BYRNE** - I do not think we have it with us, but we can provide that to you. If it does suddenly appear before the end of business we will get it for you.

**CHAIR** - You will get that for us, okay. With regard to palliative care and community nursing, I notice that the numbers accessing that appear to be pretty static going through from 2007-08 to 2010-11. I would have thought that with an ageing population some of those figures might have been ramping up a bit, but they appear to be pretty static, actually.

**Ms O'BYRNE** - I think particularly the nature of palliative care is that the models of care are changing. Whilst we do have the palliative care facilities in our regional hospitals, what we are also seeing is that there is more care in home, or care in place. There is a particular hospice without walls model, which is very much about ensuring that we provide the service where the person needs it. On occasion the person is going to need it in a hospital and there are occasions when a person will need it in a palliative care setting, and the palliative care beds that I have seen so far in the regional hospitals are extremely well supported. There are many occasions it is also about providing the type of care and care services that they need within their home. So I think what you see is a different way of allocating the money, because we are responding differently to the different sort of care needs that people have.

We do need to further improve our access, I think, to specialist palliative care services, especially in the north and the north-west of the State. We provided around 3 000 Tasmanians with palliative care during 2009-10.

**CHAIR** - So which sector of primary health services are—if you look at the forward Estimates, they climb from 2004 and they start to pick up by about $10 million or so and then it is only $3 million the next year. Is there any particular sector that is seeing increasing demand?

**Ms O'BYRNE** - For palliative care?

**CHAIR** - No, I think anything across that whole primary health service sector.

**Ms O'BYRNE** - Where we are seeing a build-up in particular areas?

**CHAIR** - Yes.

**Mr ROBERTS** - The growth in that is primarily indexation that you would expect to see during that time. There are, of course - and they are not reflected in these numbers - changes and enhancements to primary care, like the integrated care centres and the GP superclinics, but they will all come online in the future and they are not reflected in here. So this is just the general indexation that we would expect to see in that line rather than any major changes.

Of course, this is not one of those areas where there is some uncertainty in respect of the national health reforms, because some or potentially all of this would transfer over to the Commonwealth and that national health reform. We do not actually think it will, but there certainly will be a division of that along the way and at that time we expect there to be a substantial enhancement of investment in primary community services on the part of the Commonwealth. In large part the numbers here are indexation on our salaries and the like.

**O'BYRNE** - So in terms of different care needs, we will respond to them as they develop but the hospice without walls model is very much about providing support. People predominantly want to stay in their homes for as long as possible. So that means that their time in a palliative unit may be a short period of time. For some others it can be an extensive period of time. It does depend very much on their family support and the structures around them as well.

**CHAIR** - The Secretary touched on superclinics. I recall the public works that we did to the Clarence one. How many are envisaged for the State to be built?

**Ms O'BYRNE** - The GP superclinics, there is the one in Burnie. There are five.

**Mr ROBERTS** - Cooee.

**Ms O'BYRNE** - Cooee. That is where it is.

**CHAIR** - Order.

**Ms O'BYRNE** - The Burnie one is in Cooee, sorry. I can normally rattle this off the top of my head. I think there are five across the State. There is the one at Glenorchy, there is one in Clarence, there is the Burnie one, there is the integrated care GP superclinics. There is Clarence, Kingston, Glenorchy. Sorry, we are just going to have to check, but it is a Commonwealth funding issue. We certainly have the one that is in Cooee - close to Burnie - and there is the integrated care. We have the GP superclinics plus the integrated care centres occurring as well, which might be the other area. There is Clarence, Devonport and the Burnie one, which is actually Cooee. What we also have is the integrated care centres that do not include a GP superclinic.

**CHAIR** - So there is nothing in the northern area, in the Launceston area?

**Ms O'BYRNE** - We are looking at an integrated care centre.

**CHAIR** - Okay.

**Ms O'BYRNE** - But the GP super clinics are Commonwealth funded. If there are colocation opportunities, we will grab them and work with them.

[5.00 p.m.]

**Ms FORREST** - Can I ask how you are actually going to spend the palliative care dollars?

**Ms O'BYRNE** - The $2.5 million?

**Ms FORREST** - Did you actually go into that?

**Ms O'BYRNE** - No, we have not. This is the additional money that we got in the Budget?

**Ms FORREST -** Yes.

**Ms O'BYRNE -** We wanted to get $4 million and we have ended up with $2.5 million in the world as it stands. There is also the money for the Oatlands palliative care facility which they are co-funding because they have some additional money - that is a separate line item to the 2.5 - and the $2.5 million is for palliative care beds or equivalent services so it will be worked around the level of need.

**Ms FORREST -** So whereabouts?

**Ms O'BYRNE -** I think it is predominantly in the north - yes, it is beds or equivalent in the north.

**Ms FORREST -** You got less than you wanted?

**Ms O'BYRNE -** Yes.

**Ms FORREST -** You will continue to fight for more?

**Ms O'BYRNE -** I am always looking for more money, Ms Forrest, never think that I will not be going to every single budget review committee with a plan for additional funding.

**Ms FORREST -** Because palliative care is one of the areas that is really lacking up in the north-west. I am not sure about the north so much -

**Ms O'BYRNE -** The north has challenges as well. They lost some palliative care beds. They were private provider decisions where they had to create a relationship with Calvary.

**Ms FORREST -** But it is an area that is well underdone in the north-west of the State particularly.

**Ms O'BYRNE -** I actually think that we need to do more work within the area, but it is not always about beds.

**Ms FORREST -** No, I am not saying it is about beds, it is about services.

**Ms O'BYRNE -** Yes, services, and this $2.5 million will be either beds or services equivalent to that sort of expense, because it does come down to the sort of care that people might need. I am conscious of time but I am happy to have a conversation with members afterwards, if they want, about where we might end up in palliative care. But I am conscious that we have a few output groups to go and there is a time imperative upon us - unless you want to go through it now?

**Ms FORREST -** No, we will move on to oral health.

**Ms O'BYRNE -** I will get you the occupancy rates for that group. We do have them. We will just get them into a form. I do not think we necessarily want to take up the time of the committee by reading them all?

**CHAIR -** No, not at this stage.

**Ms O'BYRNE** - I am happy to take up time normally but I appreciate the good will of the committee.

**2.2 Oral health services -**

**Ms FORREST -** Oral health is obviously a social inclusion issue as well as a health issue and an issue for pregnant women. We did not see anything in the national health reforms for dental care. I acknowledge the State Government has done some work in assisting with this area of care but we still see waiting lists continuing to grow, waiting times particularly.

**Ms O'BYRNE -** Can I just talk in terms of the waiting times?

**Ms FORREST -** Yes.

**Ms O'BYRNE -** David Butler is here and I am about to quote him. I do not know if he wants to come to the table or not. We actually have put money into dental care. This is primarily because the Commonwealth contribution that we were anticipating has not arrived because of political machinations within the Senate, which is disappointing, because dental is one of those areas that is a determinant for a whole host of other health and inclusion outcomes.

**Ms FORREST -** The National Health and Hospitals Reform Commission said that the feds should pay for it.

**Ms O'BYRNE -** I spent my time when I was in the Australian Parliament arguing for the re-enactment of the Commonwealth dental health scheme. I do think that it is a role for the Australian Government as well. Regarding the waiting list issue that has been raised, what we are finding is that we are actually moving more people through the system and that means more people are going on the list, but it also means that they have more than one treatment. So that in some way skews the outcome of the figures because people who present in need of care often do not just need to come in for a check-up or a filling and go away, they often need complex cases done again and again. It is important to acknowledge that, just because the list is as it is, that is not necessarily such a bad reflection. It does mean we are working through a number of care issues for some people who do need to have significantly more than one appointment.

**Ms FORREST -** Is there any consideration being given to supporting dental patients from outlying areas with access to patient travel assistance where they cannot access a general care service in their region?

**Ms O'BYRNE -** It is not a conversation that I have had but I am happy to have a look at that issue. But I do remember that, when the Commonwealth dental health scheme was removed, it was a significant issue for our regional communities because many private dentists used that basically to subsidise the fact they were in communities that could not sustain a private facility on its own but because they could treat public patients - there is a historical -

**Ms FORREST -** On the west coast, for example, there is a private dentist who has a contract to provide emergency care only; they do not provide any public general care. So patients cannot receive general care there and they cannot receive patient travel assistance to go and access it in Burnie. To me that is a nonsense - either you include general public care in the contract or you

provide patient travel assistance for those patients who need to access it outside the region. When that contract is up for renewal, I hope that is something that will be considered.

**Ms O'BYRNE -** We certainly will consider it. I am not sure if David wants to add to that at all.

**Mr BUTLER -** At the moment we run an emergency dental care scheme, urban and rural, right across Tasmania including the west coast. We are at the moment in the throes of completing our general care pilot, which we have run on the east coast previously, and we are now going to run it across Tasmania whereby we can provide general dental care with participating private practitioners, one of which is the west coast.

**Ms FORREST -** When will that start?

**Mr BUTLER -** This calendar year. We are virtually on the verge of it now. The issue was, as the Minister has mentioned already, that the Commonwealth dental health program which was to occur was going to put through another 30 000 occasions for service over the period of funding. The Commonwealth program has not come to fruition whereby we would have been able to purchase some of the services in the private sector. So we have stepped up and started a pilot rural general dental care scheme. Ultimately they can access now through the chronic dental disease program, which is still operational through the private sector, for general care. So anyone who has a chronic illness - diabetes, pregnancy, cardiovascular disease -

**Ms FORREST -** So a pregnancy is a chronic illness?

**Mr BUTLER -** With pregnancy we look at the holistic view: the burden of inflammation, the burden of disease so diabetes, smoking, alcohol intake and just general diet.

**Ms O'BYRNE -** David has missed most of your contribution so he thinks he is saying something new to you. Ms Forrest has been mentioning these as significant issues for some time today.

**Mr BUTLER -** Sorry.

**Ms FORREST -** That is all right.

**Mr BUTLER** - We take the oral health part of the jigsaw puzzle with pregnancy as just another piece. So we work with the antenatal group, we work with obstetricians to do with pregnancy but also diabetes educators to manage diabetes -

**Ms FORREST -** So you are trying to target pregnant women to ensure they get general dental care?

**Mr BUTLER -** Ultimately 98 per cent of oral health care is in the home environment, so we inform them and we empower them and they can carry out oral home care -

**Ms FORREST -** Like cleaning their teeth.

**Mr BUTLER -** Yes, and be aware of the issues of low birth weight and also premature labour in those situations. But quite often it is only related to advanced periodontal disease. It is not related to mild gingivitis, which is the early stages of gum disease.

**Ms FORREST -** A number of the women we have seen in low socio-economic areas in rural and remote areas do have advanced periodontal disease.

**Mr BUTLER -** Yes, the national oral health survey adult back in 2008 did not show that significantly in Tasmania. When we say 'advanced' - I am going to get technical here - we are talking about six millimetre-plus pockets and in Tasmania it was only four. So you would say that it is probably not as severe as affecting the outcome of the pregnancy. The issues of gestational diabetes, alcohol intake and smoking is a higher priority than the oral health issue.

**Ms FORREST -** In pregnancy?

**Mr BUTLER -** Yes.

**Mr WILKINSON -** I know a couple of years ago that the Tasmanian Government was offering scholarships for people doing dentistry, is that right?

**Mr BUTLER -** Yes.

**Mr WILKINSON -** There was a couple who were South Australians who accepted the scholarship.

**Mr BUTLER -** Yes.

**Mr WILKINSON -** Am I right in saying that the Tasmanian Government paid for or assisted them through university in South Australia but then they did not come to Tasmania?

**Mr BUTLER -** That was not for dentistry, that was the bachelor of health which is for dental therapy and dental hygiene. There is still one occurring. We are actually revisiting that and looking specifically at the bachelor of oral health and targeting employees of Oral Health Services, because the bachelor of oral health is more applicable to say a dental attendant, which is the chairside dental assistant, one of which we have going through Adelaide at the moment who is likely to come back because she is already employed with us. With the scholarship schemes that occurred in the past, there are probably eight dentists in Tasmania now that went through many years ago doing dentistry under a scholarship scheme that are still practising in Tasmania. But dentists are less likely - I am not sure of the reason why that is - to come back than the bachelor of oral health. With the bachelor of oral health we are actually using employees. We cannot put dental attendants or some of our members of staff through dentistry, which is the full five years or postgraduate in some universities. But with dental attendants there seems to be a flow such as in Griffith University you move through and do dental attendant, then dental hygiene, then dental therapy and then move through and up to a dentist, so it is sequential. We still visiting the bachelor of oral health for scholarships rather than dentistry per se.

But what we are doing is our clinical placement program where we have University of Queensland and University of Adelaide senior students coming in to Tasmania for long-term placement: the University of Queensland for the first time this year for the whole year; and the University of Adelaide for two months. Tasmania has been put down as the gold standard for

clinical placement. It has been utilised by the Australasian Council of Dental Deans as a benchmark for clinical placements for senior years, which I think is a real feather in Tasmania's cap.

**Mr WILKINSON -** Because dentists are hard to find for Tasmania, are they not?

**Mr BUTLER -** Very much so, because we do not train them here. They come from interstate or overseas either through the public sector work force scheme or through automatic registration countries, which are the UK, Northern Ireland and New Zealand under trans-Tasman mutual recognition, so we are reliant on other dental schools. There are additional dental schools in Australia now. We had five basic schools and we have up to nine now within Australia, so hopefully we will be less reliant on overseas trained dentists in future.

**Mr WILKINSON -** For our population in Tasmania, how do we fare in the number of dentists? Are we below the national average?

**Mr BUTLER -** Yes, we are, we are significantly below. We are below the national average per 100 000. Tasmania generally is also below the average for rural and regional.

**Mr WILKINSON -** Thank you.

**Ms O'BYRNE -** Sorry, can I just give some additional information to Dr Goodwin in relation to statewide medical services. It is probably directly for her rather than a tabled document. It was of interest to you.

**Dr GOODWIN -** Yes, thank you. It was not sought to be tabled.

**CHAIR -** Special interest okay.

**2.3 population health services -**

**CHAIR -** Minister, of course the budget papers talk about the shortage of rural GPs, which is hardly surprising. We have known about it for some years.

**Ms O'BYRNE -** I believe we probably have more GPs working for us in Tasmania than we have ever had but the problem is they all used to be full time.

**Ms FORREST -** It is a distribution problem.

**Ms O'BYRNE -** It is where they are, but they also all do not work full time.

**CHAIR -** I am just quoting what the budget papers say. We know it is a national problem and it is a federal issue partly as well. You have just said that we actually have more GPs - any in rural areas at this stage?

[5.15 p.m.]

**Ms O'BYRNE -** Within Tasmania than we have ever had, but the reality is that doctors are choosing for quite legitimate reasons to not work full-time hours, which of course makes a difference. In 2009 there were 500 GPs practising in Tasmania, 355.1 FTEs, which is equivalent to 73.2 full-time or equivalent GPs per 100 000 head of population - that is the statewide figure.

We are still doing the 2010 figures so I am afraid I am operating for 2009. In the north there was 137 GPs, so a full-time equivalent of 89.1, or 63.1 GPs per 100 000 head; in the north-west there were 100 GPs with a full-time equivalent of 72, or 63.8 GPs per 100 000 head of population; and in the south 318 GPs with a full-time equivalent of 194, or 83.5 GPs per 100 000 head of population. We have had an increase of 24 GPs since 2005 but, as you said, we also have issues in terms of location. We work with services as well and I know local governments also work - the Glamorgan Spring Bay Council, for instance, is a direct employer.

**CHAIR -** Just in relation to rural areas how do we stack up against the rest of Australia?

**Ms O'BYRNE -** As a comparison with a regional area or a rural area?

**CHAIR -** A regional area.

**Ms O'BYRNE -** I will have a little look; I am not sure that I have a figure on that. I have the recent Rural Doctors Association of Australia figures which show an FTE rate of primary health care practitioners around the nation as 95 per 100 000 in Australian major cities, 85 for inner regional areas per 100 000, and 84 per 100 000 for outer regional areas. They are very broad figures though because 'outer regional' covers a significant mix of figures.

**Mr ROBERTS -** We will certainly ask the question on the GP districts from a Commonwealth perspective.

**CHAIR -** Thank you very much.

**Ms O'BYRNE -** We have provided $300 000 to General Practice Workforce Tasmania to assist in recruitment of GPs. We are assisting them in their role.

**CHAIR -** What are the latest figures for medical graduates from UTas?

**Ms O'BYRNE -** I think I do have. We were talking about the figures before - medical student graduates.

**Ms FORREST -** But medical students do not necessarily go into general practice though.

**CHAIR -** Yes, I know.

**Ms O'BYRNE -** No, they do not.

**CHAIR -** Once again, take it on notice if you like?

**Ms O'BYRNE -** No, we do have the figures. It will only take us a moment to get it. If you want to ask the next question, we will have the figures for you.

**CHAIR -** I asked you this question during the tourism component this morning relating to the issue down the east coast in regard to public health and the allegations raised - it might be one for Dr Taylor.

**Ms O'BYRNE -** I am quite happy to have Dr Roscoe Taylor come to the table on this but I do want to point out that, when the allegations were raised in the media and not directly with us

initially, we made some very firm comments about the nature of the allegations and the validity of the research. Dr Taylor might like to come forward in relation to that.

**CHAIR -** The question then is, Minister: are you satisfied from a health perspective point of view that the independent panel have done their work well and that everything is obviously clear as reported -

**Ms O'BYRNE -** I have confidence in the independent panel, yes, but I must say that I actually started off with confidence in the director of public health when the issue was first raised.

**CHAIR -** Well, as you should. Is there anything, through you, Minister, that Dr Taylor might like to add in relation to the east coast water?

**Dr TAYLOR -** I think the panel's findings have effectively confirmed our assessment of the situation from 2005 when we did look at this matter. It was in a different context at that time in relation to pesticide contamination rather than a toxin from eucalyptus trees. The panel has had the benefit of the significantly greater amount of information to look at. We are all better informed about the potential for hazards in the waterway there. The key finding from a public health perspective was that the concerns about evidence of adverse health outcomes in the community have not been validated. Cancer rates appear to be the same as the rest of Tasmania. There is no evidence of any type of cancer cluster, nor in the past could we ascertain any concerns about neurological diseases or other rare conditions or autoimmune diseases as well. At the present time, it is comforting for the community that there is no evidence of any abnormal incidence of health conditions which have conceivably contributed to the water.

**CHAIR -** A further question, Minister: if special interest groups raise these matters, obviously it is your jurisdiction and Dr Taylor is the one who is in charge of that. Are we going to react and if it becomes a media sensation again, are we going to appoint another independent panel to review these things?

**Ms O'BYRNE -** I would hope that this would stand as a precautionary note to the media perhaps to investigate matters a little deeper before they run what was a substantial campaign. I think people were quite frightened in the community. If there is a real threat to public health then it should absolutely be dealt with properly. But there are processes to go through. It did take quite some time for the data that they were relying on to be provided to us.

**Mr WILKINSON -** But it is stronger than that, is it not? People that come out and make with allegations like that which are really unfounded and then there are TV channels which jump on their back and have Australian stories relating to it - it is obnoxious to me. I think there should be a strong rebuke rather than just 'Oh well, let us not do it again,' because it really does put fear into the community which is unfounded.

**Ms O'BYRNE -** Absolutely. The Premier, as a result of the findings report, has written to the ABC asking for them to do a correction to their *Australian Story* program.

**CHAIR -** Oh, good.

**Ms O'BYRNE** - We think the people of the town deserve an apology because they have been terrified through this process. We think that there is due process to go through. If you legitimately feel that there is something that is causing or may cause a health risk, it is not that we

do not have a mechanism for people to engage with. That is the process that needs to be undertaken. I notice one of the media reports said, 'Isn't it dreadful there was so much commentary about this? Yes, it was dreadful that commentary was leapt on to without the data around it.

**Mr WILKINSON -** It is lynch mob mentality, that is what annoys me.

**Ms O'BYRNE -** It was extremely distressing for the community. This is not to in any way discourage people - if someone does have a well-founded concern that they think impacts on health then they absolutely should raise it, but there are processes by which you can do so.

**Mr HARRISS -** You need to talk to your coalition colleague Mr Morris, because he is promoting another process. But we have a statutory officer who takes care of what he said to his group anyway.

**Ms FORREST -** On another public health matter concerning methyl bromide spraying of the ship in Burnie. There are legitimate and general concerns by the community there. There have been suggestions that there are other methods of dealing with this and that scavenging the gas is much better than what would be done at the Burnie port. What information can you provide on the public health issue regarding the use of methyl bromide in the setting that it is intended to be used there?

**Ms O'BYRNE -** Before referring to Roscoe, I would say that it is not the first time that methyl bromide has been used in Tasmania. I know there is some view that this might be a new and frightening thing. It is different from the way people have understood it being used before. We do need to manage people's perceptions as well as the reality of health care so we do take that extremely seriously.

We have certainly had conversations with the other minister responsible in this area. Our concern is not only in relation to public health but also ensuring that people feel safe. We are advised that, so long as the AQIS proposals are adhered to, there should not be any additional risk, although we have had some conversation about what exists in New Zealand which is a draft report - only a draft report - into the use of restricted chemicals. One of those things does suggest an increase in the buffer zone to 100 metres rather than 50 metres. That allows you to pick up any traces - instead of five ppm at 50 metres and 1 ppm at 100 metres, which does not necessarily change it because it is actually still the same reading you are getting, just at a different level. But it might give that level of security and comfort to people. Roscoe may want to talk about that. That may be a mechanism from other nation's experiences that may be of use.

**Ms FORREST -** And the scavenging of the gases?

**Ms O'BYRNE -** I will leave you to talk about that.

**Dr TAYLOR -** We are not really involved in that side of the process.

**Ms FORREST -** That is not your area. I will ask the Minister tomorrow about that. So the public health aspect of it -

**Dr TAYLOR -** We have had discussions with TasPorts and provided some suggestions that they look at the direction of the New Zealand draft guideline that the Minister has just mentioned

so that that increases the level of stringency and I think offers a greater deal of assurance. The other agency we have discussed this with now is Workplace Standards. Because this is a foreign flag vessel therefore Workplace Standards actually has oversight of the occupational health and safety of the employees.

**Ms O'BYRNE -** Which is an interesting reality.

**Dr TAYLOR -** Had it been an Australian flag vessel, then the Commonwealth Government would have had oversight of the occupational health and safety matters at the port.

**Ms O'BYRNE -** However, someone has responsibility and that is important.

**Dr TAYLOR -** They have the ability with the Dangerous Substances Act to exert a little more control so I understand that discussions are taking place to confirm the adequacy of the emergency response, the planning and they are doing some training of staff to undertake fumigation as we speak.

**Ms FORREST -** It is interesting an emergency response, because sometimes the effects, as I understand it, are not felt for some years.

**Dr TAYLOR -** Yes, that is true. If one has had a very, very high exposure for a significant period of time there could be some subtle delayed neurological effects. However, the stories we have seen in the media about the New Zealand cases of neurological disease have not actually been substantiated. There is some work going on there. This fumigate has been used widely in Australia before, including in central business districts in buildings for example in Brisbane to remove termites. So it is clearly being used and has been used safely before in quite populated areas. That does not mean though that everything that should be done and can be done should not be done in the Burnie area to make sure that it is as safe as possible.

**Ms FORREST -** We know there is some evidence that it is harmful to humans and to the environment.

**Dr TAYLOR -** Yes.

**Ms FORREST -** It is not something that should be undertaken without the proper checks and balances, I guess. Am I hearing you say at this stage that they should not be proceeding until we have taken a better look at the buffer zone and those aspects? Is that what you are saying?

**Dr TAYLOR -** I am saying that my understanding is that Workplace Standards would like some assurances before this proceeds. Certainly, once they have assured themselves of some of those processes, and they have more expertise in this particular field of occupational health and safety, the hot zones around a ship and the procedures that would be put in place, then we will too be assured.

**CHAIR -** The only other quick question I have on a public health perspective: Minister, do you have a handle on how the swine flu vaccine and the vaccination program has been going on through the State? Are we happy with that at this stage?

**Ms O'BYRNE -** Actually we have been extremely happy with the rollout of the swine flu vaccine. We are at what percentage now?

**Dr TAYLOR -** It is 32.6 per cent.

**Ms O'BYRNE -** Thirty-two point six per cent, which is far in excess of where we had actually anticipated we would be. We are extremely pleased with the take-up that people have had. The only issue that may have caused some concern for families is that there was an issue with a flu vaccine for under six-year-olds in Western Australia, but that is different from the swine flu vaccine. We are constantly reminding people that they are completely separate vaccines. We have been extremely pleased particularly with the community clinics and also people lining up at Festivale -

**Ms FORREST -** Every show and every dog fight that is on.

**Ms O'BYRNE -** I went down to my local council, and GP services are still running clinics. My children went to our GP service clinic to have theirs.

**CHAIR -** So just as a general message, how long can people leave it now? The flu season should be starting I suppose -

**Ms O'BYRNE -** We would ask anyone who has not had it to call their GPs to find out when their GPs are running a clinic. Do we have any more public clinics planned at this stage?

**Dr TAYLOR -** No, the pandemic vaccine clinics have finished, but people in the community can still obtain it through their GP or their council clinic. And they can also get the seasonal flu vaccine which is now free for people who are sick or with a medical risk factor.

**CHAIR -** Thank you.

**Ms O'BYRNE -** Can I give you the percentage of occupancy for your regional hospitals?

**CHAIR -** Absolutely marvellous, thank you, Minister. We will now move to 2.4 mental health.

[5:30 p.m.]
**2.4 Mental Health Services-**

**Ms FORREST -** The first and most obvious question - I should not even need to ask it - is: when are we going to see the Mental Health Amendment Bill?

**Ms O'BYRNE -** The Mental Health Act is making progress.

**Ms FORREST -** It has been making progress for an awfully long time.

**Ms O'BYRNE -** Before you get on to that, I would like to speak about some of the broader debate about mental health funding.

**Ms FORREST -** The Federal Government do not seem to have much of an interest in it either.

**Ms O'BYRNE** - The resignation of Professor Mendoza has created some concern. We have written to the Federal Minister for Health and Ageing and I spoke to her about this issue last night. I also know that she addressed the Sydney Institute on Monday night at the end of a day of mental health advocacy because we want a strong response to the National Mental Health Plan.

In relation to the process of the act which is moving along, we believe it has significantly progressed. We have had a three-month period of community consultation which has facilitated 80 consultation forums, 130 written submissions and feedback has indicated support for the act. It has identified the major elements of the act we will need to implement.

**Ms FORREST** - What number draft are we up to?

**Dr CRAWSHAW** - Last time we were waiting for a completed draft which we finally have. We sent it to Rethinking Mental Health Laws who went through it and provided us with some very constructive and useful advice.

**Ms FORREST** - Is that Bernadette McSherry?

**Dr CRAWSHAW** - That is right. We have reviewed all of the drafting to date against that advice so we have largely accepted all of their advice and therefore have issued instructions to redraft on the basis of the further discussions. We have engaged with the Mental Health Review Tribunal president to ensure that whatever we come up with is a workable process and she has joined the drafting committee. At the moment we are sitting waiting for it to come back from parliamentary counsel so we can go out for the final consultation on the legislation.

**Ms FORREST** - When do you think we will see it?

**Dr CRAWSHAW** - I have been here too many times and been beholden to other people to deliver. I have worked very hard with a small team in statewide mental health services to get it to a form which we think is acceptable. At least our drafting instructions are in a form where we are just waiting for it to come out. We hope to advise the minister and through the minister the government some time this year for a consultation.

**Ms O'BYRNE** - It then has to be circulated for local government comment et cetera. We have heard from a couple of people that they are worried that it has taken so long that it will be out of date by the time it gets here.

**Ms FORREST** - Correct.

**Ms O'BYRNE** - That is in particular any reform that might happen at a national level. We are progressing with this on the basis that if there was any significant reform we would always seek to amend. We do want to get this act in place.

**Ms FORREST** - In view of that, the recommendations to the Legislative Council Select Committee on Mental Health Legislative Measures - was that last year?

**Dr CRAWSHAW** - The end of last year, yes.

**Ms FORREST** - As you are aware, the committee recommended a more comprehensive review of all the legislative measures that protect people with mental illness and disabilities. I

know this is a priority and the Attorney-General thinks it is a priority, are we likely to see a more comprehensive review once this bill is dealt with?

**Dr CRAWSHAW** - As I explained to the committee on behalf of the Government, there are a number of pieces of legislation which would need to be looked at. We are now in the process of reviewing the Alcohol and Drug Dependency Act and how that might fit with this overall, competency-based legislation and how you deal with people who have problematic behaviours and health issues which need to be addressed in the legislative context. We certainly have discussions on a regular basis with Justice in terms of this space. Ultimately it would be a need to examine whether or not we go through and revise the Guardianship and Administration Act. I do not think any decision has been made in that space but it certainly is something which we are looking at. We are trying to ensure, despite the length of time it has taken us to bring this legislation forward, that it meets best practice in terms of what we see internationally and we certainly have taken into account the findings of the Legislative Council.

**Dr GOODWIN** - Minister, I wanted to ask about drug and alcohol services and whether there has been any noticeable increase in demand, because there was something in the *Mercury* earlier in the week with the Salvation Army reporting an increase in demand and some 30 people on the waiting list for the Bridge Program. I am interested in any feedback on that particular issue.

**Ms O'BYRNE** - We do have reasonably high proportions. We have had an increase in the Tasmanian population at risk of alcohol related harm long term. This has increased since 2004 from 9.7 per cent to 12 per cent. We have the highest proportion of young people aged 18 to 24 who drink alcohol at risky or high-risk levels causing short-term harm at 19.8 per cent, which is why we have the Tasmanian Alcohol Action Framework that we released in February. There was an implementation plan for the first year, which has been done with the Inter Agency Working Group on Drugs, so it does not fall completely within our measure. This is to work on cultural change, on control, on effective assistance for control and supply of alcohol, the provision of active interventions to address the priorities of health and wellbeing in the population, community safety and amenity, intoxication in high-risk groups, and high-risk behaviours. We are working on the implementation plan as a result of the framework that we released in February. But certainly it is a concern in Tasmania, which I do not think you would be surprised at.

**Dr GOODWIN** - No. I was just a bit disturbed to read in the *Mercury* that there was an increasing demand that the Salvation Army was struggling to cope with.

**Ms O'BYRNE** - I wonder about how much that would also be seasonal. I do not know if that is an implication. If you never ask the question, you do not know.

**Dr GOODWIN** - The other issue I wanted to raise was the criminalisation of the mentally ill and the concern that the police raise from time to time about how they end up having to respond to incidents involving people with a mental illness. They might take them to the hospital and then they are released and they are back on the street, and they are picked up by police with this sort of revolving door. Where does the responsibility lie?

**Ms O'BYRNE** - I must confess that I have been taken on a bit of a journey myself on this - I will hand over to John in a minute - in that it does not sound right but the reality is that a lot of people who might have particularly suicidal tendencies might not necessarily have a mental health issue. It can be related to the amount of alcohol and substances they may have taken in a short

period of time or it may be related to particular incidents that have occurred. They are often not seen -

**Ms FORREST -** Or they have just had a relationship break-up.

**Ms O'BYRNE -** There may have been an incident that has triggered an immediate behaviour. That is not to say that that person is a person who has a mental health issue and should therefore be given the structures of mental health around them. It is a little hard to explain to people because clearly they see somebody who is so desperately distressed that they want to take a life-taking action and cannot see how they could be completely healthy. But there is a significant difference between someone with a mental health issue and someone is having a behavioural reaction to an incident such as an alcohol or substance abuse issue. John might be able to take you through that. Certainly, we are trying to work within our emergency departments to manage that better because it is hard for people to see that outside of a clinical arrangement.

**Dr CRAWSHAW -** There are several parts to the response. Firstly, you may have noted that, as part of the emergency department national partnership agreement, we are in the process of improving our coverage within ED departments here in Hobart which involves putting a specially trained nurse within the emergency department and extending our CAT team responses and doing something in each of the regions because we have to take into account regional variations. That is in terms of providing a much more comprehensive response from our service point of view.

The second part is in terms of the mentally ill being criminalised. There has been a long push to ensure that we appropriately deal with them if they do get to courts and actually provide more appropriate care. That is part of why we run a court liaison service; that is part of why we have the mental health diversion lists which have now been spread across the State. Our experience in the south of the State was that this offered a significant benefit to the people who went through, both in terms of what we could see in terms of the syllabusing, which is what the community at large sometimes worry about, but also in terms of their mental health.

The other part is related to some of the stigmatisation issues within the community at large - how they perceive and feel - and I have certainly done media statements and so forth to try to address. It is something which is part of our Promotion, Prevention and Early Intervention Framework which was released last year to try to get a consistent and coherent focus around this. This is not just a Mental Health Service issue; it is not even something which is purely a Health issue; it is something in which we need not only a whole of Government but a whole of community focus to move forward. We have an Inter Agency Working Group on Mental Health which involves all of the key government departments, the peak body for mental health and the Local Government Association so that we can try to bring forward plans and approaches to deal with this.

**Ms FORREST -** There is quite a good bit of coverage in the Mental Health Select Committee report too.

**Ms O'BYRNE -** Can I give you your GP data while we are here?

**CHAIR -** Yes.

**Ms O'BYRNE -** It is anticipated by the end of 2010 there will be 90 domestic graduates from UTas. There were 56 in 2007 and 73 in 2009. For the 2010 clinical year we offered 67 intern

positions, which was an increase of nine from the previous year. Despite the fact that we give priority to our local graduates, 47 of the 67 places were taken up by Tasmanian graduates. The increase in the 2010 domestic Tasmanian medical graduates will mean that we will need to work to support those within the hospital system, because medical graduates interns are an expensive but extremely necessary engagement that we make.

**CHAIR -** Thank you very much. We will move on to capital investment funds.

**Ms FORREST -** In the capital investment fund under the National Health and Hospitals Network reforms there is a flexible pool for emergency departments, elective surgery and sub-acute areas. How is that going to work? Do we just put up our hand if we want a bit or -

**Ms O'BYRNE -** There is $8 million of the $102 million that is allowed for us to make flexible decisions about capital works, operating costs or whatever.

**Ms FORREST -** So it has the flexibility to be used for staffing or recurrent costs?

**Ms O'BYRNE -** Yes. It is the only flexible part of it, I think.

**Mr ROBERTS -** It may be because some people may contract those services out and therefore not need as much capital, but want to put the beds into, for instance, an operating or a lease or a payment type of that description. All States are in different places and not all require capital to build. Some of them want to place it with NGOs or other providers, for instance. That was part of the negotiation that took place.

**Mr HARRISS -** On health information technology, is there going to be any noticeable or appreciable impact by the NBN, the National Broadband Network, and the infrastructure upgrade, for instance?

**Ms O'BYRNE -** I must confess I absolutely think so. One of the things we are doing is rolling out the e-health trial, which we will be doing on the west coast. We have seen some exciting models that exist in the way you can provide health care in the home through being able to use the e-health technology. As the speed, quality and accessibility gets better, we will be able to roll it out to regional communities in a much better way. For instance, bush nurses in South Australia manage diabetes clients by not going to their extremely remote property but by doing it over an e-health opportunity. So they get the person and say, 'Have you taken your medication? Can you show me what pills you are taking? Right, take one of those,' and you go and do whatever.

We also have the link for health reader systems in your home - they have a particular name -

**Mr ROBERTS -** Monitoring devices.

**Ms O'BYRNE** - Monitoring devices which will monitor basic principles of your health, so might be your sugar levels, your blood pressure levels or whatever, and that will send an automatic reading into your care area which could be your tertiary hospital or could be whatever. Then they can immediately act in order to provide you with the support that you need in regional communities. As we roll out much higher quality of access to our community, we will be able to utilise those facilities and also utilise people's understandings and knowledge about them a lot more. Virtual care in the community program is the one that is actually worth looking at. I am

wanting to get a demonstration for members and for the upper House as well about some of the ways that we can engage that.

It is one of those areas where it is almost a counter-intuitive investment. While we will spend a bit of money in the technology we will save a lot of money in terms of being able to provide service in people in regional communities and we will also save the imposts on them with the unnecessary travel that many of them have to do to come in and have a very small assessment and go home again. We are quite excited about it.

**Ms FORREST -** I want to make one important comment that today is the last day of the Nursing Board of Tasmania forever.

**Ms O'BYRNE -** I did not make it to the drinks, did you?

**Ms FORREST -** Was there drinks? I was not invited even though I did re-register.

**Ms O'BYRNE -** David got to go to the drinks.

**CHAIR -** I think we have finished Health. Minister, could I on behalf of the committee thank you and your advisers, for your enthusiasm for your two new portfolios on your first Estimates. Your rapid-fire delivery has probably guaranteed that you have plenty of words on *Hansard*. Thank you very much.

**Ms O'BYRNE -** Chair, can I thank you and members of the committee and staff, *Hansard* in particular, because I know I am a challenge for them on a daily basis.

**CHAIR -** We were not horrid, were we?

**Ms O'BYRNE -** You were not horrid, thank you all very much. Can I also thank the departmental staff who have come and been here available today. I hope that, as I remain in this portfolio, I will need to rely on them less and less for support. It is a huge area with incredible complexity but it is an exciting area to be minister for.

**CHAIR -** Thank you.

**The committee adjourned at 5.49 p.m.**