Ms GILLIAN MANGAN, HEALTH DIRECTOR, AND Mr GRAEME LYNCH, CEO TASMANIAN DIVISION, HEART FOUNDATION, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED

CHAIR - For the record, welcome to the Government Administration A Subcommittee Inquiry on Acute Health Services in Tasmania. That is to make sure that you do not think you are in a TasWater hearing or something like that. All evidence taken at the hearing is protected by parliamentary privilege. I remind you that any comments you make outside of the hearing may not be afforded that privilege. There is a copy of the information for witnesses, have you had the chance to read that?

Mr LYNCH - Yes, we have.

CHAIR - That is fine. The evidence you present is being recorded. The *Hansard* version will be published on the committee website when it becomes available. If, during the hearing, you feel that you want to make any confidential statements just please make us aware of that and we can discuss that and go forward from there. First we will ask you to make some opening statements if you wish to do that.

Mr LYNCH - We would like to, to put the context.

CHAIR - So, over to you.

Mr LYNCH - Chair, we would like to thank the subcommittee for the opportunity to present today and give oral support for our written submission of 24 August 2017. First a couple of procedural things. We would like to seek the subcommittee's permission to table an updated version of the annexure to our submission of the state-wide Cardiac Services Plan. It does not have any material changes. It has a foreword and an executive summary that was not ready at the time that we submitted our submission.

CHAIR - You wish that to replace the ...

Mr LYNCH - We wish that to replace, yes. There are no material changes to the content of the state-wide Cardiac Services Plan.

And secondly, on page four of our submission we seek to make an amendment halfway down that submission we want to replace 'the THS' with 'the DHHS'.

CHAIR - So, 'the DHHS is to commission ...'

Mr LYNCH - The role of the DHHS is to commission.

CHAIR - Under the level of engagement with the private sector in the delivery of acute health services.

I am informed it can be done by email, but then we have to table it in the committee to have it submitted.

Mr LYNCH - Could I suggest, Chair, that we make the amendment here and table the amended document.

CHAIR - They do not go in and amend the submission that is on the site. If you could simply email it to us with the attachment so it is a fresh submission. That is an important process for us.

Mr LYNCH - As the committee would be aware the Heart Foundation's submission focuses on cardiac services. It is the Heart Foundation's view that many of the issues that are given cause to this inquiry of the subcommittee would be addressed if plans like the Heart Foundation statewide Cardiac Services Plan were developed and used as a blueprint for the One Health System when it was designed several years ago. We see that as a major gap and it has led to many of the issues that this committee is addressing at the moment.

Also, unfortunately it is our view that the One Health System was developed with a view to looking at the acute sector administered by the Tasmanian Health Service in Tasmania rather than a whole system plan. By contrast, the Healthy Tasmania preventative health strategy is a more holistic approach to health and well being in Tasmania. That strategy had the benefit of recommendations to a joint parliamentary select committee on preventative health. It recognises the need for an integrated joined-up approach across all layers and sectors of the government, private for-purpose sector and the community. Unfortunately, it does not inform or connect to the One Health strategy system plan which was written in the environment of a government-controlled health service silo.

The DHHS, in its role as a commissioner, should have statewide plans, of which the statewide Cardiac Services plan may serve as a blueprint. We would see that as providing a framework for comprehensive need assessments, system design and allocation of resources across the Tasmanian health services, not just the Tasmanian Health Service but across all health services.

This is the view the Heart Foundation has promoted nearly over seven years now, as we point out in the background of the Cardiac Services plan. It is our view, it is conventional and accepted view in health systems, that integration is critical if we are to reduce the ever-increasing stresses and burdens around the world, but particularly in the Tasmanian acute health setting. That is the integration between the primary and acute, secondary patient journeys, including the role of the private sector and the not-for-government organisations, other service providers and the community more broadly.

The main recommendation the Heart Foundation makes to the committee is that the statewide Cardiac Services plan be adopted by the Tasmanian Government and implemented across the health system, and that it could form a blueprint and a way of dealing with other streams within the health system so they are holistically integrated.

The Cardiac Services plan does recognise there are different funding streams and responsibilities in the Tasmanian health system. Implementation of this plan would require joint commissioned approaches - we see commissioning as a very important part in tackling some of our issues in Tasmania - in the DHHS, which is both Commonwealth and state government funded, primary health networks, the MBS and other funding streams, to deal with an integrated, multidisciplinary approach and, as far as possible, care in communities outside the acute system. That is really the main point the Heart Foundation wishes to make to this inquiry.

CHAIR - When did you last speak with the Government about a plan such as this being put in place?

Mr LYNCH - We have been constantly discussing this, which began seven years ago with the secretary at the time. It has been something, as we outlined in the background of our submission, we strongly pursued with the government. In the previous health plan it was an action item in that plan that there should be statewide systems and plans for a range of conditions. About four years ago we realised that was not going to happen within the structure of the DHHS and the three health organisations, as they then were. The board of the Heart Foundation made a conscious decision to enable and resource us in Tasmania to take the evidence from around Australia, apply it to the Tasmanian context and come up with a document like this.

It was our original intention this plan would be endorsed by the government, by the health minister and it would be a joint plan. It has become apparent that if we continue to wait for that to happen we would not be here today.

Ms FORREST - A joint plan being both parties would adopt it?

Mr LYNCH - A joint plan the Heart Foundation and the government would adopt as evidence-based and independently produced, but taking into account stakeholders from across the whole health system and be endorsed in that way. It became apparent to us that that just wasn't going to happen. We are now using it as an advocacy document, if you like, to present and start this discussion about the need about strategic planning for what the health system should like. Glancing at, not having read in full, many of the submissions that have come before this committee already, many of them dive into the detail about what needs to be done without looking at how we coordinate the whole of the health system.

A recent example of that has been some money that became available recently in the cardiac care space. We had all sorts of stakeholders from various hospitals around Tasmania and others come into us asking, will you endorse this funding application? There was no coordination about where that might sit into a whole-of-state Cardiac Services plan. That is the same for many other issues, funding becomes available but there is no obvious place where that fits in and joins up to leverage and produce something that works toward a better system. It is more an ad hoc approach.

CHAIR - In trying to promote this, have you looked at encouraging a tripartisan approach to the delivery of this plan?

Mr LYNCH - Tripartisan in the political sense, do you mean, Chair?

CHAIR - Yes.

Mr LYNCH - We have briefed all sides of politics around this approach. It is something that has been in our advocacy documents for six years. Originally we were seeking support for funding of this. That did not appear as though that would happen. We believed it is that important, and again this inquiry is now at a point where we are looking at, 'what do we do?', and there is an absence of an integrated plan. We have bits of plans, but they are not joined up and they are not connected.

One of the most important things about the acute setting is looking at what happens at the interface of the acute setting. It is important to look at people coming into acute care and going out the other side, how we look after people in communities, how we cannot do a lot of the acute interventions in cardiology or in other disciplines. Cardiology is what we know a bit about, for example, you cannot have catheter labs in every site around Tasmania. You cannot do cardiothoracic surgery everywhere. We need to have those supports built in an integrated way so we can deliver the best care, but then look after people when they return to their communities.

CHAIR - It links with the preventative advice you submitted to us during the preventative health inquiry.

Mr LYNCH - Prevention comes into every aspect of health care. If someone has a heart attack then prevention is a very important part of their rehabilitation. It is secondary prevention. One of the main differences between secondary prevention and primary prevention is the acute event that happens in between. Unfortunately, the way the One Health System has been designed it has not addressed the whole system. It has only addressed the Tasmanian Health Service, which is really the government commissioned hospitals. It ignores all of the other factors that can contribute in this space, which includes the private health system, the not-for-profits and so on, and very much the community.

Ms MANGAN - We would also say the One Health System really only focuses on the acute four hospitals and doesn't look at the capacity of the community health centres or the smaller district hospitals in being able to look after people, keeping them out of the -

Ms FORREST - If you look in the budget papers you will see they are all separate line items. The overall message is clear and I am tempted to say it is a no-brainer.

Mr LYNCH - No, do not say that.

Ms FORREST - Sorry, I will take that back. If you are looking at better, faster access to time-critical care, I will take out 'cardiac', raising community awareness of early warning signs, support rapid access to whatever it is that person needs; you can apply it to stroke, asthma, trauma, almost anything that is an acute, life-threatening event.

Mr LYNCH - Precisely.

Ms FORREST - Has the Heart Foundation had discussion with other key peak bodies to suggest we work on the whole plan? I accept the government's job, but it is not only about us and the Heart Foundation. We are concerned with cardiac care but we are looking at the whole health system. Would that be a more effective approach as to convincing the government?

Mr LYNCH - There is the Australian Chronic Disease Prevention Alliance, the committee is aware of the members of the alliance. We discuss these issues but the prevention alliance is primarily an alliance around prevention, whereas this covers the whole journey and management of particular diseases.

We talk to our colleagues and we work very closely with Primary Health Tasmania, who are really leaders in this integrated approach because they are out in the community looking at the interface. That is why we have couched in our submission that we see this type of an approach could be applied, as you have just pointed out, to all chronic conditions, and could be adapted.

When you get into the acute sector, there are quite different methods of treatment required and different role delineations. Once you are in the acute system it is different, but the interface going in and coming out of the system is the same. Discharge, summaries, communications with GPs and interventions within the acute care system are all exactly the same. A bit of this plan is around how the cardiac services are distributed around the state and how they should be managed. That will be different to cancer treatment and it will be different to some chronic diabetes care and community care and so on.

Ms FORREST - Yes. As you have rightly identified, Graeme, there are services in the preventative space that continue up to the point of a need for an acute admission. Is the different funding stream still creating challenges here? We used to see a lot of cost-shifting going on: if they can push you into the hospital system then the state will pay for this procedure or this investigation or this test. Likewise, if they could push you out of hospital a bit quicker then the Commonwealth funding picks up on your post-operation blood tests and your physiotherapy and whatever else there might be. Is that an issue?

Mr LYNCH - Certainly the multiple funding streams are an issue. They have been the topic of a lot of discussion in Tasmania over the past four or five years. Ideally there would be a single funder. That is something that should continue to be discussed. Under our current federal arrangements and the fiscal arrangements, that is probably not going to happen soon. What we identify is a real opportunity and we have talked to both the Primary Health Networks and the DHHS about this plan. The way to implement all of the things that are in a plan like this is through commissioning.

Commissioning is becoming a new way of purchasing health services from the Tasmanian Government and from the Commonwealth Government. Commissioning is an approach where you look at what the need is, which is the needs assessment base. You look at what the right solution should be and then you commission people through an evaluation process to find who can deliver that. The real opportunity to implement something like this is through a joint commissioning approach, where the DHHS as a commissioner works with Primary Health Tasmania as a commissioner and other sources of Commonwealth funding and joins that into a commissioning bundle.

To have good care for people after an acute intervention, you need coordinated care which is joined-up commission care. The majority of that care is about how to get to appointments, how to adhere to medications. Those things we should be funding in the same way. We should be joining up the funding streams and asking how are going to get the best outcome for these heart patients using this plan? We have money in the state pool that can commission some of this, we have money in the commonwealth pool that can commission this and we commission it with the same outcome and we manage it as an improvement process.

Ms FORREST - You are talking about a patient-centred care approach, Graeme.

Mr LYNCH - It is a patient-centred care approach and it is fascinating-

Ms FORREST - Both in, out and back of various systems.

Mr LYNCH - In the introduction we have acknowledged that this has been prepared with the work of the Heart Foundation around Australia and what we have done in Australia. It has also

relied on our local health advisory committee, which is most of the main players in cardiac services in Tasmania. In those discussions it is very difficult sometimes to break away from a siloed or a location-based approach. Getting the Heart Foundation or other NGOs involved in supporting and writing these plans that are owned outside of government enables you to have an objective evidence-based approach about what is best for the whole system, rather than the political interference that comes when you are looking at bits of the system or when you are looking at entrenched silos in ways of working.

This plan, while it has had the input of many clinicians, such as the cardiac services advisory group when it existed as a DHHS group, brings an impartial evidence-based approach. As we sit with our stakeholders, they might think there is some interest or self-interest, but we have been able to bring them back with exactly what you said was about the patient. We are here to talk about the patient and not about shifting costs.

CHAIR - And the outcome for the patient.

Mr LYNCH - Yes, and the outcomes for the patient.

Mr FINCH - Graeme, do you monitor the progress of the people who suffer heart attacks or have cardiac issues? Do you monitor their progress through the system - callouts, ambulance, emergency department, the way they are treated at the hospital and the after care?

Mr LYNCH - That is a good question. I will pass that to Gillian. The ideal way to manage chronic disease is to have registers of what happens.

Ms MANGAN - That is something you have mentioned here. The data collection that happens around the state does not talk to each other. One hospital's data does not talk to the other. Tas Ambulance data does not talk to ...

CHAIR - Is that for privacy issues?

Ms MANGAN - It is different systems that have been set up.

CHAIR - They are not compatible systems.

Ms MANGAN - Not compatible. Even the inter-hospital systems do not talk to each other. There is some hope, it has been talked about for years, that there will be a single hospital system that will be the same ...

CHAIR - I worked in ICT in Health for 20 years and ...

Ms MANGAN - You were probably trying to put it in place.

Ms FORREST - Single unit health records? I was told recently when I challenged this that they are in place in the public hospitals.

Ms MANGAN - There is a unit record number but that is not necessarily linked to the ambulance data. It does not talk to GP systems, so there is not a capacity to overview that. The Heart Foundation does not have access to that level of data. We would love to, but the way to get around that would be to establish registers.

Mr LYNCH - To track what you are referring to really needs an Australian-wide registry. People move, they have their events in different places. Until we get to - if we get to - a national personal electronic health record - you are correct, there are identifiers for people in the Tasmanian health system but that is limited so that does not cover what happens when they are outside the THS …

CHAIR - Mind you, they trialled the personal electronic health record in Tasmania first.

Mr LYNCH - ... and there continues to be a lot of work around that. It is changing from an opt-in to an opt-out system. That is ideally what we need because data is very powerful in how you manage and design services.

Ms MANGAN - One small example of that. I am in a working group with the THS to try to address ambulance callouts that go to someone who is having a heart attack. Ambulance now has the capacity to do a 12-lead ECG but they cannot transmit it to a cardiologist at the Royal at the moment. We are finally getting to the point that there has been agreement that a phone shot of the ECG is going to be sufficient quality. These are the sorts of things that -

Ms FORREST - Such is the technology of our iPhones these days.

Ms MANGAN - That is exactly right, but there are ECG machines that can actually talk to the hospital system so the cardiologist at the time can go, 'Yes, that is definitely a ...'.

Mr LYNCH - That is eHealth, the ECG transfer. That is one aspect of eHealth. It is just like chatting to people. The deeper question that enables us to plan effectively for a whole of health system is those lifetime records where we can get the whole journey and then we can link the data. We do have a Tasmanian data linkage unit in Tasmania which can take records from the DHHS and link those to population records. We can link them to education; link them to criminal offences. All of that is possible. It is happening. It has been funded through significant Commonwealth funding, but you still need the whole-of-health record to be able to do that very effectively.

Ms MANGAN - That tends to be used for research purposes rather than system planning, at this point.

Mr FINCH - Would the Heart Foundation get across issues that might come out of ambulance ramping, where a person with a heart problem requires urgent treatment and they come in, in the ambulance and then it is blocked or held up or they need to be treated on a ramp. Do you get any feedback on those circumstances? Do you monitor what is going on there?

Mr LYNCH - No, we do not monitor that. We see that as a system problem. The way to address the system problem is through this sort of evidence-based activity in ensuring that these things get implemented rather than as a bandaid. That is the problem at the moment.

I have read through many of the well-informed submissions of people on the ground coming before this subcommittee. Most of them are, 'here is the problem, here is a bandaid solution to fix this or that particular problem', rather than looking at the whole of the system.

We have had, over the last two or three years, cardiologists and cardiothoracic surgeons coming to talk to us about the capacity of the cardiothoracic unit, which has been a hot issue. They have come to me because they are on our committees and I say that I cannot comment on that until I have a document like this that tells me what the evidence is we should have in Tasmania, until we work out where things should be. Now, I can comment on it because we have the evidence, we have been able to link that in with the role delineation work that has been done, which is good work, around the ranking of the THS-controlled hospitals in Tasmania. Then there are the other players with capacity in the private system.

Ms MANGAN - That only does the role delineation at the four major hospitals, not district.

Mr LYNCH - That is what I am saying.

Mr FINCH - I will be interested to see the establishment of the adult cardiac surgery unit in Tasmania. I am curious about this process. We do not have the capacity to deal with people who need surgery in Tasmania and need to travel interstate. That is all done efficaciously, not a problem there. Have you had any reports that it could not be done in Tasmania because there is a fear there could be a circumstance that beds, which might otherwise be allocated to a CHU unit, might not be available because of the shortage?

Mr LYNCH - There is an issue around cardiothoracic surgery in that. To have a cardiothoracic unit in the first place you need a certain population, which is around 500 000 to 550 000 people. We have that, but not for two or three locations in one place. That is centralised here in Hobart. To maintain that service and for a surgeon to keep his skills up to speed and so on there is a certain throughput of operations that need to occur.

To do cardiothoracic surgery you need intensive care beds and you need profusionists, particularly if it is open-heart surgery because the heart is taken into an artificial pump while the surgery operates. There are real blocks if you do not have the throughput, you do not have the number of profusionists and you do not have the intensive care beds to enable that to occur. What has been happening, we have been informed by the cardiothoracic unit, is that surgery is often planned, the intensive care beds are not available and they are delayed. Then what happens is you have cardiologists around Tasmania who have patients who need treatment, who are concerned that if they refer them to the Royal Hobart Hospital their surgery may be delayed. There is an incentive for many of them to send their patients interstate. Once that happens you start to lose the volume that is required to perform the surgery. That is because of the inefficiency and the lack of overall planning of the whole system to deal with those things. It is easy to explain it, as I just have.

The solution is to look at the whole of the system and how we manage that, to ask, what are the real blockers of those activities and what stops us from delivering it? You do have to have a cardiothoracic surgery in Tasmania because it is not just heart attacks they deal with. They also deal with traumas.

Mr FINCH - Is that happening with regularity, Graeme, that these beds are not available because of the fear there might be a delay in the service that needs to be provided, that we have a regularity of people needing to go interstate?

Mr LYNCH - Surgery is regularly cancelled because the intensive care bed for immediate post-surgery care is not available.

Mr FINCH - Is this because they are being picked up by the hospital system to use for other clients?

Mr LYNCH - Of course, yes.

Ms MANGAN - That is outlined on page 37 to 39 in the plan, the issues around cardiothoracic services that we have an understanding of.

Mr FINCH - What are your thoughts about this unit being established in Tasmania? Is there a wish list, a desire for it to be completed, or be considered and established within a certain time?

Mr LYNCH - The unit has been here for 20-odd years. It has been in service for 20-odd years. It was doing - I would have to go back and look at the numbers.

Ms MANGAN - Approximately 400 to 500 cases a year and that has dwindled down over the last number of years. They are often only doing about 300 a year.

Mr FINCH - The 'guidelines' for the establishment of an adult cardiac surgery unit, what is meant by that? An enlargement in the operation?

Ms MANGAN - They are guidelines as to what is required to have a cardiothoracic unit. The reason that is in there is because it is referred to throughout the document, as to what is required for Tasmania. There is one for Tasmania that has been established. As Graeme said, they had their 20th birthday a couple of years ago.

Mr LYNCH - Prior to that, Kerry, those patients primarily went to South Australia or Victoria.

Mr FINCH - The suggestion here is that we should have a better, bigger operation and try to cover these things required as back up for the proper functioning of the CSU?

Mr LYNCH - Absolutely. We should be doing all of the surgery that can be done safely and competently in Tasmania, which is most cardiothoracic surgery. We cannot do heart transplants and really rare things that need to go to places where they have greater throughput and more expertise. There is a lot of capacity to do surgery here in Tasmania with the burden of disease we have that is not being dealt with here in Tasmania, which is going to Melbourne, Sydney or Adelaide.

Mr FINCH - Is there pressure on to have this unit established in the form you suggest and with the recommendations you have made here?

Mr LYNCH - We have talked about it throughout, and in my comments; there are solutions. The DHHS does not just have to commission the health service. It can commission other people and there is a cardiothoracic unit proposed at Calvary, the building is there. They are in the process of enabling that. We speak to that in this plan. Our view in this plan is that is one of the ways of meeting the demand. It is a strong recommendation for a population of our size that it should be a single service. Even though it might be commissioned for the surgery to take place at a different site, it should still be the same team, same perfusionist, same cardiologist, same nursing support, and so on. It is a single service over two sites. People who might be in the

private system might elect to go to the private hospital, but it could also deal with public patients as need dictates. That is a sensible approach to a whole-of-health system, rather than looking at the Tasmanian Health Service, which is commissioned and controlled by the government.

Mr FINCH - How far down the track is this proposition?

Mr LYNCH - As I say, the building is there. Where the negotiations are at the moment we cannot tell you, we do not know, but likely to happen, as we understand it.

Ms MANGAN - As I understand it, it is looking at the new year for it to be in operation at Calvary. It is our understanding that the Royal Hobart Hospital cardiothoracic unit will continue on, but whether there is a decrease in resources because now there is this other site established we are yet to see. Our plan says that we need a certain amount of throughput. It should be considered as a single service if it is split over two sites.

Mr LYNCH - It then gives you the volume. That starts to deal with the issue of referrals interstate. We keep our own, if you like, and look after them here in Tasmania. There is always an issue and it is not just the acute event that is important. It is what happens after the acute event. If you are discharged from a hospital in Melbourne and you come back to Tasmania, which health system looks after you?

Mr FINCH - Or you cannot come back straight away. The airlines will not fly you.

Mr LYNCH - There is that as well. When you come back, you come back into this system. It is that interface in the system. In Tasmania it should be efficient and effective so that we can do the surgery here and we can have the handover through cardiac rehabilitation, whatever form that might be, back into the community, back into general practice care.

Mr FINCH - And that is how the community would prefer it to work, rather than have to travel, moving away from Tassie, to get it done.

Mr LYNCH - Yes, it is the system failure that has led to that situation.

CHAIR - You do not think that at the end of the day the total service becomes more expensive because of the private component, no control over charging?

Ms MANGAN - If the DHHS commissions it, they commission it for the -

CHAIR - They have control over that side of it.

Ms MANGAN - That is right.

Ms FORREST - You spoke about this in your opening comments. I wonder if there is anything else you wanted to say about it, Graeme. You are talking about the fact that it is impacting on the capacity of each hospital to meet the current and projected demand in the provision of acute health services. You have said that the transition from three THOs to a single THS was meant to build a system that would provide better access to care and higher quality services. You said you were concerned this promise has not been realised.

Mr LYNCH - Yes.

Ms FORREST - What do you think needs to happen? If you were the health minister and you had the power to put a system in place that did that, what would your priorities be and where would you start?

Mr LYNCH - I would start with the needs of the community, of the Tasmanian health system. I would look at the whole patient journey, as we have described it. I would look at a statewide plan that delivered the outcome you required, then I would implement it. This is the hardest part of this, and this is why it is difficult. The health system is a huge bureaucracy and employs a lot of people. There are industrial relations. You are dealing with clinicians and their bodies. There are a lot of barriers to driving significant change. Often it is thought of in terms of who the current incumbent might be delivering a particular service rather than looking what is the best way to do it.

That is difficult to manage. But if you have a plan that is evidence-based, where you can point and say, 'We do not need to be commissioning these things here. What we do need to be doing is commissioning these things over here'. Then you have the evidence base that enables you to start to drive some of that change. That has been the problem. The reason this plan has never been written in this way is because of the barriers that come up within the bureaucracy to do it. Whereas if you leverage the thinking of the university sector, of the health think tanks and the NGOs that understand, have the evidence and can implement the evidence, then you have a tool that says this is how we should do it.

At the moment if some money becomes available and someone wants to do a particular procedure in Tasmania, that we may have the need for only half a dozen operations a year, but it is the particular interest of a particular clinician, then all of a sudden we can have a whole bucket of money that goes towards implementing that service because it is of an interest. It is not in the interests of all Tasmanians, because we need another perfusionist, or we need to be doing what we do much better. Everybody comes up with innovation and new ideas but we are not doing it right.

I would have these plans that are integrated and that seriously look at how we can move as much of the acute activity, meaning that when people do get sick and we take it out of the acute system and look at the integration with the primary system. It is a planning evidence-based approach.

Ms FORREST - There are two very significant challenges that most governments shy away from addressing because it is not popular. One is telling the clinicians, 'We are only buying this one type of hip. If you want to replace hips, you use this one'. That does not go down very well with a lot of clinicians. There is that engagement with the clinicians. The other is going to the people in the community saying, 'We are not going to provide this service in your local hospital because it is not safe to do so' - they think it is not safe and that the building is going to fall down. I have had lots of discussions about this over the years, as you well know - 'What we will do is provide that service three, four or five hours away'.

We still have a lot of work to do on equity of access in terms of transport and accommodation. The community engagement is a challenge, is it not?

Mr LYNCH - The One Health System was introduced as a health plan for Tasmania, but it wasn't, it was a hospital plan. Consultation is always an issue. What we have experienced in limited application in Tasmania are concepts like citizens' juries and so on. If you have a

document that has the evidence and you talk to people in your electorate and say you are going to provide some information about the safe way of doing things, then people would say clearly we cannot be doing cardiothoracic surgery in Wynyard or Ulverstone because there just is not the number of people there. However, we do need to build that integrated care where we concentrate on how we give that access through transport, through telehealth and by grouping together for that out-of-hospital care.

CHAIR - Post-operative care.

Mr LYNCH - You have 90 percent of it that is not disease specific, such as how do I get to my doctor's appointments? How do I take my medicine? How do I do my physiotherapy? It is common to all these conditions. It is about serious community engagement and there is a move across both the DHHS and the primary health network to look at how we engage much better with consumers to get their informed feedback. If you ask everybody if they want to be able to have their stent put in at Ulverstone, they are going to say yes. Though if you then explain why that is not safe for them physically, not because the building is going to fall on them but because of the competency of the person doing that.

Ms FORREST - There are services, such as chronic pain management, that should be delivered locally. For instance one-off hip replacements. If you go to a place where they do them all the time then you are going to get a better and quicker outcome and response. There are some things that are probably not part of the acute health setting. The initial instance, maybe. Often we find people with chronic pain are put into hospital because there is nowhere else for them to be dealt with, which is probably wrong. We can do a citizens' jury, and it would be an ideal topic for a citizens' jury, but we cannot do it in isolation from the Commonwealth because the Commonwealth funds so much of it.

Mr LYNCH - This is where it comes back to this notion of commissioning that is coming to Australia. We are still learning how to do it - the Primary Health Network and DHHS - but it does provide a framework to look at how we can solve these problems together and commission for the outcomes rather than just buying the hip.

Ms FORREST - Commission for outcomes rather than outputs?

Mr LYNCH - Exactly, so rather than just buying the hip you are buying the overall care, the discharge and the care in the community. As I said earlier, single funding would be ideal because you could just commission for one person. It is a tool that if used appropriately could be very powerful. I think there is a willingness for the government to look at some of these things, or for the system to look at these things because these problems have been around. This is seven years and we have had different governments during that time. It has been a common issue, not an issue that just sits with the present Government. It has been an issue that has existed in Tasmania for the time that I have been involved, which has been eight or nine years now and Gillian the same.

CHAIR - It is often the nature of the beast, isn't it, when it comes to politics. The governments of whichever colour want to be the original thinkers, not the facilitators. What you are presenting here today with regard to this plan is the thinking has been done and we are just simply asking you to play the facilitating role and put that in place. It is not to say that you won't work with the Government to tweak it and to make it better. I presume you are saying that?

Mr LYNCH - This is what it could look like.

Ms MANGAN - We also say that it can be iterative. We have no sets on short-term, long-term, medium-term goals and outlined who we think needs to be at the table to implement those things. There are some things in this plan, since it has been written, that look as if they are starting to happen now anyway.

Ms FORREST - Never give up.

Ms MANGAN -That is right.

CHAIR - What is the time line on this plan? How far forward are you thinking?

Ms MANGAN - We have said that it is a five-year plan.

CHAIR - Five is strategic? The longer-term, broad view -

Mr LYNCH - The example I often give on the health system, in preventative health and the acute health issue; you are here and you want to go to there. There will be opportunities that come along the way. The really good example was the change to LUPA. Out of the blue came an opportunity to put a health objective in LUPA. It was not something we had been advocating for or thinking of, but we wanted to put a health objective into state policy, for example. The opportunity comes along, you grab it and in it goes, but it is on the trajectory.

We would not expect and it would be unreasonable to expect that everything in a plan like this would be implemented in five years. The point is that as you go along and you have to make a decision - a resourcing decision, a system change decision - and you use this as the blueprint. You say, 'If I put that bit in there today, tomorrow there will be an opportunity to put a bit here that will support that, and later we will put a bit in here.'. All of a sudden you have a joined up plan that is going somewhere rather than the approach that we are seeing at the moment, which is all bandaids on issues without that bigger blueprint to drive it forward. It is not the great detail in the plan itself, it is the need for these plans to be developed.

CHAIR - That is right, and it is not only in health, we should be looking at this through the whole-of-government.

Unless there is anything extra you wish to touch on, thank you again for coming along and it is an interesting concept.

THE WITNESS WITHDREW.