**CHAIR** - Minister, thank you for being ready to roll, we have a quorum so we will recommence. We are still on overview issues so I want to pick up, if I can, on some of the initiatives that were announced last year on the back of the budget saving strategy, et cetera. I want to go specifically to the business control team that was to be established. Is that team still operating? What have been the changes to the governance framework resulting from the establishment of that team? You might like to consider this as a boxed question as it goes to the business process redesign team. As well, I have had a look at the voluntary workforce renewal. We covered some of that in separations that Ruth was talking about earlier, I think.

**Ms FORREST** - We have not really gone to that one, Paul.

**CHAIR** - Let's start with the business control team.

**Ms O'BYRNE** - If I can deal with the two of them globally first, those two around control team, and the process that we put in place, and then Penny can talk in some detail on them. Part of the issue that has always been in health fat. Whenever you get different layers of the health service in the room, they may have different understanding of the same issues. So it was always really hard to sit down with Treasury and agree on what our challenges were, and even from the department of the THO there were disagreements, so it was really clear that we needed to have a set of agreed numbers and agreed positions because that was the only way we could then collaboratively track whether we are performing against them. So the business control team was to ensure that there is a governance framework to achieve the required level of savings but also to maintain that sustainable future in care. It was established to provide expert advice and support to the secretary, to ensure appropriate government arrangements were in place to implement the approved strategy, to monitor performance on the achievement of their required level of financial savings, and to provide regular reports to the budget subcommittee of cabinet, as and when the cabinet subcommittee required it.

They have met 14 times since they were put together and I understand that a number of their meeting records were produced in camera for a Legislative Council inquiry into DHHS cost reduction strategies, so in terms of questions around that I will be guided a little by what can and cannot be discussed in a public environment.

The business process redesign team was established at the same time to undertake some systematic evaluation of efficiencies, productivity, to identify opportunities for efficiency effectiveness, and set the foundation for, and systematically identify a range of areas where business units can be rationalised so that we could do things much better. That was wound up late last year as the agency savings agenda progressed to implementation, so that was an initial stage. But it does continue and that is evidenced by the reduction in our workforce numbers over 2011-12 and monitoring and evaluation of the agency savings strategies progress.

**Mr DALY** - If you don't mind me just adding, I decided to continue it after I had arrived here, principally for the reason the minister touched on locking Treasury into the process. The issues around health are so complex and often have such a history that for them just to present, whether it be verbal or written form, a major financial issue in health in the time frame the Treasury receives these submissions, I thought it was better to have a senior officer, and one of

the deputy secretaries in Treasury is on this group, who will be on part of the journey with us and he can be as aware of the health issues as we can possibly make Treasury.

**Ms O'BYRNE** - That feeds into the other point that I was making about needing to do an analysis of episodes of care in terms of the activity-based funding in national efficient price. We need the commonwealth also to accept and understand the premise from the funding points that we make so that there is not just an assessment that there is a blanket percentage that is a regional cost as opposed to an actual understanding of the cost of delivering a service. So that is the process around that.

**Ms FORREST** - On that point, you said that the budget control team continued them for those reasons and that the Treasury officials sit there as well. Is it the minister's view that the Treasury has been a bit difficult in this regard because health is so complex, that Treasury does not really get it and that has been part of the problem in trying to determine the saving strategies the budget control team has been required to progress?

**Ms O'BYRNE** - There are a couple of things. I think we have created a mythology about the complexity of the department of Health as an agency and that has been an excuse not to unpick some of the things we do. Other jurisdictions have health departments, other nations have health departments. Clearly, there is an inherent complexity in health but not to the point that you can't get involved, understand and work around that.

The issue in our relationship with Treasury - and Treasury has people who have come from Health and we have people who come from Treasury - has been understanding what is achievable because often things on paper are a different process than they are when you talk about the clinical implementation of any particular piece of work. We really wanted to understand the challenges that we were facing but also for them to understand the timeliness of progressing against certain targets - some things can be achieved quickly and some things were going to take a long time, for other reasons. So it was about having an agreed set of numbers and data that we all worked on.

It has been very beneficial because then when we said that we were concerned about the additional budget ask upon us, we could have a conversation with them with them understanding the implications of the budget ask that had been made before. So it has been one of the reasons we have been able to have a productive enough relationship with Treasury so that we do not have to find an extra $27 million and we do not have to find the $25 million because they have a strong understanding of the challenges delivering changes in Health. It has been good from a management perspective for us because it also requires us to think differently and look differently at the work we do, but I believe it has been very beneficial in our relationship with Treasury in the budget negotiations.

The other work that they are doing, of course, is the focus on cost reductions and the evaluation of business efficiency and systematic improvement.

**Ms FORREST** - Just another point, minister, you mentioned the work you have been doing with the commonwealth on the standard regional loading. Can you outline more the issues that it has and what you are doing about it?

**Ms O'BYRNE** - There are some challenges for us in the process of identifying a regional loading, which is why we wanted to work with the commonwealth in understanding and

unpicking each of the individual cost structures that we have. When every state and territory engaged in the discussion of national health reform and a national efficient price, it was always understood that there are some places where it costs more to provide the service than others, and there would need to be recognition of that.

At that point, we had a commitment to a regional loading. Every state and jurisdiction had assumed, and assumes, and will continue to assume, through negotiations, that that means that is the cost of providing the service in a particular community. As we have engaged with IHPA over the last six months - I think that is probably about the time frame - what became clear was that whilst they took and understood the nature of the regionalisation costs, in many areas across government they do analysis based on postcode and they do an assessment of the socioeconomic index in the postcode and then look how governments federally might necessarily approach that. That would be fine if every health service was provided within each postcode and it is fine in metropolitan areas where a postcode can look pretty much the same.

In Tasmania, a postcode can look significantly different from one end of the postcode to the other. Our patients travel all around the state and the cost is not necessarily where they live. The cost is where we provide the service and what it will cost to do the service there. We had some very forceful conversations with IHPA at the last ministerial council, which pointed out that a postcode analysis does not work for those reasons because you can have somewhere outside of Hobart being assessed at the same level as inside of Hobart, and we know that the difference in the needs that people might have can be quite flawed.

In the second stage of it they said, 'If we can't get the postcode data to work then we will use the rural and regional remote index'. But not a lot of data has been collected on that as the commonwealth is moving to different models. They said, 'Okay, well that does not work, then the next level we will use is Census collection district data,' but we also know that the commonwealth has not been collecting data on that because that is moving.

We spent some time explaining to the commonwealth why a postcode analysis does not give us a good outcome. For instance, it could assume in Tasmania that people living in Burnie are regional and therefore get a 10 per cent loading, but people living in the Central Highlands might get nothing at all because in theory, from a postcode analysis, they should not have the same challenge. That would be absolutely inappropriate in Tasmania because the cost is not about whether you live in the Central Highlands or Burnie. The cost is which hospital you have attended and the cost of providing the service within that hospital.

**Ms FORREST** - Where are we heading with this? You have explained how that won't work.

**Ms O'BYRNE** - We have two years before the commonwealth funding will change. At this stage, the commonwealth funding is effectively what it currently is, so there are no changes for the next two years. We have to spend the next two years getting close to the national efficient base price plus loading, so what we need is an understanding of what the loading is. We have written a number of letters, but the last letter that we have written to the commonwealth accepts that a price that is based on a measure of central tendency cannot be regarded as a measure of efficiency. The fact that a service price is above or below a national efficient level does not necessarily give you an assessment of an efficiency for providing a service. It is a bit of data that makes people feel better, but it does not necessarily unpick the information enough for you.

It also would be inconsistent across states because you would get some regions with a higher cost not necessarily getting a loading because of where they live, and that would be completely inappropriate as well. What we have asked them to do is to work with us on analysis of what it actually costs to provide the service. It is crucial they do that because otherwise we will end up with a flawed system, and whilst I am sure this would not be the case of any of my CEOs but if one region of Tasmania got a 10 per cent loading and another region did not, if you were running an effective business model you would actively pursue patients who had a higher loading because you would get more money for the work that you do. That would be inappropriate across Tasmania. We want a proper assessment of what the cost is to deliver the service -

[2.15 p.m.]

**Ms FORREST** - And be paid according to that.

**Ms O'BYRNE** - And paid according to that. Which is why we want to do the episodes of care work as well, which is probably more advanced than IHPA - the Independent Health Pricing Authority body - have worked through because we think there are a couple of compounding factors.

In Tasmania, we have a highly dispersed population with chronic disease issues. Also, some things are difficult to afford here. We are getting block funded for quite a lot of those - more so than any other jurisdiction, in fairness. Then there is the fact that the level of sometimes buying a service in a regional community costs more because the private provider has a cost structure. A regional loading needs to take an awareness of all of those things and then you know what your left with, which is actually about the efficiency of your process. CEOs can drive down the cost around that but at least then they are heading for a realistic understanding of what their cost and their loading is as opposed to just an arbitrary thing.

**Ms FORREST** - You are talking about a level playing field.

**Ms O'BYRNE** - Yes, it has to be fair. It has to be fair not only here but nationally. Western Australia has reflected the same position. The cost of providing services in northern Western Australia is absolutely different to providing services in Perth. That needs to be reflected. It is where you provide the service that has to be funded, not where you live. If you travel from east Launceston, if you travel from -

**CHAIR** - Can I just interrupt? You are stating the obvious. We have gone through that part before about regional service and you have mentioned to us in the overview about where the service is delivered. I do not want to be inefficiently using time here.

**Ms O'BYRNE** - No. The point is that we are still negotiating that with the commonwealth and anyone who sits in my place now or into the future needs to understand that that is still a challenge that we are working through with the commonwealth to fully understand the regional nature of healthcare. If it is not done properly it will be a challenge for us.

**Ms FORREST** - May I just ask how that sits with the money following the patient? You said at the outset that the money will follow the patient.

**Ms O'BYRNE** - The loading will then follow the patient as well, rather than the service.

**Ms FORREST** - Let us say there is a loading in the north-west of 10 per cent and that patient went to the south for neurosurgery -

**Ms O'BYRNE** - Probably not neurosurgery but something that is block funded.

**Ms FORREST** - Then when they go to Launceston or Hobart to have that surgery does that 10 per cent loading apply?

**Ms O'BYRNE** - Yes. It would apply everywhere. It would apply in Burnie, it would apply if they went to Launceston, it would apply if they went to Hobart, it would apply if they went to the mainland. But that does not reflect the cost of providing the service. It is not more expensive to provide a hip operation to someone in Launceston based on whether they live up the hill or an hour down the road. The cost of the service is the cost of the service. It is a really crucial matter that we need to resolve with the commonwealth.

**Mr DALY** - The leakage of those patients out will further disadvantage those local services because the volume will be even less.

**Ms FORREST** - That is exactly right; that is what concerns me.

**Mr DALY** - That is why we are arguing very strongly.

**Ms O'BYRNE** - In fairness to Gavin, if all his patients decided to go to Launceston or Hobart because they were actively attracted on the basis that they were worth more then he would get to a point of not having enough work to justify the commission of the service.

**Ms FORREST** - It would undermine the whole service.

**Ms O'BYRNE** - One of the things that we need to do through the Tas Health Plan work is understand where we provide services and put the structures around them to make them sustainable.

**Mr VALENTINE** - With respect to the NBN and e-health services, how does that affect how the payments are made? If someone has been diagnosed in King Island but the service is being provided out of Hobart, how does that affect the funding?

**Ms O'BYRNE** - The funding follows the individual so whatever the loading might be, the funding for *x* person the funding follows them regardless of care. The biggest shift that we have had in e-health work is that historically doctors have not been able to claim the Medicare component if they have done an e-health or any over-the-internet consultation. They have been able to since late last year. Is that when it came in?

**Mr DALY** - Yes, a limited range.

**Ms O'BYRNE** - We do need to do the shift of ensuring that those things are also lined up within Medicare for claimable services.

**CHAIR** - Minister, I think that you said

**Ms O'BYRNE** - Did you want some staff reduction numbers?

**CHAIR** - Rather than read through them systematically it might be just as easy to table that as a document.

**Ms O'BYRNE** - I will have a look at it while you ask me the next question.

**CHAIR** - I think you mentioned the business process redesign team had been dismantled?

**Ms O'BYRNE** - It was wound up last year.

**CHAIR** - Can you give the committee any examples of what systematic evaluation you have made of the efficiencies and the productivity gains as a result of the operation of that team, please?

**Ms EGAN** - The team was only there for a very small amount of time really so their focus at that time was delivering for us really a lot of work around our FTE reporting. That is 80 per cent of our costs, so if we are going to make efficiencies we had to understand what impacts that would have. Much of work went into the reporting which we now continue to report on and to the business control team on FTE reductions. It is reduction looking at overtime, sick leave, staff number reductions by award, and by area by award. So a lot of good reporting was put in place which has allowed us now to understand our work-flow patterns, but we can also show you the trends about where all our costs have been able to come down.

**Ms O'BYRNE** - For instance, the overtime costs we have been able to track in a way we have not before because they have been very much locked into individual business units and we have not been able to compare them.

**Ms EGAN** - Although we reported it before, mainly around FTEs, we now have a very transparent process on reporting those particular costs and FTEs.

**Mr MULDER** - That was a good segue, the fact that you so actively are tracking overtime costs as it is a really good lead into my particular area. I was going to ask the question in terms of the RHH as an example and then ask you to provide other details later on. I will leave it to you as to whether you do it across all our hospitals or whether you just focus the answer to these questions on the Royal. How many FTEs have we in the Royal at the moment in the year we are just finishing in terms of nurses?

**Ms O'BYRNE** - We do the calculations based on an awards coverage, so there are some variables in terms of whether people are still administrative or in care, but I can give you those.

**Mr MULDER** - Let us do it by the award - that may be a better way of doing it.

**Ms O'BYRNE** - For the Southern Area Health Service, under health and human services bands 1 to 9, 679.04 FTEs. On health and human services award HSO 1 to 5 573.46. Under the nurses award we have 1 275.55 FTEs and allied health professionals, 399.94; medical practitioners, 379.43 FTEs; rural medical practitioner is 0.64 and those under a VMO - a visiting medical officer agreement - 16.85. We then have some radiation senior executive service dental officers with a total of FTE at 3 378.33. I am just making sure everyone is agreed that I am giving the right numbers.

**Mr MULDER** - Is that to April?

**Ms O'BYRNE** - That is at pay 20, which was 14 April.

**Mr MULDER** - Thank you very much. You said that you had those figures for the last financial year?

**Ms O'BYRNE** - I am just looking to see if I can provide last year's figures in the same areas. I do not know if you want to pick a particular one that you would like me to go through or I can go through all of them. Allied health professionals from 2007-08 was 368.75 FTEs; in 2008-09, 39 334 FTEs; in 2009-10, 40 397 FTEs; in 2010-11, 41 862 FTEs and, at the pay of 14 April 2012, 39 884 FTEs which is still above where we were in 2008-09 [TBC]. In nursing -

**CHAIR** - As a matter of process, how many lines do you have?

**Ms O'BYRNE** - I have allied health dental, Health and Human Services, 1 to 9; Health and Human Services 1 to 5; nursing, other -

**Mr MULDER** - I am happy for those to be tabled -

**Ms O'BYRNE** – Yes, I can do that. I can give you the total -

**Mr MULDER** - At this stage they are just numbers. I will take some time to digest them.

**Ms O'BYRNE** - That is fine. I will table them but the headlines in terms of the overall staff - in 2007-08 we had 3 146.05; in 2008-09 we went to 3 297.14; in 2009-10 we went to 3 373.21; 2010-11, 3 556.07; and 2011-12 is 3 330.17. Once again, still reasonably above.

**Mr MULDER** - Thank you, minister. I gather you are going to table it.

**Ms O'BYRNE** - Do you want each region, chair?

**CHAIR** - Yes, I think so.

**Mr MULDER** - Yes, by region.

**Ms O'BYRNE** - I have lots of bits and I am going to get someone to sort them into something that can be handed over.

**CHAIR -** Thanks.

**Mr MULDER** - We are happy to take that. Also, can you tell us, by award, and by region, perhaps, or even by business unit - as many of those as you can possibly do - how much overtime in hours, not dollars, each of those areas earn. If you can do that by award, by business unit, and by area, that would be greatly appreciated.

**Ms O'BYRNE** - We can probably give you all of that. I do not know whether you necessarily want me to read it.

**Mr MULDER** - I am happy for you to table that, minister. I do not need you to read all that out.

**Ms O'BYRNE** - Overtime costs, year to date. Do you want the variants and the breakdown?

**Mr MULDER** - Can you give me the head line figures now, minister, and then perhaps table the breakdown by business unit, by area and by award?

**Ms O'BYRNE** - I will give you a comparison otherwise the figures make no sense. It is to 31 March, so we have gone year-to-date to year-to-date. The overtime total costs were $19 188 891. In 2011-12, for the exactly the same period, that is through to March, it was $15 206 482, a reduction of $3 982 409.

**Mr MULDER** - Will you provide a breakdown by awards?

**Ms O'BYRNE** - And each of the businesses areas shows a reduction in overtime costs. We will give you that.

**Mr MULDER** - And by region, and by award?

**Ms O'BYRNE** - We can give you Ambulance Tasmania, Business Services Network, Care Reform, Chief Health Officer, Northern Area Health Service, North West Area Health Service, Nursing and Allied Health, Strategic and Portfolio Services, Policy and Information Commission, Population Health, Southern Tasmania Area Health Services, Statewide Mental Health Services and Statewide Forensic Services.

**Mr MULDER** - Whatever they are, they will tabled?

**Ms O'BYRNE** - You will have them all.

**Mr MULDER** - Thank you. You made the point that they have gone down -

**Ms O'BYRNE** - In every area.

**Mr MULDER** - They have gone down in every area, so the $19-odd million is for the full year?

**Ms O'BYRNE** - That is to March.

**Mr MULDER** – That is $19 million to March this year?

**Ms O'BYRNE** - Yes, to 31 March.

**Mr MULDER** - Didn't you say, the comparison figure the year before was -

**Ms O'BYRNE** - Sorry, it is 12 months. We have compared the 12 months to the 12 months, so the first figure I gave you was for 12 months to 31 March 2011.

One of the issues you need to understand in hospital overtime is that at Christmas and December and in some of the school holidays, throughput of hospitals changes because that is

when people take leave. Emergency presentations change in December so you need to measure month against month, otherwise the fluctuations are quite extreme. That is the reason -

**Mr MULDER** - I was just asking year by year. Did you get that figure right? Just to clarify, I think you said that the 12-month period that ended in 2011 was $19 million. Is that right?

**Ms O'BYRNE** - $19 188 891.

**Mr MULDER** - And to date, extrapolated to 30 June this year, it is $15.2 million.

**Ms O'BYRNE** - Yes, but they are both the 12-month periods.

**Mr MULDER** - Yes, that is why it is extrapolated this year.

**Ms EGAN** - No, it is not extrapolated.

**Mr MULDER** - As at March. So, you are comparing 12 months, both ending in March.

**Ms O'BYRNE** - Yes.

**Ms FORREST** - On that point of overtime, is it possible to look at, or provide, detail of the overtime done in specific areas? For instance, in nursing, it is not unreasonable in highly specialised areas like DEM, ICU, and the operating theatre, to have to use overtime to cover shortfalls, whereas in the general ward area you would expect not to.

**Ms O'BYRNE** - I will have to see how much data I can get you on that, but I will certainly try. Overtime is often the easiest thing to organise. It is easier to get someone to work a double shift, but it is more cost-effective to get part-time workers to take some additional hours and use the casual part of the workforce as well. The change in the overtime figure may be because there is more cost-effective staffing.

**Ms FORREST** - That is what I am suggesting, but can you break it down to acute or speciality units, as opposed to general areas?

**Ms O'BYRNE** - We will try to get it to you before the end of the day. I will see how quickly we can achieve that. One of my KPIs is not to go away with too many things that we have to hand in to you on notice, because the department gets freaked.

**Mr HALL** - Minister, if I can ask about voluntary workforce renewal. If I look at the progress report on the budget saving strategies, that is on page 3, I notice in the whole agency the numbers have dropped by 547 FTEs up until the end of the March quarter. Do you have a breakdown of where those reductions have come from, and have you a further reduction target by 30 June of this year?

**Ms O'BYRNE** - As at 14 April, we had 137 employees separate through the workforce renewal incentive program with an average payment of $14 397. That particularly was something the ANF asked us to do to allow older nurses to leave the workforce, so that they could be replaced with newer graduates. One hundred and nine employees separated from the agency through targeted voluntary redundancy arrangements, with an average payment of $62 588, and 15 employees had secured permanent placements in the state service through redeployment. We

have four requests for targeted voluntary redundancy arrangements, and one request for the workforce renewal incentive program being assessed. That has seen a reduction in paid FTE, together with natural attrition, of 651.82 FTEs from 1 July to 14 April. Someone is going to hand me magically in a moment how many of those are what roles.

**Mr HALL** - Is it a long list, minister? Can we table that?

**Ms O'BYRNE** - I do not think it will be a particularly long list. One of the biggest changes we made was in the IT area, and of the 651.82 FTEs, 163 - I think, and I will double check the figure - are from head office, or from the bureaucracy.

**Mr HALL** - What is the target on 30 June this year? They were the end of April figures, weren't they?

**Ms O'BYRNE** - I might table that when we have it.

**Mr HALL** - Sorry, is that -

**Ms O'BYRNE** - The breakdown per work area - per award structure - of the 651.82 FTEs - is that what you wanted?

**Mr HALL** - Then, what is the target by 30 June?

**Mr DALY -** The target was 630, and today it is 658, so we are over the target at the moment.

**Mr HALL** - Okay, right. Just a further question in regard to those voluntary redundancies. Are there any rules or incentives regarding returning to work in the public sector, if people take a redundancy?

**Ms O'BYRNE** - Matthew might not be aware of a very famous issue of redundancy some years ago in Tasmania where people took redundancies and turned up to work the next day.

**Mr HALL** - That's right. That is what I am alluding to.

**Ms O'BYRNE** - There is a structure for it, done by Treasury across the public sector, which means you cannot return within two years.

**Mrs ARMITAGE** - While we are on staffing levels, would you be able to give me the number of specialists at the three DEMs - North, North West and South - as well as the RMOs and registrars? How many do you have in each division plus the percentage of the patient presentations of those divisions compared to the numbers of staff you have in those areas?

**Ms O'BYRNE** - What I can give you now is the total medical numbers for the three regions, which will include medical practitioners award, rural medical practitioners, and VMOs for each of those areas.

**Mrs ARMITAGE** - Do you have a breakdown that you can provide?

**Ms O'BYRNE** - What I am saying is I can give you this now while someone says if they can give me a different breakdown. In the Southern Tasmania Area Health Service the total medical awards - and that excludes radiation therapists and those sorts of things - were 396.91 FTEs.

**Mrs ARMITAGE** - Sorry, I am asking at DEM - the Department of Emergency Medicine.

**Ms O'BYRNE** - That will take me a little longer to get. What I said is I can give you the totals now and we will search for the other information for you while we are speaking.

**Mrs ARMITAGE** - That was mainly what I wanted, but anyway.

**Mr DALY** - We would not have that here today.

**Mrs ARMITAGE** - No, that is fine. Give me those and then I have some other questions that lead on from it.

**Ms O'BYRNE** - All right - 396.91 total medical practitioners under the medical practitioners award, the rural medical practitioner and the VMO agreement in the Southern Tasmania Area Health Service as at 14 April pay day. For the Northern Area Health Service, 214.45 FTEs; and for the North West Area Health Service, 101.88 FTEs in the medical work group.

**Mrs ARMITAGE** - I thought what you meant before was that you were going to give me the specialists, RMOs and VMOs for the DEM, but that is fine.

**Ms O'BYRNE** - I can give you a break-up of intern resident registrar specialists for each one.

**CHAIR** - Can I just intervene there, we are getting on to 1.3, which is the emergency -

**Mrs ARMITAGE** - We were talking staffing and that is was why I was so insistent.

**CHAIR** - I understand that, but if you want to drill down deeper then I would indicate that it would come under emergency department services.

**Mrs ARMITAGE** - I will go back to that but one question I will ask now then, and I have asked this before and I have not quite received a satisfactory answer but you might be able to get it to us: are you able to provide the number of staff that are not directly involved in patient care?

**Ms O'BYRNE** - No, I do not think any health bureaucracy anywhere can do that.

**Mrs ARMITAGE** - I know it has been asked many times but just to find out who are the clinicians and who are the other staff, when you come under the umbrella the number of staff you have, how many are actually involved in direct -

**Ms O'BYRNE** - This is something when people talk about protecting frontline services, we immediately say, 'Tell me where the frontline services are'. The reality is, you could have a senior nurse who spends some time on the floor and spends the rest of the time in unit management so only a portion of his or her time would actually be direct patient care. What we can do is break down in the award structures those who are purely administrative but there will be some people in the nursing award and in the medical practitioners award who do a combination of roles.

For instance, you might be the person who is the director of surgery in a hospital and a portion of your time is spent on surgical procedures, which is direct clinical care, and another part of your time will be spent on reporting to statewide clinical bodies, which is not clinical care. What are you actually after?

**Mrs ARMITAGE** - No, that is fine. I do not have a problem with that but the answer we would like to find out is: how many staff in your department have no involvement with patients?

**Ms O'BYRNE** - Everyone has an involvement with patients because everything we do is about patient care, Mrs Armitage.

**Mrs ARMITAGE** - No, you are being a little facetious here now - a clinical involvement with the patients as in physicians and nursing, staff and I am not saying nursing staff who do a little bit of nursing and a little bit of nurse educator work. Fine, they are actually having involvement with a patient. I am talking about the people who are purely behind the desk, sitting at a computer who have absolutely nothing to do -

**Ms O'BYRNE** - Wearing their pin stripe suits.

**Mrs ARMITAGE** - Possibly, but have absolutely nothing to do with a patient. It would be interesting to find out and I have asked the question before and I had this answer come back that 'Even a cleaner has something to do with patients'. That was not the answer I wanted.

**Ms O'BYRNE** - I know it is not the answer that you want, Mrs Armitage, but the reality is that even the cleaner - and my mother was a hospital cleaner - has a significant role in infection control and healthcare management. They have a significant role.

**Mrs ARMITAGE** - I understand that. I am certainly not criticising the cleaners here; they do a wonderful job. It is more realistically -

**Ms O'BYRNE** - My issue with it is it is actually very difficult to do that. What I can do is give you an explanation of what the bands are in each of the awards and some of those specify only 'clerical' or only 'administrative', but once you get into some of the other areas that are a mixture of patient care and non-hands-on patient care, if that is what you are after, that is actually more difficult to do. For instance, the health and services award band 1-9, we can break that down to give an assessment of how many of those would be predominantly administrative but bearing in mind that the person who books you in does have an engagement in your care.

**Mrs ARMITAGE -** I understand that -

**Ms O'BYRNE** - We can give you that as much as we can.

**Mrs ARMITAGE** - Thank you.

**CHAIR** - Anything more on the overview before we go specifically to work systematically through the line items?

**Ms FORREST** - I have a couple of things. I wanted to go to the funding, minister. You mentioned before lunch that a review of the Tasmanian Health Plan and those more difficult

discussions that need to happen, what is the timeline for that, who is going to lead it, and when do you expect to have a meaningful outcome?

**Ms O'BYRNE** - We will be calling for expressions of interest from people to be engaged in that. I have had preliminary discussions with some clinical leaders already about the form that it might need to take and with Medicare locals to shape up what the picture might look like. There was a view earlier on that we could use our lead clinicians group to lead the discussion, and our lead clinicians group will be a well respected and good group but I need to ensure that we have a community engagement. I think it will probably be a separate group to the lead clinicians group made up of clinicians from around the state, Medicare local representation, and community people who have an interest in health because we also need to make sure that it traverses acute acre all the way into preventative engagement. We will be calling for expressions of interest hopefully in the next -

**Mr DALY** - We will want to get over estimates and then certainly within a month after that.

**Ms O'BYRNE** - At the close of estimates we will shaping up what that might look like.

**Ms FORREST** - What is the timeline? When do you expect to have something meaningful -

**Ms O'BYRNE** - I think it will be one of those groups that will go on in its engagements but we would be expecting some preliminary work -

**Mr DALY** - I was hoping to have the group together with their terms of reference in terms of the net separation of the Tas Health Plan within the next six to eight weeks after we go through a period of garnering support, particularly community support, and I trust there will be a lot of interest within our hospitals for senior clinicians to participate, too. Certainly I am talking to many clinicians as I get around who have shown an interest in -

**Ms FORREST** - The point why I am asking for it is -

**Ms O'BYRNE** - At what stage would we get something?

**Ms FORREST** - Yes, because it is all right to have a talkfest -

**Ms O'BYRNE** - I would like to have some work to inform the next situation for service agreements which have to be bedded down by May. Whether or not we would have everything done by then -

**Ms FORREST** - Is it the next service agreements next year you are talking about?

**Mr DALY** - Yes.

**Ms O'BYRNE** - We would like to have some of that work done and it might be that in some of the areas it is a longer discussion. I think that particularly if we are dealing with issues around the end-of-life stage then that will be a longer discussion and a longer engagement because it is a particularly sensitive issue. If it something that is reasonably clinically manageable then we should be able to get feedback hopefully for the next service agreements.

**Ms FORREST** - Within 12 months we should see some sort of direction as to where these discussions are taking us.

**Ms O'BYRNE** - In some areas. I think it would be too much to assume that every issue would be resolved but we would want some key data informing our next service agreements by then.

**Mr VALENTINE** - One question, and it touches on THOs as much as anything else but it could be considered 'overview' because it involves many different services. We are dealing with lots of dollars around the table here today but -

**Ms O'BYRNE** - $1.8 billion.

**Mr VALENTINE** - the thing that is important in health services are the clients, the people that the service is being delivered to, so the issue I am concerned about is continuity of care across the state. If people are being treated in certain areas, a different region and then come south to some other area, in getting that continuity of care, what sort of processes are you putting place to make sure that sort of thing happens across the different service provision areas?

**Ms O'BYRNE** - There are a few elements around it. From a THO perspective, one of the reasons that we have a common chair is that we do want negotiations based on an understanding of everything the THOs do. The Tasmanian Health Plan will inform a statewide analysis of what services are required and we would then purchase against that. But more important for the individual is the fact that the commonwealth are pursuing individual patient records which will allow the data to travel not only within the hospitals sphere but also in your GP interactions or other health interactions. We are further advanced because every Tasmanian already has an individual patient record number. That already exists for us, which means that someone does transfer, as long as the IT system is backing it up, there should be a seamless transition of the information that travels around that particular patient.

**Ms FORREST** - That is not entirely true, as we still have different record numbers for private and public patients.

**Ms O'BYRNE** - One of the issues with the individual patient record is whether or not we are able to engage with the private sector in sharing data. There are a number of issues being resolved around that.

**Mr DALY** - The patients would have the capacity to enrol to ensure that their private episodes of care are fed into their medical record electronically for access whenever they fronted an emergency department at any public hospital.

**Mr VALENTINE** - Is that an opt-in or an opt-out?

**Mr DALY** - Opt-in.

**Ms O'BYRNE** - There are many arguments around how opt-out might be better but at this stage the commonwealth are pursuing the opt-in model.

**Mr DALY -** We have been working very closely with NEHTA, the National e-Health Transition Authority and they recently made a $200 000 grant to assist us in getting this project

up. We brought them down here several times and I have met with them numerous times with Belinda Quinn, our chief information officer, to get them to recognise, and they have as evidenced by this grant, that Tasmania is a unique site for them to kick some goals in what is a terribly ambitious project for the nation, but one if it comes off will lead the world. They recognise courtesy of the fact that we are the only jurisdiction that has that single patient identifier and they are prepared to put some money to try to get us up. It is a unique opportunity for Tassie and we are jumping on it.

**Mr VALENTINE** - It is just a concern, obviously people's experiences across the system will vary depending on which service is being delivered, but it is important that there is continuity of care and almost transparency of service.

**Ms O'BYRNE** - There is a good example that has been working in a hospital in Melbourne - and I cannot remember the name - but also in a Darwin hospital. It is a piece of technology that they use in the emergency department that is actually game technology, so playing computer games is good for the health system. They are using the technology that they did in devising games to sit over all of the patient records that exist within the NT health system, so that they can call up when a patient comes in whether or not they just went to their doctor and got a series of tests, whether or not the registrar on duty who just knocked off ordered those tests, so they can cut down the amount of testing that we do to people, which can be quite invasive, costly but certainly invasive for the individual.

What they have found is with three clicks they can get all of the data they need about a person. It will come up and say we are waiting for these five tests to come back and these three have come back and you need to action that one. It is a prompting mechanism that saved 9 FTEs in their emergency department simply by only needing to do three clicks and they have had a clinical outcome in that we are not over-testing people, but also they are finding that they were missing follow-ups from tests because the results had come in after the person had been discharged. This system creates a flag that then makes them contact that person's GP in order to get that clinical care done.

There is some really good technology that is being funded through NEHTA. Our opportunity is great, but it is actually about saying how do we get a better patient outcome by getting our information services right.

**Ms FORREST** - I would like to just try to understand the funding model in the THO and the DHHS, and the whole structure around that. In the information in the budget covering DHHS and the three THOs, they are quite confusing if you try to get an overall picture of what is going on.

**Ms O'BYRNE** - So for currently or the new one?

**Ms FORREST** - The new one. If you can understand it all it would be great because I will be quite in awe of you, and you can explain to us how all the funding flows.

**Ms O'BYRNE** - This is actually - you ask the question and then I will come back to it.

**Ms FORREST** - I will keep going. One of the problems is the lack of itemisation of the grants as they flow from the feds through to the national health funding pool to the three different areas: the DHHS state account, the state-managed fund, and the activity-based funding going directly to the THOs. So if we start with the THOs, their outlays are reasonably self-explanatory

and fairly well described in the budget papers. If you add it all up, all the acute services across the three THOs, the figure is $756 million. But if you go to the DHHS budget, output group 1, the admin services is about $419 million and I take it that this is the state's share, which is about 55 per cent.

**Ms O'BYRNE** - Yes, because our budget does not necessarily have the commonwealth dollars, this is just the state share.

**Ms FORREST** - So the same goes to the non-admitted services in these departments and we know that the state grants are actually paid direct to the THOs, the activity-based funding goes direct to the THOs from the commonwealth; is that right?

**Ms O'BYRNE** - It goes through a national pool.

**Ms FORREST** - A national pool, yes, but it does not come through the state's coffers?

**Ms O'BYRNE** - No. The only risk of that is if the upper House does not have time to pass the legislation that will be before you next week.

**Ms FORREST** - That is up to the government, not us.

**Ms O'BYRNE** - It is on its way, we have done it.

**Ms FORREST** - It is up to the government to bring it on in our House too.

**Ms O'BYRNE** - I just meant that is the only risk for us and the only way that money would come back into the state from the commonwealth now is if we had not done our legislation to set up a national health funding pool.

**Ms FORREST** - If all the services, provided by the THOs combined, including the community and aged care and oral health section, of which there is some of that in the THOs, you have a total of just over $1 billion in the THOs and $654 million in the DHHS budget. When I read volume one of the budget papers, looking at the general government revenue, it included all the federal health grants - assuming those going straight to the THOs, assuming this is all set up - it seems the federal grants appear in the THOs books as grants. Is that right?

**Ms EGAN** - That's right. They come out of the DHHS accounts and flow out of here as a grant into the THO. We can show you that in the accounts.

**Ms FORREST** - So the rest of the federal funds included as grants in DHHS in the income statement or the cash-flow statement - can you show me where that is?

**Ms EGAN** - On the income statement, in the DHHS accounts, which is table 5.9, under grants and transfer payments -

**Ms FORREST** - So it is all there?

**Ms EGAN** - You will see that has increased by $600 000 from the year before.

**Ms FORREST** - Yes.

**Ms EGAN** - In principle, that is the majority of the flow-on effect from DHHS paying the state funds into the THOs.

**Ms O'BYRNE** - Can I provide some assistance, Penny? The work that we did which actually itemised all of that - is there a piece of work that we can table for the committee for that because it might be a little bit easier. We might not be able to do it by the end of today but we could that -

**Ms EGAN** - I believe we could, yes.

**Ms O'BYRNE** - It might make it easier because I think it is going to be a little bit -

**Ms EGAN** - Just to recap; you want a split of the individual components of that grant that goes to the three THOs.

**Ms FORREST** - Yes.

The other question is, what about the Mersey money? It is there in the THOs, I cannot see it come in anywhere. Where does it come? It just appears out of magic.

**Ms O'BYRNE** - No, the Mersey is somewhat different.

*Laughter*.

**Ms O'BYRNE** - The Mersey is commonwealth.

**Ms FORREST** - I know. Does that come in the block funding?

**Ms O'BYRNE** - The commonwealth is block funding the entire Mersey.

**Mr WILKINSON** - Am I right in saying, in relation to the Mersey, there is going to be a commonwealth audit?

**Ms O'BYRNE** - When we were negotiating the last contract, we opened our books up to the commonwealth so that they could come down and assess the transfer of the dollar and what the implications are for the state. It would be the same opening up the data that we gave before. I think the question becomes, for the Mersey, that it is the only commonwealth-funded hospital in Australia; therefore, it is the only hospital in Australia that is excluded from activity-based funding. The reality for healthcare on the north west, and what we did in the last contract was include the Mersey as part of the North West Area Health Service because we know that patients travel between both facilities.

**Ms FORREST** - And so do staff.

**Ms O'BYRNE** - Yes, and staff. We also know that patients from other facilities in Tasmania go to the Mersey. They have done quite a lot of dental care surgery from Launceston's region. It has been done in the Mersey. One of the reasons we had to open up the books before was to be able to be really transparent about where the dollar flows because the commonwealth is block funding that area, and it is really important that it is not seen, in any way, as cash flowing or non-

cash flowing other areas. However, the audits, I understand, take place but it is no different to the work that we did when we were negotiating the last Mersey agreement which was to open up books when we were making our argument about the cost of the Mersey to say here it is and you can track every expenditure we have had. The state also opened up some facilities recently that the state paid for so the commonwealth does not pay for absolutely everything around the Mersey. The infrastructure investment is the one that we are engaged in as well.

**Mr WILKINSON** - This audit that the commonwealth Auditor-General is doing in relation to the Mersey, do you know when that is going to be concluded?

**Ms O'BYRNE** - Sorry, I was answering two questions and answered the other question.

**Mr WILKINSON** - That's all right.

**Ms O'BYRNE** - The national audits are actually going to take place around Australia in a number of areas under the Oakschott legislation. This is the first one. There will be a number of others but we are not particularly concerned about it. What was your other question, sorry, Mr Wilkinson?

**Mr WILKINSON** - I was wondering when it was going to be concluded?

**Mr DALY** - We have not been given any indication as yet.

**Ms O'BYRNE** - We have not been given any framework around it.

**Mr DALY** - We only received the details on 5 April, around the nature of the audit.

**Ms O'BYRNE** - It appears to be pretty much the same as the one we have done before in terms of opening up the books. We are absolutely under scrutiny. We welcome the commonwealth engagement into health costs in Tasmania because it will help in our arguments around the regional imposts of health services in Tasmania.

**Ms FORREST** - Could I go back to the issue of the funding of the Mersey Hospital?

**Ms O'BYRNE** - Yes.

**Ms FORREST** - I was asking about where this money miraculously appeared from - we are very glad to have it up there, and I am sure the government is, too.

**Ms O'BYRNE** - For those who think closing the Mersey becomes money we could spend in the rest of the health system, be assured, there is no guarantee the Australian government would give us the money if they closed the Mersey.

**Ms FORREST** - On page 4.3, and the following page in general government revenue, in budget paper 1, it talks about specific purpose grants including the national health reform and some national partnership payments, but even in there there is no money for the Mersey Hospital. How does it flow in, and where do we see it in the budget papers? The first time you see it is in the THO North West.

**Ms EGAN** - It comes via Treasury.

**Ms FORREST** - Does Treasury just hand it straight over to the THO? So, THO North West will get the $68 million?

**Ms EGAN** - We get prepaid. We get prepaid each month in advance for it - one-twelfth of the funds.

**Ms FORREST** - There are also funds that flow out of DHHS as expenses. Can you also provide a break-up of the grants that are included in that?

**Ms O'BYRNE** - We can get that for you.

**Ms EGAN** - That is the $240 million we pay to the NGO sector.

**Ms FORREST** - I expect so, yes. Does that also include the state's block payments?

**Ms EGAN** - I think we can probably give you that figure pretty soon.

**Ms FORREST** - All right. And the activity-based funding from the state to the THOs as well - it includes all of that? I am just looking for a breakdown.

**Ms EGAN** - No, not in there. That comes straight from the commonwealth into the funding pool for the THOs. This is only the state component.

**Ms FORREST** - The state does not provide any activity-based funding - that is all commonwealth funding?

**Ms EGAN** - No, it does. It provides its share into the funding pool.

**Ms FORREST** - The DHHS, right. Some goes up and some goes down, more or less, and around in circles. After money has come in from the commonwealth, and been distributed to the THOs by the state, what is left - what is the residual health expenditure? We are having a pared back department, and a funder/provider model -

**Ms O'BYRNE** - But the department still has Ambulance Tasmania, and population health and those other -

**Ms FORREST** - Yes, and then human services still sit under that same umbrella.

**Ms O'BYRNE** - They do in disability.

**Ms FORREST** - The criticism could be that we are setting up these three new structures - the Tasmanian health organisations - and we still have a department to run it.

**Ms O'BYRNE** - No, the department does not run the THOs.

**Ms FORREST** - But, we still have a department to operate.

**Ms O'BYRNE** - A very, very small one.

**Ms FORREST** - Yes, but how much is that costing? And, if you add that to how much the THOs are costing, you can see whether we are going backwards, or ahead.

**Mr DALY** - We report by business units, the three largest being the three THOs, and we report in those papers our expenditure under each of those business units, including the component parts of the department. Some areas in the department provide a whole host of clinical support arrangements, like the network under the chief health officer's area, but we show that.

**Ms EGAN** - We do not show it in the budget papers -

**Mr DALY** - Yes, but we do have a bit of paper that will show it.

**Ms FORREST** - That would really help, because it is very difficult to know what is costing what.

**Ms O'BYRNE** - Absolutely, and it also provides an assessment measure when we are here again in 12 months' time. One of the challenges is that this is the first time the data has been presented in this way - we have been trying to be as open as possible so that you have the information. Previously, before the national health reform process, commonwealth dollars went into Treasury, then they were sent to DHHS, then they were divvied up around a whole host of departments and it was really difficult to track where they ended up.

**Ms FORREST** - That is right.

**Ms O'BYRNE** - Under this model, we should be able to track the commonwealth dollar against the activity.

**Ms FORREST** - You have a flow chart there -

**Ms O'BYRNE** - Yes, this is a simplistic model of the legislation. What effectively happens -

**Ms FORREST** - Are you going to table that?

**Ms O'BYRNE** - Yes, I am happy to table it if that is easy. What effectively happens is that we set up a national funding pool, the state puts its money into it, the commonwealth puts its money into it and then it channels down to where it is supposed to be. It will be the first time that we will be able to see where commonwealth dollars went, and where state dollars went.

**Mr MULDER** - I am sure, minister, you meant 'simplify' not 'simplistic'.

**Ms O'BYRNE** - I am hoping that it is simplistic.

**Ms FORREST** - Is it possible to add the dollars to this flow chart? How much is going where?

**Mr DALY** - In raw terms. They would be very raw.

**Ms O'BYRNE** - The commonwealth money does not change at this point, so it is just a bucket of money.

**Ms FORREST** - We will probably need a slightly more detailed flow chart than this, because they are like separate bank accounts.

**Ms O'BYRNE** - Did you want that for the committee, or did you want that before the legislation?

**Ms FORREST** - Both. We will need it for the legislation as well.

**Ms O'BYRNE** - I know that you will, but I am just wondering when you need it. With a lot of riders around the fact that the dollars would be very -

**Mr DALY -** Rubbery - not rubbery.

**Ms FORREST** - There is appropriation in here for the THOs -

**Ms O'BYRNE** - In terms of the commonwealth, yes, we should be okay. Yes, we would be able to do that.

**Ms FORREST** - So, the money comes from the commonwealth and it goes into the national funding pool, and then it goes out to the three THOs - $X to South, $Y to North and $Z to North West. The state funding then comes in, and flows to the block grant state-managed fund, and the DHHS state account. I want the dollars attached to each of those flows.

**Mr DALY -** We are maintaining the historical allocations to each of these hospitals for purchasing -

**Ms O'BYRNE** - The other area to look at might be on page 21.7.

**Ms FORREST** - In health?

**Ms EGAN** - The THO chapters.

**Ms O'BYRNE** - The THOs should each show revenue from the Tasmanian government whether it is block funded or activity-based funding and if you align that against the THO documents you will get the divvy up between the three.

**Ms EGAN** - Each chapter has a table - 21.4, 22.4, 23.4.

**Ms O'BYRNE** - Yes, so that exists already.

**Ms EGAN** - That is indicative of the dollars.

**Ms O'BYRNE** - That is on page 21.7 for the North, for the North West on -

**Ms FORREST** - I have them all, that is fine and I know where they are. Could you also provide a description of the process used to establish the service agreements - the corporate plan and your business plan for the THOs, because this will drive the money as well?

**Mr DALY -** Under the legislation the service agreement has to be signed off by the minister by 30 June.

**Ms FORREST** - Federal minister?

**Mr DALY -** No, our state minister. We finalised the draft and the format of it with the chief executives going back over many weeks now. We are now populating it - now that the budget has been handed down - into the block components of those services and that is largely on advice from the chief executives. We have the balances and the purchasing pool and we are going into negotiation about the volume, the price, and the mix - the detail meeting will probably start next Monday, and we will tie down those numbers based on historical budget allocations. That is why it is easy to track that previous question. That will be finalised by 30 June.

Also, in the legislation there is a requirement for a corporate plan and a business plan. Normally they will be done in advance of the service agreement, but as this is our first year they will be finished early in the new financial year for formally tabling through parliament, as required by the legislation.

**Ms O'BYRNE** - That is the position from the purchaser. From the provider's point of view the other thing to remember is that Graeme, as the Chair of the THOs, reports direct to me from the provider perspective, so I might ask if you have anything you want to add to that?

**Mr HOUGHTON** - No, I think that is a pretty complete summary. Obviously things are different this year because of delays in getting things started, but it is as Matthew has described in terms of dates and requirements.

**Ms FORREST** - So, a similar approach has been taken with the activity projections then?

**Mr HOUGHTON** - Yes, I think that is fair. I am not close enough to the negotiations between the commissioning unit and the CEOs to be really certain about the detail, but broadly that is right.

**Ms FORREST** - The determination of the areas subject to block grants - that has been a negotiated position between the Area Health Services, at this point -

**Ms O'BYRNE** - It is fundamentally shaped by what the commonwealth will block fund - what is excluded from ABF under the national health reform.

**Mr DALY -** That is right. There is a commonwealth determination of what can be block funded and what will be ABF funded, and we talked about those exceptions. What will be block funded is really a negotiation with the chief executive. Most of it is fairly clear because our cost modelling has picked up things like teaching and research, et cetera, primary care or ambulatory care that is not part of ABF. That is fairly clear but -

**Ms FORREST** - Things like neurosurgery I will be interested in. Is there a list available of all the block grant -

**Ms O'BYRNE** - They are the ones that -

**Ms FORREST** - Was that all of them? There were no others?

**Mr DALY** - No, they were the specialty services that the commonwealth have agreed.

**Ms FORREST** - Right. But there are no more that you are seeking?

**Ms O'BYRNE** - We would be happy to get lots of things block funded, frankly. We are close to final sign-off so I would not think there would be many more additions to that.

**Mr DALY** - It is mainly the regionality issue.

**Ms FORREST** - That will be evident in the service agreement, won't it?

**Ms O'BYRNE** - That will be depicted within a service agreement. For instance, a block funding for a regional facility will be we gave *x* and now we are giving you *y* and that is block funding for that facility. Is that an easy explanation of that?

**Mr DALY** - Yes.

**Ms FORREST** - Yes. As far as the governing councils go, have members been appointed to the three other governing councils?

**Ms O'BYRNE** - Recommendations have arrived in my office but I have not looked at them today yet.

**Ms FORREST** - Really?

**Ms O'BYRNE** - I did a scan on an e-mail but that is about it. We should hopefully get that to cabinet next week.

**Ms FORREST** - It is going to be announced after cabinet approves?

**Ms O'BYRNE** - I can speak to the Premier about it. She and I as the appropriate minister may be announcing it earlier but I have not had it yet. I would need to speak to the Premier about that. We would like them in operation but under the legislation Graeme is appointed as the interim chair and therefore has the capacity to negotiate on behalf of the three governing councils. We would like them in as soon as possible.

**Ms FORREST** - Before we move into the line items, I have a couple of questions. One is about the treatment for superannuation liabilities within DHHS now that Treasury has made a decision.

**Ms O'BYRNE** - Are we moving into line items now?

**Ms FORREST** - No, this is an overview about the whole department. In last year's budget paper 1, page 7.17, it is stated that agencies are currently contributing an employer contribution rate of 12.3 per cent of salary regarding defined benefits members and a gap payment of 3.3 per cent of defined contribution members. These, I believe, end up in the SPA - the Superannuation Provision Account, as opposed to the bubbly spa.

**Ms EGAN** - I would never have thought.

**Ms FORREST** - Then they would be internally borrowed effectively. Just a few questions on this line. In the past, did the DHHS use part of its appropriations to pay these amounts?

**Ms EGAN -** We would have. We do not have an unfunded liability of our own, no, so on emerging basis.

**Ms FORREST** - Where were they paid, to finance general or into the SPA?

**Ms EGAN** - I would have to check that; I am not sure.

**CHAIR** - That one is on notice then.

**Ms O'BYRNE** - We will get that here today.

**Ms FORREST** - How and where are such payments recorded in the DHHS's books in the income statements and cash flow statements? You will have to take that one on notice as well I should think.

**Ms EGAN** - With our superannuation payments that we make on behalf of everyone, that goes straight to their own fund, RBF or whatever, so we do not make a provision for any unfunded components. I will clarify that for you.

**Ms FORREST** - Moving now to the future, with the abolition of the SPA, how will DHHS now treat the expense of the defined benefits superannuation? Will this be a superannuation expense in the income statement? Will the actuary calculate employer costs, or how will it work?

**Ms EGAN** - The actuary only calculates at the moment the superannuation unfunded liability for Ambulance Tasmania and Housing, but I will double-check that. However, there is no actuarial assessment of DHHS. That would be like other government departments. It is treated in the same manner.

**Ms FORREST** - How will it be treated now then?

**Ms EGAN** - Going to THOs?

**Ms FORREST** - No, across the whole department. Will the THOs have to manage their own?

**Ms EGAN** - The unfunded liabilities or just the superannuation payments?

**Ms FORREST** - Both. If they have the unfunded liability but also the money you have to contribute for defined benefits superannuation.

**Ms EGAN** - There are no unfunded liability in our accounts so they would only be expensing their superannuation expense which is their 9 or 12 per cent. They will not be receiving an unfunded liability from the department for superannuation.

**Ms FORREST** - Okay. Effectively with the closure of the SPA, how will DHHS manage? Will you have to change what you do to afford it?

**Ms EGAN** - No, not that I understand, no change.

**Ms FORREST** - The income statement on page 5.28**(TBC)** regarding grants -

**Ms O'BYRNE** - Grants and transfer funds?

**Ms FORREST** - Yes. Footnote 4 talks about 'increase in grants reflects movements in funding from special capital investment funds'. I am interested in how you can shift money from the special capital investment fund and call it revenue in this way. Can you address your mind to that and how much was moved or shifted in this way?

**Ms EGAN** - Under an accounting treatment, grants are treated as revenue, so they are unlike some other grants for capital works, which are treated in a different way. So they are specific grants that go into our income statement as revenue and then they are expended or depreciated over time. That is an accounting treatment; it is not specific just to government.

**Ms FORREST** - Oh right. So, it was not appropriated out of works and services because it is always recurrent. Is that what you are saying?

**Ms EGAN** - For certain types of grants, yes.

**Ms FORREST** - The ones this refers to, obviously.

**Ms EGAN** - Correct, yes. So it is not a shifting of money from one to the other. They are a defined grant; so for accounting purposes, they are treated as revenue in the year that they are received.

**Ms FORREST** - Okay. It looked a bit like creative accounting as in works and services, changing it to -

*Laughter*.

**Ms EGAN** - We would never do that.

**Ms FORREST** - I knew there would be a reasonable answer.

**Mr WILKINSON** - It is not my area at the moment but if you are over budget, do you have any appraisals with let us say, heads of department or heads of agency, to see how they are going monthly on budget; if they are not going well, what happens? What happens to their contract if they do not meet budget?

**Ms O'BYRNE** - Do you mean in terms of the THOs in particular, because the CEOs are given powers as heads of agency, or do you mean in terms of -

**Mr WILKINSON** - The man on your left.

*Laughter*.

**Mr WILKINSON** - In other words, do you put him under the microscope?

**Ms O'BYRNE** - Matthew signs a performance agreement with the Premier. He is an employee directly of the Department of Premier and Cabinet in his role so, under his performance agreement he is assessed against the targets that the Premier identifies.

**Mr WILKINSON** - I was going to ask this in relation to all areas because of the situation -

**Ms O'BYRNE** - I just add that the three area health service CEOs, when they come into the THOs, will have powers as heads of agency as well.

**Mr WILKINSON** - Some, for example police, have come in on budget year-in year-out whereas health, obviously partly because of the type of agency it is, has not come in on budget for many years. Are there going to be any -

**Ms O'BYRNE** - We always come in on budget.

*Laughter*.

**Mr WILKINSON** - Well, you have to ask for extra.

**Ms FORREST** - With a bit of help at the end of the year; when the appropriation comes in.

**Mr MULDER** - After the supplementary appropriation.

**Ms O'BYRNE** - Yes, bless them.

**Mr WILKINSON** - What I am looking at is what stick, if you want to call it that, have you to ensure that people are doing all they can to come in on budget and, if they are not, are there going to be penalties?

**Ms O'BYRNE** - THOs are the bulk of the work that we do, and the legislation for the THOs spells out their obligations around budgets and the capacity of the minister to intervene and engage with the boards because we are moving to a governance board model. The management tools that are in the act are that I, or the minister of the day, can instigate a review and an audit if there is a perception that they are not tracking against the budget initiatives. The minister can require the production of a performance improvement plan if they identify that there is a problem so they would need to identify the acts that they were taking to remedy the concerns. If there is a concern that it might not be able to be delivered, the minister can establish a performance improvement team to work with the governing council. In the second-most extreme, you can put a ministerial delegate to governing council so if you thought the governing council was really struggling, we could give them a resource to work with them on whatever the specified problem might be. The ultimate sanction that the minister of the day can do is to terminate a governing council.

**Mr WILKINSON** - That is all within, not just -

**Ms O'BYRNE** - That is all within the legislation.

**Ms FORREST** - That is what we passed last time.

**Mr WILKINSON** - Yes.

**Ms O'BYRNE** - Yes, that was the last but also we will be monitoring it through the system, purchasing and performance group so, because many of the targets in the service agreements will be quarterly targets - within a quarter you must have done - it will become very clear if there is a challenge. In the next two years we are going through a transition so it is not that from 1 July we expect every single issue to be resolved and everything working perfectly, the transition recognises that we will be moving towards a new model. So there will be flexibilities to work with any challenges that come up because they may be challenges to do with capacity to deliver an outcome, but they might also be that the ask was framed inappropriately as well. That is what the two years gives us the capacity to do, and that is why the transitions are really important to get that right. I expect there will be a number of changes, particularly in the first 12 months, as we move through. The two years are to ensure that by the time we get to a point of there being gross funding from the feds and the feds actually engaging in an ABF analysis we have lined up everything that we need to have lined up.

**Mr WILKINSON** - Because of the transition, are those meetings going to be regular each month, each week or each fortnight?

**Ms O'BYRNE** - The executive team meet mid-monthly, don't they?

**Mr DALY** - We certainly do. I could go to Graeme at this point because clearly the governance of the THOs, which is the bulk of health expenditure, is now under the governing councils and - I don't want to put the words into your mouth - Graeme is in the process of setting up those governance mechanisms in relation to how the councils are going to monitor the performance and liaise with the chief executive on a regular basis.

**Ms O'BYRNE** – Historically, the CEOs have always been reporting at an executive level anyway.

**Mr WILKINSON** - I ask the question because a number of people - it is in single figures but it is close to 10 - have asked, 'Is it a situation that times are tough, that you really put the acid on the people who are looking after the money, and if they are overbudget you say, "Sorry, you've tried, but see ya later"? I know that is a bit hard but that is the type of comment that is coming from outside. That is why I want to investigate that area for a short time to see what there is to ensure that people are going to come in on budget to the best ability that they can.

**Ms O'BYRNE** - Governing councils and THOs will have to come in on budget because we are at the end of the opportunities for bail-out funding if they do not.

**Mr WILKINSON** - So there is no opportunity at all for any bail-out funding?

**Ms O'BYRNE** - I could go to Treasury but I am pretty sure I know what they would tell me. The reason for the transition is to assess whether or not the ask that we have - because we will be buying services and if it becomes clear that there is a challenge on delivering the service for the dollar we have, that is what the two-year transition is about. But Graeme can talk about the governance mechanisms that they will put in place.

**Mr HOUGHTON** - The ultimate sanction is as you have described it, the governing council or the management can be changed and I strongly agree with what the minister said about the budget being an absolute requirement. I am really concerned that we have the kind of relationship

with the department so that there is mutual understanding of the issues that we are facing and that the THOs understand exactly what is going on in the department, in the requirements of government, and that on the other hand the department understands the pressures that the THOs are dealing with.

Given the graduated mechanism for intervention that the minister has described, that is a really healthy process and there are many steps before we get to the ultimate draconian termination of a government council, or of a CEO, or other parts of a management team.

**Ms O'BYRNE** - The other thing to remember is that within a demand-driven system there will be unusual circumstances that come up that might not have been identified in a service agreement. So if there was a significant state emergency or incident, then we would not be expecting THOs to absorb the cost of such a significant event within a service agreement. So there will always be the opportunity to manage the unusual circumstance that could occur because that is a reality that we face in a demand-driven service.

**Mr WILKINSON** - Is there going to be ability for people such as us - I would imagine it would be a committee as opposed to an estimates because it would want to be confidential - to look at what people are being judged and assessed upon?

**Ms O'BYRNE** - In terms of the service agreements?

**Mr WILKINSON** - Yes, let's say in charge of the THOs, did you obtain budget? What areas do you believe that you could make improvements in, if so, how much money? They are just a couple off the top of my head.

**Ms O'BYRNE** - That is the work we will be doing all the time but the same powers that exist for a committee to summon a bureaucrat now will exist into the future. I am not aware that that would change at all.

**Mr WILKINSON** - What I am looking at is appraisal forms. I understand there are presently appraisal forms in relation to, let's say, heads of agency. They are appraised at certain times to see how they are performing. There is certain criteria upon which they are appraised and there are certain comments made by government as to how they perform on that criteria. Are we able to see that at any stage in order that the process is transparent and so no-one can hide behind closed doors and just say, 'Look, it is an agreement between minister and the head of agency'.

**Ms O'BYRNE** - The service agreement will be totally public, in parliament and available publicly, so that assessment of what our expectations are will be very clear. The service agreement will have clear things that must be achieved within each quarter and that becomes the identifier that there might be a challenge, bearing in mind that in the first two years there is going to be a degree of flexibility as we work through how ABF funding will work because, in all fairness, none of us have done activity-based funding in this sense before - Graeme is probably the closest to it perhaps, I do not know. It is a very new framework for us and we need to get it right but monthly there will be assessment as to whether or not the THOs are achieving against their service agreements and there is always a capacity for any government official to be asked to appear.

**Mr DALY** - In essence, the service agreement is the performance agreement of the chief executive. It will have anything from budget, to activity, to clinical patient safety -

**Ms O'BYRNE** - This is the point where you look at them all smiling.

**Mr DALY** - Sitting alongside that would be the formal performance agreement that Premier and cabinet require us to complete and that would have some more personal things around professional development objectives and those types of things, but the vast majority of objectives in KPIs will be within the service agreement that will be publicly available on the web.

**Mr WILKINSON** - Do people, if they achieve targets, get added benefits, added money, added -

**Ms O'BYRNE** - The added benefit of exceeding targets will be more people coming through the door that in the event that we get to the next two years in the whole will mean growth funding. That is the added benefit. That is the reward.

**Mr WILKINSON** - Let us say, I am in charge of a department, I bring it under budget. Do I therefore get an extra wage or an incentive for achieving budget?

**Ms O'BYRNE** - No.

**Mrs ARMITAGE** - Through you, Chair - We mentioned the CEOs. With the new CEOs, will they have to reapply for their positions as CEO of the boards as of 1 July, or will they carry on until the end of their contracts currently?

**Ms O'BYRNE** - This was canvassed when the legislation went through the House both in the -

**Mrs ARMITAGE** - Yes, but I thought it was that they had to reapply with the boards.

**Ms O'BYRNE** - No. Their existing contracts are held. We have just recently reappointed the Royal Hobart Hospital, as there can be some delays in resolving the issue of a consistent head of the Royal Hobart Hospital. The North West Area Health Service is a position that will be advertised. Have we started advertising yet?

**Mr HOUGHTON** - No, it is imminent - very soon.

**Ms O'BYRNE** - Imminent for that - and the Northern Area Health Service has an incumbent on a contract. It is not the intention to unpick any existing contract.

**Mrs ARMITAGE** - No, that is fine. It was just that I was of the understanding that the new boards were actually choosing their CEOs.

**Ms O'BYRNE** - The new boards will choose any new CEO.

**Mrs ARMITAGE** - As of their contracts expiring.

**Ms O'BYRNE** - As at the time when they advertise for a new CEO.

**CHAIR** - Minister, I want to go to one area - and it embraces 1.1, 2 and 3 and 2.1, and I am going to the footnotes, 2, 3 and 4 from the appropriation line - if you go to page 530 if you want,

5.30 - and this is the snapshot. Those three footnotes and particularly footnote 4 indicate clearly that all of those figures which you have there are very preliminary and they will be reviewed during the looming financial year. What confidence do we have in your forward estimates given they are very preliminary numbers?

**Ms O'BYRNE** - For instance, these ones do not include the $4 million - I am just going to check that - so that would vary the figures for the $4 million that we might get for particular services - endoscopy and acute.

**Ms EGAN** - They have been apportioned in the THO side.

**Ms O'BYRNE** - Yes, the THO budgets have been aligned.

**Ms EGAN** - But preliminary and not to be given, so just for the $4 million that has been apportioned. The THO side is not in here.

**Ms FORREST** - Is that why there is some differences in the numbers then, because the $4 million has been apportioned to the THOs but not in this area?

**Ms O'BYRNE** - There has to be a clinical assessment around the $4 million.

**Ms EGAN** - The $4 million, so we have received the money and we have had to allocate it just on a percentage basis for no other reason and then going forward there will be a budget that will be negotiated with the THOs, which is a cash budget and quite different to what you will see in these budget papers.

**Ms O'BYRNE** - This is the point where we would normally go to Mr Pervan, who is the commissioner who is in the process of negotiating but Mike is not available for the reasons we discussed earlier.

**CHAIR** - The review is going to take place during the looming financial year. Do you have a time frame on that?

**Ms O'BYRNE** - We have the service agreement. I am not sure but I think we might be talking cross-purposes here.

**Mr DALY** - I did not think the $4 million was going to be in the service agreement. We will not have had clinical advice yet in terms of the distribution of those fundings to the clinical priorities.

**Ms O'BYRNE** - I am not sure that that is actually what Mr Harriss is asking me.

**CHAIR** - I am looking specifically at the department not the THOs.

**Ms O'BYRNE** - It is because what may change is anything that might be negotiated in the service agreement, which will be tabled in parliament. The service agreements are being negotiated now. I do not think there would be very much variation to them, but what do you anticipate might be different in the service agreement, bearing in mind that the people we are negotiating with are just sitting right there?

**Mr DALY** - That is right. They will be developing a financial plan that might see more ambulatory activity, adjustments to day-only activity, and same-day activity, and overnight activity. These figures are just projected on the current activity at the moment but subject to finalising financial plans in the service agreements, there could be changes between -

**Ms O'BYRNE** - There will be some variations, but not in the overall budget that we are allocating.

**Mr DALY -** Not in the dollar budget, no.

**Ms FORREST** - Just to clarify then, the 2012-13 figure for admitted services, for example, is $385 million there. That is for admitted services. What service are we talking about being funded here?

**Mr DALY** - That would be an amount that would go into the acute service purchasing pool. What that would purchase and the nature of that purchase is subject to the negotiation with the chiefs and the governing council.

**CHAIR** - Just one other in this area of Overview: historically, and I am taking you to table 5.3 on page 5.12 and they are performance indicators, specifically with regard to waiting lists. For 2010-11, the actual is recorded, the expected for 2011-12 is there. My first question is what is it year to date? Where is it trending?

**Ms O'BYRNE** - I did give those figures before on waiting lists. Did I give the totals or just the reduction? I will give it again just in case. The statewide waiting list, do you want some trending pictures of it?

**CHAIR** - Yes. What the current year is likely to be, given that the target was 8 914.

**Ms O'BYRNE** - At 31 March, the statewide waiting list was 7 925. Did you want some dates from before that to get a picture of how that is trending?

**CHAIR** - No, that is fine, thank you. The only other question with regard to that, with the establishment of the THOs, will there be an opportunity to compare a statewide waiting list?

**Ms O'BYRNE** - Yes, we will still get statewide waiting list data.

**Ms FORREST** - And individual THOs.

**Ms O'BYRNE** - We will need that to report to the commonwealth anyway.

**Mr VALENTINE** - We were talking about e-health before in a different context. With the NBN rolling out in Tasmania, there are going to be opportunities to be able to develop e-health services across that. What sort of provision is the department making to fund projects to do that, or is that not something that you see as important?

**Ms O'BYRNE** - No, it is absolutely important and it builds on work that we have done - as someone hands me the figures on that - it builds on the trial, for instance, that we have done around the Central Highlands Multipurpose Centre, which has been that instead of patients having to come in and do their blood tests, or community nurses going out to their home, we are using

mobile phone technology, which is not as good as NBN, to do daily readings of blood sugar levels and heart levels and that has actually meant a more efficient service but also a quicker identification if they might need to present, or if we do need to engage in care.

**Mr VALENTINE** - So they are doing that in the home, are they?

**Ms O'BYRNE** - They are doing that in the home. There is some really good technology being developed in placing facilities in people's homes - particularly those who need more constant monitoring who are required to come into hospitals or we have to send someone to - so we can actually plot the data and therefore notice if there is a problem. In South Australia, the rural, particularly Aboriginal rural nurses, get onto their screen to for some patients who have challenges managing medication, and they say, 'Show me your medication', and they show it to them and then say, 'Show me the label, yes, now you can take two of those', and two will be taken. Those things can manage chronic disease to keep them out of the acute sector.

The work we have been doing in IT, particularly around clinical administrative systems, we have the patient administration system in all the hospitals and the community hospitals, of $14 million; the RIS/PACS, which is the medical imaging one and that means you do not need to take expensive files around -

**Mr VALENTINE** - I understand that. I have been involved in some of those.

**Ms O'BYRNE** - Oh, sure.

**Mr VALENTINE** - In my previous life. I am wondering whether ongoing funding, once the THOs come into play -

**Ms O'BYRNE** - It will still be an obligation because that is one of the ways we will drive down the cost of health care.

**Mr VALENTINE** - Exactly.

**Ms O'BYRNE** - We will be engaging in IT projects and the CEOs have all been looking at different models on how they use NBN but also how they use e-health in order to manage presentations, reductions in presentations and also even their own systems flows so that we are not double-counting. We have all heard the stories about the person who comes into emergency and gets referred for the same set of tests by a series of different clinicians that they may encounter.

**Mr VALENTINE** - Yes.

**Ms O'BYRNE** - There is a whole lot of savings we can make so it is in everyone's interests to get the IT right.

**Mr VALENTINE** - It is an opportunity, that is all, with the NBN and I just wanted to make sure that it was going to continue.

**Ms O'BYRNE** - Yes. There is a huge capacity within the NBN for e-health and for keeping people, particularly within regional communities. One of the issues is, often you might need to travel from St Helens to Launceston to see a physiotherapist who just wants to see if you are

walking straight now or without a gait, and then they will send you home; that is a massive journey. What they can do now is go into the St Helens District Hospital, if it is not flooded, and view that over the e-health capacity to ensure and give the person the release then, rather than making the person travel all the way to Launceston, sit there for however long for a short appointment and go home again. That is good, not only for us because we are giving better health care, but it is certainly better for the individual.

**Mr VALENTINE** - Or someone on King Island who does not have to hop on a plane.

**Ms O'BYRNE** - Yes, absolutely. Every existing health facility has that.

**Mr MULDER** - And the NBN is coming to King Island when?

**CHAIR** - We will adjourn for 15 minutes and then we will get stuck into the specific layouts.

**The committee suspended from 3.33 p.m. to 3.51 p.m.**

**Ms O'BYRNE** - Can I table some additional information? This is sponsored by the optometrists society because it is teeny tiny writing but I am sure that we will be able to e-mail it as well so that the committee will be able to read it properly. This is the pay debtees??? by group and award from pay period 26 06, through to pay period 14 April and covers each of the area health services in a break-down of all professional groups. It also does include children, youth services and some areas that are the responsibility of Minister O'Connor, but it is a little difficult to unpick. We will e-mail you a document that is easier to read. We will print it out in a more manageable form but formally table it.

**Ms FORREST** - Like A1 or something maybe.

**Ms O'BYRNE** - I can give you the headline of that and that is that in pay period 26, 2011, the total staff we employed was 9 878.68 FTEs. The year to date on 14 April was 9 226.86, a difference overall of 651.82. I can give you where the variance occurs from those two points but it is in the documentation.

**Ms FORREST** - That is fine.

We will move into the line items - output group 1, Admitted services. Under the national health reform, general government revenue, budget paper 1, page 4.9, talks about additional funding for a range of services like elective surgery, elective surgery capital, emergency services department capital, emergency department capital, elective surgery in subacute areas - not a huge amount of money, I admit, for our national access target and subacute beds. Were any of these reliant on meeting certain targets or were they unconditional and you get them regardless?

**Mr DALY** - There is no condition attached to those moneys.

**Ms FORREST** - You get those anyway?

**Mr DALY** - Yes. In order to start the reengineering process to move health services across the country towards those in the commonwealth targets.

**Ms FORREST** - They have had a bit of assistance in getting up to speed to meet the requirements.

**Mr DALY** - Yes.

**Ms FORREST** - What have the staffing ratios been between ENs to RNs in our major hospitals? Could we have a little bit of historical data about the last couple of years up to this year?

**Ms O'BYRNE** - We will get that brought down. We do not have a staffing ratio comparison. What period did you want the historical data to cover?

**Ms FORREST** - 2009-10 to current. There was the AIN trial last year or the year before.

**Ms O'BYRNE** - It has taken a while to get off the ground. The AIN trial is currently being undertaken at the Royal Hobart Hospital. I do not know if you wanted Jane to talk about how that is progressing. Jane, are you comfortable to come and talk about the AIN trial?

**Ms HOLDEN** - Sure.

**Ms FORREST** - An update on where that is at and how long it has been going.

**Ms O'BYRNE** - It took a very long to get a framework around the trial. -

**Ms HOLDEN** - It is only just beginning, in fact, so I don't really have any progress to talk about.

**Ms FORREST** - What has been the hold up with it?

**Ms HOLDEN** - We needed two sites to do a comparison with and we changed a number of beds in one of those sites which made the rostering impossible so we needed to find another site. There was some resistance from the nursing and HACSU workforce around understanding what the specific roles of the staff would be. We have worked through all of those issues, including working them through with the State Services Commission on one particular issue and we have been able to move forward and start the trial. One area has just started and one starts in about July.

**Ms FORREST** - How long is the trial going for?

**Ms HOLDEN** - Six months was agreed, before we review it.

**Ms FORREST** - You will review it to see if there are any impacts on staffing costs?

**Ms HOLDEN** - Also on care as well, so it is the whole outcome and how much clinical input there is, what the role of the AIN is in terms of the clinical mix of staff and whether it means that there is more clinical time for nurses because AINs are picking up this other time.

**Ms FORREST** - As far as the cancellation of elective surgery goes, how does that compare? Have you got the same time last year and the same time this year? The time since the cuts have been in place really.

**Ms O'BYRNE** - Elective surgery postponements - I can give you the 2012 data. We would have the previous data available, but I am not sure how quickly someone can hand that to me. In 2012 to date we have postponed a total of 756 elective surgeries - 556 of those prior to admission and 200 after admission. In some cases, the surgery would have been undertaken again in a very short period of time and for others it may have been longer. I will get some figures for you on that. Did you want them for each region?

**Ms FORREST** - Yes, but also if there is a break-down of ones that are because the patients were not ready, they were unwell or -

**Ms O'BYRNE** - There are some that are initiated by the patient, so we will get that for you as well. I do not have that in front of me.

**Ms FORREST** - What I am particularly interested in is the number that was postponed because of lack of beds, or lack of ICU bed, or unavailability of a medical team.

**Ms O'BYRNE** - We can get you those figures. I do not have them in front of me now, but we do have them.

**Ms FORREST** - Okay. As far as the comparison, one would assume it would have increased in the last 12 months compared to last year?

**Ms O'BYRNE** - I have January 2012 to March 2012, which shows an increase, but January is difficult because the amount of throughput we had is so much lower anyway. It is probably a little hard to give it from that, but we will get some for last year.

**Ms HOLDEN** - In terms of data I agree, but I think in terms of position there is no reason ???**(3.58.57)** that postponements have increased because that is have we not booked the patient correctly, have we cancelled the theatre, so the issue is we certainly slowed down the throughput. But for the postponements, once patients have booked there is really no good reason why postponements would increase.

**Ms O'BYRNE** - I have spoken to some of the surgeons, because there has been a lot of media around postponements, and there are some people to whom we say, 'Look, no guarantee, but if you turn up and we manage to get through a heap of surgeries today we can put you on a stand-by list'. Individual patients are often quite happy with that because they say yes, but individual patients' families can be very distressed about all of the work that they have done in getting mum or dad to the hospital in order to have that.

We do also run a stand-by list, so if someone does not front, which does happen, or we get through the list further, there are people we are probably not expecting to get through but we will try to deal with if a bed opens up, so we do not waste that opened-up bed. We do also keep a list almost like a stand-by list for people. We try very hard to make sure that those are local people, so that they can get a phone call and come from home. On occasion, there have been issues where people have been asked if they want to be on standby and they are a long way away and then by the time they get their call and arrive it is such a long period - we do not have the efficiency to

handle those situations. Surgeons try very hard to manage that, and move patients through as quickly as they can sustainably possible, but we will get to the comparisons.

**Ms FORREST** - It has been a criticism in the past that you have not been collecting as much revenue as you could from the private health funds in respect of private patients. How is that going?

**Ms O'BYRNE** - It is always good to collect other revenues. The reality is that we can ask people on admission if they have private health care, they can tell us if they have private health care, but we cannot ask them to use their private health care. We need to encourage people to understand the benefit of using their care and, in many cases, we can cover any gap they might have to pay. Deloraine, for instance, has a very good throughput of people opting to use their private health care cover, predominantly because the senior nurse there says, 'Look, you don't have to, because it is against the law to make anyone use private health care, but it really helps the health system if you do this and we can cover the gap and it won't be a problem for you in the future', and almost all people in Deloraine say, 'Sure, no worries then'. It is a very fine line because we cannot coerce people to use their private health care arrangements.

**Ms FORREST** - But as far as collecting the revenue from those who declare as private patients, is that consistent?

**Ms O'BYRNE** - Who opt to use it?

**Ms FORREST** - Yes.

**Ms O'BYRNE** - I think we are better at that than we possibly were.

**Ms EGAN** - I think there might be something in here. Dr Paul Tridgell has been reviewing all our revenue streams and there will be a number of initiatives coming from that review which will increase revenue in the future.

**Ms FORREST** - What sort of money are we talking about? What are we collecting now as private patient revenues compared to what we could receive if we collected for all patients that identify, and use private health cover?

**Ms O'BYRNE** - Once they have identified, or -

**Ms FORREST** - Yes, the moment someone identifies, I understand the revenues are not being collected.

**Ms O'BYRNE** - Do you mean the people who identify that they will use it and there is a concern about whether we would collect it, as opposed to someone who has it and does not tell us, or does not choose to use it?

**Ms FORREST** - Yes.

**Ms EGAN** - I am not sure we could give you a definitive figure because if they do not tell us they are private we will never know.

**Ms O'BYRNE** - Ms Forrest is saying that if they do tell us, are we absolutely sure that we are getting the money, and I think we are probably a lot better at that. I got nods from CEOs there. Did you want to talk on that at all, John? We are just getting better but we would not have any data at this point.

**Ms FORREST** - He is nodding.

**Ms O'BYRNE** - But it is an area that has historically been a challenge for us.

**Ms FORREST** - Has the amount of private patient work increased?

**Mr DALY** - The latest data is that we are plateaued at 19 per cent, which is not a bad figure nationally - so 19 per cent of all our separations in 2010-11, and roughly year to date 2011-12 as well. There are revenue initiatives open to us and we have had some work done which we will be passing on to the THOs, to have a look at the applicability, because clearly generating revenue is a lot more productive than reducing costs, particularly if it impacts on services. In terms of our private patient admitted, I think we are doing pretty well but there are some other models of revenue generation, particularly for the next two years before the commonwealth comes to the party with their funding for public health in the new arrangement, that we have open to us.

**Ms O'BYRNE** - I can give you some figures - 43.9 per cent of Tasmanians have private health insurance as of December 2011, compared with 45.7 nationally. There are obligations related to access to free care, so we cannot require people -

**Mr HARRISS -** What was the national figure again?

**Ms O'BYRNE** - Nationally, 45.7 per cent.

**Ms FORREST** - So, there has been an increase in the number of Tasmanians with private health cover, in difficult times? You said it had gone up.

**Ms O'BYRNE** - I do not have trend data to see if 43.9 per cent is an increase but I thought it would have been around that figure anyway. I do not think it is significant. The biggest jump in private health insurance came when the Australian government brought in penalties for joining private health insurance later on - that was the biggest shift. Sorry, I making a noise with paper and annoying *Hansard*, I think.

Of the total number of separations in Tasmanian hospitals in 2010-11, 90 per cent were private patients. Of these private patients, 76 per cent were privately insured, 15 per cent were DVA, 4 per cent were third party vehicle insurance, and 2 per cent were covered by workers compensation. The vast majority of privately insured patients in 2010-11 were medical patients with the single biggest proportion - 40 per cent - being dialysis patients, which is a service that is not available in the private sector. The next largest proportion was 5 per cent, for chemotherapy patients. One of the issues we regularly raise, and everyone in ED tells me, is that after Saturday sport they have a truckload of people come in with injuries suffered while playing sport. All sporting organisations, and as the sports minister I know this, take out insurance. It is very hard to get sporting organisations to use that insurance, and for individuals to ask for sporting insurance cover, so we do carry a fair load of people for whom there is another insurance opportunity.

Many of those people who present are using the public health system, when they have another level of insurance. That is worth exploring, but how much could you get out of that without making it more difficult for people to play sport? You would need to look at the overall public good of the outcome.

**Mr VALENTINE** - It is a two-edged sword.

**Ms FORREST** - As far as agreements with private hospitals and utilising their services, if they have some redundancy, is there money to pay for service in the private sector?

**Ms O'BYRNE** - We purchase some services from the private sector already because they are the most appropriate available. We talked about maternity contract before, and the Launceston General Hospital uses the The Eye Hospital for much of its ophthalmology work. There are always opportunities, but the key is that you would purchase if it were more cost effective to do so. That work is always ongoing. Certainly, when there have been discussions about what the Australian government may or may not do to assist with some of the particular challenges in Tasmania, a private sector purchase option is always on the table. Remember that the doctors and nurses working in public and private facilities are often the same doctors and nurses. On occasions when we have received a large sum of money in order to buy private services, it has put pressure on both the private and public sectors, particularly if the funds are to be used within a defined period.

**Ms FORREST** - It shifts staff to the private sector, and they are not available to the public sector.

**Mr MULDER** - I have a supplementary when you are done on that one.

**Ms FORREST** - On that one?

**Mr MULDER** - The insurance issue.

**Ms FORREST** - Yes.

**Mr MULDER** - What incentives are there for people to be insured if they have a public health system that picks up everything anyway?

**Ms O'BYRNE** - The health insurance model is an Australian government responsibility, but if you are in an area that does not have private health care then clearly there is no issue. That is certainly the case in the Northern Territory - I think they only have one private facility. Your time on a waiting list is the incentive.

We will provide emergency care to those who need it - private health insurance does not impact on the right to receive emergency care. However, with elective surgery, the choice is to do with waiting times. That is the incentive, or disincentive.

**Mr MULDER** - My point goes to the long-term need for the public system to somehow cope with ever-increasing demand. It seems to me that here is an avenue that everyone is too frightened to touch.

**Ms O'BYRNE** - Under the National Healthcare Agreement 'eligible persons are to be given a choice to receive, free of charge, as public patients, health and emergency services of the kind or kinds that are currently or historically provided by hospitals. Access to such services by public patients, free of charge, is to be on the basis of clinical need and within an appropriate period, and arrangements are to be in place to ensure equitable access across such services'.

We have had a number of surgeons saying you should ask people to contribute a co-payment, or some other type of payment. There are issues with that suggestion. You do not want people to not seek medical care because they are worried about not being able to pay. Also, the Australian government would need to change the universality principles of access to health care, and that is not a debate that anyone is ready for at the moment.

**Mr MULDER** - No-one is ready for it, but the problem is that we have to have it sooner or later. Perhaps, in your position, seeing the impacts of the current situation, you might become its champion.

**Ms O'BYRNE** - I do not think that we should remove the universality of access to service. Doing so means that you immediately deny some people access because they will be too frightened to turn up because of cost. I do not think that Australia as a community would ever accept that kind of preclusion. There is scope to look at things such as single funding models. The model that we are agreeing to for how funding is channelled to Tasmania from a Tasmanian and commonwealth service gives us an opportunity to say that is the sort of model that you could use to look at a single funding service to reduce the duplication that occurs in levels of service.

**Mr MULDER** - What I am hearing here is an argument for the national health service system as opposed to a mix of private and public health.

**Ms O'BYRNE** - I think we are always going to have a private health facility. Remembering of course the primary care in Australia is, in fact, a private health system, it is funded by Medicare but they are all small private businesses. That is where we differ from some other models where you can engage in primary health because you employ them. We do not employ GPs in the broad scale so you do not have that capacity to impact on GP behaviour to deliver on an acute sector outcome. The Medicare local model does allow us to start exploring where those opportunities exist. I do not think, certainly from my perspective, access to universal health care is a fundamental right of Australians. The biggest challenge we have is how quickly we provide that service and it is going to become increasingly difficult. We need to look at where we provide the services and how many places we provide the services but we absolutely should provide health care services that individuals do not have to find money for, otherwise they just will not turn up.

**Mr MULDER** - You see no end to the ever increasing costs and range of services provided by a public health service.

**Ms O'BYRNE** - The increasing cost of health care is a challenge for all of us at this stage. We have all talked about the estimates of how much of the state budget and the federal budgets it will employ which means that we have to look at where we provide services and how efficiently we provide services not do we deny access to services for some people.

**Mr MULDER** - Or if we provide services.

**Ms FORREST** - Minister, one of the matters raised in estimates was the number of patients who have died on waiting lists waiting for surgery. Do you have an update of figures for this year on that?

**Ms O'BYRNE** - We do. I always caution to remind people that they have not necessarily died because they are on the elective surgery waiting lists. People do reach the end of their life for a host of reasons not all just because they were on the elective list.

**Ms FORREST** - If it was because you had been placed on the waiting list you would not want to be placed on it would you, if that was the ultimate outcome.

**Ms O'BYRNE** - The other issue to remember is that a number of people are on waiting lists and they have a series of co-morbidities or complexities. Sometimes we cannot give them the service they require until other things are managed. If that is not managed early enough then it does have an impact. Surgeons will not operate if it is clinically unsafe to do so. The reliable data on deaths among patients awaiting elective surgery - the number who have died whilst on a waiting list - do you want some trend data or do you just want the totals?

**Ms FORREST** - The totals.

**Ms O'BYRNE** - What I have here is in a smaller table that is easier to explain. I will pick out some key items and then I will table the full list for you. In July 2010, there were 13 people who died. In August 2010, there were 6. I will table all of them so there is no attempt to move around them. They tend to range in any given month. From July 2010 to March 2012, a range of between 6 through to 17. Six were in August 2010 and 17 in March 2011. In March 2012, there were 16. I hasten to add, this is mainly for the media: they do not die because they are on the waiting list. They are on the waiting list and they have died. I have not had any advice from surgeons at this point that has said someone has died as a result of being on the elective waiting list.

**Ms FORREST** - Or not getting the elective surgery in a timely manner.

**Ms O'BYRNE** - It is certainly something I am very conscious of. I have not been given that data when I have spoken to surgeons. I am just checking with the three CEOs and they say no.

**Ms FORREST** - As far as any other adverse outcomes are concerned we know that hospitals are nearly the most dangerous places on earth.

**Ms O'BYRNE** - We try not to say that in front of the media too, Ms Forrest.

**Ms FORREST** - Yes, but it is the truth. In your performance information for your health organisations there are a couple: golden staph and MRSA infections.

**Ms O'BYRNE** - I like the way that you can say that much faster than I can.

**Ms FORREST** - That is a particularly nasty one. Are these infection rates the only sorts of things that we are going to be measuring, or are we going to be looking at other measures?

**Ms O'BYRNE** - We are publishing all infection rate data, both for Tasmania and also there is the national reporting process. The reason they are in there is they are ones the commonwealth specifically asked us to report against. I am getting the nod that that is the case.

**Mr DALY -** There will be other national data around hand hygiene, et cetera; if it is part of either a national performance agreement, or if it is a state priority that will be included.

**Ms FORREST** - So are there state priorities that are going to be included, minister, that don't appear here?

**Ms O'BYRNE** – Certainly, if there appears to be any increase in numbers in an area that can be identified through the Chief Medical Office.

**Mr DALY -** I have KPIs for the minister to consider in the service agreement.

**Ms O'BYRNE** - One of the issues is that there was - was it staphylococcus aureus bacteremia - that we had the increase in? I am looking here at Craig. There was a particular infection rate that Tasmania had an increase in and it appears to be an increase that is happening across Australia, so a lot of work is being done on whether there is a development of that.

Chlostridium difficile is presenting in high numbers all across Australia. We were quite concerned when we saw it because we started our reporting earlier than any other jurisdictions did. We were the first ones to publish hand hygiene data and the infection rates and possibly that is why we tracked it as quickly, but when we saw the growth we were quite concerned because we had spent quite a bit of work and effort on managing hospital-related infections. However, it appears that every jurisdiction is now experiencing the same increase, which is quite concerning.

**Ms FORREST** - As far as unexpected readmissions as well, because one of my concerns with activity-based funding models is ship them in and ship them out as quickly as you can. That way you keep your costs down and you meet the amount of money you get for each procedure. Is that something we are going to be looking at?

**Mr DALY -** Yes, unplanned readmissions within 28 days is a standard national indicator that will be reported on, both in the service agreement and nationally.

**Ms FORREST** - One other question I have - and across the three areas - is the number of nursing staff, like ENs and RNs -

**Ms O'BYRNE** - We have asked for that information to be tabled.

**Ms FORREST** - who basically have lost their jobs, or have moved from their positions; perhaps not necessarily left their jobs because they might have left for a very good reason, but the positions that are no longer filled. How many nurses were employed in each of those regions last year as opposed to this year?

**Ms O'BYRNE** - We can do that. We can give you the headline figures but not necessarily by region, but we could get region, is that the word that I am hearing from behind me? We can do it through the nursing award. We can give you an FTE count for each of them. So you are interested in some tracking data on that as well?

**Ms FORREST** - Yes.

**Ms O'BYRNE** - Okay. From 2007-08, 2009-10 and to date 2012, is that okay? So for the nursing award in 2007-08 in the Southern Area Health Service we had 1 207.42 FTE. That grew in 2008-09 to 1 249.02. It grew again in 2009-10 to 1 307.67. It grew again in 2010-11 to 1 379.18 and is back to 1 241.27 which is still above the 2007-08 rate with the number of nurses that we employed in the south.

In the Northern Area Health Service for 2007-08 there were 840.91 FTE. That grew to 860.50 in 2008-09. It grew to 922.57 in 2009-10. It grew again to 949.14 in 2010-11 and is at 873.29, so it is still above our 2007-08 employment levels.

The North West Area Health Service for nursing for 2007-08 was 512.50; in 2008-09, it went to 535.97; in 2009-10, it went to 558.23; in 2010-11, it went to 591.56 and, at 14 April 2012, it is at 539.82, which is once again way above 2007-08 and in all those cases they are above 2008-09 figures as well.

**Ms FORREST** - As far as the non-admitted service goes, it is a little bit hard to know exactly what is going to be included in that - and certainly from the budget papers you have no idea -

**Ms O'BYRNE** - It just talks about ambulatory and -

**Ms FORREST** - Yes, but I expect this will all be outlined in the service agreements?

**Ms O'BYRNE** - Yes. A service agreement - this is an unpopulated draft with no data in it. Part B of the services to be maintained would include things such as palliative care, rural health facilities, community health centres, allied health, community nursing, aged care assessment programs, health promotion, orthotics and prosthetics, Tas equipment scheme, youth health, community rehab, HACC and community recovery plus, I would imagine, there will be some further ones being negotiated through that, but that is where we are starting.

**Ms FORREST** - Women's and children's services are now subsumed into admitted and non-admitted services, is that right?

**Mr DALY** - That is how their activity data is collected.

**Ms O'BYRNE** - But we would still be able to give you women's and children's -

**Mr DALY** - We would be able to source it back to clinical departments.

**Ms FORREST** - Yes, because I am interested in things like the Insight Program and antenatal clinics and that sort of thing. Where do they fit? Is that under the non-admitted services?

**Mr DALY** - I am not envisaging in the first year of the service agreement that we would be documenting to that detail with the chief executives in terms of the speciality and subspecialty clinical programs for admitted and non-admitted activity for the first year of the agreement. I do not think we are sophisticated enough to do that.

**Ms FORREST** - How will I know that the Insight Program, for example, will continue on the north-west?

**Mr DALY** - Because they continue to collect the activity statistics around patients or clients that they are seeing through that service and would record it through.

**Ms O'BYRNE** - And the commonwealth would require that kind of data as well.

**Mr DALY** - The commonwealth fund that one, do they?

**Ms O'BYRNE** - Yes, it is commonwealth-funded.

**Mr DALY** - Then we will definitely report it if the commonwealth is funding it.

*Laughter.*

**Ms O'BYRNE** - In fact, I think we need to encourage more of it.

**Mr DALY** - Can you open two more of those, please?

*Laughter.*

**Ms FORREST** - Obviously the service agreements are really important documents once they are finalised for us as elected members to say -

**Ms O'BYRNE** - Which is one of the reasons we will put it on the website before tabling it in parliament. Parliament does not come back until after they are done and I do not want them to sit without an investigation. But this is a transition time and we are not going to hold them to not being able to achieve things.

**Ms FORREST** - Yes, and I want to actually understand how it is determined what services are continued and what is not? If there are programs out there and we look at hospital-in-the-home, for example, in Launceston that was deemed to be not the best way of providing that service in a cost-effective manner. That could be in some cases but those sorts of programs, are they either removed from a service agreement if they are initially put in there, or how do you add programs to it if it is only on the annual review?

**Ms O'BYRNE** - There is capacity at any time for a CEO to say, 'This is another challenge that we have but we would like to negotiate a funding mechanism with you'.

**Mr DALY** - I have written to the CEOs around the financial plan for next year perpetuating these and I am sure past years arrangements that if there are going to be any service closures or dramatic restriction in the provision of a service then it requires the minister's approval.

**Ms O'BYRNE** - I have kept calling powers for that reason, and I think future ministers will be keen to have the calling power as well.

**Ms FORREST** - So you can wave the big stick around.

**Ms O'BYRNE** - The other thing to remember is that the THOs will actually have a community consultation forum so that they are talking to their community about needs. The Tasmanian Health Plan will also have some expectations of what people want to have delivered and we will need to work against them, so you do need the capacity to say, 'From a business model you might want to make this decision but here is the broader health implication around making that decision because healthcare does not stop at the boundaries of hospitals or even community health facilities. The policy decisions will also inform funding.

**CHAIR** - Are you still overarching stuff, Ruth?

**Ms FORREST** - No, 1.1 and 1.2.

**CHAIR** - Any more on 1.1 or 1.2?

**Mr WILKINSON** - Can I ask about medical graduates as a result of comments that were made to me last Thursday?

**Ms O'BYRNE** - Bless the commonwealth for funding lots of them.

*Laughter*.

**Ms O'BYRNE** - Educating them.

**Mr WILKINSON** - Am I right in saying that the scenario is that, in relation to interns, there are presently first year, second year and third year interns?

**Ms O'BYRNE** - Yes.

**Mr WILKINSON** - Is that correct?

**Ms HOLDEN** - An intern is one year. A junior doctor is -

**Ms O'BYRNE** - I ask Jane to come to the table.

**Ms HOLDEN** - An intern is one year of the training. Then you can have junior doctors who are year one, year two or year three.

**Mr WILKINSON** - And registrars?

**Ms HOLDEN** - Registrars can be first year registrars, second year registrars or registrars who are on a training program, or an advanced registrar who is getting close to sitting their fellowship and just about to become a consultant.

**Mr WILKINSON** - The concern that these medical practitioners had and shared with me was what is going to happen, or is happening already, is that we are going to get the first year people, being your interns, into the hospitals and they, because of the pay increases that second and third year students are having are not going to be there because the first year people or the registrars are going to take their positions. Therefore, there will be this lack of grading of expertise. Is that correct?

**Ms O'BYRNE** - No. There have been occasions in the past when we have assigned some of the registrar positions to junior positions but I do not think there is any capacity to go any more into that.

**Ms HOLDEN** - We do not usually assign registrar positions to juniors because there are three tiers of registrars in a hospital. There are the residents; the interns are not yet there so then you are a year one resident, year two resident; then the registrars and then the consultants. You actually need those three tiers, by and large, in most services to make it work. Some services are small enough just to have registrars and some just have residents because they are that small as well. Most would have the three-tier structure but what we have to make sure is that we get the right kind of tier to actually support the residents doing much of the clerking and much of the assessment work, and to get their learning as well, of course. Then you have the registrars who are in a position so they are actually doing quite a lot of the other work, decision-making and those sorts of things. Then, obviously, you have the consultants who are the prime decision-makers.

**Ms O'BYRNE** - Would it help to have some statistics on how many are in each of those roles? Would that give you any systems, or is that not where you are heading?

**Mr WILKINSON** - Yes, if you can, but can I then be confident that there is still going to be this tiered system that is in place at present? Is that right?

**Ms HOLDEN** - Well, we run those kinds of tiered systems. Obviously, if we get more pressure in any one area, we have to look at the costs of those, but that is very classically the way we run the services.

**Mr WILKINSON** - So, if I understand correctly, you are saying that if we are under cost pressure, there could be a situation where there is not going to be that tiered system.

**Ms HOLDEN** - I don't think there will be that tiered system but we will look at that like we will look at anything else that is going on to make sure it is the most cost effective use of the health dollar. By and large, that structure generally works.

**Mr WILKINSON** - Do you accept that the structure I am talking about is the best structure?

**Ms HOLDEN** - It is classically the structure that works in hospitals, so our systems support that. I have no doubt that there are other structures that might require a complete behavioural change but could provide a safer environment. To clarify my point, there are some resident positions, some of those junior doctor resident or senior resident positions are, in fact, very safely delivered by nurse experts now and certain parts of our health systems that we would never have thought would happen 15 years ago, so the world does change. Generally, it is related to the training of doctors that we have those three tiers.

**Ms O'BYRNE** - Health Workforce Australia is doing a lot of work around qualifications and training in opportunities because what is quite clear is that the number of doctors and nurses we would have to train if nothing changed would be unimaginably large, and we simply would not be able to support them in any consistent appropriate training environment.

What Health Workforce Australia has to do is look at how you might provide things differently. For instance, the north-west has applied to HWA to run a training program for nurse-

led endoscopies. One of our senior clinicians in that area says that you could train anyone to do an endoscopy; the point is having the capacity and the time to train them in a simulated environment if we are able to do so. It is also about looking at how tasks are done differently by different levels of nurses, doctors and allied health professionals, so that we do get a more sustainable service into the future. That is the sort of work that they are doing,

**Mr WILKINSON** - May I ask what the latest figure is for medical graduates and intern places, and how do they compare with previous years?

**Ms O'BYRNE** - We are anticipating that there will be 98 graduates this year if they all pass. Last year we increased our funding again and we had 73 placements. One of the issues that we have been discussing with Health Workforce Australia is the way they have been responding to the workforce planning needs in the future by just putting their money into universities to train more people. It is fantastic that we take more graduates; the problem is that we as a state or we as a health service do not get any additional money for placing them and giving them their internship which is **TBC(4.31.44)**$9 000 per intern plus the supervision costs.

One of the issues we have been raising with HWA is that if they are going to fund universities for increased medical placements in universities then they should be looking at how they then purchase that training environment from teaching hospitals. It is becoming more and more difficult to provide a strong learning experience for our interns. There is no-one in our hospitals who wants to just have an intern come in and tick and flick their course. We want to make sure that they are getting the best access to the best training. I believe Tasmania has trained extremely well across all of our sites with our interns but it is a significant challenge for us in that HWA fund universities for more placements but they do not fund us to then give them their internship and there is a cost associated with their internship, just in the same way that there is a benefit. The biggest benefit is that quite often people stay and live in the communities they have trained in, and that is a positive for us. So there is a reason for us to do it but there is a cost imperative as well.

**Mr WILKINSON** - Over the last four years can we -

**Ms O'BYRNE** - We have grown the numbers substantially.

**Mr WILKINSON** - If you could send the numbers that would be good.

**Ms O'BYRNE** - Unfortunately we grew them before the commonwealth set the growth targets. So the growth that we had prior to that we did not get any recognition for in terms of funding support from the commonwealth. We have raised this with them on many occasions and they smile and nod.

**Mr WILKINSON** - Are we able to say how many unfilled doctors positions there are at present across the hospitals.

**Ms O'BYRNE** - Total vacancies at the Southern Area Health Service is 2.5. This is interns, residents, registrars and specialists. There are 409.05 budgeted positions and 2.5 vacancies. In Northern Area Health Service there are 208.61 budgeted positions and 3.91 total vacancies. In the south there is one locum-filled position; and in the north we have 3.71 locum-filled positions. In the north-west there are 109 budgeted positions, 14 total vacancies, and 10.5 locum-filled

positions. Everyone has worked well in reducing our locum costs but it is harder to reduce locum costs in regional communities. That is simply the nature of service.

**Mr WILKINSON** - How many resignations of doctors or surgeons have we had at the hospitals in the past year? Are we able to have a break-down of those? If you want to give it to us at a later stage you can.

**Ms O'BYRNE** - I do not have it sitting in front of me at the moment. I will see if someone can give that to me. I have doctors but not necessarily surgeons.

**Mr WILKINSON** - Doctors first and maybe surgeons later when you can get those.

**Ms O'BYRNE** - I am letting you know that any doctor who resigned within a week of their contract expiring has not been recorded in this report. The final figures from 1 July 2011 to 14 April 2012, 36.85 FTEs resigned from their fixed-term positions prior to the contract expiry date, that is a 45 **???TBC (4.35.11)**headcount, of which 31.32 were junior doctors, 6.2 from permanent positions and two from SES-equivalent positions. Some of them have resigned because they have taken clinical positions elsewhere, and we have 18.5 vacancies at the moment for medical positions. In the south one surgeon resigned. You have one from the north-west and none from the north - 1, 1 and zip.

**Ms HOLDEN** - Surgeons.

**Mr WILKINSON** - Can I ask about the incidence of infections?

**Ms O'BYRNE** - Sorry, Ms Forrest did ask that.

**Mr WILKINSON** - I must not have been listening.

**Ms FORREST** - You must have phased out at that point.

**Ms O'BYRNE** - The other thing is there is a nationally reported rate now that is part of the commonwealth's My Hospitals reporting. That has the infection rates.

**Mr WILKINSON** - Thank you.

**CHAIR** - Minister, before the break you indicated to the committee wait lists year-on-year to 31 March. Can you give us the current figure, please?

**Ms O'BYRNE** - The current waiting list figure? Elective surgery waiting lists?

**CHAIR** - Yes, please.

**Ms O'BYRNE** - The current figure is for 31 March.

**CHAIR** - You have already given us that one.

**Ms O'BYRNE** - Do I have something beyond 31 March?

**CHAIR** - That was the year-on-year, as I understand it.

**Ms O'BYRNE** - 31 March, no, the actual waiting list at 31 March is 7 925.

**CHAIR** - As of today?

**Ms O'BYRNE** - I only have the data to then - we do have some projections of where we think we might be, but they are projections.

**CHAIR** - Don't you gather these monthly?

**Ms O'BYRNE** - We do, but because the collection of data has historically been quite different it then goes through a process to ensure that all the CEOs agree that their list is being interpreted appropriately. I have 7 925 - I am sorry I will get you a more recent figure. I will get someone to provide the monthly, because they are normally assessed quarterly.

**Ms FORREST** - Minister, I am interested in the number of over-boundary patients now, too. I see you have the comparative from the year to year.

**Ms O'BYRNE** - I will get the comparative figure. As at 31 March, the statewide over-boundary procedures awaiting treatment is sitting at 4 220.

**Ms FORREST** - Can we have the break-downs for the regions there and is there any further breakdown of the numbers?

**Ms O'BYRNE** - I do not have that in front of me, but we can get that - sorry, I do; 2 190 at the Royal Hobart Hospital, 1 835 at the Launceston General Hospital, and 195 at the North West Area Health Service.

**Ms FORREST** - How does that compare with the last two years?

**Ms O'BYRNE** - It would be an increase, but let me get the data for you to have the comparative data.

**Ms FORREST** - For example, up in the north-west all over-boundary cases were down to 9 per cent and I don't know in the health inquiry that it has significantly increased, so I am just wondering about the amount of time as well that they are over-boundary.

**Ms O'BYRNE** - I will check how much data we can get per specialty and see what we can get for you. I am sure we will be able to do that.

**Ms FORREST** - Thank you, Chair. That is all from me.

**1.3 Emergency Department Services**

**Mrs ARMITAGE** - Minister, it is a general belief in the community that many people go to the Department of Emergency Medicine rather than go to their GPs. I believe that attendances at the DEM, particularly in the north and I am wondering if it is right across the state, appear to be down, yet admittances are actually up. Would that be fairly accurate across the state?

**Ms O'BYRNE** - Emergency department presentations - I can give you the percentage change for each of the areas, if that gives you a picture.

**Mrs ARMITAGE** - I was just wondering if it is right that attendances are down, but admittances are up. So really it is a misconception that people are going there rather than going to their GPs, because most people who are going there are being admitted.

**Ms O'BYRNE** - The other thing to recognise is the different way that EMUs are operating in the north where people who historically would have been admitted into the hospital proper might be in a short-stay unit or might be managed in the EMU. That is one of the things that might be skewing the figures there.

What I can give you is the emergency department presentations - I thought Rosemary was after the admissions -

**Mrs ARMITAGE** - Could I have presentations and admittances for each region?

**Ms O'BYRNE** - While someone finds me the admission rates I can give you the presentations, which are for the Royal Hobart Hospital at 31 December 2010 - do I have something beyond 2011 or not?

**Mr DALY** - They have done it on a six-month period.

**Ms O'BYRNE** - I will give you what I have currently. I am just trying to give you the right data, Mrs Armitage. Emergency presentations by hospital as at 1 July to 31 December 2010 at the Royal Hobart were 23 885; from 1 July to 31 December 2011, they were 24 004. At the LGH for that period, 22 737 to 22 056. The North West Regional, 13 435 to 12 775, and the Mersey from 13 580 to 12 749. Overall, that is a 2.8 per cent reduction in emergency presentations.

For admitted patients on the raw separations for 2010-11, the total was 48 643 in 2010; 48 553 in 2011. Did you want those by hospital?

**Mrs ARMITAGE** - By hospital, if I could.

**Ms O'BYRNE** - The Royal Hobart, 23 220 to 22 647; the LGH, 16 453 to 17 175; the North West, 4 314 to 4 228 and the Mersey, 4 656 to 4 503, and that is the six-month period ending 31 December, so that is comparable to the second figure that I gave you in the emergency presentations.

**Mrs ARMITAGE** - Another question about the Department of Emergency Medicine, how are they going with their targets as regard to waiting times? How long are people waiting at the hospitals in comparison to perhaps what the national standards are?

**Ms O'BYRNE** - Within the recommended time frames for Australasian triage categories: the Royal Hobart Hospital, category 1, in 2010 were 98.9 per cent and by 2011 were 100 per cent. In category 2, 73.9 per cent to 86.4 per cent; category 3, 27.6 per cent to 51.7 per cent; category 4, 31.7 per cent to 55.5 per cent; and category 5, 71.5 per cent to 82 per cent.

For the LGH, the difference between 2010 and 2011: category 1, 100 per cent to 97.6 per cent but there is a discrepancy with the classification of a triage category for that so that is a

classification change that has been altered. Category 2, 52.8 per cent to 47.9 per cent; category 3, 52.1 per cent to 47.2 per cent; category 4, 56.8 per cent to 59.3 per cent; and category 5, 88.8 per cent to 90.7 per cent.

The North West Regional on the same basis: category 1, 100 per cent to 98.1 per cent; category 2, 86.6 per cent to 95.3 per cent; category 3, 87.9 per cent to 92.1 per cent; category 4, 85.6 per cent to 90.1 per cent; category 5, 96 per cent to 96.2 per cent. Did you want the Mersey as well?

**Mrs ARMITAGE** - You may as well give me it to me now, unless you give me the Mersey with the other ones.

**Ms O'BYRNE** - Category 1, 100 per cent to 100 per cent; category 2, 86.2 per cent to 86.5 per cent; category 3, 76.8 per cent to 76.7 per cent; category 4, 76.2 per cent to 81 per cent; and category 5, 94 per cent to 93.5 per cent.

We will not have the March 2012 figures yet but they will be in the June edition of the progress charts so you will be able to assess them there.

**Mrs ARMITAGE** - Thank you. This is a question I was asking before with regard to staffing levels at our three A and E departments. How many specialists, how many RMOs and how many registrars by rostered line?

**Ms O'BYRNE** - I would have to get that for you. I would not have that data right now. Is that something I can get by looking at -? They are all nodding. We can get that.

**Mrs ARMITAGE** - Because I would like to see the comparisons of how many staff we actually have in each and then compare it to admission levels.

**Ms O'BYRNE** - We can have a look. We won't have it by the end of today but we will attempt to get it to respond to you -

**Mrs ARMITAGE** - No, that is fine. Out of interest, are there any nurse practitioners working in any of our A and Es?

**Ms O'BYRNE** - Yes, there are. Jane has one; John has one.

**Mr HOUGHTON** - Not yet.

**Ms O'BYRNE** - Gavin is letting the team down but he will get there. When we go back to that staffing profile, nurse practitioners are an incredible opportunity to build and change the way we profile the work to ensure we are getting the increased throughput. Many GP clinics are now using nurse practitioners.

**Mrs ARMITAGE** - Would they be equivalent on a pay level to a registrar, an RMO?

**Ms O'BYRNE** - No, I don't think so.

**Ms FORREST** - They wish.

**Ms O'BYRNE** - Yes, they wish.

**Mrs ARMITAGE** - A second-year RMO?

**Mr HOUGHTON** - A junior resident.

**Ms O'BYRNE** - A junior.

**Mrs ARMITAGE** - It is interesting the number of years one puts in as doctors as opposed to a nurse practitioner.

**Ms O'BYRNE** - That is very much the debate about how the work profile is changing and how we ensure that the most skilled people are doing the most skilled jobs, and that we are able to take skilled people off work that can be done at another level, particularly as we are getting a much more professionalised nursing industry now.

**Mrs ARMITAGE** - Does a nurse practitioner work unsupervised?

**Ms O'BYRNE** - No more unsupervised than anyone else, I would have thought.

**Mrs ARMITAGE** - No, but -

**Ms HOLDEN** - In the special -

**Mrs ARMITAGE** - In her or his area.

**Ms O'BYRNE** - I will get Fiona to quickly talk a bit about it in answering the question. I am conscious of time. I introduce Fiona Stoker, the chief nurse.

**Ms STOKER** - The nurse practitioner - all professionals work under some sort of supervision. They work collaboratively usually. If you have a trainee health professional then they work under either direct or indirect supervision, and as a nurse practitioner has an extended scope of practice, which means they can prescribe and do advanced assessments. They can work independently but the way that we have employed nurse practitioners within the department is that we prefer to have them working collaboratively in a model of care where you have not only a medical practitioner but also an allied health practitioner so they have worked within that team.

In the community with GPs then, in order to access Medicare benefits, they have to demonstrate that they are working under a collaborative care model with general practitioners but they have a relationship which is more collaborative than actually working in a supervisory model. Each nurse practitioner would have a scope of practice and they are credentialled to work within that scope of practice. If you specialise in wound care then you are credentialled to work in wound care or in the emergency department.

**Mrs ARMITAGE** - Just wondering, obviously it is not going to be a newly created position; you have only a certain amount of salary and staff so whose position would they have taken? Would they have taken the position - would there be one less RMO or one less registrar or one less -

**Ms O'BYRNE** - It is not about taking positions. It is about changing models of care.

**Mrs ARMITAGE** - That is what I mean, but there are obviously numbers.

**Ms O'BYRNE** - It is to do with changing models of care as opposed to changing positions or taking positions off anyone.

**Mrs ARMITAGE** - So you have not actually lost any of these positions?

**Ms O'BYRNE** - Models of care have been amended.

**Mrs ARMITAGE** - Thank you.

**Mr HALL** - Minister, I am not sure whether you may have already answered whether there are any anticipated further reductions in staff in this area at all?

**Ms O'BYRNE** - Administration-wise, we are always looking for service changes that we can make.

**Mr HALL** - No, per se, across the whole emergency area?

**Ms O'BYRNE** - I don't think you can because there are the clinical levels that we need to deal with for emergencies. Unless we had a significant downturn in the number of people who are presenting for emergencies there is not really a capacity to change the staffing profile.

**Mr HALL** - Okay, so in admin then, maybe there are some?

**Ms O'BYRNE** - It is mainly ward clerk areas for emergencies so I am not sure you could either. Not unless you completely changed our model of care. For instance, Launceston would be -

**Ms FORREST** - Self check-in.

**Ms O'BYRNE** - Self check-in, swipe your card.

*Laughter*.

**Ms O'BYRNE** - For instance, the work that the LGH has done around AMU is a completely different way of flowing patients. That has meant that they have changed who is there and who does what in order to get a better clinical outcome through that process. But that is an ongoing journey. . On those models of care change, I think, you wouldn't be seeing staffing reductions.

**Mr HALL** - With regard to unnecessary presentations, have you had it in your initiatives to try to reduce those numbers coming in?

**Ms O'BYRNE** - Hospitals are looking at the way they are managing patients when they come in. So you might be treated by a nurse, or through a fast track component as well, so we get you in and out of the system as quickly as possible. We are working with the Australian government around the primary care model because if people present because they cannot access a GP then that is a cost that we bear but it is an obligation and responsibility of the Australian

government. This is what I am hoping for through the partnerships with Medicare Local - that we can start identifying where the gaps in care exist and then deal with that.

Ambulance is the other area that has significant presentations or calls that may not necessarily be requiring care. This is one of the reasons why we did the ad campaign highlighting the range of calls - and they were real calls - that ambulances get in terms of acuity. Whilst the ambulance officers are dealing with the call for someone who is in absolute crisis and requiring care they may also be dealing with someone who wants their prescription refilled.

These are the public information campaigns that we have been working on. We have universal access to healthcare and if people front at emergency if they are at a lower level and it really is non-urgent then they will wait while we deal with the other mandatory situations.

**Mr HALL** - So it is a two-speed process.

**Ms O'BYRNE** - In a sense, yes. The triage that occurs is about your urgency of requiring care. Just because you are there and someone comes in after you, does not mean you will get treated before them. One of the things that we have looked at which I have started some conversations around, and the AMA is quite keen, are models that are GP-led or are led outside of hospital emergency areas. So you can take your urgent GP matters to that area rather than coming into the hospital system because the cost of triaging you alone in the acute system is around six, seven or eight times more than it is if you are seen in the GP clinic.

We are looking at the Pegasus model in New Zealand, but also any GP-led initiative, which also includes the GP phone line - GP Assist - that would actually move people out of the acute sector so that they are dealt with in an appropriate time frame in an appropriate setting for their requirements.

**Mr HALL** - The final question I have, Mr Chair, is regarding drug overdoses. Do you have any figures for this last year and how do these compare with previous years?

**Ms O'BYRNE** - I could probably give you this year's, the presentations.

**Mr HALL** - We can take than on notice.

**Ms O'BYRNE** - Okay, I will provide that for you.

**CHAIR** - Are there any further questions on emergency department services? We will move then to ambulance services.

**Ms O'BYRNE** - Perhaps if we deal with THOs before you go.

**CHAIR** - We will then go to Rob and into community and aged care services for that purpose because it is cutting across to THOs.

**Mr VALENTINE** - Can you look at two tables - table 5.10 and table 5.4 - performance information and the revenue from appropriation by output. Given we are the oldest age profile in any state, this is becoming increasingly important and is likely to grow. However, the funding in the years ahead seems to be reducing. The funding seems to go down from 2011-12 to 2012-13

by about $47 million and yet the activity is going to increase. Is it just the way I am looking at this?

**Ms O'BYRNE** - The Australian government is responsible for aged care services. The work we do in this area is for people in aged care in rural facilities primarily.

**Mr VALENTINE -** I realise they fund it, but if you go over the performance information where you have the rural hospital separations and occupancy rates, there seems to be a little bit of an interesting situation there as you go out 2011-12 to 2012-13. You have a dip down at 3 382 with rural hospital separations and yet the occupancy rate seems to be static. I cannot understand why that would be.

**Ms O'BYRNE -** No, the occupancy rate is not static.

**Mr VALENTINE –** Sixty-seven and 67 for those two years?

**Ms O'BYRNE -** They are targets.

**Mr VALENTINE -** Yes, but why wouldn't the target go up along with the separations?

**Ms O'BYRNE –** I am going to assume that it is probably because we are only in the space where the private sector is not there. I will have get some more information on that. But also what would impact on that would be things like Hospice Without Walls programs, transition programs -

**Mr VALENTINE -** So this is like ageing in place?

**Ms FORREST** - Just on that point, when you say that the target is at 67 per cent occupancy rate, we know that is probably not the case. Can you give us the occupancy rates; table-to-table would be good, because there are a number of rural hospitals, obviously. I am not talking about aged care; I am talking about rural hospital separations.

**Ms O'BYRNE** - In the interests of time, I might take it on notice, but we will be able to provide that data. In rural areas, we are better dealing with demand in the acute sector by appropriately transferring people back to their communities when it is possible to do so. From there, they often transfer into the aged care sector.

**Mr VALENTINE** - Which is again funded by the feds.

**Ms O'BYRNE** - If that is the appropriate care place for them. The last thing you want for people who require aged care support for their issues around the nature of being old, is to be in an acute facility, which is not the appropriate environment for them. We are using our rural services better in this regard. For instance, if you are in the LGH you might transfer to George Town and then you might move to Ainslie at Low Head and that would be an appropriate move. We have done work with subacute beds in ageing facilities and that often allows family's time to understand that the aged care facility is the best and most appropriate option. It is not necessarily the individual you are dealing with; you are dealing with their family and their concerns.

The other change that has an impact under the national health reform is the change to the Home and Community Care program. From 1 July 2012, the funding for HACC programs is

going to be split on the basis of age, with the two target populations. The older population is aged 65 years and over, or 50 years and over for Aboriginal and Torres Strait Islanders, and the younger population is under that, with responsibility for the older target population transferring to the Australian government, and the younger population to the states and territories. The Australian government is going to commence directly contracting the service providers from 1 July. That is part of the Living Longer Living Better work that was announced in April.

The key is that an individual should not notice any change in terms of where they get the service or how that service is funded.

**Mr VALENTINE** - It is seamless?

**Ms O'BYRNE** - It should be. With the national health reform, patients should not notice any difference in care, but we should be able to offer better episodes of care as a result of better efficiencies.

**Mr VALENTINE** - Given this is obviously going to an area of increased activity for us, I notice you are funding the Council on the Ageing to do some survey work. Is there any other work being done in that area, so we have lots of information to lobby Canberra?

**Ms O'BYRNE** - In terms of demand for aged care services?

**Mr VALENTINE** - In terms of knowing what our profile is like, so when we go to Canberra we can argue for a good slice of the pie.

**Ms O'BYRNE** - Except we do not go to Canberra in quite the same way with the new funding model, so the world has shifted a little bit. The commonwealth does the work in terms of -

**Mr VALENTINE** - It is not up to you to do that?

**Ms O'BYRNE** - The commonwealth identifies how many aged care placements are needed per head of population. I will argue that there could be variations affecting that number, which probably need to be taken into account. We provide aged care where there is market failure in the commonwealth's model of aged care provision - where there is no private provider in the environment. In Scottsdale, for example, we have more aged care beds than the private provider does, and we are the reason the private provider struggles to be commercially viable. But, there has been a very good partnership between the two sites and, over the past six months we have looked at how to transfer some of those beds. It is not a cost saving to us because the same funding goes to the same bed, but we are the reason that the private sector is in market failure in the north-east. If they had enough beds filled, they could look at promoting other programs, and we would get a different level of engagement in the aged care sector, but we are effectively undercutting them by taking up some of their market.

**Mr VALENTINE** - So you are looking to do that are you?

**Ms O'BYRNE** - Very gently and very slowly, because it is an issue that we need to get right. Also, the existing nursing staff would be on a lower wage on transitioning and we would need to manage that very gently and carefully as well. We are only supposed to be in the area if there is no private provider. We are not supposed to be the reason why the private provider cannot do the

work that the Australian government funds. But it is being done very carefully and very gently, and will probably take a very long time.

**Mr MULDER** – 'Trust me, it won't hurt', said the doctor.

**Ms O'BYRNE** - The other issue for those who are familiar with the site is that the aged care area we have is very modern, and the aged care area the private sector has on the other side of the complex is not particularly modern. They struggle with accreditation issues on a regular basis. If they had a guaranteed level of beds they would invest in developing new facilities. So the outcome for everyone would be better.

**Ms FORREST** - With regard to occupancy rates of rural hospitals, is it also possible to provide the costs associated with running each facility?

**Ms O'BYRNE** - Yes. We can do that.

**Ms FORREST** - That would dictate, to some extent, the block grant they get.

**Ms O'BYRNE** - Absolutely.

**Ms FORREST** - When you look at the comparative budget, on page 5.39 there is a reduction of $6.3 million in this line item.

**Ms O'BYRNE** - You are looking at?

**Ms FORREST** - Page 5.39 - the comparative budget statements. You can see 'Community and Aged Care Services'. Taking that much out is not insignificant. How are you going to achieve that? You say we are not cutting back on health anymore, but there is a reduction?

**Ms O'BYRNE** - Is that the national partnership agreement money.

**Ms EGAN** - Some of it will be that. There are movements in commonwealth funding so as the national partnership agreements complete, we will see a reduction in some of these areas.

**Ms O'BYRNE** - They are not necessarily a bed or an access that someone gets, but they would be investments happening within the facility that are part of a national partnership agreement.

**Ms FORREST** - As far restraining costs and trying to make savings, has there been any requirement, or will there be any requirement in the coming year, for rural hospitals to increase efficiencies and make savings. They seem to have been mostly exempted last year, with mainly the acute services copping the cuts. Have the people who work in those hospitals been asked for input into how they could achieve some savings? I understand a few people have made suggestions that have not been taken up. They might be small bits here and there, but it all adds up.

**Ms O'BYRNE** - I believe every hospital has an engagement process for people to put their ideas forward. Sometimes they are not taken up because they are legally not possible and sometimes it is just a bit too difficult to make the journey. Sometimes they are taken up and the person has not received feedback. That is going to be a matter for the THOs. Our position is that

we are block funding these services for a reason. That does not mean there might not be changes in the types of services that are being offered, but that is the natural progression of facilities - they make changes depending on community need.

The service agreement will identify the things we are funding.

**Mr DALY** - But if a decision is made in a financial plan for a THO to decrease expenditure at any of its block funded services, whether it be a rural hospital or otherwise, then that funding is freed up for the purchase of additional acute activity, or to lower costs generally. That will be within the financial plan. It is within the entirety of that health service - acute, primary, community and rural hospitals.

**Ms O'BYRNE** - We are not expecting closures of rural hospitals, or significant downgrades.

**Ms FORREST** - None are under threat. It is awkward not having the occupancy rates because some of them possibly have quite low occupancy rates.

**Ms O'BYRNE** - They do, but rural hospitals provide things other than just beds. They are often the way to attract doctors to a rural community, and they provide facilities for other primary healthcare services. All of that has to be assessed against the community's needs in terms of what THOs will provide to them.

**Ms FORREST** - None of them need to get the community revved at this stage?

**Ms O'BYRNE** - I do not think at this stage it is worth getting too concerned about. If we do, we will let you know. This will be an issue for the THOs. I can give you some occupancy rates now.

**Ms FORREST** - Is it easier to table it?

**Ms O'BYRNE** - Yes, could I do that.

**2.2 Oral Health Services -**

**Ms FORREST** - Oral health?

**CHAIR** - Is oral health under THOs?

**Ms FORREST** - It is, yes. It is all in the south.

**Ms O'BYRNE** - It is statewide but instead of the oral health services now fitting outside, linked as part of a convoluted mechanism through Population Health, the organisation will be based from the south but actually still the statewide service that it is.

**Ms FORREST** - How will people in the north-west access services?

**Ms O'BYRNE** - No, it will not change. That will not change.

**Ms FORREST** - Will the south charge the north-west for north-west services?

**Ms O'BYRNE** - No, there are absolutely no changes. It is simply administratively where we have put oral services for our purposes. The argument behind it has been you want a better engagement between oral health and acute because if you do not get the preventative and primary health care right then you get massive acute presentations as a result. It is merely a place where it sits. It does not change in any way anything that any individual would have in terms of accessing a service. It should not change at all.

**Mrs ARMITAGE** - What services are there available to treat emergency services after hours for oral health? I am told that most patients outside the 9 to 5 hours needing emergency treatment are told to either see their GP or go to casualty. GPs say they are not the people to treat an abscess as it is a surgical procedure. All they can do is give antibiotics and analgesia. What is the situation?

**Ms O'BYRNE** - There is certainly a long and passionate argument about where oral health sits in emergency care. However, if there is an emergency care need then you can access out-of-hours care.

**Mrs ARMITAGE** - Is there an after-hours dentist?

**Ms O'BYRNE** - We do not have an out-of-hours service that operates every night but there is an on-call capacity. I know David Butler in Launceston regularly gets called into emergency in order to manage anyone who may present. There is a debate within the clinicians themselves as to whether it is a surgical procedure and therefore an acute care issue, or whether it is a dental care issue. I am not sure that I have been able to resolve that. Do we have a dental health person here today? Is it you, Jane, yes or not?

**Ms HOLDEN** - Yes.

**Ms O'BYRNE** - Why not.

**Mrs ARMITAGE** - I am concerned that you say David Butler gets called in regularly.

**Ms O'BYRNE** - That was just an aside because I am aware of that.

**Mrs ARMITAGE** - I realise that, but David is basically in charge up there and he is one person so he cannot be on call 24/7.

**Ms O'BYRNE** - No, sorry Rosemary, I was using that as an example of someone who we both know who does that work, but it is not uncommon for people to be called in should that be the case. There is a natural tension between saying it is something a dentist should deal with and it is something a surgeon should deal with. It is not an easy one to resolve, so I pass to Jane.

**Mrs ARMITAGE** - Before you go on, I have been told it is not the case, that there is no-one basically to come in. If David is not available there is no after-hours dentist. Is it true? Is there someone or not?

**Ms O'BYRNE** - You and I both know the person who told you - they would say no-one comes in and we know people do go in.

**Mrs ARMITAGE** - It is more than one person who has told me that.

**Ms HOLDEN** - No, we do not have a routine on-call system for dental services but there is an understanding with not just David but with other dentists that if there is an absolute emergency they will come in. But patients do present to the emergency department. By and large, it can be managed overnight with pain relief and maybe antibiotics or something and then present the next day to a dentist. In the south there is also an oral and maxillofacial service which supports after-hours services as well. That is an area we are looking at as an oral health service but it varies across the state what that response is.

**Mrs ARMITAGE** - If a dentist comes in, is it a public dentist or is it a dentist who comes in and charges a fee?

**Ms HOLDEN** - Again it depends on which part of the state you are talking about.

**Mrs ARMITAGE** - Say we are talking in the north, for example, where we do not have an after-hours dental surgery.

**Ms HOLDEN** - Sometimes the dental staff do come in after hours and they will charge a proper fee for that. If a clinician phones someone and asks for a hand they will come in but they will be doing an overtime claim for that.

**Mrs ARMITAGE** - Right, so they will not charge the patient? That is my question.

**Ms HOLDEN** - It is public presentation for an emergency situation.

**Mrs ARMITAGE** - If a dentist comes in it is a public dentist that is coming in and the patient will not have a fee?

**Ms HOLDEN** - That is right.

**CHAIR** - Rosemary, anything else on oral health services?

**Mrs ARMITAGE** - Not a lot actually, no. There are not a lot of places to go with it.

**Mr VALENTINE** - One final question on emergency departments. Can I do that? Just go back slightly?

**Ms O'BYRNE** - Absolutely not.

**Mr MULDER** - Disguised as an oral health question.

**Ms FORREST** - It is his first time.

**Ms O'BYRNE** - In the lower House where they are much ruder then we would say no but of course because of the fabulously flexible way you have approached things -

[5.15 p.m.]

**Mr VALENTINE** - I was going to ask what is actually being done to try to stop people who just come in for trivial things into emergency departments. Obviously, it takes up a heck of a lot of your time and resources.

**Ms O'BYRNE** - It is not just time, it actually costs over $600 to triage someone. We did touch on this before as someone did ask that question.

**Mr VALENTINE** - Sorry, I must have been phased out.

**Ms O'BYRNE** - Public education campaigns about the other places that are available for you, the fast-track clinics which often allow us to deal with some of the other issues and get people in and out but also the biggest way to manage people who turn up for issues that are not emergencies is that they will wait until everyone above them who is of greater clinical need is dealt with, and that is possibly the best way. But if they are presenting because they cannot get access to a GP then we need to get that right as well.

I thank the CEOs and THOs, and ask Mr Dominic Morgan to the table.

**Output group 1**
**Acute Health services**

**1.4 Ambulance Services**

**CHAIR** - We are now ready to move to ambulance services.

**Ms O'BYRNE** - Dominic Morgan is the CEO of Ambulance Tasmania, for the record.

**CHAIR** - Minister, referring to page 5.12, table 5.3, we consistently have the total ambulance responses both in actuals and in targets. I am just looking at the actual of 2010-11, the target for 2011-12 was a 4.7 per cent increase, but just the trend figure as to how it looks like. Are we going to get to the 76 600 or thereabouts or are we falling short?

**Ms O'BYRNE** - I might go straight to Dominic on that one. I am losing my voice.

**Mr MORGAN** - Far from falling short, that actually is an indication of anticipated workload. The minister touched on a number of initiatives that we were doing to manage demand over the last 12 months including a public education campaign. Whilst we have been averaging a 6.7 per cent increase in demand over the last five years, over the last 12 months we have been averaging 2 per cent now. There was a fairly notable decline in demand for ambulance services immediately following the initial television campaign. You would need to do much more sophisticated analysis to attribute it to that but there is no doubt that our numbers are projecting much lower, which is a positive in making our ability to manage response time and time to care much more achievable.

**Ms O'BYRNE** - Can I just get you to talk about the triaging that occurs and the difference when someone makes a call. If they demand an ambulance then an ambulance will come but we actually do work to see whether or not an ambulance is required, and we always err on the side of caution.

**Mr MORGAN** - About 18 months ago we introduced and updated an electronic triage system. When a caller phones for the ambulance service they now go through structured call taking. It allows us to work out the priority of that call much more accurately and consistently than we were ever able to before. In the past, as for every ambulance service in the country, if

someone rang 000 you would immediately get a lights and sirens response. Now what we are able to do is work out whether a patient may be able to wait within an hour and that makes our ambulances relatively more available to go to those patients who really do need an ambulance right here and right now.

**Ms O'BYRNE** - The challenge can be in the information that is given to the call taker about the condition as well so we try to drill down as much as possible but the response is only as good as the information that can be provided.

**Mr MORGAN** - That is absolutely right, and there is no doubt that an emergency call taking in a non-visual environment is exceedingly difficult to do. The initial few minutes of any emergency for anyone can be quite confronting and challenging sometimes. I have been called to a person who had a cut head only to arrive there to find they certainly did have a cut head but it was because they had fallen when they had had their cardiac arrest. This is the challenge of call taking in an emergency environment. However, confidently, we can say that the introduction of our dedicated emergency call takers and the introduction of the structured call-taking allows us to get it right significantly more often than under the old systems.

**CHAIR** - I am reluctant to go to specific cases, but you have led into a matter of triage with regard to taking advice over the telephone and then making some decisions. The recently mentioned case in the *Mercury* about a young pregnant woman in the south of the state, blocked airway, asthmatic and so on, how was that then triaged? In fact it might be under further investigation.

**Ms O'BYRNE** - Is that currently under coronial investigation?

**Mr MORGAN** - It is.

**CHAIR** - I accept that.

**Ms O'BYRNE** - But we are happy to talk to you about that outside of a public environment. Dominic did meet with the family and go through it a number of times with them.

**Mr MORGAN** - A number of times.

**CHAIR** - I understand the coronial process. That then leads into the natural question then: what recommendations, if any, from past cases - recommendations by the Coroner, as to changes in process, et cetera, have either been actioned or not actioned, or are in the pipeline, please?

**Ms O'BYRNE** - The work that we have done on triaging the calls is probably the primary thing that has been in response to identifications of how much knowledge we have had before dispatching an appropriate service. One of the challenges we have in rural communities is the ability to get volunteers. That is a challenge across Tasmania, so we are looking at other mechanisms that allow us to support volunteers in that engagement. We have, I believe, more response points per capita than any other jurisdiction, but we have a highly dispersed population as well, so there are challenges within that.

Some of the work we have done is on the Focus Project, which is a continual process of reform, improving ambulance services and the work that Dominic has mentioned has come out of that. Also what has come out of that is our new response vehicles, which are community

emergency response vehicles. Particularly for communities where there is an ambulance station and it is hard to attract the amounts of people you would need to staff an ambulance station, these vehicles allow an immediate response time. That is probably one of the other areas. In terms of other specific coronial ones, whilst Dominic is talking, I will see if I can find another change.

**Mr MORGAN** - Generally speaking, certainly over the last three years, any recommendations that the Coroner has made have been about initiatives that we have already had in train or come on line. Specifically, they have been things like the structured call taking, putting in dedicated emergency call-takers, having an integrated communication centre, having a clinical presence within our communications centre - all of these things are now things that are complete and they are the first part of what the minister was referring to in the Focus Project. Essentially what we are doing in the meantime all relates to these things.

What the minister refers to in relation to the challenges of rural and remote equity, there is no doubt that Tasmania has a very dispersed population that creates a response challenge for us. How we have chosen to deal with that was that we have adopted a program that has been highly successful in Victoria and also in South Australia called these community emergency response teams. Approximately a month ago we launched the first four of these. We have a bid before the commonwealth at the moment that if successful we will be rolling out another eight of these across rural and remote Tasmania.

Essentially, if you think about the immediately life-threatening conditions that any member of the public would be presented with: hangings, chokings, drownings, electrocution, arterial bleeding or cardiac arrest, these are the things that do not necessarily immediately have to have an intensive care paramedic right on top. What they do need is someone who is very highly trained in first aid to cut them down, to pull them out of a pool, to put a pad on their bleeding, to shock their heart with a public access defib. These are all of the skills that we are giving to our community emergency response teams to deal with exactly the sorts of scenarios you are referring to.

**CHAIR** - Is there any liability that might be sitting out there? I am talking about claims against the service for alleged negligence.

**Mr MORGAN** - What I can say is that we recently had an inquiry from a law firm which asked for documentation on a case dating back some years, I understand, that was in a rural and remote area. We have had no further advice from them since then.

**Ms O'BYRNE** - We do not have any current ones before us.

**CHAIR** - The use of the helicopter service for emergency response - there are two components: the number of cases and the case profile.

**Mr MORGAN** - We would have non-validated data. We are not principal to the contract; it is Tasmania Police.

**Ms O'BYRNE** - We could try to access that.

**Mr MORGAN** - I can advise operationally it would be non-validated data. In the last financial year there were 88 cases; we are trending along a lower number this financial year if my

memory serves me, I think it was in the order of about 450 flying hours last year and it is expected to be less than that this year for the total police and ambulance usage.

**CHAIR** - On that area, you indicated that the jurisdiction sits with the police.

**Ms O'BYRNE** - It has been an historical position whereby once a upon a time, many years ago, emergency services actually sat with police and when Ambulance Tasmania came out of Tas Police and Tas Police were left with a proportion of their budget that was into the future to cover this issue. However, times are changing and cost structures are changing. We are currently discussing with police what a new contract might look like and what the implications will be for Ambulance Tasmania through that. It is due to an historical position where, when Ambulance left the money stayed on the basis that at that point the decision was that every department should not be paying bits of contracts, that it should be one global position. But as increasing costs have occurred for helicopters, there is a desire to look at it again and see what it means and what that would mean for Ambulance Tasmania and other service providers.

**CHAIR** - If it rests with the Department of Police and Emergency Management, does that then sit against their budget for the dispatch of the helicopter to retrieve -

**Ms O'BYRNE** - It historically has on the basis that they were funded - when Ambulance left, the budget for that remained with Police in order to cover that. But that was how many years ago now?

**Mr MORGAN** - At least 20 years ago.

**Ms O'BYRNE** - So it is an historical anomaly that has not been looked at again. We are in the process of looking at it now as to how appropriate that divvy up is, how appropriate those contract arrangements are, and we are working through that. You are working with police at the moment, if I am correct on that.

**Mr MORGAN** - Yes, importantly police will remain the principal to the contract with the successful tenderer. They are currently undergoing contract negotiations. Our arrangement for access and billing and payment on a user-pays basis will be separate to that arrangement, purposefully so that it does not interfere with the progression of the contract.

**CHAIR** - If a paramedic arrives at a scene and makes a judgment that air evacuation is required, the budget for dispatching the helicopter expenditure goes to police, is that right?

**Ms O'BYRNE** - Yes, but that is not how the recommendations are made.

**Mr MORGAN** - No, it is a slightly more convoluted process. Essentially there is an agreed dispatch process. If I was to distil it down it is roughly along the lines that police hold a statutory responsibility in Tasmania for search and rescue, loosely a case that can be driven to or accessed by road defaults to being an ambulance case; where it cannot reasonably be accessed by road then it defaults to a search-and-rescue case.

There is a positive working relationship that Ambulance Tasmania and Police have had for many years. It would be fair to say that if you spoke to the crew about it, in their own minds they never distinguish between what is a police case or an ambulance case. It is a model that has served the state well. I suppose, from that point of view though, in the brass hats of who pays,

you are entirely correct that there are certain cases where, for right and proper clinical reasons, when they determine that air evacuation is the right way to go and because of the historical arrangements in the past, police has borne the costs of that as part of their contract. They invariably contract for a minimum number of hours per year and, as the minister said, that was because the ambulance budget remained with police many moons ago.

**Mr MULDER** - Most of it is covered but I think the simple observation and the question is, this has been going on for about 20 years and it is not that it has just suddenly come to notice or the police have suddenly objected. This has been a huge issue because the demand has been rising. I would like to know why it has taken 20 years to get an assurance that it will be fixed within the next 12 months.

**Ms O'BYRNE** - Well, it is not that it has taken 20 years of wrangling over it. As I understand, the system was actually accepted and appropriate. It has been only recently that we have been asked to engage in a conversation about how we might change it now. Whilst -

**Mr MULDER** - As the guy whose budget area it was for a long time in police, I can assure you that it has been going on for that long.

**Ms O'BYRNE** - That may be key at that level but in terms of any formal approach being made to us around it, or being made through cabinet or budget subcommittees, that has not been an issue that we have had raised with us. I accept that you may have a different knowledge of it at a different level but that does not necessarily mean that it then gets translated by the Commissioner of Police to the head of Ambulance Tasmania.

**Mr MULDER** - I will also refer you to the estimates committee of the police minister. That is where we will take this issue up. It is a perspective that you are looking forward.

The other point is did I get an assurance that this would be sorted out within the next 12 months?

**Ms O'BYRNE** - I believe we are attempting to resolve it as the new contract is currently being negotiated now. So I would imagine the time frame is reasonably tight on that.

**Mr MORGAN** - Correct.

**Mr MULDER** - That is a good commitment for me, thank you.

**Mr HALL** - Minister, as I understand it, every other state or jurisdiction has a charge-out call for an ambulance, every time. In Tasmania, we have talked about it. I remember the former Treasurer spoke about it at one stage. Given that we have pretty tight fiscal times, I put it to you, is that something that the government is reconsidering? Also, the other dimension to this, of course, is that it has been put to me by GPs and people in general hospitals that even if a small charge were placed, it would stop many of these calls coming in, despite what you said about education which totally wastes everyone's resources and time.

**Ms O'BYRNE** - I have a fundamental view about universal access and that the moment you put a price on something, you absolutely might deal with some people who are inappropriately calling the service but, within that, you will probably catch other people who genuinely need the

service. I believe that was one of the concerns, particularly around the model that former Treasurer Aird looked at, which was very much a direct user pays model.

What some of the other jurisdictions do is around a more global engagement so that you would get a fee attached to another fee that you were paying so you, as an individual, might not see that direct payment being made. Queensland, however, has had a fee around ambulances and has just a year ago removed theirs. We are looking at that information now because the research appears to indicate - and it is untested but this is one of the reasons we probably would not go willy-nilly down this path at the moment - that once people pay for something and see that they are paying for something, they then treat it as a right. There is a belief from the Queensland infrastructure on ambulance services that they will see a reduction in ambulance call-outs because people do not see it as something they pay for and, therefore, should have.

We are having a look at that research at the moment because the last thing you would want to do is, by implementing a mechanism designed to reduce a call-out rate, inadvertently get a massive call-out growth. That is why we were looking at the Queensland work in particular just recently.

**Mr HALL** - With the Queensland model, is a levy hidden somewhere else or if you call the ambulance do you actually have to pay a fee?

**Ms O'BYRNE** - I think in Queensland they had a direct payment.

**Mr MORGAN** - It was off the electricity bill.

**Mr HALL** - Okay.

**Mr MORGAN** - Interestingly, although it almost sounds a little counterintuitive, the Ambulance Tasmania or demand for ambulance services in Tasmania, according to the productivity commission, is quite a bit below the national average for demand. Many of the proponents for charges would say it would discount it, whereas we are actually per capita a lower user of ambulance services than those who had those jurisdictions that charge.

**Ms O'BYRNE** - Which is why this research is quite interesting about whether or not it changes your behaviour to something you call when you need or something that is there as an entitlement that should turn up anyway. I think that is interesting work.

**Mr HALL** - So the short answer is no. Were you looking at the Queensland model?

**Ms O'BYRNE** - There is no evidence at this stage to show that you would have any greater reduction in call-outs or service provision at this stage. In particular, we are going to look at what is happening in Queensland before we think about it.

**Mr HALL** - From a purely financial viewpoint you are looking then at that as an option?

**Ms O'BYRNE** - When we put out our 'please give us any option that anyone would like to think of in terms of savings' that was one that came through, but there is no evidence to indicate there would be a benefit from it.

**Ms FORREST** - In dollar terms or others?

**Ms O'BYRNE** - In dollar terms, because if you then have a little bit of money, but a massive increase in demand then you would be cutting your own throat in the process, so there is no evidence for it.

**Mr MULDER** - It is an interesting debate because it would be one of the few areas where attaching a price to something would result in an increase in its usage?

**Ms O'BYRNE** - Because it is perceived as an entitlement, 'I have paid for it therefore I shall have it'. That seems to be the case. There is other research that needs to be looked at, but that seems to be the motivation for Queensland stepping away last year from having the ambulance levy.

**Mr HALL** - Sorry, and other states?

**Ms O'BYRNE** - Yes, it really is phenomenally interesting that it would change behaviour that way.

**Mr HALL** - Other states, what is the model there?

**Ms O'BYRNE** - Everyone has different ones.

**Mr HALL** - But they all charge in one way or another?

**Mr MORGAN** - One way or another, but whether that charge is directly handed on to the patient is different, and the categories upon which that happens are different in different states as well.

**Mr HALL** - Thank you.

**CHAIR** - The incidence of ramping because of the blockage within the hospital, do you track that in any way? There is never anything in the budget papers about it, but it is often reported.

**Ms O'BYRNE** - We do. Ramping occurs when you are, by definition, more than 15 minutes after the triage.

**Ms FORREST** - After arrival at the door?

**Ms O'BYRNE** - Sorry?

**Ms FORREST** - What is the 15 minutes?

**Mr MORGAN** - From triage. From the nurse triage and the clock starts and then 15 minutes later it is considered to be ramping where the patient has not been able to be offloaded.

**Ms O'BYRNE** - We are the only state that uses a time frame that is that short. Most of them define ramping as failure to unload at 20 or 30 minutes. We think that ramping impacts on our capacity for ambulances to go out and do their next job and we would rather that they were not doing that. The challenge for us is that if we have an emergency department that is particularly

busy, that is it, whereas in larger jurisdictions you can go to the next hospital or the next hospital. Hospitals will identify themselves on - is it a bypass?

**Mr MORGAN** - Different models in different states.

**Ms O'BYRNE** - They identify that you would not bring someone, so people would go to the next level of care. There is also an issue in some jurisdictions that if you are in an ambulance the ambulance has to get you into an emergency, whereas if you turn up to emergency in a taxi, then you will be triaged in the same way, so there are impacts around how each different state views how you access the service.

We have done a fair bit of work in each of our hospitals around ramping. At North West Tasmania amazingly it is incredibly rare to have a ramping experience. I am not sure that we have had any instances of ramping in recent memory at the North West. There has been the odd occasion at the Mersey, but not at Burnie as far as I am aware.

In terms of the LGH and southern Tasmania, they have had different ways of dealing with ramping as well. The Royal got some funding under the National Partnership Agreement to relieve pressure on emergency departments. They then worked in collaboration with Ambulance Tasmania to eliminate offload delays. They also do patient throughput work throughout the rest of the hospital to ensure that there is constant movement and they can manage where a blockage might occur that would prevent someone coming in. The wards are now interacting directly with emergency department flow nurses, so that they cannot get caught up in some administrative middle person in the way of moving people through.

The LGH has been recently sporadic. We have had some higher rates recently and the LGH is working with Ambulance Tasmania to manage not only their own issue but also whether we need to look at other statewide mechanisms we can use.

Interestingly, when we had a peak demand time at the LGH and there were people waiting for beds, and there were people ramped, there were beds available. We need to improve the transition of patients through the system. Patient flow seems to be the key in managing ramping, but it is a challenge.

**Ms FORREST** - The problem does not lie in just one spot.

**Ms O'BYRNE** - No, you cannot say any single point is the reason for the ramping. It would be much easier if you could.

**Mr HALL** - In regard to private ambulance services, have we done a comparative analysis as to whether taxpayers might be better off using more private services than public services? Is that something you have looked at?

**Ms O'BYRNE** - We had a conversation about this last year that I am sure we all remember. For emergencies we use Ambulance Tasmania. We do emergency despatch. We have the paramedics and that is what we do. For patient transfers there is a mix of opportunities for both Ambulance Tasmania and for private ambulances, because we do not have the capacity to provide every single service.

One of the key recommendations arising from the work of Vance, Scott and Charlie (TBC) was to look at the cost structure for patient transport - why it was costing so much and why we were not getting the efficiencies we needed. When we did that analysis, it became clear that every different patient transport directive was being done in isolation. We now have a coordinated program, so if someone from Burnie says, 'I have someone who needs to go to the LGH, can you come and pick them up at 10' the person can say, 'Can you have them ready by 9.45 because I am dropping someone else back there at 9.30 and we can manage the patient flow'.

We expected to get some savings and efficiencies through that program, but we did not expect the level of savings and efficiencies we achieved. That impacted on the amount of work we were able to give to private providers, but we have worked with those private providers to ensure they have enough work. We do not want them to disappear from the market because obviously we need them, but when we are spending taxpayers' dollars we have to do it in the most efficient way. Is there anything you wanted to add to that?

**Mr MORGAN** - Yes. To directly answer the question, 'Did we do any comparison?' Yes, we did when we first amalgamated in the North West. We did a comparison of our fees against the private providers, and Ambulance Tasmania's fees were significantly less than those of the private providers. Since then, we have issued a tender to the private market to determine what their costs to the government would be, on a contract basis, to supply services if the government service is either at capacity or unavailable. The results of that tender process will inform where we go to from here.

**CHAIR** - Any further on Ambulance Services?

**Mr MULDER** - Just back to the ramping issue - we got a lot of figures about times but did we get data about how many ambulances are providing services?

**Ms O'BYRNE** - Yes, we will provide the data, and it would not be a comparative analysis.

**Mr MULDER** - You do not have it at your fingerprints?

**Ms O'BYRNE** - No, I thought I did but I do not have the figures in front of me, or do we?

**Mr DALY** - We have 'hours of ramping'.

**Ms O'BYRNE** - Tony is interested in comparative figures from last year as well.

**Mr MULDER** - First, the ramping that is happening now and, second, the trending?

**Ms O'BYRNE** - February 2012, the number of ambulances ramped were 62. In March 2012, there were 50. In April 2012, there were 60, but we will get you some longer-term data on that.

**Mr MORGAN** - Actually, minister, there are areas you will not be able to provide figures for, because ramping was only a problem in the Southern Tasmanian Area Health Service.

**Ms O'BYRNE** - So, we can give figures for the South?

**Mr MORGAN** - We can certainly give figures for the South, however, the North and North West have only been recorded for a short period of time.

**Mr MULDER** - I would be very happy to get what you can - as soon as.

**Ms O'BYRNE** - Yes, we will provide that.

**Mr MORGAN** - It occurred, but just was not measured.

**Ms O'BYRNE** - No, in the North West it did not really occur, and in the North it occurred very, very rarely.

**Mr MORGAN** - It is very limited.

**Ms O'BYRNE** - They also used a different definition when they managed ramping. You cannot compare like to like.

**CHAIR** - We shall move then to Forensic Medicine Services.

**1.5 Forensic Medicine Services**

**Ms O'BYRNE** - I remember when we got to this issue last time. There were never in the history of time questions on forensic medicine so Christopher Lawrence never had to come to the table, and the one time there was a question, he was not here. No-one ever asks questions in this area but we are very pleased to take some.

**Ms FORREST** - Minister, the line on this item continues to increase just marginally. I assume it is not being altered in any way?

**Ms O'BYRNE** - No. Forensic medicine is not one we can play around with.

**Ms FORREST** - No. Demand does not change.

**Ms O'BYRNE** - No.

**CHAIR** - The next area then is Population Health Services.

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

**2.3 Population Health Services**

**Ms O'BYRNE** - Welcome to the table the guru of Population Health, Dr Roscoe Taylor. Can I respond to the previous question about occupancy rates for aged care and the difference in the 2011-12 to 2012-13 figures of 48 to 52? The reduction in the number of assessments was due to legislative changes reducing the need for some assessments, which was reflected in the target for 2011-12.

The target for 2012-13 has been increased as the impact of the commonwealth legislative change for assessments has now passed actual data year-to-date for 2011-12 and looks like projecting 4 975 assessments for the year which exceeds the 2011-12 targets, so it is a commonwealth legislative engagement. The aged care assessment program funding increased for

that reason. That is the only additional information I can provide at the moment, but I am sure we will struggle through without Matthew as we go into Population and Health.

I have two tables to table - the activity data for rural hospitals for the 10 months to 30 April 2012, and the agency facilities providing aged care occupancies 2010-11 and up to 30 April 2012.

**Mr MULDER** – Do you have the FTEs and overtime things yet?

**Ms O'BYRNE** - For? I thought we gave -

**Mr MULDER** - Nurses awards and things. No, you read some out but you were going to give us the -

**Ms FORREST** - You gave us a big sheet, did you not?

**Mr MULDER** - You gave us the high level stuff but you did not give us the detailed stuff.

**Ms O'BYRNE** - I believe we tabled that but if we have not we will do so. I thought we had.

**CHAIR** - Population Health Services. Ruth, is there anything particular -

**Ms FORREST** - There a few things I would like to ask about. Minister, I notice this line item has a reduction of about a million dollars. There is no note to tell you why that is going backwards by that amount. Perhaps you could address your mind to that.

**Ms O'BYRNE** - My initial analysis is that some areas have moved outside of population health, and into the THOs, but I am seeking some advice from Penny, who missed the question. The reduction in the Population Health budget - does that include areas like oral health care and those sorts of things?

**Ms EGAN** - The reduction once again, without going into detail, would be explained by changes in commonwealth funding. Roscoe's area is funded probably half and half by commonwealth funding and state funding, so when those commonwealth funding programs drop off we reduce.

**Ms FORREST** - Does that mean there are certain programs or services that are going to be discontinued, or is it an adjustment that will not affect service delivery?

**Ms O'BYRNE** - Everyone is looking to find savings. That is not necessarily going to change our service, but it might change the way we deliver the service. I am looking for some other data at the moment.

**Ms EGAN** - The other issue relates to reallocation of some savings strategies in Roscoe's budget. When the budget was put together last year it was prior to us internally allocating the savings strategies of $100 million. This year we have gone back and adjusted budgets accordingly, so there is some reallocation within the Population Health Services budget. It is purely an accounting exercise to deal with those savings strategies.

**Ms FORREST** - So, we are not seeing services cut or anything like that?

**Ms EGAN** - No, you certainly are not.

**Ms O'BYRNE** - That does not mean services do not change over time, though.

**Ms FORREST** - No. Minister, one of the screening things that is not a universal screening opportunity in Tasmania at this stage is chlamydia screening. What is the government's view on universal chlamydia screening? I know that it has to be listed with the commonwealth to be funded, but because of the huge costs that has to the health budget later on, human and financial cost, is that something that you will look at trying to progress?

**Ms O'BYRNE** - We have done some work in the public health prevention and promotion space on chlamydia. At the risk of offending people I believe the last campaign was 'Don't be a fool, wrap your tool' which was particularly around the reduction of chlamydia rates, which are very high and in some areas of Tasmania extremely high. We have been engaging in those sorts of campaigns. In terms of universal screening, that is probably a conversation that we are yet to formally have, but it is not something I would want to rule out if there was a way of getting some support to do so.

**Ms FORREST** - Are you aware that there are a couple of programs, and one in the ACT where it is called Pay to Pee, and you go to the pharmacy and provide a urine sample and get paid $10 for it?

**Ms O'BYRNE** - Roscoe is very familiar; he is nodding excitedly about that option.

**Ms FORREST** - Yes. The West Australians also have an online system where you can go online and answer a few questions then get a pathology slip that is then funded. There are other jurisdictions, I don't think in Australia, but certainly in other countries where they have booths at events where young people gather, like music events and sporting events, where they can get a urine sample and just a mobile phone text message with the result.

**Ms O'BYRNE** - That would be a disturbing text message.

**Ms FORREST** - Not the result but these sorts of things are targeting the key group, which is the 16- to 29-year-olds, sexually active, of course.

**Ms O'BYRNE** - The issue with chlamydia is you can have an infection with no symptoms whatsoever and that is the biggest difficulty.

**Ms FORREST** - That is why you need universal screening.

**Ms O'BYRNE** - I am not opposed to that. The question is how we would progress down that. In 2011, we had 1 774 chlamydia notifications. It is 10 per cent down on the peak that we had the previous year, but it is still very high and it reflects very high rates overall of chlamydia. In Australia, gonorrhoea is much lower, but still is another area where there isn't necessarily a symptom that people can be aware of, so promoting health messages around sexual health appears to be the area that we focus on.

**Ms FORREST** - But are we looking at any of those sorts of innovative programs?

**Ms O'BYRNE** - I am happy to have a look at some.

**Mr TAYLOR** - We have been in discussion with the university. The new head of the clinical school there is interested in working on chlamydia.

**Ms FORREST** - I have chatted with him as well.

**Mr TAYLOR** - Some of the options you have mentioned to improve the testing rates of the community have been canvassed in theoretical terms, but in practice there are significant resource constraints for Tasmania at the moment. One of them is the cost of laboratories and underwriting assistance where it is self-initiated testing. There is no Medicare rebate to pathologists for the test, so that is an immediate barrier.

**Ms FORREST** - You can contact the commonwealth to try to address that.

**Ms O'BYRNE** - I think that is worth doing.

**Mr TAYLOR** - There is the National Sexual Transmission Infections strategy, which we hope to work through over time, but it would be very handy if young people could have online access to testing. That would improve it. The general philosophy at the moment is to test, treat and retest, and you need to do that in a very large percentage of the young people from 15 to 24 years of age if you are really going to make an impact on the prevalence in the community.

**Ms FORREST** - It is being looked at.

**Ms O'BYRNE** - It is. A picture of how we would do it is the challenge for us at the moment.

**Ms FORREST** - It would be good if you could write to the federal minister at least to put it on the Medicare schedule.

**Ms O'BYRNE** - I am happy to take that on.

**Mr HALL** - Minister, just in terms of vaccinations, are we up to speed on that? I read in the press this morning about whooping cough, for example, particularly in infants.

**Ms O'BYRNE** - Can I just advise that if you have not had a whooping cough vaccination as an adult I suggest you do that. Your previous immunisation will not protect you from the 100-day cough, which is like the 100 days war or longer than 100 days. Whooping cough is at a very high rate at the moment.

**Mr HALL** - In the adult population are you talking about?

**Ms O'BYRNE** - In adult population as well, but also for children and there is a pause between your first and your second vaccination in which you are still at risk. We have quite a few littlies now who are identifying with whooping cough.

**Mr VALENTINE** - Just to finish the consultation, how long does that vaccination last?

**Ms O'BYRNE** - My GP said, 'Get vaccinated, you fool'.

**Mr WILKINSON** - If I might, you should get an update. I found out that I had whooping cough, even though I had a whooping cough vaccination. I found out that I had it again, even though I did not know I had it.

**Ms O'BYRNE** - A 100-day cough is what most people identify it as.

**Mr WILKINSON** - Yes. I just point out to people out there who might think they do not need a booster, that they definitely do need a booster.

**Ms O'BYRNE** - Absolutely; we would encourage everyone to look at getting boosters as adults, particularly if you are around children or if you have a particular sensitivity such as lung issues or any other pre-existing health condition.

We have met three of the four national benchmarks for immunisations, which is 92.5 per cent of children fully immunised in each cohort. Immunisation coverage rates for children zero to seven of age in Australia derive from Australian childhood immunisation register. The percentage of children fully immunised is determined by counting immunisation at 12 months of age, two years of age and five years of age. The latest published figures show that Tasmanian children fully immunised in the 12-month age group increased from 91.27 to 92.38 per cent, which is above the national average of 91.81 per cent. That is, once again, not every child.

Fully immunised children in the two to five year age groups fell by 0.87 per cent to 93.42 per cent and 1.06 per cent to 91.13 per cent respectively. We are above the national average in both of those cohorts but it is clearly still an issue and we do have some very high profile people who campaign against immunisations. There is a very rare risk of an immunisation having a complication. There is a much greater risk of significant disease throughout the entire community without immunisation.

**Mr HALL** - Are you talking about immunisation per se, right across the board?

**Ms O'BYRNE** - Yes.

**Mr HALL** - In regard to flu, how are we tracking at the moment?

**Ms O'BYRNE** - Are we are tracking okay on the flu vaccination level?

**Mr TAYLOR** - We do not collect specific data on influenza vaccination coverage rates in the whole community. Our best proxy is what is happening with the people aged 65 years and over who are accessing the government-paid vaccine. Typically, in that area, we do quite well in Tasmania compared to the other states but there is nowhere near 100 per cent uptake. Even in the health care services, the uptake amongst our own staff still is not 100 per cent. It is usually more like 50 to 60 per cent.

**Mr HALL** - Are there any indicators of a probable worse-than-usual flu season coming up, or are we not seeing that at this stage?

**Ms O'BYRNE** - We are not looking at anything like a swine flu issue at the moment. I don't think we are predicting a particularly bad flu season.

**Mr TAYLOR** - If I may say, minister, it is always difficult to predict a flu season until it is over, which is an unfortunate thing. At the moment there are no indications of a severe epidemic coming through this winter. There is nothing on the horizon.

**Ms O'BYRNE** - But we would not want to be held to that in case something occurred, Roscoe; I think that is the point you are making.

**Mr TAYLOR** - Yes, there is always unfortunately the possibility of an unexpected strain emerging that was not covered by the vaccine that is going through.

**Mr HALL** - Another point, Mr Chair, in regard to cancers, are we seeing any positive new or positive or negative trends in any particular cancer types, and what are our biggest challenges in that area?

**Ms O'BYRNE** - The biggest issue around cancer is that early detection means a far greater rate of treatment and resolution for people, so the biggest focus is on those earlier detection works as well which goes into one of the issues that we have needed to find additional money for endoscopy services. This is through the national bowel-screening program identifying a lot more people who are presenting for further assessments.

**Mr HALL** - Nothing stands out that we can see in the community at this stage?

**Ms O'BYRNE** - We still have high rates.

**Mr TAYLOR** - Perhaps one cancer type worth commenting on is bowel cancer where we do have the national screening program which is picking up more people and it is an effective intervention. Tasmania's rates of positive tests are higher than the other jurisdictions to a degree.

**Ms O'BYRNE** - It does not necessarily mean they have cancer. It is the one that says you should go and have another test.

**Mr HALL** - Is it perhaps dietary related?

[6.00 p.m.]

**Mr TAYLOR** - Indeed, I think that is the issue for Tasmania. The risk factors are more prevalent in some cases. Sometimes it is about physical inactivity, which is another risk factor.

**Ms FORREST** - Familial as a rule being related.

**Mr TAYLOR** - Actually bowel cancer is one of the cancers where there is a familial tendency.

**Ms FORREST** – Correct, I was not joking. You thought I was, didn't you.

**Ms O'BYRNE** - The most recent published article in Tasmanian cancer registry for 2008 showed that 159 Tasmanians died from bowel cancer which was more than four time the number of road fatalities that year. It is the second biggest cause of cancer-related death in Tasmania behind lung cancer, which is the biggest cause of cancer death Australia-wide.

**Mr HALL** - That leaves me my final question in regard to tobacco use or misuse - a very short snapshot.

**Ms O'BYRNE** - I will table it for the committee, this is going smoke free, this is the work place kit. We are giving them to workplaces to assist them in making the decision for their workplaces to be smoke free. Smoking costs the Australian economy $31 billion nationally, $900 million if you extrapolate that to Tasmania. It is the largest cause of death within the cancer screen. Our trend data is indicating that Tasmanian smoking rates are declining as a result of much of the work that we have done. We hold out for the figures that we will get later this year, which are the AIH -

**Mr HALL** - We are still not getting that dirty ashtray award are we?

**Ms O'BYRNE** - No. We at the moment are leading the nation in smoking reform and have a number of states that have engaged with us.

**Mr HALL** - Reform but we still have a number of underage smokers.

**Ms O'BYRNE** - We do, and the high rates of young people smoking and pregnant women smoking are of significant concern for us. There is no smoking rate that is safe. There is no evidence that you can have any cigarette and not have some kind of impact as a result from it. That is one of the reasons why we have taken such a strong line in legislative reform. That is only part of it. We also engage in public media campaigns with Quit Tasmania and the Cancer Council around quitting and preventing.

**Mr VALENTINE** - With local government backing you.

**Ms O'BYRNE** - Absolutely. The role of different local governments engaging in this issue has been supportive. There was one local government that suggested we just ban cigarettes entirely in Tasmania and while Roscoe and I got excited for a few minutes we decided that the black market in cigarettes might become more of an issue.

**Mr HALL** - Chop, chop.

**Ms O'BYRNE** - One of the things that I do have an interest in - and it is not something that I can ask population health to do necessarily because our tobacco control people are very busy implementing the last round of reforms and we will start consultation on the new range of reforms - is the work that is being looked at in Singapore about a tobacco-free generation. That is the principle by where you accept that the people around this table, people older than us, were prevented from getting a whole host of information about the dangers of smoking. That is not the case for children now. There is no reason that children now cannot understand the inherent risks and dangers of smoking.

One of the preliminary conversations I have had with the Commissioner for Children is whether there would be in her role as an advocate for public health for children a capacity to investigate and implement the capacity to pursue a tobacco-free generation, which is about picking a date and saying that any children born after this year, and let's use 2000 as an example but I am not saying that is an absolute, if you were born in the year 2000 then by the time you get to the year 2018 we are allowed to sell you cigarettes. What they are suggesting, because of the year 2018 the smoking age goes up to 19. Then in the year 2019, the smoking age goes up to 20.

So you actually make it much easier for people who sell cigarettes, because you do not want to have people to be scrutinised with their passports at all occasions, and have to do calculations of when their birth date is.

We would have two cohorts then. We would have a cohort of young people who should never take up smoking because they know that it will kill you, and they know the risks associated. Then we have a cohort of people for whom it is an addiction and we need to manage addiction and, where possible, support people to give up but accept that it is not always possible. For some people it takes three, four, five, eight attempts in order to give up. It is a highly addictive substance.

That is one of the things that I would like. In fairness to the Commissioner for Children, we have only had one conversation about this but we did look at the work being done by doctors in Singapore on whether or not you could lead that kind of opportunity. Even if you decided not to do that, I think that we are of a generation now with young people where we should say that we should not have smoking because we know it kills you. There we go. There is an opportunity there for us all to embrace, I think.

**Mr HALL** - Yes, reformed smokers like me.

**Ms O'BYRNE** - You are a reformed smoker and you are probably more of a zealot than me. I am a daughter of someone who is a reformed smoker but also has significant cancers as a result of his smoking. So I put on the table my personal issue with that, but it is backed up by research nationally and internationally.

**Mr MULDER** - Are we going to extend this to the prison service?

**Ms O'BYRNE** - We have extended it to Wilfred Lopez, which is the mental health facility. There is a longer conversation that needs to happen with prisoners because smoking in prisons is also used as part of the behaviour management role and that would be a longer journey of change before you could go to smoke-free environments there. I believe it is a conversation we should have but it does have to be very much done in consultation with those who work in the prison service. That is a particularly difficult environment, but we have had so far some pretty good responses from the work that we have done at Wilfred Lopez. It took a year of engaging with staff and our clients there and it will be an ongoing engagement around cessation programs and support and counselling. It is not an easy one, but we also know that if you are receiving treatment for mental health issues, if you smoke, it actually can impair the capacity for other treatments to work.

**CHAIR** - We are done with population health services. I will go to Mr Mulder because he has had a look at the table, which you have provided, and he informs that the data is not there. Tony?

**Ms O'BYRNE** - Can you specifically point out what it is that you want?

**Mr MULDER** - Thank you, this is half of what I asked for, the FTEs by area, by unit, et cetera - but what I also asked for was the overtime for last year compared to this year.

**Ms O'BYRNE** - Sorry, that is still coming. We are taking the overtime. Is there anything else other than overtime?

**Mr MULDER** - No. With the overtime, I was just wondering when it was likely to arrive?

**Ms O'BYRNE** - We will not get that now, I should not think, given that it is 10 past six but we will submit it.

**Mr MULDER** - Thank you for the fine definition of your printer.

**Ms O'BYRNE** - I am assuring you we will e-mail it as well because it is obviously sponsored by someone who wants us to wear more glasses.

**CHAIR** - Standing order 99 will be invoked and we will move to 2.4 Mental Health Services.

**Ms O'BYRNE** - Can I just add, and table the general elective surgery performance data and the DHHS income. This is the grants and transfer payments that was raised by Ms Forrest.

**2.4 Mental Health Services**

**Ms O'BYRNE** - On mental health I invite Nick Goddard, the Acting CEO of Statewide and Mental Health Services, to the table.

**Ms FORREST** - Where are we up to with the new Mental Health Act?

**Ms O'BYRNE** - Would you believe someone actually wrote to us and asked us if they could have more time to comment the other day.

**Ms FORREST** - This will be consulted to an inch of its life, if it is not already dead.

**Ms O'BYRNE** - And in fact the draft has been recognised as being - and I am going to hand to Nick so he can take the glory for this.

**Mr GODDARD** - I think finally, from our perspective, we have a final draft and we are now going through the process of getting it ready to present to parliament.

**Ms O'BYRNE** - But the work we are doing was recognised nationally as being quite progressive in this place.

**Ms FORREST** - How many pages, is it?

**Ms O'BYRNE** - It is huge.

**Mr GODDARD** - It is seen in terms of human rights as a very progressive piece of legislation and it has been well lauded on that basis. I believe the wait has been worth it.

**Ms FORREST** - Has Bernadette McSherry been involved in the review of that?

**Mr GODDARD** - I think she was a part of the peer review that we had done.

**Ms O'BYRNE** - For other members, it is a really big shift in the focus from detention to treatment and that is the reason we are getting recognition for it being very progressive

legislation. Having said that, once it is done I am sure we will immediately commence, after everyone relaxes and breathes a little bit, further conversations about where it might go because it has been a long time in the progress.

**Mr GODDARD** - Hopefully, at the conclusion of the autumn session.

**Ms O'BYRNE** - Yes, I am hoping to table it before we rise, all going well.

**Mr GODDARD** - And we would be very happy to do briefings for anyone.

**Ms O'BYRNE** - I am not inclined to rush it through, though, because it is such significant legislation. There will be time for members to be briefed on it because it is quite a big piece of work and I would not want it to be forced through in any way.

**Ms FORREST** - I think it would get pushed back if that was the case.

**Ms O'BYRNE** - I think it was just too much to ask.

**Ms FORREST** - With regard to the economic climate we are facing and the quite well publicised impacts on people's mental wellbeing, and the high unemployment rate with the forestry industry job losses and all that sort of thing. Is the health system, as far as Mental Health Services, going to be able to cope with an increased demand if the people need the health procedures?

**Ms O'BYRNE** - We funded Rural Alive and Well to do some work in this space to get an indication of any additional presentations because it is not just the forestry, it is the changing rural services -

**Mr GODDARD** - In terms of our suicide prevention strategy we have funded organisations like Rural Alive and Well to provide support across the community so we are continually working in that space. We are also working with the Australian government in relation to the National Mental Health Reform and that is going to be a significant factor in helping us manage demand for mental health services across the state.

**Ms FORREST** - In fact, there is a fall in the forward estimates budget allocation. This year we see a small increase, but the following forward estimates we are seeing a decline, so how can we be assured that the needs of people with mental health issues will be adequately supported with a declining budget? It is declining in numbers and it is even worse when you consider adding CPI to that.

**Ms O'BYRNE** - Part of the decline is in money that has been provided for health and human services reform, so that was a 2008-09 initiative over four years that is coming to an end. They were funds allocated to alcohol, tobacco and drugs, primary health services, clinical service plan, the out-of-home care reform, family services reform and disability services. There is an ending of some specific initiatives that were in that space. I think for alcohol, tobacco and other drugs there was some $17 million, was it, for the reform package?

**Mr GODDARD** - Yes, so there was a future services directions initiative, which was a $17.1 million initiative, which has been running for four years and its final year is next year.

**Ms FORREST** - Just on this to clarify this line item, we are not talking about the cost of inpatient mental health services; that is all in the output group 1 -

**Mr GODDARD** - None of that reduction impacts directly on mental health services as such. It is in relation to the future services directions.

**Ms FORREST** - As far as mental health staff and those in the drug and alcohol areas, and the other areas that you work, is there an ongoing challenge to get adequately skilled staff in that area?

**Mr GODDARD** - Recruitment and retention is always a critical issue in the alcohol and drug service. Earlier this year we had the best medical complement, for example, that we had and it took several years of effort, and we have now lost a couple because they tend to come for a couple of years and then go. We struggle at times to recruit the nursing workforce that we need, particularly in the north and north-west, so it is difficult to fill vacancies sometimes on that basis.

**Ms O'BYRNE** - One of the issues within the nursing framework as well is that we also need to look at other levels of employment because we have community health nurses who take people shopping. It is lovely that they take them shopping, but we could have a better use of their time in relation to the clinical service that they can provide and we probably need to look at other programs and other NGOs that provide that support service as well. That is the conversation that we need to have. The biggest issue for us is that we really need to join together the myriad people who provide care and services in the mental health space and that is some of the work that we have been doing with the commonwealth.

It is quite a difficult journey to navigate as an individual because there are so many different pockets of services and we really need to change the continuum for our clients, and that would stop some of our more acute presentations as a result of that. That is work we want to do with the commonwealth and we just got that additional money for individual care packages.

**Mr GODDARD** - Indeed, we have a $6 million initiative through the National Mental Health Reform process, which is aimed at keeping mental health patients in the community with flexible packages of care. It will take the pressure off our inpatient facilities and will be a real boon for our service across the state.

**Ms FORREST** - Do we have unfilled vacancies that you are trying to fill at the moment?

**Mr GODDARD** - There are some unfilled vacancies.

**Ms FORREST** - How many do you have, and in what areas?

**Ms O'BYRNE** - Available vacancies for mental health services in particular?

**Ms FORREST** - Yes.

**Ms O'BYRNE** - I have 30.6, does that equate for you?

**Mr GODDARD** - It varies from time to time, but the last time we had a look there were around 27 vacancies across our system that we are actively trying to fill at the moment.

**Ms O'BYRNE** - That is in Drug and Alcohol Services, Forensic Health.

**Mr GODDARD** - Across the entire statewide Mental Health Services.

**Ms O'BYRNE** - Yes, that is the whole gamut.

**Ms FORREST** - That is including your inpatient services as well?

**Mr GODDARD** - That is including inpatient services.

**Ms FORREST** - What sort of positions are we looking at?

**Mr GODDARD** - It varies. There are some medical positions, there are some nursing and some allied health positions, so it is across the board.

**Ms O'BYRNE** - And some Health and Human Services award positions.

**Mr GODDARD** - They would be aid and support-type positions and maybe some clerical. Generally, we have been able to recruit and maintain the workforce that we have needed to provide services.

**CHAIR** - Anything further, members, on mental health services?

**Mrs ARMITAGE** - What is the current situation for a general practitioner referring? Do they refer through the casualty now or is there another means of referring them to Northside, for example?

**Mr GODDARD** - There is a state-wide help line which is the first point of access for Mental Health Services. We also do work directly with GPs in various regions when there are particularly difficult cases that need to be managed but generally there is a very rapid triage through the help line. Otherwise there are presentations through the emergency department. The help line applies right across the state in the north, south and north-west.

**Mrs ARMITAGE** - Is it a 24-hour help line?

**Mr GODDARD** - It is a 24-hour help line, yes.

**Mrs ARMITAGE** - I have heard from some GPs that they will refer a patient and of course if they have to go to casualty they may not sit and wait and they may leave and then often the police will bring them back and it can be an awkward situation.

**Ms O'BYRNE** - The other challenge for casualty presentations as well is that - and this is where we have had a couple of incidents - the care plan that is available for an individual who is known to Mental Health Services might include not admitting them, that that is actually a structure of their care plan because otherwise you are reinforcing a particular behaviour. That would not be known to everyone because of the privacy issues around it so you do get a mixture whereby for some people there is a clinical decision that we would not necessarily then make that referral and for some others there is a challenge to make sure that we are always responding through the help line.

**Mrs ARMITAGE** - If a general practitioner, for example, has someone in their room who is suicidal, exactly what can they do? They would ring the help line and they would be triaged?

**Mr GODDARD** - I would ring the help line. That call would be triaged and if it was a category 1 there would be an immediate response and probably someone from the crisis and assessment team would make contact.

**Mrs ARMITAGE** - That is 24 hours?

**Ms O'BYRNE** – Yes, and any self-harm ones would be a category 1, any risk of self harm.

**CHAIR** - Minister, we are done with that particular line item. The only thing remaining for this consideration is the Capital Investment Program. Minister, I understand this includes special capital investment funds which are set out in table 5.7. Can I go to the Special Capital Investment Fund first, table 5.7 please, page 5.23?

It is just a simple comparison - Glenorchy and Kingston are both looking at a tier 3 community health services facility. There is a huge difference in estimated cost. What is the process in the determination of tier 3? What does it really mean and if they are both a tier 3, why the huge difference?

**Ms O'BYRNE** - It would very much depend on the investment or the engagement we are putting in, but I will just seek some advice on that. Penny knows, thank you. I was not sure if it was something we needed Jack back for.

**Ms EGAN** - I am not clear on the different tiers but certainly they are different types of construction. With the one for Glenorchy, the original funding was to do integration with Glenorchy Council and there was some money I think from police as well -

**Ms O'BYRNE** - That is right.

**Ms EGAN** - that was put towards the whole-of-Glenorchy area so our 21 is purely to build an integrated care centre at Glenorchy versus Kingston. I am unsure why there is such a difference in the money, I will be honest, so I will need to have a look at that.

**Ms O'BYRNE** - Yes. I will take some more advice but that would be based on what -

**Mr VALENTINE** - It is probably one is a new building and the other is already there.

**Ms O'BYRNE** - Glenorchy is a new building.

**Ms EGAN** - Glenorchy was looking to be a combination of redeveloping their current building. Some of the funding was going towards, at that time, Glenorchy to help with their council chambers. Different combinations. Kingston was also part of that funding to purchase some of the land from Kingston High School. The balance was also then to build an integrated care centre. One is actually integrated care versus a high-level community health centre. Perhaps we could just find out some information for you on what the actual differences are.

**CHAIR** - We will stay on the SCIF for the moment. Any other questions on the SCIF before we move to the capital investment program? No.

**Mrs ARMITAGE** - On behalf of the member for Apsley, could I ask about the Flinders Island Multipurpose Centre upgrade, page 5.23, and why the re-announcement of the funding for the multipurpose centre and when will it be completed?

**Ms O'BYRNE** - We are tendering for the building works before the end of June. We will seek some advice when it will be completed but we are tendering before the end of June.

**Mrs ARMITAGE** - The other question, and it is not about capital works but it is Flinders Island so I will ask it at the same time if that is all right. Because they have only had a temporary doctor on Flinders Island and the husband and wife doctors have left the island, what will the new arrangements be? Sorry to throw that to you now but it was all together with Flinders Island. Could you get back to us with that?

**Ms O'BYRNE** - We will. They are part of the contract that we have with some regional medical and that contract has been signed off. I do not have any details with me at the moment. It is not filled by us; we contract an organisation the same way we do on the west coast.

**Mrs ARMITAGE** - The husband and wife have left and there is someone temporary there. She wondered what was going to be the situation.

**Ms O'BYRNE** - That would be part of the contract that we have signed with - I cannot remember their new name.

**Mrs ARMITAGE** - If you get the information that would be great and we can pass it on to the member.

**Ms O'BYRNE** - One of the biggest issues there has always been housing, so we actually own a house in order to attract staff. It is part of what used to be Gemini medical.

**CHAIR** - I could have ordered out of order but we are going pretty swimmingly at the moment so the member for Apsley can possibly take that up with you herself.

**Ms O'BYRNE** - I will follow through with that.

**CHAIR** - We will move to the capital investment program.

**Capital Investment Program**

**CHAIR** - Can it be taken that the projects identified for the 2012-13 financial year will all be commenced, or those that are listed for commencement? There are some that are already underway.

**Ms O'BYRNE** - Yes, are you looking at table page 5.25 and the table 5.8?

**CHAIR** - Yes.

**Ms O'BYRNE** - All of those are on track.

**Ms EGAN** - They are all commenced. There may be some changing to the values because we have not completed the end of this financial year where there might be some funding that needs to be carried forward but certainly all those projects are under way.

**CHAIR** - Further questions? We are done, minister.

**Ms O'BYRNE** - Thank you very much Chair. I take the opportunity to thank all the members and the team from the department for their availability and the work that they have done in preparing for that. I thank members of the committee for their very solid questioning. I look forward to the next opportunity that we have to do this.

**The committee adjourned at 6.25 p.m.**