TUESDAY, 15 JULY 2014

ESTIMATES—HEALTH AND COMMUNITY SERVICES COMMITTEE—HEALTH

Estimates Committee Members

Mr TJ Ruthenberg (Chair)

Mrs JR Miller

Ms RM Bates

Dr AR Douglas

Mr JD Hathaway

Mr JM Krause

Mr DE Shuttleworth

In Attendance

Hon. LJ Springborg, Minister for Health

Mr A Bibb, Senior Policy Adviser

Department of Health

Mr I Maynard, Director-General

Dr J Young, Chief Health Officer

Dr M Cleary, Deputy Director-General, System Support Services and Acting Chief Executive, Health Support Queensland

Office of the Health Ombudsman

Mr L Atkinson-MacEwen, Health Ombudsman

Hospital and Health Services

Ms J Hartley-Jones, Health Service Chief Executive, Cairns and Hinterland Hospital and Health Service

Dr P Steer, Health Service Chief Executive, Children's Health Queensland Hospital and Health Service

Mr R Calvert, Health Service Chief Executive, Gold Coast Hospital and Health Service

Mr M Stamp, Health Service Chief Executive, Metro North Hospital and Health Service

Mr M Lok, Health Service Chief Executive, Central West Hospital and Health Service

Mr L Richards, Health Service Chief Executive, Central Queensland Hospital and Health Service

Dr R Ashby, Health Service Chief Executive, Metro South Hospital and Health Service

Ms J Squire, Health Service Chief Executive, Townsville Hospital and Health Service

Ms L Dwyer, Health Service Chief Executive, West Moreton Hospital and Health Service

Mr A Pennington, Health Service Chief Executive, Wide Bay Hospital and Health Service

Ms S Belsham, Health Service Chief Executive, North West Hospital and Health Service

Ms G Schultz, Health Service Chief Executive, South West Hospital and Health Service

Mr K Hegarty, Health Service Chief Executive, Sunshine Coast Hospital and Health Service

Dr P Bristow, Health Service Chief Executive, Darling Downs Hospital and Health Service

Ms D Hornsby, Health Service Chief Executive, Mackay Hospital and Health Service

Dr K Freeman, Acting Health Service Chief Executive, Torres and Cape Hospital and Health Service

Queensland Ambulance Service

Mr R Bowles, Commissioner

Queensland Mental Health Commission

Dr L van Schoubroeck, Mental Health Commissioner

Queensland Institute of Medical Research Berghofer Medical Research Institute

Prof. F Gannon, Director and Chief Executive Officer

Committee met at 8.59 am

CHAIR: Good morning. I declare this estimates hearing of the Health and Community Services Committee open. I am Trevor Ruthenberg, the member for Kallangur and the chair of the committee. Mrs Jo-Ann Miller MP, the member for Bundamba, is the deputy chair. The other committee members are Ms Ros Bates MP, the member for Mudgeeraba; Dr Alex Douglas MP, the member for Gaven; Mr John Hathaway MP, the member for Townsville; Mr Dale Shuttleworth MP, the member for Ferny Grove; and Mr Jon Krause MP, the member for Beaudesert. We do not have any substitute members appointed for today's hearing. However, the committee has granted leave for non-committee members to attend and ask questions during the hearing. The committee has resolved that the whole of the proceedings of the committee may be broadcast in line with the conditions of broadcasting and guidelines for camera operators, which are available from one of the parliamentary attendants in the room. I ask that mobile phones or pagers be either switched to off or silent.

The committee will examine the proposed expenditure in the Appropriation Bill 2014 for the Health portfolio in the following order: the department of health and hospital and health services from 9 to 10.30 and from 11 to 12.30; from 1.30 to 3 pm the Queensland Institute of Medical Research, the Queensland Mental Health Commission, the Health Ombudsman and hospital and health services; and from 3.30 to 5 pm continuing with the department of health and hospital and health services. The director-general of Queensland Health and the chief executives of the hospital and health services are therefore expected to be present for the whole day. The committee will suspend proceedings for the following breaks: morning tea from 10.30 to 11; lunch from 12.30 to 1.30; and afternoon tea from 3 to 3.30. Under standing order 181, the minister may have advisers present to assist. Some officials and advisors are located in another room. If it is necessary for an official to come from another room to provide advice or answer a question, I may allow another question to be asked to allow time for that person to arrive and then return to the initial question.

I remind those present that these proceedings are similar to parliament and subject to the standing rules and orders of parliament. I remind members of the public that, under the standing orders, the public may be admitted to or excluded from the hearing at the discretion of the committee. It is important that questions and answers remain relevant and succinct. The same rule for questions that apply in the parliament apply here. I refer particularly to standing orders 112 and 115. Questions should be brief, relate to one issue and should not contain lengthy or subjective preambles or argument or opinion. I intend to guide proceedings today so that relevant issues can be explored without imposing artificial time limits on questions and to ensure there is adequate opportunity to address questions from government and non-government members of the committee. Where necessary, I will remind ministers, directors-general, CEOs and their advisers that their answers to questions should be finalised so that other issues can be examined. I intend to run questions as follows: we will do a 15-minute block from government members and then a 15-minute block from non-government members and loosely follow that format so that we can try as best as possible to ensure that government and non-government members both have equal opportunity.

On behalf of the committee, I welcome the Minister for Health, the director-general and the officials of the department of health and hospital and health services, chief executives and other officials and members of the public. For the benefit of Hansard, I ask officials to state their name the first time they answer a question and to bring their nameplate if they come to the table to answer a question. I now declare the proposed expenditure for the portfolio area of Health open for examination. The question before the committee is—

That the proposed expenditure be agreed to.

Minister, would you care to make a brief opening statement? The committee has resolved that the minister may make an opening statement of up to five minutes.

Mr SPRINGBORG: Thank you very much, Mr Chairman and members of your committee, and thank you for the opportunity to present the highlights of the department of health over the last year in particular and also the achievements over the last couple of years. Indeed, I received probably one of the most extraordinary letters of invitation from the Premier when I was invited to become the Minister for Health—a great privilege—and in it he said that I had inherited a basket case and was inviting me to liberate waste and inefficiency and change the system in order to revitalise front-line services. By and large utilising exactly the same people and exactly the same human capacity in Queensland Health as existed previously, there has been a fundamental and significant turnaround for the people of this state and much is owed to the doctors and nurses, allied healthcare professionals and administrators in Queensland Health who have risen to the challenge of providing better outcomes for patients in Queensland. We had an unmanageable bureaucracy. We had people who were underpaid, overpaid or not paid at all. Indeed, 49,000 of our roughly 80,000 staff were not being properly paid as a consequence of the payroll debacle, and of course who can forget our friend the fake Tahitian prince? Now hospitals are on budget, there is no more ambulance bypassing and local hospital boards are accountable to their community and also to the minister for their performance and they are funded on actual activity. Ambulances arrive up to a full minute quicker than under our predecessors and clinical teams have redesigned services for better health outcomes, and we are seeing those in so many areas.

This year's Health funding will increase by some 6.4 per cent or around an additional $2 billion since we were elected to government in this state. Nurses are paid almost 10 per cent more than what they were paid by our predecessors, and indeed roughly 27 per cent of our enrolled nurses and our registered nurses are now paid more than $100,000, so we do value them and this will also form a very important part of our deliberate attempts to recruit more nurses to amongst the most highly paid cohort of nurses in the nation. More than $11 billion will fund hospital and health services and other public health providers including Mater Health and also St Vincents. In relation to Mater, this is a very proud relationship—one of long standing and respect which goes back more than 100 years in Queensland. We are very keen to continue to work with it and partner with it in places such as Springfield and the western corridor, where we recently announced a commitment of some $26 million each year for 4,800 separations.

This budget also includes head office savings of some $96 million by reducing bureaucracy, red tape and process which is now being reinvested into front-line health services—another thing the Premier chartered me to do as well. There are capital investments of some $1.55 billion which will provide new facilities and address the longstanding maintenance backlog which we inherited from our predecessors. For example, Block C at Mount Isa Hospital needed $2.1 million worth of basic repairs just to ensure that it was habitable and more than 20 paediatric, medical and surgical patients and allied health and administrative staff were displaced during that particular work. New initiatives this year include Queensland's Health Ombudsman—and I look forward to the work which he and his team will be undertaking to ensure that we provide better responsiveness to those who have complaints about the quality of their clinical care for both registered and unregistered professions—and also the establishment of the new Mental Health Commission. The Lady Cilento Children's Hospital will open. This will be Australia's biggest public children's hospital with a state-wide supporting network and also care coordinators. Some 155 new and replacement ambulances and an extra 100 ambulance officers will be recruited during the course of the year.

New ambulance services will include a low acuity paramedic service in Townsville, Metro South, Metro North and the Gold Coast. Also with regard to performance of the system overall, in 2012 there were 6,485 people waiting for surgery longer than clinically recommended. That number was 2,842 as of the end of March, and I understand that that number has been at least halved in the last quarter. We should also not forget the fact of the extraordinary turnaround of our dental performance—62,000 long-wait dental patients now reduced to zero. The performance of our

emergency departments has improved from 63 per cent of people being seen and attended to appropriately in under four hours to now 78 per cent in March 2014. The previous government said that the model was so toxic that the department of health should be torn in two, it was a basket case and it was not fixable. It has been fixable and we are getting extraordinary results which are the envy of the rest of the nation. Unfortunately, we do not know what our opponents are proposing for us—more dysfunctionality or a commitment to the achievements which we have made.

The other thing that I think is important for rural and regional areas of the state is the reopening of maternity services in places such as Beaudesert and Cooktown next year; later next year a remote surgical van which will take services to areas around the state which have never had them before or have not had them for some time; and also a rollout of telehealth which will assist us in being able to do remote renal dialysis support. Chemotherapy, mental health, paediatrics, orthopaedics and all of those sorts of things are on the cards for further service expansion during the course of this year and beyond. Thank you for the opportunity.

CHAIR: Thank you, Minister.

Mr SHUTTLEWORTH: Minister, I note that the very opening page of the SDS confirms that the can-do LNP government will this year make a record investment in Queensland Health—in fact, $2 billion on Labor's last budget. Minister, can you give an undertaking that the overwhelmingly majority of this additional funding will go to hospital and health services that are at the front line of health care and that additional funding will not go into more bureaucracy or the pockets of IBM executives, as would have happened under Labor?

Mr SPRINGBORG: I thank the honourable member for the question. It is very true that the Newman government has made a record commitment to investment in public health services in this state. Indeed, around about $11 billion, as I said, of the $13.6 billion which has been allocated will be allocated directly to front-line patient services, so that will be across our hospital and health services in this state and the 16 independent local hospital and health boards and the services that they oversee and of course in partnership with Mater Health Services, St Vincents and some of the other providers. The other thing of course is that we do have clinical support services which are provisioned through our central agency, and that might be in the area of radiology, pathology, pharmacy and those sorts of areas. Of course, we are putting a greater degree of focus of not only investment with regard to resources but also making sure that we get efficiencies because we are also a service provider to our hospital and health services. We are engaging with the hospital and health services to make sure that they are satisfied with our performance and we are improving that all of the time. We always have more work that can be done in that area.

Importantly as well, it is envisaged during the course of this year across our 16 hospital and health services that an additional 2,096-odd, I think that is the projection, people will be employed—principally nurses, many doctors and allied healthcare professionals—to support the expansion of those services across the state. The other thing as well is that we just do not count inputs. The days of basically counting things in the context of the number of beds, the number of staff employed or the amount of money spent as an effective indicator of our performance are gone. We look at the performance with regard to our emergency departments, elective surgery, dental waiting lists and outpatients, which are a challenge for us. Even though we have done additional occasions of service for new patients this year, that is something we will be moving to improve as one of our other priority areas as we deal with things such as emergency department first year, dental, elective surgery, ophthalmology, cochlear and then we work through that particular process. So there has been significant improvement and we are not in the business of employing management for the sake of management, bureaucracy for the sake of bureaucracy. This system is not about bureaucracy; it is about the patient. It is about their care, and that is what we are delivering.

Mr KRAUSE: Minister, I refer to the very first paragraph of page 10 of the SDS which commits to reducing the rate of those who are overweight and the issue of obesity, which you have identified as the No. 1 health challenge into the future. In addition to the personal health costs, can you give an insight into what obesity is costing the taxpayer in terms of hospital and ambulance redesign?

Mr SPRINGBORG: I thank the honourable member for the question. This is one of the great challenges that we have. We are very fortunate to have some excellent people who work in Queensland Health in preventative health and, of course, an extremely dynamic and very focused chief health officer in Dr Jeannette Young, who continues to remind me and Queenslanders about the importance of this particular issue.

Honourable member, we do know that some 60 per cent of the presentations and, therefore, expenditure on health services are avoidable. Now, in an ideal world we would be able to do that. We do not live in an ideal world. Unfortunately, the patient, or the consumer out there, does not necessarily see themselves front and centre of health care. They have become more reliant upon a system which can fix their challenges medically. Hospitals will make a person better, but we do not necessarily make a person well. Wellness comes from the relationship you have with your primary carer and the decisions you make in your life. So the messages around eating properly, drinking responsibly, not smoking and exercising more continue to be a challenge not only here but right across the Western and developing world.

It also brings with it a range of challenges for us and those particular challenges are quite extraordinary as well. What we have to do is to do more and more investments in facilities which will take bariatric patients up to 250 kilograms and also super bariatric patients up to 450 kilograms. For example, if we invest in the Royal Flying Doctor Service to modify a door on a plane to take bariatric patients—around about $1 million. We have increasing investment in the number of bariatric ambulances around the state as well and it costs us at least $50,000 more to provision a bariatric ambulance. So it costs more and more, not to include the costs of such things as when you go into the new Gold Coast University Hospital and other hospitals to have to have the winches and the hoists that are able to cater for people over 400 kilograms. Indeed, during the course of this year we performed a bariatric caesarean on a patient just under 300 kilograms. One can only imagine the challenges for the obstetrician and the scrub team as well as for the patient and the infant as well. So this is the growing challenge that we have around the place.

Ms BATES: Minister, I refer to page 12 of the SDS, which highlights that public funds will create almost 2,000 full-time Health jobs throughout the 2014-15 year where it really matters at the hospital and health service level. Can you provide details on how many doctors are currently employed by Queensland Health and how many were there when the LNP won office just over two years ago?

Mr SPRINGBORG: Can I just indicate that, yes, we are intending to employ an additional 2,096 people in front-line positions across the state during the course of this year—front-line or support positions. Indeed, principally, as I mentioned to the honourable member for Beaudesert, most of those will be in nursing areas, because the nursing workforce for us makes up around about 50 per cent, or just under 50 per cent, of our workforce.

But, of course, there is increasing employment in the number of doctors that we have employed in Queensland. That number of doctors, I think in overall terms, has risen from just short of 7,000 when we were elected to over 8,000 at this particular time. Also, with regard to the number of doctors' contracts which have finalised, we have around about 3,590 of those doctors' contracts finalised. We have some others pending, but to date we have around about 99 per cent plus of the doctors who have signed up. So we are talking about the SMO and the VMO workforce—the cohort. Indeed, they are a part of the overall 8,000 or so doctors who we employ across Queensland, whether they be residents and others in the system as well. We are encouraged also by the fact that it looks as though we may indeed have more doctors as a consequence of our contracts than we had when we started earlier this year.

Ms BATES: Minister, I refer to the last paragraph at page 7 of the SDS, which highlights that since the LNP came to office just over two years ago nurses and midwifes have received across-the-board salary increases of 9.27 per cent. Given that nurses were underpaid, overpaid or infamously not paid at all under Labor, can you indicate what these LNP pay increases mean in real dollar terms for our front-line nurses and midwifes?

Mr SPRINGBORG: I thank the honourable member for her question. Indeed, one of the things that we were very keen to do when we came to government—and the first meeting that I had when I became minister was actually with the Queensland Nurses Union. I actually met the Queensland Nurses Union before I actually met with my director-general and the executive management team, which probably sounds strange given that they do not have much political alignment or sympathy for our side regardless of what we did and what we were going to do, but we respect the nurses and the quandary that they found themselves in. For me, I was very, very disturbed by what we had to deal with when I was Deputy Leader of the Opposition a number years ago when we had nurses ringing in to us saying that they were not being paid and they basically had to beg for charity. We did not get any sort of contrition from the government of the day around that.

Indeed, our predecessors were going to offer the nurses—and it is in their budget action plan—2.5 per cent. We actually came to an arrangement of 3.16 per cent per annum with the nurses. That was over three years. So they are paid almost 10 per cent more on a cumulative basis than what they were under our predecessors. As I understand it, under our predecessors in the area of clinical nurses—the ENs and RNs—in their last full year in government there were 34,040 FTEs. We have 35,538. Twenty-seven per cent of those are paid more than $100,000 a year vis-à-vis 18.8 per cent under our predecessors in their last full year in government.

Ms BATES: Thank you.

Mr HATHAWAY: Minister, I refer to page 75 of the SDS, in particular footnote 4. It mentions own-source revenue. Can I get a crystal-clear commitment that the LNP government has no plans whatsoever to implement a Queensland Labor style policy to introduce a $100 co-payment for surgery?

Mr SPRINGBORG: In actual fact, honourable member, I can give an absolute, categorical guarantee that we have no plans whatsoever to implement the Labor Party's report, which was commissioned when the honourable member for Bundamba was the assistant minister for health, which the government of the day commissioned—this just did not grow out of thin air; the government of the day commissioned it—which looked at such things as co-payments for outpatients and also admissions in Queensland. The previous government's proposal was for a universal co-payment of $50 for same-day admissions and $100 for overnight admissions. That is something that which we absolutely and completely repudiate. We have no plans to even revisit anything that our predecessors were looking at in Queensland. We would be most interested to know how they propose to fund their healthcare system in this state, because they were looking in desperation at things like this, because it was in such a parlous state.

We believe in universal, free, public hospital access. We believe in that. That is something that we are going to remain committed to and that is by active repudiation of plans such as our predecessors to bring in those co-payments, such as $50 for same-day admissions and $100 for overnight admissions.

CHAIR: Thank you. We will move to non-government questions now. I call the member for Bundamba.

Mrs MILLER: Thank very much, chair. Minister, I refer to page 4 of the SDS, paragraph 3. Minister, will you table the list of all assets under consideration for sale by the department of health or any HHS? Does this include in metropolitan north the Royal Children's Hospital, the 4.8 hectares of further land and heritage buildings on this Herston site; the Brisbane Dental Hospital in Turbot Street; the community health centre and sexual health clinic in Roma Street, known as Biala; and the land at the corner of Bowen Bridge Road and O'Connell Terrace, Bowen Hills, which was identified in resolution 77 of the LNP convention last week? I table the resolution of the LNP.

Mr SPRINGBORG: I thank the honourable member for her question. As the honourable member is well aware, because I have said so publicly, the LNP government has absolutely no plans whatsoever to be selling off our public hospitals. We have absolutely no plans to be privatising our existing public hospitals. Indeed, from time to time there may be vacant land or other assets—small pieces of land—that will be sold. This is no different under ourselves from under our predecessors.

But again, with the honourable member, she makes an extraordinary flight of fancy. With regard to the Herston campus, it is a matter of public record that I am very keen to preserve that as a health precinct. Indeed, that is what we will be doing. We will be going to market around the development of a master plan, which will actually preserve that as a health precinct into the future, because there are very few places within the close areas of Brisbane—the CBD—where you can do those sorts of things. So from my particular perspective, that will be preserved for a health precinct. We are engaged at the moment with experts around that, including involvement from QIMR, QUT, also with regard to UQ and the Metro North Hospital and Health Board.

There may be some small parcels of land from time to time that will be managed for sale and reinvestment. That is not an unusual thing, but it does not apply in the circumstances, as was dealt with by the honourable member. So she has particular issues. As small pieces of land may be listed from time to time, that will be a matter of record. I think that the government land asset management people also handle these issues, but we do not have any plan whatsoever for the sale of hospitals or major health precincts around Queensland.

Dr DOUGLAS: Thank you, Minister. I will get to the SDS questions in a minute. I would like to just take you back to something that you mentioned before—

Mr SPRINGBORG: Mr Chairman, I thought we were supposed to make at least an oblique reference to the SDS. I am guided by the chair on that.

Dr DOUGLAS: I am just referring to comments that you made in a statement—

CHAIR: Sorry, Dr Douglas, is this a follow-up question?

Dr DOUGLAS: Yes, a follow-up question.

CHAIR: Okay. If you would get to the question, please?

Dr DOUGLAS: Okay. It relates to the issue you mentioned of co-payments. I wish to expand on that issue of co-payments. The federal budget has gone through. This budget has subsequently followed. What provision have you made within these documents with regard to the impact of GP co-payments and the knock-on effect to the hospital system in general in Queensland—the transfer of patients; basically cost shifting?

Mr SPRINGBORG: What ultimately may happen with the co-payment in Canberra, somebody who you are very closely aligned to maybe relatively influential in that particular process—

Dr DOUGLAS: I thank you for that.

Mr SPRINGBORG: On 1 July next year, I understand the federal government proposes to introduce a co-payment. That will depend upon the political machinations in Canberra. We have already indicated our concern around that if it does come in. It is very, very difficult to model, because you really do not know whether there will be an impact, short, medium or long term around that. We do know that around about 50 per cent of the presentations to our emergency departments are category 4 and 5. The greatest majority of those—around about 80 per cent of those—already should be seeing a GP; so around 400,000 of those. It is possible that there would be an increase in that. I have already instructed my department to start to look about how we would deal with any upsurge, whether that be short term or longer term. There are a range of strategies that we can involve, and we already do in places such as Proserpine and Mackay and elsewhere with a co-located GP type clinic. So we do have ways that we can deal with it. We also have the low acuity work which the Ambulance Commissioner, Russell Bowles, is doing—doing a great job around it—where we are sending trained paramedics around to deal with people in their own home environment and then also being able to put them into an alternative primary care environment. So that also assists. So we will do more investment in that area. We can't determine the machinations in Canberra, but we can actually do work around contingency and I have indicated some of that to you.

Dr DOUGLAS: Have you got specific allocations or can you be a little bit more specific?

Mr SPRINGBORG: No, because we are dealing with hypotheticals, but we have resources which we have already allocated in the low acuity work with the Queensland Ambulance Service and also there is enough contingency in our system to be able to address an upswing. But we do have other options such as the provisioning and expansion of the GP type services which we provide co-located in our emergency departments which may provide an opportunity for a shorter term capital investment, but longer term would be relatively cost neutral. But if this does come to pass and we need to make a bigger investment I can assure the honourable member that such costs will be fully disclosed, but we are working within it at moment.

Dr DOUGLAS: Could I just continue along that line?

CHAIR: As long as we are not asking the same question.

Dr DOUGLAS: No. I did like some of your examples more regionally based but I mean in terms of numbers of people moving through A&E, for example, on the Gold Coast alone you are looking at 130—or 650,000 separations a year, but we are looking at huge numbers of people, and even a two per cent increase is a significant amount so I am asking about the major hospitals in this SEQ region. Can you give me some ideas about that?

Mr SPRINGBORG: Honourable member, the issue with regards to type 4 and 5 or category 4, 5 presentations are a greater issue outside the inner metro area than what they are inside. So you get out towards your outside areas, your Redcliffes, your Caboolture, going down towards maybe Logan, that area. The Gold Coast has seen a 16 per cent increase in presentations through its emergency departments I think in the last 12 months. Some 24 per cent, if you look at the weighted activity units around it. So it has been an extraordinary increase. I don't have the breakdown of categories 4 and 5 around it, but it is unrelated to the co-payment. There is some argument around

whether the talk of a co-payment has driven any of this. We haven't seen anything beyond the anecdotal. But we have some capacity in our system to deal with those sorts of issues because we do run a budget surplus centrally which we reinvest locally. If we have to make contingency reinvestment it just means that we will need to divert more of those funds into that particular area, but at least we have them, and also our local hospital and health services are in a reasonable position to deal with some stuff. But having said that, we are looking at something that will be in the 2015-16 financial year. We have already started work around how we would address this and we are not in a position to give a potential financial cost because we don't know. But the low acuity work that the Ambulance Service is doing, the work that is being done with regards to GP type clinics, all of those things are already assisting us, plus better performing hospital emergency departments. So we are aware of it and some of the other states are already looking at following what we have done. Like New South Wales is looking at the model here in Queensland around GP type clinics.

Dr DOUGLAS: Can I continue? Would it be timely to take stock of the fact that we do need to take decisions? The admission rate is one in four currently out of people presenting, if I can use the Gold Coast as an example. Then the pressure is to try to get it from one in three which it had been almost. One in four, each admission is costing about $4,000 to $5,000. That is a lot of money. Within a budget that is an extraordinarily large amount of money. I need a little bit more information which is really not contained within here and I know that it is a difficult question.

CHAIR: Dr Douglas, could you ask your question.

Dr DOUGLAS: My question is if this planning is going on, can you tell me a bit more about it? We need to know as a committee, and the public need to know.

CHAIR: Dr Douglas, I actually think the minister has answered that question.

Mr SPRINGBORG: I am happy to assist the honourable member more.

CHAIR: Please.

Mr SPRINGBORG: I think I indicated a figure of around about 16 per cent for on the Gold Coast. I have been given some figures here that it was 13 per cent. Nevertheless, it is very, very significant. I think there may be some more updated figures since that to the end of June that may reflect a higher rate of presentation than the 13 per cent. But, honourable member, we routinely undertake planning in a whole range of areas. It is very difficult to know what may need to be invested until you actually get to that particular course of action that needs to be taken. We have already started the work. We routinely invest in additional capacity. That capacity may be able to deal with the issue. We also know that if you present to an emergency department I think the cost is around about $400 for a treatment in an emergency department or thereabouts—$400 to $450. If you can go to a GP then that variously is between around about $30 and may range up to $60—$30 to $60 depending upon whether there is a gap at the moment. We are doing that work. We have sufficient resources in the system. We don't need to really put particular additional resources in when we have a whole range of resources already working within the system and also we have got Medicare Local pilots which are happening in Metro North and also the Gold Coast where there is cooperation happening between the hospital and health board and also the Medicare Local around the diversion of people away from emergency departments as well. That is all happening. And a growth in after-hours GP type mobile services. But we really have difficulty understanding what a hypothetical situation may be depending what happens in Canberra. But we will keep you up-to-date, I vow and declare that.

CHAIR: Thank you, Minister. I call the member for Bundamba.

Mrs MILLER: I refer to SDS page 39 and my question is directed to the Director-General. Director-General, have you ever seen any details in any form of Dr Anthony Lynham's personnel file or payroll details?

Mr Maynard: I thank the member for Bundamba for that question. I have seen some details associated with Dr Lynham's payroll information.

Mrs MILLER: Okay. Why?

Mr Maynard: I was made aware late last week of allegations in the media that information relating to Dr Lynham may have been publicly available. The allegation was that information was leaked and the purpose of me making an inquiry of my HR department was to understand (a) what processes are in place around managing payroll data and to see what payroll data related to Dr Lynham.

Mrs MILLER: So, Mr Maynard, you have initiated an inquiry in relation to the leaking of these payroll details, have you?

CHAIR: Sorry—

Mrs MILLER: In relation to SDS page 39, particularly the last paragraph.

Mr Maynard: I have not initiated an inquiry. There have been no complaints raised with me and to my knowledge no complaints raised with the department in relation to Dr Lynham. I may refer to the minister. The minister did request me to—

Mrs MILLER: I am asking the questions.

Mr SPRINGBORG: Please ask me.

Mr Maynard: There may be further information that the minister would like to make available to the committee.

Mrs MILLER: I have continued questions in relation to this matter to the Director-General.

CHAIR: Minister, I will come to you shortly. If you would continue, but please stick to the SDS.

Mrs MILLER: Yes, I am. In fact, it is SDS page 39, Chair, the last paragraph in particular that I am referring to.

CHAIR: Thank you.

Mrs MILLER: Mr Maynard, can you please advise me of the terms of reference of this inquiry that you have initiated in relation to Dr Anthony Lynham's payroll and personnel records?

Mr Maynard: Thank you for that further question. In my earlier answer to the question I indicated that I had not initiated an inquiry or investigation. I have received no complaint. I did receive a request from the minister's office to look at Mr Lynham's payroll data in relation to the allegations that were made late last week. So, no inquiry or investigation has been initiated.

Mrs MILLER: Following on from that, Mr Maynard, are you aware of information privacy principles that cover this sort of information in your department?

Mr HATHAWAY: Point of order, Chair.

Mrs MILLER: In relation to SDS, page 39.

Mr HATHAWAY: Even with a broad interpretation of the last bullet point on page 39 I fail to see the relevance of this line of questioning in regard to that particular bullet point that the member refers to.

Mrs MILLER: So we are in a secret state, are we?

CHAIR: Member for Bundamba, can you point out to me within that how we—

Mrs MILLER: It says 'ongoing improvements to the payroll and rostering system' and this is about payroll and it is particularly in relation to the information privacy principles which cover all government departments, including the Department of Health.

CHAIR: Member for Bundamba, you are drawing a very, very specific question that is an incredibly tenuous link and I would ask you to get to—

Mrs MILLER: No, it is a question in relation to accountability and it is a question in relation to integrity. Mr Maynard, as Director-General of the Department of Health, throughout the department and also throughout the HHS's there are tens of thousands of people employed within the health area. Mr Maynard, I am asking why you have not initiated an inquiry or an investigation into the leaking of Dr Anthony Lynham's personnel file in relation—

CHAIR: I'm sorry, I don't see the relevance of that to expenditure.

Mrs MILLER: So this is a secret state, is it? It is, because Mr Lynham was paid.

CHAIR: Member for Bundamba, please draw your questions back closer to what the SDS is intending.

Mrs MILLER: I now call Mr Stamp.

CHAIR: While Mr Stamp attends, Minister, is there anything you want to add to this?

Mr SPRINGBORG: Absolutely.

Mrs MILLER: You can ask that in your own time. I have called Mr Stamp.

CHAIR: Excuse me, member for Bundamba. I am chair of this committee and right now I have asked the minister if he would like to add to it.

Mrs MILLER: So are we now in government questions?

CHAIR: Member for Bundamba, I do not intend to engage in an argument with you. I have asked the minister if the minister would indicate anything here and if the minister wants to answer I have asked him to answer and if not then we will move to Mr Stamp immediately.

Mr SPRINGBORG: Mr Chairman, I am happy for you to stop the clock or you can give the honourable member for Bundamba double time if she wants, it doesn't bother me one way or the other, if she is going to be upset about it.

Mrs MILLER: Good.

Mr SPRINGBORG: Mr Chairman, it is completely what you would expect from the honourable member for Bundamba, because the one who stands to lose the most if Dr Lynham is elected is her. Mr Chairman, 49,000 Queensland Health workers out of 80,000 were overpaid, underpaid or not paid at all. So it is of no surprise that someone should actually ask, if 60-odd per cent of your health workers aren't paid, if that was one of them, and Dr Lynham was one of the Queensland Health workers. We received an inquiry into our office last week from the media asking us if he had been overpaid and to confirm the figure, which I refused to do because that is not something that I would actually do. So we did that. Then the opposition leader raised the possibility of questions in this place during the course of estimates and I requested Mr Maynard to get hold of that information in case it needs to be detailed in here. I would be very reluctant to do that. I would be very, very reluctant to do that, Mr Chairman, but that is why I actually asked that. So I had no idea of the amount prior to actually asking for that at the end of last week. Subsequent to that, Dr Lynham has actually confirmed figures out there in the community, of which it was news to me because we hadn't asked for those figures. So that is it. So it is a matter for Dr Lynham. But there have been 15,000 Queensland Health workers that have already paid back or started their process of paying back and there has also been 5,000 registered plans by people such as Dr Lynham who have actually been invited as a part of the standard correspondence that they get to actually start a process of payment on a voluntary basis. The question I would ask is why wasn't Dr Lynham one of them, if you want to go that way. We now have 20,000 Queensland Health workers. We have recovered around about $60 million since we have been in government. If we hadn't have done what we had done it would be $150 million today not around $87 million. So the issue here is, Mr Chairman, 49,000 people, no-one should be surprised that the media would ask that question. We didn't confirm it. We didn't play in that area, and I asked the Director-General to get that information in case it were raised today. If the honourable member for Bundamba has the authority of Dr Lynham for us to go through this on a detailed basis I am happy to do that, but I would be very, very reluctant to do so. I understand Dr Lynham contacted the department last week to make arrangements for repayment and there were no formal complaints that are actually made. But really you have got 1,000 health employees in payroll, 500 extra as a consequence of the Labor Party's maladministration who have been put on to manage payroll. I would be surprised if there weren't hundreds and hundreds of people, if you want to start talking about leaks. Most of those people have a direct connection into unions around this state so there is a whole range of issues.

We had no such fretting from the opposition about ongoing improvements in the SDS. They never asked one question when nurses were not being paid. The whole system blew up. They were not worried about an inquiry when there was a 20,000 per cent blowout, from $6 million to $1.253 billion, but now they are worried about something like this. I think they should get their priorities right.

CHAIR: Member for Bundamba, we will add extra time to your block. If you direct your question to Mr Stamp, please.

Mrs MILLER: Thank you, Mr Stamp. I refer to SDS page 39. Mr Stamp, have you had any conversations, sighted any documents or received or given any instructions relating to the unauthorised release of personal information of any public sector employee?

Mr Stamp: As far as I am aware, no.

Mrs MILLER: Mr Stamp, would that include Dr Anthony Lynham?

Mr Stamp: I have had no request about any information on payroll about Dr Lynham.

Mrs MILLER: From anyone at all?

Mr Stamp: From anyone at all.

Mrs MILLER: What if the media had contacted your HHS directly and not gone through the ministerial office?

Mr HATHAWAY: Chair, point of order.

Mrs MILLER: What would your response have been?

CHAIR: Just a second: there is a point of order.

Mr HATHAWAY: That is a hypothetical question.

Mrs MILLER: It is a question in relation to the policies and procedures of Metro North HHS in relation to SDS page 39.

Mr HATHAWAY: Chair, under standing order 115(b).

CHAIR: Member for Bundamba, can you rephrase your question to be directed towards policy and procedure, please?

Mrs MILLER: Yes. Mr Stamp, I refer to page 39 and particularly the last paragraph. I am now referring to the policies and procedures of the Metro North HHS. Mr Stamp, if a person from the media, a journalist or a researcher, contacted the Metro North HHS particularly in relation to any employee within your HHS, whether it be a surgeon, a nurse or an occupational therapist, what is the policy and the procedures that you have in place to cope with such a request from the media?

Mr Stamp: If such a request from the media was made about any personal information regarding pay or payroll information about an individual employee, it would be the same as any information about a patient: it would not be released.

Mrs MILLER: It would not be released at all?

Mr Stamp: No.

Mrs MILLER: Mr Stamp, in relation to page 39 of the SDS, because Dr Anthony Lynham was an employee at Metro North HHS, how did the information then get to Mr Maynard?

CHAIR: I am sorry, that is out of order, member for Bundamba. Mr Maynard has already said—

Mrs MILLER: So it is a secret state?

CHAIR: No. Mr Maynard has already answered the question. That is out of order. Can you please ask your next question.

Mrs MILLER: I will ask another question. Mr Stamp, in relation to SDS page 39, in relation to previous questions that I have asked, if the director-general, acting on behalf of the minister or in his own right, asked about a particular person—and in this case I am referring to Dr Anthony Lynham—and his personal record, including payroll information, if it came from the director-general, do your policy and procedures allow for that information to go to the director-general?

Mr Stamp: I have never had such an event happen. As you know, at the present time we do not own our payroll. Our payroll is run independent from us. It is a central payroll system and has been for a number of years. Therefore, I have received no request to this date about any details relating to Anthony Lynham, be they personal, be they payroll or anything else.

Mrs MILLER: I have a follow-up question in relation to SDS page 39, to the director-general. Mr Maynard, could you tell me please how many people within your department or within the central payroll system would have had access to this information in relation to Dr Anthony Lynham? I want to know how many and at what levels?

CHAIR: Mr Maynard, you need to answer that from a procedural perspective, please, and what your processes and procedures allow or do not allow.

Mr Maynard: We have a payroll team of just over 800 employees. They have access to the payroll system. There are processes in place that protect the private information of all of our employees. When I received a lawful request for information from the minister, I made inquiries of my chief HR officer to provide that information.

Mrs MILLER: Just one follow-up question, please: Mr Maynard, are you sure it was a lawful request?

Mr Maynard: When the request was provided, I believe it was a lawful request. There were comments that I had heard from the Leader of the Opposition late last week in the media indicating that this would be a matter that would be further discussed at the estimates hearings this week and I believe it was lawful for the minister to request me to provide background information so that he was prepared to answer those questions.

Mrs MILLER: Just a brief follow-up question: Mr Maynard, did you have this request reviewed by your legal unit within your department to determine whether it actually was a lawful request?

Mr Maynard: I sought advice from my chief legal officer in terms of if I was requested to provide information to the minister was that a lawful request. That advice confirmed that it was lawful for the minister to ask for that information.

Mrs MILLER: Even if it is a breach of the information privacy principles?

Ms BATES: Point of order, Mr Chair.

Mrs MILLER: Did you ask that, in relation to SDS page 39?

CHAIR: Just a second, member for Bundamba. There is a point of order.

Ms BATES: Point of order, Mr Chair. The member is asking for a legal opinion, so I ask that you rule that question out of order under 115(c).

CHAIR: The director-general has answered the question in regard to the question you asked. I would ask you to move on, please. Thank you. We will move to government questions. I call the member for Townsville, please.

Mr HATHAWAY: Thank you, Chair. Minister, I refer to the second last paragraph on page 4 of the SDS, which makes reference to the newly established HIV Foundation Queensland and the E.N.D.H.I.V. campaign. As I recall, under the LNP Queensland led the nation by being the first state to introduce free rapid HIV testing as part of our regular clinical practice. How will this be built upon in the current financial year with the foundation's $2.4 million budget?

Mr SPRINGBORG: I thank the honourable member for the question. I am very proud of the work that the Ministerial Advisory Committee on HIV has done and, of course, they have now become the new HIV Foundation in Queensland. The concern I had when I became minister was that we had seen a significant increase, around about 100 per cent, in the number of notifications for HIV over the previous decade. So there had been a significant trend and, indeed, in Queensland it was higher than elsewhere around the country. We had a very encouraging decrease in 2013 on 2012, down around about 12 per cent.

As I indicated at the time when I announced that Queensland would be leading the nation with regards to rapid testing, we expected to see a spike with regards to HIV diagnosis. We estimate that around about 20 per cent of people with HIV in the community are living with HIV and they do not know that they have HIV. For a range of particular medical and individual reasons, it does not necessarily manifest itself in the traditional symptoms, so they are living with HIV. The important thing about rapid testing is to have something where that test can be done discreetly, very, very quickly and it will provide virtually immediate results after exposure to the virus. We intend to actually roll that out around the state even more. We have already started to detect people who would not have been detected otherwise if we had not been at the front of the game with regards to rolling out rapid testing. We are detecting people who would not otherwise have been picked up. We can go out and test them in their own homes and we can counsel them in their own homes. Certainly we have examples of that as well.

The other thing that we have done is to lead the nation with regards to the advocacy of the access to antiretrovirals for people who are in the lower stage of the infection, so they have been able to access those at a much later stage, but we believe in treatment as prevention and we have certainly led the way. We have been acknowledged by the committee that provides the advice to the federal minister for expanding access to that pharmaceutical that it was our advocacy that was one of the key points with regards to their agreement to assist in providing that at a lower subsidised rate to people who are HIV positive but would not have traditionally been able to access that previously. We believe that with treatment as prevention, and also the rolling out of rapid testing and a whole range of other initiatives, and also more active marketing and awareness in the general community, we will be able to deal with this far more effectively.

A lot of people in the community still believe that HIV is not an issue; basically it went away in the eighties. It is a problem out there. It is still a problem in a particular subsector of our community and, therefore, for families and friends. We need to be aware of it and concerned. There is a lot of misinformation with people thinking that they will get it if they kiss somebody or share a cup. We even saw the over-the-top stuff recently with regards to the breastmilk issue in the northern outskirts of Brisbane at Caboolture. We really do have to get people far more aware of the reality, stop stereotyping around it and try innovative new programs. Indeed, the world HIV/AIDS conference is in Melbourne in the next little while as well. That will be recommitting nations to reducing the rate of HIV.

CHAIR: Before I call the next member, I remind members that if we are looking to call other than the minister or the director-general, point to me and I will call that person so that you can ask the question of them. Thank you. Member for Mudgeeraba, your question, please.

Ms BATES: Minister, with reference to page 7 of the SDS and the $1.55 billion capital works program administered by the department over the 2014-15 budget, can you advise if any contracts entered into by the former administration may have had an adverse impact on patient access to the new Gold Coast University Hospital?

Mr SPRINGBORG: I am sorry, honourable member: can you please repeat the last part of the question?

Ms BATES: Minister, can you advise if any contracts entered into by the former administration may have had an adverse impact on patient access to the new Gold Coast University Hospital?

Mr SPRINGBORG: Thank you very much for the question. Certainly there is a continuing investment in capital works of projects that had already been committed to and also some new projects as well that have been identified over the past year or so. There is no doubt that the Gold Coast University Hospital is a fantastic facility and already is starting to treat tertiary level patients who would never have been treated on the Gold Coast before. We have already seen a significant increase in the number of patients presenting, both through the ED and elsewhere, on the Gold Coast. We look forward to the collocation opportunity that will be provided with the opening of the new private hospital there as well, because that brings a whole range of other capacity. We certainly are very concerned with regards to the, I think, 20- or 30-year contract that was entered into by our predecessors around the issue of car parking on the Gold Coast and at the hospital. Also I understand that there is a cost-escalation clause that may exist that could cause more access issues or costs for patients accessing the Gold Coast University Hospital. I make the point that neither myself nor the current hospital board is involved in that contract. Through you, Mr Chairman, I would ask if the Chief Executive of the Gold Coast Hospital and Health Service may like to say a few words with some more details: Mr Calvert.

CHAIR: Mr Calvert, please. I remind chief executives if you would please start your answer by identifying who you are.

Mr Calvert: My name is Ron Calvert. I am the Chief Executive of the Gold Coast Hospital and Health Service. Yes, there has been a lot of negative media about car park charges recently and there is certainly a suggestion that access to the services we provide has been affected as a result of that, because people are complaining they cannot pay the charges. The car park is a commercial operation and was procured as a BOOT or build-own-operate-transfer facility and there has been an increase in car parking fees from 1 July.

There is an escalator built into the agreement which increases the cost each year. It does appear that there is some doubt about the interpretation of that agreement, which we are challenging. I am confident that we will come to an agreement with Surepark about the interpretation which will lessen the charge, but it will be more.

Ms BATES: Minister, with reference to the FTE staffing figures contained on page 12 of the SDS, can you provide the committee with some detail about the headcount figures of nurses and doctors making up the FTE figures we see in the SDS—namely, how does the number of nurses and doctors employed currently by Queensland Health compare to those employed at the time the LNP was elected to government?

Mr SPRINGBORG: As I indicated earlier, honourable member, with regard to nurses in Queensland for the last full year of the previous government the figure was 34,040. That was an actual headcount. Today the headcount for nurses is 35,538. That excludes assistants in nursing. So we are talking about registered nurses and enrolled nurses there. There has been a general increase. We also have assistants in nursing. I indicated earlier that we have just over 8,000—I think it is around 8,300—who are in the medical cohort in Queensland. Of course we also have a range of other allied healthcare professionals. I might ask if there are some figures available. I am happy to actually provide them to you later on as well. I think it is in the vicinity of getting up to 10,000.

We have a very strong focus on growing our services more towards front-line services. This is something I have indicated very strongly to the department that they need to focus on. That is why we are seeing such a significant investment in those particular areas. I will get the figures down to the person today, if you wish.

Mr KRAUSE: Minister, the committee appreciates the fact that there is in fact an SDS for the committee to discuss. As we know, Labor's policy position when it comes to Queensland Health has been, in the words of Anna Bligh, 'Queensland Health as we know it will be abolished.' With reference to the 2,080 increase in staff this year, outlined in the staffing table at page 12 of the SDS, how does this contrast to the rate of staff reduction witnessed in Queensland Health in the last nine months of the former administration?

Mr SPRINGBORG: I thank the honourable member for his question. With regard to the previous government in Queensland, I think we had a total number of people separated from 1 July 2011 to 25 March 2012 of some 4,570, or 0.39 to be precise. That was the total number of separations. Who can forget the infamous letter that was sent around by our predecessor. I think about 3,900 people in Health actually received a letter out of the blue and it started off by saying—and I paraphrase—'You have been identified as surplus to requirements. Please confirm if that is the case.' That was a little ripper. As a consequence of that, I think it made way for just short of around a thousand people leaving the system—many of whom were in front-line service areas.

We certainly did go through a process of some reduction in staffing. That was a matter of public record. I am probably the first minister who has actually ever broadcast to the entire cohort of Queensland Health, prior to the announcement being made public, that there would be around 2,700 positions that would be lost—1,200 of those we took direct responsibility for because they were in head office. We indicated that 1,500 of those were as a consequence of Labor's unfunded payroll debacle of $130 million.

Of course, who can forget our really good friend Wayne Swan running through the place with a machete to the extent of $103 million—$40 million-odd retrospective and another probably $30 million which had already been paid to the state which, on the surface, could have added up to around 2,000 job cuts across the state. Our hospital and health services moved to reduce that. The only cuts that have occurred in the hospital and health services have been as a consequence of Labor's payroll debacle and Wayne Swan. Notwithstanding that, if you look at the figures that we are proposing—and they are in the SDS—there will be an additional 2,096 staff this year. We increased the number of people in front-line positions across the state last year. Those figures are readily available in the SDS.

For Queensland Health the actual figure last year was 59,982 staff. The adjusted budget figure indicated 58,937staff. There was an increase over and above what we planned to put in place. We are going to also expand that significantly during the course of this year. Of course, do not forget the 100-odd ambulance officers, paramedics principally.

CHAIR: Thank you, Minister. We will go to non-government questions now. I call for the member for Bundamba.

Mrs MILLER: My question is to the director-general, Mr Maynard. Mr Maynard, just following up from your previous answers in relation to page 39 of the SDS—particularly in relation to policies and procedures. It seems to me to be the case, given your answer, that if a journalist rings the minister's office in relation to any employee of Queensland Health, whether they be a cleaner, a wards man, a radiographer or even an ambulance officer, in relation to personnel and payroll information—

Mr SPRINGBORG: We do not give it to them.

Mrs MILLER:—that you will get this information for him. Is that the policy and procedure in relation to—

Mr HATHAWAY: Point of order, Chair.

Mrs MILLER:—previous—

CHAIR: Just a second, member for Bundamba, there is a point of order.

Mrs MILLER: Are you precedenting this?

CHAIR: There is a point of order. What is your point of order?

Mr HATHAWAY: The question contains an inference or imputation. Under standing order 115(b) I ask you to rule it out of order.

CHAIR: Member for Bundamba, I actually think the director-general has answered this question.

Mrs MILLER: No, I am asking this now in relation to specific categories of workers within Queensland Health.

CHAIR: But member for Bundamba, the last question you asked you asked around process and procedure and the director-general answered around process and procedure.

Mrs MILLER: No, no.

CHAIR: So unless it is different—

Mrs MILLER: It is different because I am asking in relation to people who work within hospitals who are wards men, who are cleaners, who are ambulance officers and who are radiographers, in particular in relation to the SDS at page 39. Basically what I am asking is: is there any difference between your precedent in relation to getting this information for the minister because the person was a doctor or will you get this information if they are a cleaner, a wards man, an ambulance officer or a radiographer? Is there any difference there?

CHAIR: Mr Maynard, I will allow you to answer, but we are on very tenuous ground here.

Mr Maynard: The process that I would use if the minister asked me to provide information relating to an individual would be the same. I would take legal advice from my chief legal officer to determine whether it was a lawful request for information and then I would respond accordingly.

Mrs MILLER: Just to follow-up—

CHAIR: It needs to be different.

Mrs MILLER: It will be different. There is a difference between lawfulness and disclosure in terms of the Privacy Act.

Ms BATES: Point of order, Mr Chair. Again the member is asking for a legal opinion. I ask you to rule it out of order.

Mrs MILLER: No, I am not asking for a legal opinion.

Ms BATES: You are asking the director-general to provide a legal opinion—

Mrs MILLER: No, I am not.

Ms BATES:—for which that question needs to be ruled out of order under standing order 115(c).

CHAIR: Member for Bundamba, I—

Mrs MILLER: I will rephrase it—

CHAIR: Thank you.

Mrs MILLER:—for the benefit of the Chair. Mr Maynard, did it cross your mind at any point in time that there is a difference between lawfulness and unauthorised disclosure?

Mr SPRINGBORG: Who disclosed it?

Mr Maynard: As I indicated in my earlier answer, I took legal advice.

Mrs MILLER: Thank you. I would just like to go on in relation to the Metro North HHS. Chair, I would like to request that Mr Malcolm Stamp come to the table.

CHAIR: Mr Stamp, could you please come to the table.

Mrs MILLER: Mr Stamp, does Metro North HHS now have the responsibility for the site of the Brisbane Dental Hospital in Turbot Street or is this asset still controlled by Queensland Health to the best of your knowledge? I am referring here to the SDS at page 132?

Mr Stamp: This asset is controlled by Queensland Health.

Mrs MILLER: In relation to the asset the Brisbane Dental Hospital, and I am relating it to page 132 of the SDS, have there been any discussions in relation to basically Metro North HHS taking over this asset and then possibly selling it?

Mr Stamp: I think the two things are not related, if I may offer that view. Metro North occupy the Dental Hospital. The adjoining building to that hospital in Turbot Street is the University of Queensland dental school which we work very closely with, both in terms of service provision and student teaching.

As you probably are aware, the University of Queensland has built a fantastic new facility adjacent to the Herston site that you were referring to earlier in your discussion with the minister and the committee. We have had discussions with the people who are looking at what to do with the vacated University of Queensland building, as I say, adjoining the Dental Hospital. The opportunity to improve not only the delivery of oral health services but also the overall teaching environmental for

our future dentists is something that Metro North would not ignore. Clearly, we have entered into those discussions to see whether there is scope for us to do something in collaboration or partnership with the University of Queensland in terms of the vacated dental hospital.

At this moment in time no such decision has been taken. At this point in time only brief outline discussions have been held with our relevant staff. But, of course, if it was to come that we had a proposal that worked in terms of improving the patient delivery service and the teaching environment for our future students in what is a sensational building at UQ then I think we would be interested.

Mrs MILLER: Just as a follow-up question in relation to the SDS at page 132, thank you for telling us about those discussions. Have any of those discussions revolved around the potential sale of the Brisbane Dental Hospital and the other sites there?

Mr Stamp: There is an expression of interest for the UQ site. We have agreed, in line with Queensland Health, through the HIB facility, that that expression of interest would, if you like, tenuously link the Dental Hospital disposal to see if there was any major advantage in the disposal of both sites together as opposed to separately.

Mrs MILLER: Are you saying 'disposal' which in the normal course of language would mean sold? Is that what you are talking about here?

Mr Stamp: Yes, sold.

Mrs MILLER: So you are talking about Biala being sold as well?

Mr Stamp: No, I have no knowledge of Biala being sold.

Mrs MILLER: Can you tell me in particular what land or what buildings are on this disposal list?

Mr Stamp: I think that you have already covered the ones that I am aware of in your presentation with the exception of Biala. I have no knowledge of Biala being on the disposal list.

Mrs MILLER: In relation to the SDS at page 132, do you have a long-term facilities plan for the Herston campus that forecasts service delivery in, say, 20 years time?

Mr Stamp: No, we do not go to 2020 in terms of the Royal Brisbane and Women's Hospital. As you know, the rear of the Herston site, if you go above what you would identify naturally as the Royal Brisbane and Women's Hospital, also contains the Royal Children's Hospital going all the way across to Lady Lamington and there are a number of facilities between the two. There is the University of Queensland, a number of NGOs and a number of other facilities, including some from UQ. That forms part of the Herston campus as per the dialogue between yourself and the minister at the beginning of this committee meeting.

Mrs MILLER: Mr Stamp, in relation to the SDS at page 132, could you tell us when the outcome of this disposal process will be known?

Mr Stamp: Which disposal process, sorry?

Mrs MILLER: The disposal process and the discussions you were talking about before?

Mr Stamp: With regard to the Dental Hospital, I understand that the expression of interest is due for completion sometime around August, at which time we would know whether there was anything that gave advantage to Metro North in relation to disposing of the two—the sale—properties together, but whether it does or it does not the Dental Hospital still needs somewhere appropriate to move to.

Mrs MILLER: Thank you.

CHAIR: We are actually out of non-government time, but I am going to allow a question from Dr Douglas.

Dr DOUGLAS: My question is to the minister. Minister, you may ask Malcolm Wright, who is your chief financial officer, to step in as well with this question. My question is related to pages 28 to 39 of the SDS and is with regard to the labour cost of the health department, excluding the cost of capital. I calculate that 54 per cent of Queensland's total cost is labour costs. I cannot get detailed information on the issues of superannuation and other provisions of liability that may pertain to the government and I would ask as a first question whether you would be prepared to table that information to the committee.

Mr SPRINGBORG: No problem whatsoever.

Dr DOUGLAS: Good. Thank you.

Mr SPRINGBORG: If you want to write out your question on notice, unless somebody wants to come up and answer the absolute detail. In terms of one of the largest components of our costs, of course labour is an extraordinary part of the cost within running our hospital and health services. I think we have a wages bill of around about $7-odd billion. It is a significant amount of money because I think we have the most highly remunerated cohort across the state obviously when you are dealing with specialists and a whole range of people in those sorts of areas. If the honourable member wants to write out a question in that particular scope of what he has asked, I am happy to get him the particular details.

Dr DOUGLAS: I would appreciate that; thank you. Minister, you have alluded to the next part of my question. It leads to the labour costs being significant costs. What is the percentage growth of the labour cost within the budget? It is very difficult to calculate it year on year, but I have gone back and done my own estimates. What do you believe it is currently?

Mr SPRINGBORG: I am not going to speculate on percentage terms because we do not actually report here in percentage terms, but I am happy to get that for the honourable member. To give you an indication, before we came to government we had expenditure growth increasing around about 11 per cent. As everyone agreed across the nation, that was not able to be sustained and we currently have expenditure growth of around about six per cent. A lot of our additional investment in the first year in government and ongoing has been around paying our people more as well, but there has been investment in areas of capital works. But on percentage terms, I am happy to get that information for the honourable member. If he wants percentages, I am happy to give him percentages.

Dr DOUGLAS: I just want to know within the budget what strategies do you have to address that issue of growth of the labour component of that cost? You talked about the six per cent, and that is the expenditure. I am talking about the labour cost.

Mr SPRINGBORG: The honourable member will appreciate very much that there is a lot of discussion at the moment around the issue of the long-term sustainability of cost of health care in our country in both the private and the public sector. Indeed, last year the Commonwealth government actually ticked off on an over six per cent increase in private health insurance premiums. We have committed ourselves to activity based funding to very much measuring the cost of weighted activity units and a national efficient price, and that is actually about making sure that we more efficiently deliver the services so that we can address what has been a cost escalation. That is how we are achieving it. I understand that now our hospital and health services are generally working in an environment where they are under the national efficient price. That is something we agreed at a national and state level to deal with those sorts of things. So we are actually controlling our cost escalation significantly. We have to do that and it has to be very much productivity based. The new contracts for senior medical officers and VMOs are a crucial part of that as well where after 1 July 2016 some 25 per cent of their payments will be actually judged around agreed KPIs and productivity. So they are the sorts of things that we are doing to try to address that and I think everyone understands that, but I am happy to get you the percentage figures.

Dr DOUGLAS: I have two more bits to add to that because you have raised issues. I want to take you to the issue of the efficiency of the expenditure. Can you give us an indication of the matching amount that comes back from the Commonwealth in terms of the efficiency of capital argument—in other words, the labour cost—and given the fact that we pay in the order of, say, 30 per cent back to the Commonwealth, do we effectively get that back within the budget from the Commonwealth grants?

Mr SPRINGBORG: I am not sure we do such a thing like that with regard to the Commonwealth. The Commonwealth provides us with an amount of money. Around about 25 per cent or just over of the budget comes through from the Commonwealth government. It does make some contributions towards capital and it makes contributions towards what is new efficient growth—that is, 45 per cent supposedly growing to 50 per cent in 2017-18. The new Commonwealth government has changed that formula and what we have is the national Independent Hospital Pricing Authority. We also have what is the set price of a unit of service which is actually agreed at a national level. That undergoes some transformation and reconsideration from time to time. That actually sets the benchmark with regard to that, so basically the Commonwealth's contribution to us will be very much around an agreed formula of efficiency in the future. If we are inefficient, then we do not get the same proportion of funding from the Commonwealth. If we continue to be inefficient, rather than the Commonwealth paying us 45 per cent and us 55 per cent in effect we would probably be paying 60 per cent or 70 per cent of that service if we continue to be inefficient. So now we are under the

efficient price. We have an agreed efficient price and that allows us to be able to leverage that funding from the Commonwealth. If we continue to be inefficient, it means that we have to go back to the Treasurer and have to use our own resources to fill the gap of that inefficiency. So I am not aware that we rebate anything back to the Commonwealth in any way with regard to formulas like that.

Dr DOUGLAS: We do rebate 31 per cent of our money back in tax, do we not? The question was really about the efficiencies and whether it compared.

Mr SPRINGBORG: That is probably a question better addressed to the Treasurer or somebody else about how much goes back in—

Dr DOUGLAS: No, not really. It is within the budget. It is actually a—

CHAIR: Dr Douglas, I am actually not clear and I do not remember seeing anything in the budget. I ask you to identify that and include that as part of your question on notice. Minister, are you happy to take that on notice?

Mr SPRINGBORG: Yes, as long as it is around the construct of what the question was that was asked of me.

Dr DOUGLAS: The final part of the question is the effect of the doctor contracts on the efficiency of that capital, excluding the capital expenditure, within that budget. Can you give me an indication of how that will impact on the overall total labour cost?

Mr SPRINGBORG: The calculation of the state Treasury and the calculation of the federal Treasury and the federal Department of Finance had probably very little to do with the doctor contract issue. The doctor contract issue grew out of an Auditor-General's report and a need for greater transparency and productivity. The thing that may reassure the member is the doctor contracts issue will allow us to be able to have performance based contracts which will start in early August where some 25 per cent of that income component will ultimately be measured around agreed KPIs and outcomes and productivity. I do not think that it would be possible to calculate what is an overall Treasury taxation consideration around that.

Dr DOUGLAS: So in general terms can the department give some sort of indication of whether it will have an impact on the total cost of labour within this budget?

CHAIR: Can you clarify your question please?

Dr DOUGLAS: The total cost of labour is 54 per cent of your budget, excluding capital. My final question is: will the new contracts have a significant impact? I am not asking you for the percentage now, but I would like in time what that percentage will be. What will it be and will it have an impact on that cost of labour within the budget?

Mr SPRINGBORG: I invite the honourable member to write down the question and we will do our very best to be able to interpret that to give you the answer that you require. I will just conclude with this remark: we know that labour is a major cost for a healthcare system, as it is for education. We do have capital obligations from time to time. Making sure that we get the most efficiency out of our workforce is absolutely crucial. The only judgement that the Commonwealth seeks to make on our performance is making sure that we work within the national efficient price—the work of the Independent Hospital Pricing Authority—and that is what we seek to do with the health pricing authority. That is what we seek to do because if we do not do that we cannot afford it and if we do not do it we have to put more money in as a proportion. So we have agreed modelling that goes on, but it does not consider the taxation issues. With regard to the cost of capital, what I will say to the honourable member is that it is expected into the future that we will consider the traditional provision of capital as a part of how we will invest in health care because in the past that has not necessarily been looked at. For example, in terms of the construction of hospitals, we are more cost ineffective and inefficient than the private or not-for-profit sector, probably two to one. I think there is no disagreement.

Dr DOUGLAS: There is no disagreement.

Mr SPRINGBORG: So in the future what will happen is we will be probably more going to market and saying to health service providers, 'We have this amount of taxpayer funded free public services that we want to provide.' They will bid for that and so that may shift the cost of capital elsewhere because they can do that more efficiently and allow us to get more services, like we are doing with Mater in Springfield where they invest in the capital, we agree on the price and we are able to do it probably even under the national efficient price. So I think that is probably where you are heading to.

Dr DOUGLAS: That is where I am heading.

Mr SPRINGBORG: We have to consider that in the future, but there is not necessarily an agreed formula. We have to consider that as a part of the overall national efficient price.

Dr DOUGLAS: I might come back to it later on.

CHAIR: We are actually hard up against going into morning tea, so we will adjourn now and return at 11 o'clock.

Proceedings suspended from 10.27 am to 10.58 am

CHAIR: Welcome back, Minister and officials. The committee will continue with its examination of the estimates for the department of health and hospital and health services. I call the member for Townsville.

Mr HATHAWAY: Minister, with reference to the allocation of $81.4 million—that is on page 7 of the SDS bullet point 4—towards the Cairns Hospital redevelopment project, can you advise the committee of any areas of concern that this committee should be aware of in relation to the rollout of that project?

Mr SPRINGBORG: I am very happy to answer some of these issues and then I might call the chief executive who may wish to add some things as well. Can I also indicate that, when we talk about the disposal of assets in order to invest in hospitals in Queensland, it is very interesting because, with regard to the Cairns and Mackay hospital redevelopments, the previous government sold both airports in both places in order to reinvest in hospital upgrades. I do not think that there is any argument around those things. So it is an indication about how you can divest an older asset in order to get a better asset. So let us get away from this nonsense that these sorts of things are new with regard to selling an asset in order to invest in another asset.

We are continuing that upgrade and that investment in that area. But, of course, a major challenge for us is trying to get people into the new unit D. That has been frustrated a little bit to date. The reason it has been frustrated is that, when the board took practical possession of that and started to run their tests, they noticed that it had one omission and that omission was a second major power cable redundancy that was left out by our predecessors in the redesign process. Rather than put those patients in there and decant them into that block D and then have to fix it up and do the testing and decant people, they decided to then go and fix all of that. So that has delayed the move towards taking that over. That has frustrated many people, obviously, but the staff and I think patients understand that as well. I understand that that is well and truly underway to fix that issue.

The other challenge, of course, that we have at the moment in Cairns is that there are some 60, as I understand it, aged-care eligible type patients who are waiting a placement in an aged-care environment. That is putting some pressure on the system. I will ask Julie Hartley-Jones if she might like to come and give any further details around the honourable member's question.

Ms Hartley-Jones: Thank you, Minister. Just to reiterate, we have had some decanting issues into our new block D, which is part of the redevelopment of Cairns Hospital. They relate primarily to HV—high voltage—power issues. We are in the process—we have had external support through the redevelopment team and the health infrastructure branch and have got independent experts in to assist us with these issues—and we are on target to recommence decanting into block D in the middle of August.

CHAIR: Thank you. Minister, I note on page 26 of the SDS that employee expenses for the 2014-15 period is some $8.2 billion. We have had some discussion around that already today. In relation to employee expenses, can you advise the committee if senior medical officers and visiting medical officers are any worse off as a result of being placed on individual employment contracts?

Mr SPRINGBORG: I think it is important to understand that we do properly remunerate our employees. Indeed, not only are we paying them more; we are actually paying them, which is probably a novelty based on the track record of our predecessors. With regard to SMOs and VMOs, for the 2012-13 year remuneration for SMOs and VMOs eligible for contracts was $638 million and $58 million respectively. So that is $638 for SM0s and $58 million for VMOs at a total headcount at that stage of 3,268.

Modelling of this same population indicates that, in 2014-15, annual remuneration for SMOs and for VMOs will be $816 million and $70 million respectively. So our most senior medical cohort is going to be much better off than what they were previously. But, of course, again, it is not just what you pay people; it is what they do with the money that you pay them. Progressively we will be going

more and more towards a productivity based measuring system under performance based contracts where we can measure what the outcomes are and productivity as well. I think that our workforce is very much looking forward to that.

That probably explains why we are finding that there is no great issue in recruiting doctors. I think that we actually have now more doctors than when we started on this journey going back several months ago. So that is quite encouraging as well. These are the senior SMOs and VMOs. As I said, we have around about 99 per cent of those who were eligible who actually signed up. So that is very encouraging. There is a small number of people who have left the system, but there does not seem to be any greater increase in the number of people—the SMO and VMO category—leaving the system this year than what there was last year.

Ms BATES: With reference to page 26 of the SDS on employee expenses, I note the recent departmental campaign regarding the modernisation of awards for Queensland Health employees. As a registered nurse with a current practising certificate, will this process see a reduction in the take-home pay of Queensland Health nurses?

Mr SPRINGBORG: I thank the honourable member and, can I say, well done and congratulations. It is great to have a registered nurse as part of our parliament and, obviously, bringing a lot of expertise in that area as well.

One thing that we made it very clear when we came to government was that we needed to do something to address the complexity of awards and industrial instruments for our Queensland Health employees—an over 80,000 headcount. So a significant number of employees and, indeed, some 4½ thousand award variations, 24,000 pay combinations. That is extraordinarily complicated and one of the reasons it is a struggle to have a payroll system that works very simply. But having said that, the payroll system now has no technical glitches and any challenges around overpayments comes about because of people not getting their time sheets in on time. Every time we go through a system fix we actually find some historical issues that we need to correct.

So that is encouraging, but we need to simplify the system and we are moving to do that. This is about a reduction in bureaucracy and paperwork and red tape. It costs around about $65 million a year just to pay our people. We want to reduce the cost of running our payroll so that we can reinvest it into front-line services. We are going through of process of award modernisation and simplification. Many nurses I speak to actually say that they support this because, when they read their pay slip, it is like trying to read the Dead Sea scrolls—it just goes all over the place. You have a 32-page manual on how to understand your pay slip. It is quite ridiculous. There is a whole myriad of different allowances and those things. So they say that they would like simplification.

I have written to nurses. I think we may even have a copy of the letter here, which has gone to all Queensland Health nurses and also to the Nurse's Union, giving a clear commitment that, for actual work done, we are not going to be reducing the pay of nurses. Indeed, they will be the beneficiary of a negotiated new enterprise bargaining agreement, which will happen sometime after we modernise our awards. But this is about not affecting the quantum—making it simpler and easier to understand. People want simplicity in their lives and that will actually also help us to address any disputes over particular complex allowances and amounts.

CHAIR: Thank you.

Mr KRAUSE: Minister, in relation to the transition from the Royal Children's Hospital to the Lady Cilento Children's Hospital by Children's Health Queensland, referred to on page 87 of the SDS, can you please provide the committee with an overview of the current activities being undertaken with regard to staff transfers from both Queensland Health and the Mater?

Mr SPRINGBORG: Thank you very much. This has been an interesting journey, of course—the move towards a single consolidated Queensland children's hospital, otherwise known as the Lady Cilento Children's Hospital. It has been a really interesting journey for the hardworking and dedicated staff of the Royal Children's Hospital and also, of course, for the Mater Children's, which has been doing a great job with regard to care over a long period of time.

As a part of that process, inevitably, there is going to be some realignment of staff profiles. When you bring two organisations together in some areas you will not need to have the same number of people. That is the simple reality—always was the case. Currently, the management and the senior clinicians—the team leaders—are working with the staff to transition to that process for the opening of the Lady Cilento Children's Hospital sometime in November of this year.

It will be a stand-out children's hospital in the country. Even though the cost of building has blown out from, say, around $600 million to $1.5 billion, it is still going to be quite an exceptional hospital. I might ask Dr Peter Steer if he might want to talk about the specifics. I thank him for his contribution. He has made an amazing contribution not only in this transformation but also previously.

Dr Steer: As the minister says, we are on time to open at the end of the year the new Lady Cilento Children's Hospital. It is an extraordinary step forward: an opportunity for the quality and consolidation of very highly specialised children's health services in Queensland. As the minister also said, it has been a very complex process to consolidate the services. There has been some very thoughtful and careful work done in terms of our human resources plan to consolidate services, make sure that we were careful about equity for both the current Mater Children's Hospital employees and the Royal Children's Hospital employees and also a plan that would see us maximise the retention of what are very, very talented and highly skilled staff in both of those facilities. Finally, as the minister says, while we should always be looking for efficiencies in such a consolidation, our strategy was to minimise any redundancies and loss of staff through that process.

CHAIR: Thank you.

Ms BATES: Minister, last year you provided the committee with the business plans associated with services for the Sunshine Coast and Gold Coast university hospitals. With reference to the answer provided to question on notice No. 7, the committee notes that there were no business plans when it came to the former government signing the memorandum of understanding on the new children's hospital. I ask: despite there being no business plans, are there contractual obligations contained within the MOU signed by the former Labor government which place an obligation on Queensland Health to consider the outsourcing of services?

Mr SPRINGBORG: I thank the honourable member for the question. As the honourable member will remember last year, I tabled for the benefit of the committee a number of consultants' reports which were being done by Queensland Health. They were, of course, into the Sunshine Coast University Hospital and outsourcing considerations and into as well the Lady Cilento Children's Hospital and also around the Gold Coast University Hospital. This was unprecedented transparency, because it certainly never happened under our predecessors. Indeed, when there was an MOU that was signed by the previous government with Mater around the move towards a new consolidated Queensland Children's Hospital, that has never been made public. It has never, ever been made public because of the conditions of it. The honourable member for Bundamba talks about a secret state. I do not know why the honourable member for Bundamba and her colleagues never told people about this. Indeed, when I have talked to the unions about it, they all feign ignorance as well, even though they were bankrolling the Labor Party in 2009 to basically go to market to knock public pathology services, also porterage and catering and a whole range of other soft and hard FM and clinical support services on the head for public sector employees. They were never, ever told about that.

We have told the people of Queensland about that. Obviously, for a range of reasons we are not able to release that document. But what we have done, through an open and transparent process, has gone out to market. They have tested the market through Queensland children's services and they have been able to keep within house services such as pathology, which the previous government did plan to outsource as part of that arrangement. It did need to be market tested. Also, they did come up with an arrangement with an external provider around soft and hard facilities management, which does make sense. So we really do have what is the best value-for-money proposition. I think it frees up to the tune of around about $4 million, which can be reinvested into front-line health services. But we did not go ahead with the plans of the previous government to outsource pathology.

But really it does make you wonder why it was such a secret deal that even was withheld from the unions who were running around and having conniptions about outsourcing when their very obvious soul mates and benefactors in the Labor Party were pulling the rug out from underneath them and doing a dodgy deal to sell them out.

CHAIR: We will now move to non-government questions. I call the member for Bundamba.

Mrs MILLER: Thank you, Chair. I refer to SDS page 9. Minister, you have said that hospital bypass would be, from 1 January 2013, 'a thing of the past', and the Premier has said, 'Gone are the days of long wait lists in emergency departments and ambulance ramping.' On how many occasions have the local Ambulance Service networks activated the QAS escalation process?

Mr SPRINGBORG: Are you talking about the level 1, 2 and 3 escalation process?

Mrs MILLER: Yes.

Mr SPRINGBORG: Okay. Can I just say, Mr Chairman, that there is no doubt whatsoever that we have significantly addressed this issue following on from the MEDAI report where ambulance bypass has been banned—been absolutely banned in Queensland. There is greater planning. I was talking to a paramedic the other day who told me that his job was basically, under the previous government, running around working out how to pass the parcel from one hospital to the next. So a hospital must actually accept a patient. We are better coordinated today where they ring up, find out the capacity capability and if you can get in somewhere earlier that is where you go to. Also I think there has been a reduction of more than 50 per cent in the number of lost ambulance minutes as a consequence of ambulance ramping being reduced and also our emergency department times in under four hours have improved from 63 to 78 per cent over the last couple of years. Also I think, if you go across Metro North, ambulances are turning out to code 1—I think it is code 1—a full one minute quicker than what they were under our predecessors. And also gone are the days of this, Mr Chairman. I can sign it for the honourable member for Bundamba. But that was, I think, at the PA.

Mrs MILLER: It is a bit sad when you have to rely on props.

Mr SPRINGBORG: Rely on props?

Mrs MILLER: Relying on props!

Mr SPRINGBORG: From the mistress of relying on props. Anyway, 27 May 2011. That is what we call memories, and there are plenty of memories for those across the back who would like to have one. We had plenty of these minted earlier. But 27 May 2011, I think some 25-plus ambulances ramped out there. So sometimes a system will come under pressure but that routine ambulance ramping is a thing of the past. We will have pressure from time to time. There are issues of escalation that happen and that is a proper process that was actually identified as a part of MEDAI as well, right to 1, 2 and 3. As I understand, when that escalation happens it is dealt with very, very quickly. Commissioner, would you like to come up and talk about any of those specifics if you so wish?

CHAIR: Thank you, Commissioner, if you would just identify yourself before you start talking.

Commissioner Bowles: Russell Bowles, Commissioner at Queensland Ambulance Service. Yes, I suppose, just to add to what the minister said there first, I suppose the most important thing about the level of escalation, whether it be level 1, level 2, level 3, is that now we actually have a way of resolving issues. I think one of the criticisms that came out of the MEDAI process is that there was no 'joined up-ness' between the Ambulance Service and the executive of the health system. What happens now is that if we go through an escalation process and it goes 1, 2, 3, we are actually talking to the chief executive of the health district. That is a significant step forward and something that we wouldn't have dreamed about once upon time. That is having a significant effect on how quickly we can actually free up our resources and send them back to do the next patient. That all fits in the broader 15 recommendations that came out of the MEDAI program of which escalation was one of them.

Mrs MILLER: I have a follow-up.

CHAIR: You cannot ask the Commissioner but you can ask the minister.

Mrs MILLER: Yes, I know. Minister, in relation to SDS page 9, for the following hospitals, Redlands, Prince Charles, Caboolture and the PA, on how many occasions between June 2013 and July 2014 has level 3 escalation been initiated? For members of the committee, level 3 is the most severe and it is defined as 'QAS is unable to deliver emergency pre hospital care'. For QAS it means they are unable to respond to critical emergencies because ambulances are ramped outside hospital EDs.

Mr SPRINGBORG: Mr Chairman, if I can start off and just reflect on the answer by the commissioner for the Ambulance Service, he actually indicated that prior to MEDAI being enacted from the end of 2012, I think bypass was banned from the start of 2013, we now have an escalation process which never operated previously, and that does get used from time to time. It never operated effectively previously and that is operating at the moment. We are actually seeing it in our performance across the system. If we look at the QAS performance response time for code 1, first unit on the scene—this is state-wide—first quarter of 2012 16.5 minutes, first quarter of 2014 16.2. So 18 seconds, and a second is a life saver. With regards to patient off stretcher, on the 90th percentile, which is the standard which is used not only here but across the country as I understand it, in the first quarter of 2012 44 minutes, 31 minutes in the first quarter of 2014, so a 13 minute reduction with regards to patient off stretcher. And also with regards to the lost time in minutes, we are dealing with

a reduction from 507,000 minutes in 2012 to 209,000, so a reduction of 298,000. So we have had significant improvements around that but we do have a process, Mr Chairman, that allows us to deal with this.

Mrs MILLER: Mr Chair, I asked a specific question around Redlands, Prince Charles, Caboolture and the PA. I am happy for the minister to take this on notice, because you are talking state-wide, but I am particularly after that information between June 2013 and July 2014, which you haven't answered, but I will go on to another question. So would you take that on notice, Minister?

Mr SPRINGBORG: I can assure the honourable member that I am happy to table that information, but she is going to get a proper context and a good old reminder along the way.

Mrs MILLER: Well, don't bother then.

Mr SPRINGBORG: Hey?

Mrs MILLER: Don't bother then. If you are saying that you are treating my genuine question with disregard.

Mr SPRINGBORG: I am just concerned that I wouldn't want anyone to misrepresent the information on your behalf. We will provide you with the answer and the context around it.

Mrs MILLER: I refer to SDS page 9 and I ask the minister: on 23 June this year how many times was there a level 3 escalation initiated at the Prince Charles Hospital on that day?

Mr SPRINGBORG: Honourable member, as indicated, there is a process for level 3 escalation. If you want absolute details of what happened at the time, you probably know because your United Voice mates would be telling you so maybe you can ask them.

Mrs MILLER: I know the answer, Minister, I want to know if you know the answer.

Mr SPRINGBORG: We can get that sort of information, but maybe you can edify us and edify us with regards to the previous response times.

Mrs MILLER: You are the minister, not me.

Mr SPRINGBORG: Maybe you can also explain to us why under your reign it was taking four minutes longer to turn out to code 1 life-threatening situations across Metro North.

Mrs MILLER: You are in charge now, Minister.

Mr SPRINGBORG: Maybe you can indicate why our Prince Charles Hospital is one of the best performing emergency departments in the entire country. You have got to put all those things in context.

Mrs MILLER: Mr Chair, I asked the minister, in relation to SDS page 9, what was the longest time an ambulance was ramped at the Prince Charles Hospital on 23 June this year.

CHAIR: Minister, these are fairly specific questions and I would be happy if you want to take them on notice because they are fairly specific.

Mr SPRINGBORG: We are happy to take whatever on notice, but the honourable member knows because of her lifeline to the United Voice union. They are in the middle of an industrial campaign and this is the normal thing. From blood brothers they have got this information, so maybe she can save us all the trouble and tell us what information she has at the moment.

Mrs MILLER: Minister, I expect to be in your place in a few years time—or even closer.

CHAIR: Would you move to the next question.

Mr HATHAWAY: Hypothetical.

Mrs MILLER: Chair, I have another question for the minister in relation to SDS page 9. Minister, if hospital bypass is a thing of the past as you have said, how many ambulances travelling to the nearest appropriate hospital have been redirected to another hospital under, and I quote, 'load-sharing arrangements'.

Mr SPRINGBORG: Mr Chairman, the honourable member already purports to have certain information because of the very close relationship of her and the industrial arm of her party so maybe she should help us with it and we can verify her information, but let us actually go back to the MEDAI report in Queensland which was so ably overseen by Dr David Rosengren and I had absolutely no hesitation in implementing in Queensland because it made enormous sense. The previous government would never have done these sorts of things, they would never have been as adventurous in actually banning ambulance bypass. I remember going and talking to a lady down at

the QEII Hospital who had been bounced ignominiously in the back of an ambulance from one place to another. Now, it wasn't unusual under the previous government for people to be bounced in an ambulance as there was no sharing of information between various emergency departments. They would turn up at Logan, sorry we are on bypass. They would turn up at PA, sorry we are on bypass. Ipswich were on bypass. QEII were on bypass. People died in the back of ambulances. One of the recommendations of the many out of MEDAI was that we actually do some work in ensuring that we understand what is happening in various emergency departments so that we go to an emergency department where the person can be admitted straight away. And that is what happens under this. So gone are the days of 10 hours in the back of an ambulance. The figures actually show it. And basically if you can get into another emergency department quicker then we do those sorts of things, okay, and that was a recommendation of the MEDAI committee. We make no apologies for it because it is actually saving lives and getting better outcomes.

Mrs MILLER: Mr Chair, I refer the minister to SDS page 9. I ask the minister is the new term 'load-sharing arrangements' just another phrase for hospital bypassing?

Mr SPRINGBORG: No. Go and talk to Dr David Rosengren and everyone else who was on the committee. Ambulance bypass was when hospitals went on bypass: do not come here full stop. That has actually stopped. All hospitals need to be able to accept patients. They must accept the patient. What we actually do now is if one emergency department is under pressure vis-à-vis another emergency department because of an incident or event, if there is another hospital that is 10 or 15 minutes away and the person is able to go in and be seen in the ED a little quicker—we keep an eye on it—that is where we take the person. That actually reduces it from 10 hours bouncing around in some sort of hazy sort of parallel universe of the previous government where you closed your hospital emergency department with no idea of what is going on to now we do know what is going on. We get the person in there in a matter of minutes not 10 hours.

Mrs MILLER: I refer the minister to SDS page 9. Minister, has a contestability process started or is about to start for the QAS communications system?

Mr SPRINGBORG: This government is very committed to contestability. With regards to specifics on that, I am happy for the commissioner to answer. But before we go that way, people should not draw any conclusion around any contestability, whether it relates to anything in QAS around hospital authorised non-urgent transport, or pathology or radiology or a whole range of areas that is in any way related to automatic outsourcing. I remember one of the unions that came to see me just after I became a minister and they said, 'Minister, we're really concerned about the secret agenda of outsourcing under your predecessors and we want that to stop'. I said, 'Yes, it does stop. We are going to tell you we are moving to outsourcing, so we are not secret any more about it'. We will look at contestability but we want to get the best value for money.

Mrs MILLER: So the answer is, yes.

Mr SPRINGBORG: I never said anything—I understand that there was a process that had been started some time ago to actually look at that. That is right, isn't it, Commissioner?

Commissioner Bowles: There is an overall strategy that is being looked at. I should make the point that this probably does fall under the Public Safety Business Agency, which actually manages the critical infrastructure on behalf of the Ambulance Service. As far as whether there is a contestability agenda around our communication centres at this point, I suppose I would say that we are heading on a journey to have a look at what best practice is, what happens around the world in all different places, because there is a whole different range of ways in which public safety communications are delivered.

Mrs MILLER: Thank you. Chair, in relation to SDS page 9—

CHAIR: We probably have time for one more and then we will have to move on.

Mrs MILLER: Yes. Minister, how many trauma trucks are currently available in Brisbane?

Mr SPRINGBORG: Commissioner, do you have any information on that that you are happy to provide? You can probably cut to the chase and ask her mates from United Voice. They can probably tell us already.

Commissioner Bowles: At this point in time, it would be approximately about 100-odd crews, I imagine, in the broader metropolitan area.

Mrs MILLER: No. I am talking about trauma trucks. Do you understand what I am talking about?

Commissioner Bowles: You probably just need to clarify what you mean, because every ambulance that is on the road, no matter what its capability, is able to respond to a traumatic incident.

Mrs MILLER: No. My question is specifically in relation to trauma trucks, not ambulances.

Mr SPRINGBORG: That question needs to come back through me, Mr Chairman.

Mrs MILLER: That is okay. I do not care who answers it.

Mr SPRINGBORG: If you want a specific detail around the number of trauma trucks, we can find that. I would have thought some issue would be around how come our emergency departments function better; how come ambulances are not routinely bypassing—

Mrs MILLER: I ask the questions.

Mr SPRINGBORG:—how come there has been a 60 per cent reduction in the wasted time for ambulances—

Mrs MILLER: You cannot answer it, can you?

Mr SPRINGBORG:—queuing up at the ambulance bays at hospitals around here. On a specific around trauma trucks—

Mrs MILLER: It is a trauma truck; not an ambulance.

Mr SPRINGBORG:—or whatever categorisation, we can find that for the honourable member.

Mrs MILLER: You will take that on notice?

Mr SPRINGBORG: I will. I am happy to find that information and provide it to you during the course of today's estimates.

Mrs MILLER: Okay. Thank you.

CHAIR: Thank you. We will move to government questions. I call Mr Shuttleworth, the member for Ferny Grove.

Mr SHUTTLEWORTH: Thank you, Chair. Minister, with reference to the 4.3 per cent increase in activity expected to be delivered over the 2014-15 budget period as outlined on page 5 of the SDS, can you advise how Queensland Health is implementing a suite of initiatives to optimise the use of the allied health professional workforce to improve patient access and address waiting times in key waiting areas?

Mr SPRINGBORG: I thank the honourable member for the question. We are very keen to be at the cutting edge of innovation with regards to the delivery of healthcare in Queensland. As I have indicated, any decision that we will make now or in the future will be based on evidence. We are not at all interested in traditional patch protection, that is, because one cohort of clinicians or allied healthcare professionals have done something in the past that they are the ones who should continue to do those sorts of things. I am not interested in the restriction of practice based on some antiquated notion.

Recently, we have undertaken a process of reviewing the scope of practice for a range of the professions in this state, particularly the allied professions. That is being implemented by the government at this stage. I very much thank those involved right across allied healthcare professionals, nurses, doctors and people with a significant interest with regards to this. Already we have seen significantly fantastic work done across the state as the hospital and health services have moved to involve the allied healthcare professions more in the assessment of outpatients. Great work has been done by the Royal Children's and great work has been done right across Metro North and other areas with regards to ENT. Basically, they have an audiologist do the assessment to see what needs to be escalated, rather than having people waiting on the waiting list just to see the specialist. A child, for example, can be seen by an audiologist. They may have issues with regards to their hearing. Rather than waiting some years to see a specialist, they can start on their process with speech therapy and those sorts of things much earlier, to assist them.

This work which is being done will see more physiotherapists in emergency departments—where that has happened over the past few years it has been very successful in trial—as I said, audiologist-led ENT clinics and also rural and remote allied health generalist roles. We will be seeing a move towards nurse endoscopy, which is done very safely and successfully around the rest of the world. One of our big challenges at the moment is the National Bowel Cancer Screening Program is showing up a range of potential positives, but there has not been enough investment over the years in being able to provide the scoping services that people need. Of course, the ability to get that will actually mean that we can save lives as well. I have already ticked off on a podiatrist being able to

order a greater range of images and also prescribe antibiotics. Look at what we have done only recently with regards to the immunisation strategy with a broader range of opportunities for pharmacists to deliver vaccinations for adults in pharmacies.

We are doing a lot of things in nurse-led clinics and other allied healthcare involvement, not only within the scope of practice but extended scope of practice. It is all based on evidence. I am not interested in arguments that we cannot do that because they have always done it. Unfortunately often, for what is an evidence based profession or professions, when it comes to change the first thing that goes out the window is evidence. We are saying that if the evidence says we can safely do it, we will do more and more of this because it makes sense and there are plenty of examples around the world.

CHAIR: Thank you, Minister. Member for Mudgeeraba?

Ms BATES: Minister, with reference to the increased staffing levels of Queensland Health in 2014-15 as outlined in the staffing table on page 12 of the SDS, can you advise if there are any changes for indemnity insurance coverage of Queensland Health's medical workforce?

Mr SPRINGBORG: I thank the honourable member for the question. This is one of the important things that Queensland Health workers raised with us. The great majority of our Queensland Health workers are fantastic professionals. They just want to know that they are protected if they make decisions based on the best interests of the patient and something may not necessarily go right, so if they have gone out in good faith to do something. The issue of indemnity for them is very important. The Queensland government is very much aware of that and we are moving to ensure that we have indemnified all those who provide that type of care to our patients in Queensland. They do not have to apply for it. They will basically have that indemnity.

The Queensland government, effective 31 March this year, implemented new legislative protection from civil liabilities for state employees. The legislative protection extends to the public service, the Ambulance Service and health service employees including nurses, doctors and other registered health professionals, including public sector health services across Queensland. The legislative change provides better protection to state employees for civil proceedings that may arise in the course of an employee undertaking their key duties and functions. Prior to these new arrangements, an employee had to complete an application for an indemnity. Under the new arrangements, indemnity will be automatically provided to an employee in relation to proceedings that arise out of or relate to their duties where they have acted in good faith and without gross negligence.

In regards to nurses, to practise and be employed in Queensland Health nurses as part of their registration are required to have appropriate professional indemnity insurance cover. These improved legal protections continue to meet the professional indemnity insurance registration standards of the national registration boards, and the honourable member would know all about this being a registered nurse, including the Nursing and Midwifery Board of Australia. In relation to doctors, the specialist role of doctors in our public health system and the scope of circumstances in which a doctor may need to seek an indemnity and/or legal assistance are acknowledged. In this regard, the indemnity for Queensland Health medical practitioners, human resources policy 12, remains in place to provide indemnity arrangements for our registered medical practitioners. This policy is being revised to reflect the new employment framework for senior medical officers, including cover for granted private practice, that will be effective from 1 August 2014.

The good news for doctors and nurses is that they are now covered as a matter of their employment. I know that this has been one of the reasons why many of them said they have not necessarily wanted to join an industrial organisation but they have done it only because of the indemnity issue. Now they have a choice: they can join an industrial organisation if they wish to or they will be completely indemnified easily by the government.

CHAIR: Thank you, Minister. I call the member for Townsville.

Mr HATHAWAY: Minister, page 57, third paragraph of the SDS refers to child and maternal health services in the Cairns and Hinterland Hospital and Health Service. Is it anticipated that resources allocated in the 2014-15 budget will improve paediatric care within the community?

Mr SPRINGBORG: There have been some great initiatives in this area, of course, not only across Cairns but elsewhere. I might ask Julie Hartley-Jones, the Chief Executive of the Cairns and Hinterland HHS to come up and answer your question.

Ms Hartley-Jones: Thank you, Minister. My name is Julie Hartley-Jones, the Chief Executive, Cairns and Hinterland Hospital and Health Service. I am delighted to talk about paediatric services in the Cairns and Hinterland Hospital and Health Service. We have had an initiative called 'paediatric hospital in the home' for some time, where we have been able to look after children discharged early from hospital or avoid admission to hospital through our Hospital in the Home program. This program has been successfully in place since 2011. This year we have expanded the service so it is actually a 12-hour service, seven days a week; so we have been able to further expand the service. As usual with these hospital and health service initiatives, we also have an adult program occurring as well which is also very successful. With the pressure on emergency services in the Cairns and hinterland hospital region, any services we can do to avoid hospital admissions and look after our children in their homes is a great initiative for the communities that we serve.

CHAIR: Thank you. Member for Townsville?

Mr HATHAWAY: Minister, this is another question on Cairns and the hinterland. On page 58 of the SDS, it advises that—

> In 2014-15, work will continue to progress on maintaining performance against elective surgery and emergency access targets, as well as an emphasis on reducing waiting times for outpatients.

Can the minister advise what impact this strategy is expected to have on the number of long-wait patients for elective surgery?

Mr SPRINGBORG: We have already set ourselves the very deliberate target across the state to make sure that we address the challenges that were given to us as legacy issues. Of course, on emergency department access performance, which is going to be a real challenge for us, we have improved; we are the most improved state in the nation. Also with regards to elective surgery, we have had a number of long-wait patients in Queensland who have been waiting much longer than they should have. As I indicated earlier on, the basic reduction was about from 6,500 to just over 1,000 in the last couple of years.

In particular with regards to Cairns, my understanding is that they now have zero long waits in all surgical categories. That is probably a first, but it is an exceptionally good performance. Also as I indicated earlier on, we are moving across the state to see more outpatients as well. Not all of those outpatients will require listing for surgery. One of the big issues has been because we have had such pressure with regards to these long-wait surgical patients, some of them waiting years and years and years, that just navigating the journey through outpatients to get people their surgery on time has been one of the challenges. We need to clear that waiting time.

With regards to Cairns, as I understand it we provided funding of $14.8 million in two tranches to progress the plan. The HHS has really risen to the challenge with regards to that, notwithstanding some of the capacity issues in their hospital. They do not have the ability to share. They only have one emergency department, so if you have pressure there they have to deal with that as well and to prioritise along those lines. They have actually been running their whole integrated system very well to ensure that the beds capacity across the circumstances, whether it be south of Cairns or west of Cairns, actually provides better utilization in that area. We are very encouraged by what has happened there. Julie, you might want to make some comments in conclusion.

Ms Hartley-Jones: Just to add to that, in September 2013 we had 769 patients who were beyond the clinically recommended time for surgery in categories 1 to 3. We worked with the department to achieve a zero long wait target in June 2014. I would like to take this opportunity to thank the staff of the Cairns and Hinterland Hospital and Health Service who have worked incredibly hard in order to achieve this target.

CHAIR: We will move to non-government questions. I ask Dr Douglas to ask a question.

Dr DOUGLAS: Minister, I refer to pages 5 and 15 of the SDS. What was the cost of advertising to date in total numbers and in percentages in the budget? It is very difficult to work it out. I am specifically interested in the health targets advertising?

Mr SPRINGBORG: If I cannot put my hands on the specifics around that I am happy to provide that information to the honourable member later on. Can I just say, honourable member, that the advertising, travel and consultancy spend in our first year in government was actually reduced significantly and those savings were put back into front-line health services across the state.

We have very much geared up our program of ensuring that we take good public preventative health messages out to the community. You are probably aware of the work we have done recently with regard to the 'You're on your own' campaign around smoking, which cost around $1.6 million or

thereabouts, off the top of my head. The 'Your futures not pretty' campaign was aimed particularly at smoking among young women and girls. I think around $1.5 million was spent on that. We have already seen a significant upturn in the number of people who are ringing in to Quitline and wanting to quit smoking. We are also going to be rolling out more in the area of immunisation and addressing obesity and those sorts of things.

In 2013 the department of health had a budget of $14.69 million for marketing and advertising campaigns, including production, research and sponsorship. Of the $14.69 million, $12.55 million was spent on advertising, production, research and evaluation, $970,000 on the whole-of-government newsletter 'My Queensland' community, $372,000 on the Workplaces for Wellness initiative, which is Commonwealth funded, and $184,000 on sponsorship.

We have also done advertising around the issue of HIV awareness, which is very much within the scope of the money which would normally go to that group to do that. We are currently in the process of marketing around some of the government's initiatives with regard to award simplification and modernisation. That information will be available once those campaigns have been completed.

Dr DOUGLAS: So the allocation to the meeting of the health targets is continuing, is that what you are saying?

Mr SPRINGBORG: Absolutely.

Dr DOUGLAS: Even though you have stated that we have met these targets you want to continue doing that?

Mr SPRINGBORG: With regard to advertising around preventative health and meeting health targets in general—

Dr DOUGLAS: There is a specific program called meeting the health targets?

Mr SPRINGBORG: We will. We cannot drop the ball on this, but I think you understand our big challenge—

Dr DOUGLAS: I am going to that.

Mr SPRINGBORG: That is one of our big challenges. We can give people information—and we do give people lots of information—but it is up to the individual to then take the decision to change. We will be continuing to advertise in preventative health areas. We will be continuing to provide information to Queenslanders around the achievements of Queensland Health, around the dashboard which we publish on a quarterly basis to let people know what is happening with regard to the performance of their health system. So, yes, there will be advertising with regard to awareness of the performance of Health and also with regard to preventative health campaigns. Things will continue. At the end of the financial year when all things are consolidated and reported all that information will be available.

Dr DOUGLAS: But that does not include the Pap Smear Register and the difficulty that has been presented recently with the inadequacies around people being informed of a problem. I would like you to elaborate on that with regard to the advertising budget?

Mr SPRINGBORG: Honourable member, there has been a propensity in the past—and I have a whole range of examples—when those issues arose, whether it be around the reading of plain film X-rays or around issues—

Dr DOUGLAS: We will get to X-rays. We will just talk about pap smears first.

Mr SPRINGBORG: No—

CHAIR: Member, just let the minister answer, thanks.

Mr SPRINGBORG: In the past these matters were not routinely outlined to Queenslanders by our predecessor. I have a very strong view that if a matter affects a number of people then we need to make people aware of it. That is why when the issue around the Pap Smear Register with regard to what were low-risk abnormalities and the secondary letter which was supposed to go out and did not go out and it was escalated to me and I had discussion with the Chief Health Officer, who does a wonderful job, the Chief Health Officer informed the public of the situation. Contact will and is being made with women around this. It is an extremely low risk. But the important thing is that we inform people around these sorts of things.

As I understand it, all of those women were supposed to have been contacted by their doctor. Their doctor is the primary care provider. For most people it is their GP but sometimes it is a pap smear clinic somewhere. The first responsibility is for their doctor to inform them. I think even the

AMAQ president has indicated that. Ours is a secondary line of backup. If there is a system failure I will always inform people about that. The public notification and discussions by the Chief Health Officer have raised awareness around this issue. We know who we are dealing with and those people have been contacted.

Dr DOUGLAS: So there is no advertising for that group? It is a significant number, is it not? Do you want to tell us what the number of people is?

Mr SPRINGBORG: I do not have the figure off the top of my head. If the Chief Health Officer wants to come forward and indicate anything around this she can. An audit of more than 1.6 million client records indicated that nearly a thousand women with mildly abnormal results and their pap smear providers did not receive a letter. That is of no issue with regard to providing that information. What I would say to the honourable member is that no-one should assume that those women did not receive follow-up notification from their doctor because their doctor is responsible in the first instance. Ours is the second line of reassurance. When it comes to high-risk abnormalities the system actually sent out letters to those women. It was low-risk cases.

This was noticed by one of our internal people who brought it to our attention. In the past it would not have even been notified publicly that this was an issue. We indicated that we needed to inform people. I understand that things have been travelling reasonably well in that regard. With regard to mass screening campaigns and all of those sorts of things, we will continue to market in those areas because mass screening campaigns, whether they be in breast cancer, pap smears or whatever—

Dr DOUGLAS: I will talk about breast cancer in a while.

Mr SPRINGBORG: You can talk about it. You have plenty of time to talk about it. But I am telling you that these areas are significant priorities for us and we are very encouraged by the results.

Dr DOUGLAS: So what allocation—

Mr SPRINGBORG: Just hold on. Can I just ask the Chief Health Officer to provide any assurances that she needs to.

CHAIR: I think that is appropriate; absolutely.

Dr Young: Yes, 980 women were not sent a letter informing them that they had a mildly abnormal result in their pap smear that was done. We have now contacted most of those women. We are still trying to find another 285 of them. But we are actually trying to ring the women where we have their phone number. We have sent all of them a letter through certified mail so that we know that they have received it and we can continue trying to follow them up. These were all women who had mild abnormal results. So that would mean that we would normally send them a letter saying that they should have another pap smear in nine to 12 months time.

We have also rung all the providers where they are still around. Some of the GP surgeries that these women had pap smears at have closed. But where they have not we have rung the providers. In the majority of cases, as I would expect, the provider who took the pap smear had already followed up with the woman. All that had happened appropriately.

Our aim is always to send letters out to all women who have pap smears outlining the results if there is any abnormality and also indeed to remind women who have not had their two-yearly pap smear that they are due for one, if they have not already gone and done it. That is the role of the register. We have 1.6 million women whom we manage on that register.

CHAIR: Thank you.

Dr DOUGLAS: Minister, we are on the issue of advertising and safety. Can you give us an idea in terms of numbers or percentages of the amount of the advertising budget that is allocated to healthcare safety issues? I am talking about safety issues.

Mr SPRINGBORG: When you are talking about safety issues this obviously involves preventative health matters. Making people aware of immunisation, of the need for a breast screen check every two years—their mammogram—or whatever are safety issues. It involves protecting women. Then there are safety issues around safety in the workplace for our doctors and nurses. What do you mean by safety issues?

Dr DOUGLAS: Safety issues with regard to advertising are issues where there has been a problem and you advertise that there has been a problem with, say, a vaccine or cervical cancer checks. I refer to an allocation of an amount of money with regard to a problem. These things in modern health systems are common.

Mr SPRINGBORG: We have a range of safety issues that we keep people aware of. If we are dealing with the particular women in question here or the earlier one with regard to the issue of breast screening we are able to identify those women and follow them up one on one. There are causes where it is very important to track down people. If somebody has come into contact with somebody with tuberculosis the Chief Health Officer might go out and say, 'We have a concern and people should come forward.' The same could be said with regard to somebody being exposed to the Hendra virus. Often having the Chief Health Officer go out and talk about these things raises awareness. Our public health officials contact tracing assists us along the way.

Not everything requires an advertising campaign. If you can identify the individuals you are far better off targeting them. If it is more of a broad nature then of course we would do advertising. But what we would do would be within the overall state-wide Health budget for advertising. We allocate that and use it to draw it down as needs be. There are a whole range of issues around safety.

Dr DOUGLAS: So there is no fixed percentage.

Mr SPRINGBORG: We should not necessarily need to. How you can actually guess what may be required from time to time—

Dr DOUGLAS: You have answered the question. I am now going to get to the issue of X-rays on the Gold Coast which is part of the same problem—the issue of safety. There are 48,000 X-rays that have gone unreported since 2013. This has been widely reported. This is a safety issue. What is the department going to do as an emergency measure for the 48,000 people whose X-rays have gone unreported? I know that you have announced an inquiry. What I want to know about is how you are going to tell people that they may have been affected.

CHAIR: Just to clarify, what you are asking about is how they are going to identify and tell the people—

Dr DOUGLAS: You have a big advertising budget within the Health budget.

Mr SPRINGBORG: I thank the honourable member for his question. I just want to give people a bit of context around this because it is very important. In 2009 a former director-general wrote to every single district manager of hospital and health services around Queensland saying that there was a state-wide problem with regard to the reporting on and reviewing of plain film X-rays. That was never made public. There was never any public reporting of that and there was never any awareness and there was never any advertising campaign around it.

The hospital and health services conceivably could have had millions of unreported plain film X-rays sitting in their system. No-one knew about that. With regard to this issue, when the chief executive of the Gold Coast Hospital and Health Service came on board, going back 18 months or so ago, he became aware of a number of clinical governance issues that caused him and the board concern. They wanted to address the issue of endoscopy and the issue of emergency department performance which led to the establishment of the medical assessment unit. They also undertook an investment program to address the reading of these X-rays.

The assumption from management was that that work was being done to satisfaction. They continued to review. They established a patient safety and clinical governance committee, which is a requirement under the board, and they have been looking at this. They reported last week to the board that they were not satisfied with the way it was done and it was escalated to me Friday, so I heard about it last Friday and then said that, yes, we would accept to have a review with regard to it. The other thing that needs to be made clear is every single one of these patients who have had a plain film X-ray has had their X-ray read by a doctor or a specialist for the primary condition. The reason that this is read by radiologists is to reconfirm the diagnosis—it may be an orthopaedic issue—or to pick up what may be a secondary lesion which was not the subject of the original investigation. That can sometimes turn up other things which may be beneficial. There are two patients who have been identified that predate the investment of this money and resources by the hospital and health service.

We have made the decision to tell Queenslanders about this in the isolation of one example across the state when in 2009 no-one in Queensland was told about it. This is the best way the money is being invested by the hospital and health service. I think $1.4 million is being invested in this, so it is not a money issue. It is not a resourcing issue. It is a prioritisation issue. They have been dealing with a whole range of clinical governance legacy issues. The best way we can assist those people is to read these images as quickly as possible to make sure that there are no issues and that we contact the patients who might have identified issues to reassure them. So that is what will be

happening as a matter of posthaste. They have been reading as a matter of priority MRIs and CT scans and they are better ways to actually identify some of these other lesions, particularly if they are a primary source. It should not have happened. It did. They recognised they had a problem. They have invested into it and they are working through it.

Dr DOUGLAS: Minister, just to be clear, you will not be advertising in any press? In and out of Australia the conventional way is that we do that in medicine—that is what does happen—and it indicates what whoever has provision of service will provide. So you will not be doing that? Can you answer that question? We are talking about 48,000 X-rays.

Mr SPRINGBORG: In 2009 when there were probably millions of X-rays our predecessors did not even tell Queenslanders about it, let alone advertise. The hospital and health service going about it in the very open way they did yesterday, us conducting a review and the general awareness around it is inviting people to come forward and ring 13HEALTH, which we use on a regular basis, and that is going out to people in the community. The best way we can deal with this is in public. No-one is saying it is not public. In the past it was never public. When our predecessors had a state-wide issue, they did not tell anyone about it.

Dr DOUGLAS: So the answer is no?

Mr SPRINGBORG: The answer is that we are contacting the people individually and they have been made aware by the notification publicly and the hospital and health service will be working to contact these people. Basically the priority is to report on the X-rays and to contact the individual patients, and that is what is being done. We have also told Queenslanders about it, which is a long way from what happened in the past. Also, if the investigation says that we need to have ads into this or any other thing, then I do not have any problem with it. But, really, we have to make sure that we get the best use of our resources.

Dr DOUGLAS: In terms of the people who were affected, it is a five per cent incidence of abnormalities found by other people, particularly when a radiologist looks at it. Even though not all of those are lethal—they are often not lethal—what will the state be offering to those people in response of this massive crisis of lack of confidence in the service, really?

Mr SPRINGBORG: Massive what, sorry?

Dr DOUGLAS: What happens is that, in terms of the unreported X-rays, people assume that those X-rays will be reviewed by a professional. That is the assumption. So what will the state be offering those people?

Mr SPRINGBORG: The best thing the state can do is when we identify a problem we actually tell people we have one, not cover it up as happened previously, and the priority will be contacting those people. If they have a misdiagnosis with regard to the primary source of their investigation, then that will be addressed by a part of remedial action. Let us keep in mind that I do not know where you get five per cent from. It may be, but let us not—

Dr DOUGLAS: That is the figure. It is a commonly available figure stated on—

Mr SPRINGBORG: I am not so sure, because I asked about this figure yesterday and there is no commonly available figure around this.

Dr DOUGLAS: The Queensland director of the college last night stated it publicly—that is, Greg Slater in a publicly available document. I can provide that for you if you would like.

Mr SPRINGBORG: Okay. I have asked for other advice around it, but I just think we should not jump the gun in regard to that. If there is an orthopaedic issue, we have to keep in mind that an orthopaedic specialist reads those X-rays. They know what they are looking for and generally in most cases they will get it right, but that is why a radiologist will review it just in case they may have missed a hairline fracture or something along the way. With regard to, say, a chest X-ray where there is considered to be significant intervention—a cardiac procedure—the surgeon will request something. The procedure will be done. They have it for a particular purpose. A radiologist may read that and find another issue like a lesion which was not the primary course of that investigation. That will all be done as a part of this. Obviously if there are issues that require further treatment or interventions then the best thing we can do is assist those people through the resources allocated to help them with their particular health issue if it has not been properly addressed. So that will be done as a matter of priority.

Dr DOUGLAS: So you will be offering them compensation? Is that what you are saying? If there was an assumption—

Mr SPRINGBORG: No, I never said that. A person has normal access to apply for remedial recompense as a part of any process. They do that each and every year in Queensland Health. That is totally separate to a process of where we may be contacting a person saying, 'We've reviewed your plain film X-ray and we've identified something. Can you come in and we'll address the issue with regard to medical assistance,' or whatever it may be. The issue of recompense is a totally separate process which is handled in a different way and that is entitled to any Queenslander who believes that they have a suboptimal outcome in the system.

CHAIR: Thank you. Just to explain briefly, I allowed Dr Douglas some latitude over the 15 minutes as he will not be here this afternoon. I think he is leaving to go to a few other committees.

Mr SPRINGBORG: If he has any more questions before he goes, I am more than happy to take them.

CHAIR: Thank you.

Mr SHUTTLEWORTH: Minister, at page 67 of the SDS we are advised that the Central Queensland HHS is responsible for direct management of more than 16 hospitals and facilities, including Gladstone Hospital. Can the minister advise the committee of any improvements and upgrades planned for the Gladstone Hospital?

Mr SPRINGBORG: I think we have seen some really good performance over the last little while with regard to the performance of the Central Queensland Hospital and Health Service. Their surgical performance is very good, as is their emergency access performance. In March of 2012 76 per cent of people were seen in under four hours, and they have always performed well. That is now 79 per cent, so I think people can be very encouraged with regard to that. Recently they have also made a major call for investment in a new radiology contract which will see radiology and radiography services being provided across that area to a higher level than ever before and with CT scanners in places where they have not previously had those. I might call upon the hospital and health service CEO who might bring the committee up to date.

Mr Richards: In terms of Gladstone, we are looking at the development of a high-dependency unit in that particular area. That is funded through business commercial moneys. We are also investing in an upgrade in the theatre complex within the hospital.

CHAIR: Minister, do you have anything else to add there?

Mr SPRINGBORG: The other thing is that we are very interested in continuing to partner. We have had a very good relationship in Gladstone with the local resources sector around planning for the future. The other great thing that is happening in Gladstone is we are finally getting a far better collegiate arrangement with the Mater Hospital with regard to joint appointments so we can get a greater capability with regard to specialist appointments in that area. In terms of what has been a hospital and a community which has been largely in the doldrums around its health care over a long period of time, we are starting to see some improvements around that. Much of it is owed to the local hospital and health service and locals on that hospital and health board from Gladstone and also the very strong advocacy from the member for Gladstone, Liz Cunningham, over a long period of time. She is now being listened to with her concerns.

Mr Richards: I might just add to some of the developments that we have made in terms of new appointments to Gladstone. We have made an appointment of an orthopaedic surgeon to work between the Mater and Gladstone Hospital. We have an anaesthetist planned—and that is funded—and we are going out to the market for that. We have two paediatricians who are coming to Gladstone as well and we have just appointed—and he has just taken up post—a general surgeon for the Gladstone area. That has increased the critical mass of senior medical staff within that area, so by working with the Mater we have seen a much greater success in the attraction of senior medical staff.

CHAIR: Minister, page 67 of the SDS refers to the Central Queensland HHS working with partners to deliver a sustainable level of service into the future, and you just started to leverage on this. Can you please advise of any such partnerships aimed at increasing the intake of midwifery students in 2014-15?

Mr SPRINGBORG: As anyone would know, I have a very strong commitment particularly to rural and remote health care for a whole range of areas. This is a fantastic portfolio that is life changing for so many people, but one of the issues of course is to provide some form of equity of service to people living in rural and remote areas of this state who have lost their services over a period of time or should reasonably have a greater expectation of those services. I have a particularly strong commitment to increasing midwifery services across this state and also a greater range of

opportunities for women and their families to be able to birth locally. That is why we have reopened birthing services at Logan, Cooktown starts early next year and then on from there. An important part of building this workforce in the future is to make sure that we can identify those people who can be our midwives of tomorrow. We announced last year a special program to provide support scholarship type arrangements per se to some 50 nursing graduates who want to take on midwifery as a profession, and the first 25 of those went into the system last year. It is an 18-month program where they would be supported by a hospital and health service whilst doing their studies at a university in partnership and of course be associated with a local private practising midwifery group.

In the case of Central Queensland, they have been very much involved in supporting the development of the model with the Central Queensland University where from 1 February this year a cohort of some 25 nursing graduates have gone into this midwifery 18-month program, so at the end of that we will actually have additional midwives across Queensland. Very importantly, many of those will be placed in rural and remote and regional areas of this state. This program is unlike anything else that has happened in the country previously. So there will be some 50 midwives, the last 25 of them with Central Queensland University. If we are going to grow the opportunities for women to have greater choice with regard to birthing and continuity of care, then we need to do this. With regard to Emerald and Gladstone, they currently have midwifery group practices offering a greater range of continuity of care. Rockhampton, as I understand it, will be aiming to offer that particular service from 1 October this year.

CHAIR: Thank you, Minister. That is particularly pertinent for me because, as you are aware, we have the midwifery services at Jinibara State School which are providing real community building opportunities.

Ms BATES: Minister, page 9 of the SDS refers to the government's activities with regard to increasing immunisation. Minister, how has the Central West HHS performed with regard to the immunisation rates of children?

Mr SPRINGBORG: I might start and just make some general comments regarding immunisation and then I will ask Michel Lok to come forward. He is the chief executive of Central West. We are very keen to not only raise awareness about immunisation but, very importantly, offer access to immunisation services. There are a small number of people, but an alarming number of people, who have an objection—vaccination deniers. There is probably little we can do about that cohort other than try to educate them. But for some people, it is an issue of access and availability. What we need to do is to ensure that we continue to roll out that access and availability.

I think it is very encouraging that many of our hospital and health services in rural and remote areas have very high rates of vaccination even compared to the bigger regional centres and also the metro areas of the state. So for people out there, there is not a general aversion to immunisation; it is access. I understand that Central West HHS achieved the highest rate of immunisation for children in Queensland in 2013, with 97.8 per cent of five-year-olds being fully immunised compared with Queensland and the national average immunisation rates of just 92 per cent. That is pretty amazing. So well done to them. Our new immunisation program will also see $3 million worth of incentive funding that will go out to HHSs as well. Michel might want to make some comments.

Mr Lok: As the minister has indicated, 97.8 per cent achievement is the highest in the state and it has been consistently high, as many of the rural and remotes are probably better at connecting with local communities, work more closely with general practices that we work very closely with in our rural and remote areas and achieve very high rates. It is an acknowledgement to the staff and our community health personnel for achieving that kind of result.

CHAIR: Thank you. I call the member for Beaudesert.

Mr KRAUSE: Minister, with reference to page 79 of the SDS, the committee notes that the model of service delivery in areas such as Central Queensland has traditionally had a high reliance on locums. Has the Central West HHS had any success in reducing the HHS's reliance on external medical locums?

Mr SPRINGBORG: The simple answer to this question is yes. I really applaud the hospital and the health services for the wonderful work that they have been doing generally in reducing the reliance on locums. Locums are an important part of our workforce—they are a necessary part—but we need to reduce our overreliance on locums, because we need to have a continuity of people within our community. Also, there is a cost ineffectiveness that comes from the overutilisation of locums.

I understand in the Central West HHS over the last 12 months or thereabouts they have increased the number of resident doctors from five to 15, but Michel might want to tell us about the overall success of how you deal with that. Also, before I throw to Michel, basically, our new contracts arrangements provide us with a greater degree of flexibility for the HHSs to provide recruitment and retention components in those contracts.

Mr Lok: The major lead here is through the board itself, who came in two years ago and were very concerned about the very high rates of locum usage and agency nursing, particularly in our region. They set about a task of restructuring our medical workforce and focusing on our recruitment and retention strategies, which has led to the kind of results. So a 50 per cent reduction target was set two years ago. We have almost achieved 100 per cent replacement of locums out in the Central West.

As I mentioned, it is largely the result of restructuring the medical workforce. Many of our posts were single posts or two medical officer posts. So we have restructured to make each of our sites part of an integrated workforce across the Central West, where the workforce will be shared and self-relieve and also try to draw in skills that can be used across the region so that doctors with advanced skills in one area or another will be able to work in each of our locations. The result is that we have been able to attract doctors, because we have been able to build up a training focus and also take on board some junior doctors as well as our student doctors. So people want to be out in the Central West, be part of a training workforce and be part of delivering services.

Mr HATHAWAY: Minister, page 87 of the SDS advises that the Children's Health Queensland HHS is developing closer working relationships with patients, community groups and other primary health providers. What results have we seen under the Deadly Ears program across Queensland communities?

Mr SPRINGBORG: Thank you very much. We are endeavouring to provide more equitable health outcomes to people right across this state. Indeed, when it comes to Indigenous health outcomes, that is one of our greatest challenges. There is little doubt about that. It is a part of remoteness. It is a part of some of the socioeconomic disadvantage that exists. Of course, that then cascades down the line, particularly to the children. We know that if you have developmental issues at an early stage around hearing—those sorts of things—that can lead to other outcomes further up the line. I think that overrepresentation in our hospitals and possibly even overrepresentation in our prison population is because, if there are developmental issues and you cannot hear and you cannot disseminate information as a consequence of that, that does not assist your outcomes further along the line.

We have invested significantly in the Deadly Ears program, with a very, very significant focus on otitis media, which is hearing loss, in children or circumstances surrounding that. The outcomes of the program include a reduction in the presentations of chronic otitis media, or chronic ear diseases, at its ear, nose and throat outreach clinics across Queensland from 20 per cent in 2009-10 to four per cent in 2013-14. So we are making some headway in that area as well. There have been over 9,600 assessments of Aboriginal and Torres Strait Islander children at its ENT clinics across Queensland. This is in the children's hospital and health service program across the state. There have been over 1,900 surgical procedures that have been provided to Aboriginal and Torres Strait Islander children with ear disease and hearing loss. To date, the program has delivered training in ear and hearing screening to over 500 staff from over 70 health facilities and providers across Queensland, including staff from over 20 Indigenous communities. So it has been quite successful, but we have a lot of work to do still to close that relative disadvantage gap. So we are making some progress in those areas and also with regard to eyes that we have put out as part of the jubilee trust as well, moving around Queensland. That is also providing some really good diagnostic and also treatment outcomes for particularly Indigenous people across this state.

CHAIR: Thank you, Minister. We will do one more government question and then we will shoot across to non-government questions. Minister, specifically with reference to programs administered by the Children's Health Queensland HHS, how are those programs providing pathways for treatment for children with hearing difficulties?

Mr SPRINGBORG: I indicated some of that a little while ago, but the whole point is that what we have to do is have programs, have them very well identified, have them extremely well coordinated and then, of course, have the pathway towards treatment. Children's Health Queensland has been extremely innovative in a whole range of areas—right from involving our audiologists early

on in outpatients through to innovative approaches around care coordination across the state. That gives far better outcomes. I might ask Dr Peter Steer if he wishes to come forward and make any comments around that.

Dr Steer: Thank you, Minister. As the minister said, there has been a number of initiatives—comprehensive measures—across Queensland that we lead, but certainly in partnership with other hospital and health services in other non-government agencies. We have touched on the Deadly Ears program, which has been an extraordinarily successful program. The minister has spoken about the statistics, but we cannot understate the long-term effects in investment in children who would have suffered not just hearing difficulties but subsequent speech language delay right down to future economic opportunities.

But we also lead in partnership the Healthy Hearing Program, which really is an extraordinary program now, with more than 99 per cent of children—over 500,000 children—screened for hearing loss after birth throughout Queensland. This provides not only an early opportunity to innovate—be with those with moderate and severe hearing loss—but also pathways of referral for those with minimal hearing loss. The other mapping of some really neat, innovative care, not just with ourselves but with Metro North, is the innovation of having our ENT referrals, which has been an extraordinarily pressured waiting time issue for children's health, which has seen allied health and audiology interventions working with our ENT surgeons to drop our long waiting list for ENT from what they were by 75 per cent in category 2 long waits and 80 per cent in category 3 long waits—again, making a huge difference not just to children and families but to children's speech, language and future development opportunities.

CHAIR: Thank you, Dr Steer.

Mr SPRINGBORG: As Dr Steer is departing, can I also thank him for the work they have done around the cochlear implant program as well. We had a waiting list of some 22 at the start of the last financial year. Not only did they do the 22 but I think, as of around May, they managed to do another 19—or 41. So absolutely fantastic work is being done there. Well done.

Dr DOUGLAS: Hear, hear. Good on you.

CHAIR: We have time for probably one question.

Mrs MILLER: Minister, I refer to page 119 of the SDS and I ask: is the birthing pool in the new birthing centre at Mackay Hospital substandard compared with other Queensland hospitals because of budget cuts or because your staff in that HHS have not listened to the local community as they are required to under standard 2, 'Partnering with consumers' in the National Safety and Quality Health Service Standards? I table the photo as evidence of the substandard birthing pool.

Mr SPRINGBORG: The honourable member should know, because her government designed it. Your government designed it.

Mrs MILLER: And you are in government now.

Mr SPRINGBORG: Once again—

Mrs MILLER: You are in government now. You have had two years.

CHAIR: Member for Bundamba, please let the minister answer the question.

Mr SPRINGBORG: This is the problem with selective amnesia, or 'Don't look backwards because we might be scared of what we see'.

Mrs MILLER: What about ramping?

Mr SPRINGBORG: The honourable member's government actually designed that hospital some five years ago as a part of its redevelopment. The honourable member's government also redesigned Cairns block D without the second power redundancy. Those rooms were actually designed some four to five years ago and that configuration of those facilities for birthing women were actually designed at that particular time. So—

Mrs MILLER: Are you sure? Really sure?

Mr SPRINGBORG: It is a great pity, Mr Chairman, they did not consider those matters of consultation then as we actually consider now. They are of the original design issues. As I understand it, to change those particular design issues require internally, with regard to the fit-out, significant redesign of the superstructure as well.

Mrs MILLER: So you are saying that you did have the opportunity to redesign it but, because of money, you decided not to?

Mr SPRINGBORG: Sorry, Mr Chairman, I think the honourable member misunderstands the answer. The configuration of those rooms were actually designed by the previous government and for that to actually be changed requires redesign work with regard to structures within those particular rooms as well. So it actually goes back to that. We understand the concerns that have been raised by the women who have an aspiration to birth there in a supportive water birthing environment. We understand those issues. But I just say that it is a great pity that our predecessors did not appropriately design it. But the hospital and health service is working through with those women now to try to address those issues. Again, it is a great pity that the former government did not properly address that. The construction for this hospital redevelopment began in 2009 and that is when this path was set off on.

Mrs MILLER: Just as a follow-up question, are you saying that you are going to put in safer and more appropriate water birthing facilities there? Have you got a budget set aside for that?

Mr SPRINGBORG: Again, I take the honourable member back on a trip down memory lane—

Mrs MILLER: You are the minister now.

CHAIR: Member, please allow the minister to answer the question.

Mr SPRINGBORG: There are a range of other legacy issues that we are trying to address going right back to the days when you were ably assisting Gordon Nuttall so very well and subsequent to that. The design layout of this was set in 2009, including the superstructure that underpins the layout of those particular rooms. As I understand, to refurbish, or to do as the honourable member would want to do—to correct the design fault that was a legacy of their government not getting it right—would cost potentially between $300,000 and $500,000.

CHAIR: Thank you. The committee will now adjourn for lunch. The video broadcast of this session will be available on the parliament's website shortly. The hearing will resume at 1.30. The committee will continue examining the estimates of the department of health and health and hospital services. It will examine the estimates of the Queensland Institute of Medical Research, the Queensland Mental Health Commission and the Health Ombudsman. We will come back here at 1.30.

Proceedings suspended from 12.29 pm to 1.30 pm

CHAIR: Welcome back. Welcome to the minister and officials. The committee will continue its examination of the estimates for the Department of Health and the health and hospital services and commence examining the estimates for the Queensland Institute of Medical Research, the Queensland Mental Health Commission and the Health Ombudsman. On behalf of the committee, I welcome the chief executive officer of the Queensland Institute of Medical Research, the Queensland Mental Health Commission and the Health Ombudsman. For the benefit of Hansard, I ask officials to identify themselves the first time they answer a question and to bring their name plate if they come to the table. We will move straight to non-government questions and I call the member for Bundamba.

Mrs MILLER: Thank you, Chair. I refer to SDS page 39, and I am seeking clarification from the Director-General, please, Mr Ian Maynard. I am seeking clarification of the previous answer given this morning where you stated that you had retrieved Dr Anthony Lynham's personal payroll details at the minister's instructions. What I am asking, Mr Maynard, is for you to confirm the time and the date of these actions, please?

Mr Maynard: I thank the member for the question. In respect of the details that I requested for Dr Anthony Lynham, that request I believe came through some time during Sunday. I took some legal advice and I was provided with the information during the course of Monday. That is this week.

Mrs MILLER: Do you believe that in relation to the leaking of that information or that information being given out, that that information was given out earlier than Sunday?

CHAIR: Sorry, I am struggling to understand—

Mrs MILLER: In relation to SDS page 39 it says 'ongoing improvements to the payroll and rostering system', and it also says in here 'improved recovery of overpayments'. It is directly in relation to the SDS.

CHAIR: What you are asking for is an opinion.

Mrs MILLER: No, I am not. I am asking for a statement of fact.

CHAIR: You are asking for an opinion and that would be out of order.

Mrs MILLER: No, I am asking for a statement of fact. With respect, I am asking—

CHAIR: If you could restate your question.

Mrs MILLER: Okay. In relation to SDS page 39, particularly the last paragraph where it says 'improved recovery of overpayments', and in relation in particular to the alleged leaking of information in relation to Dr Anthony Lynham—and you can take this on notice, Director-General, if you would like—I would like to know whether or not that information was given to the media by anybody in your department. I would like to know approximately the date and time that that information was accessed. Now, you should be able to find that through forensic computer inquiries.

CHAIR: Mr Maynard, you can only answer that to the best of your capacity.

Mrs MILLER: I am quite happy for him to take that on notice.

Mr Maynard: I can only answer in respect of myself. The information that I requested I received yesterday. I have not provided that information to the media.

Mrs MILLER: Okay. Thank you very much. I move on to another issue. This is in relation to SDS page 9, particularly point 6. Minister, I ask that for the period of June, July and August for the Local Area Service Networks, this is in relation to Queensland Ambulance, of the Gold Coast, Metro South, Metro North and the Sunshine Coast, how many shifts were unrostered in the respective LASN roster projections?

Mr SPRINGBORG: Mr Chairman, I thank the honourable member for the question. I mean, as the question requires some quite specific detail, which we may or may not have here, I would be very happy for the commissioner, if he has it at his fingertips, or to take that on notice, but for me the assertion out of this, of course, is that we have an Ambulance Service which is not functioning or not functioning well enough. Now, the Queensland Ambulance Service is actually functioning probably far better than it has ever functioned at any time in the past. Our response times are dramatically improved. The time that we are being delayed with regards to getting patients off stretcher is reduced, and if we look at the fact about 3,905 personnel FTE, and that is going to increase by now about another 100 during the course of this particular year. But if the honourable member wants specific individual details around an area of roster then we might see if we have got that information if it can be routinely available. Commissioner?

Commissioner Bowles: Thank you very much, Minister.

CHAIR: Can I get you to introduce yourself first. If you have your name plaque that would be good, and just speak very closely to the microphone. Folks, when you come up, if you would speak very directly into the microphone. We are having some difficulty otherwise with the broadcast so if you would just be cognisant of that. Thank you, Commissioner?

Commissioner Bowles: No problems. Russell Bowles, Queensland Ambulance Service Commissioner. I suppose just to put a little bit of context around the question first of all about unfilled shifts, the first thing I would like to say is that we endeavour to fill every shift. Should someone ring up and go off sick, or for whatever other reason, injured or whatever, we will go through a three-step process. We will go through a process whereby we try to identify excess staff within the system, within the various networks, that allows us to move between networks. The second phase is that we would go to a casual qualified paramedic or the third phase is that we would go to overtime for the filling of that shift. Now, as we get into different parts of the year I think it is fair to say that no matter how hard you try using that three-step methodology that was introduced in the industrial arrangements in 2005, that it is just not always possible. And that again is the advantage of a network whereby we move units around to service the community. If I just refer back to our performance, at a state level it is as good or it is better than it has been in recent time and that is as a result of making every effort to make sure that we have the necessary resources available to fill shifts. I can give just some broad data just on unfilled shifts that is being currently prepared for an RTI, I think it is, by the United Voice.

Mr SPRINGBORG: Oh, surprise, surprise.

Commissioner Bowles: Unfilled shifts July 2013 and up until July 2014 in the south-east corner, well, there is 7,258 shifts that we would have to cover in that network. It looks like, with the data that I have here, there is about 208 of that 7,258 shifts that weren't filled. If I go unfilled shifts for June for 2014, there was 211 against the number of 17,016. Unfilled shifts May 2014, 179 unfilled shifts against 17,548 shifts. Unfilled shifts June 2013, 183 against 15,157. If you go through the

relevant percentages of that, it is 1.24 per cent in June, one per cent in May and 1.21 in June. I accept that the figures are what they are, but a lot of good work by a lot of good people goes into making sure that each and every shift is actually filled so that we can provide the excellent response that our paramedics do each and every day.

Mrs MILLER: Thank you. Chair, I just wanted to talk about the minister's comment about the QAS functioning far better, which he just said before, and this is in relation to SDS page 9, and I would just like to table these photographs and to show people, seeing the minister did this this morning, this was the ambulance ramping at the Royal Brisbane and Women's Hospital yesterday. I really don't think it is functioning far better. I would like to table that. Also you made a comment about inpatients off stretcher having being reduced. This is a photo of ambulances, ambulance officers and patients last week at the Royal Brisbane and Women's Hospital who could not even get into the front door of the emergency department. So, Minister, I don't know where you are getting your advice from but it is obviously wrong. Obviously I think in relation to your comments about ambulance ramping and bypassing et cetera, I think given these photos, which are very recent—like last night and last week—that you have been telling this parliament and the people of Queensland porky pies. I refer to SDS page 19, and also the question on notice, the answer 490. Whilst there has been some marginal improvement for some category 1 patients in some HHS's, is it not the case that waiting times for categories 2 and 3 patients has in many hospitals not improved and has actually got worse whilst you have been Minister for Health?

Mr SPRINGBORG: Thank you very much, through you Mr Chairman, to the honourable member for Bundamba. Endemically I want to segue into this by making at least an oblique reference to the previous assertion from the honourable member. I remember the first visit that I made to the Royal Brisbane and Women's Hospital just after I became a minister. There are actually routine places that were actually lined out in corridors for patients to actually wait on stretchers. There was overflowing ambulance bays out the back. Now, that thing, Mr Chairman, is something which is largely a thing of the past now. The last time that I went over there, there was no-one in the corridors and everyone actually made the assertion to me—the emergency clinicians and right down—how much it was better. There were not ambulance bays that were overflowing out the back. I also want to just refer to figures because this actually really makes the most strong and strident points. Average hospital to clear interval in minutes code 1 and 2 QAS state-wide, first quarter of 2012, 41.9 minutes, first quarter of 2014, 35.2 minutes. So a 6.7 minute improvement—290,000-odd minutes less lost in getting patients off the stretcher in under 30 minutes. Now, we are always going to have an element of pressure, but the routine day-to-day headlines and snaps on the front of the *Courier-Mail* and also in the media is largely a thing of the past. With regards to the performances that we are seeing in our hospitals and health services across Queensland, meeting waiting times for elective surgery was 28 days in the March 2014 quarter, category 1, 12 days, category 2, 63, days and category 3, 159 days. Basically if we use, Mr Chairman, the 90th percentile, waiting time for elective surgery was 217 days March 2014 quarter, category 1 was 29 days, category 2, 130 days and category 3, 378 days. So basically what it means is at that particular stage 90 per cent of patients can actually be expected to be seen within that particular period of time.

With our surgical long waits, there has been a significant reduction. We are also seeing far more treatment of outpatients in our hospitals. I think we had around about 100,000 additional patients—can we get those figures, please—in the last year who had their first—100,000 more patients, I think; an increase of over 20 per cent, getting close to 30 per cent, of outpatients. It is a 30 per cent-odd increase, or close on, of outpatients who actually had an initial appointment. That was one of the highest proportions that I have ever seen of new outpatients actually having an initial appointment, so we are improving significantly in those areas. I will just get hold of those figures to confirm.

Whilst that is being found, I also want to confirm what I said earlier on today, when I initially said the Gold Coast hospital had had a 16 per cent increase in the number of emergency department presentations in actual numbers. That is true. The hospital and health service: 13 per cent overall in the past 12 months, so that includes Robina. We are seeing significant increases in that area. I want to make sure that we provide accurate information to the committee.

It is projected that the number of initial service events by the end of the financial year will have increased from 324,755 in 2012-13 to 411,283 in 2013. This is an increase of some 27 per cent. We are actually seeing more patients with their initial outpatient appointments, more returns and also we are getting more people into the waiting lists. But it is true that you are always going to have some

fluctuation in outpatients. As I have said before, our target is NEAT, which we are addressing. It is then addressing the dental long waits, the surgical long waits, ophthalmology and then moving on from there to these other areas. We have never made any secret of that.

Mrs MILLER: Mr Chair, I would like to call up Mr Malcolm Stamp, the CEO of Metro North.

CHAIR: Mr Stamp, please come to the desk.

Mrs MILLER: Thank you, Mr Stamp. In relation to SDS page 134 and question on notice answer No. 490, I am particularly concerned for the people of Brisbane north where overall outpatient performance has declined over the past three years by 17 per cent for category 3 patients and by 15 per cent for both category 1 and 2 patients. Mr Stamp, has this decline in service performance been the result of the SMO contract dispute, the wider budget cuts in your HHS or the fact that 1,431 positions have gone—disappeared—by retrenchments or whatever from Metro North since 2012?

Mr Stamp: Malcolm Stamp, Chief Executive, Metro North Hospital and Health Service. Thank you for the question. Between last year and the year before, we have seen an increase of four per cent in outpatients. We have seen an improvement in the uncategorised category of outpatients. We have seen an improvement, a reduction, in the number of category 3 outpatients. We have seen a small increase in category 2 of around about 1,100 on 25,500 and we have seen a small increase on category 1 patients of around about 100 on 2,700 parents. I think our overall performance on outpatients has, if you like, stabilised with that increase of four per cent. We have a strategy in place to reduce our long-wait outpatients by 50 per cent over the coming year, a challenge that we embrace and take very seriously. During that same time, we have seen an increase in in-patient and accident and emergency workloads. Also, we have embraced the central patient intake, which is an initiative that is aimed at streamlining the allocation of patients' requests through GPs to the appropriate clinic in a timely fashion. We have around about half our external referrals on that system already, with the aim that during the course of this year it will be the full system. We have engaged the Medicare Local with our primary care partners to engage on pathways of care. We have 25 of those pathways now clinically agreed, demonstrating again that we are taking our outpatient position seriously.

In terms of the reduction of 1,400 staff reported, I think that last year Metro North was appearing before the committee and gave a detailed explanation of not only its overall but specific staffing position at that time. Between last year's committee and this year's, we have seen our overall staffing reduced by around about 50 staff, from 12,706 to 12,685. That is all pay points in that time. We recognise that we have a legacy in outpatients, so I am not diminishing the importance of the question that is being asked and it is one that, as I have already said, we take very seriously. We have over 51,000 people on our outpatient waiting list and 32,576 of those are what we would describe as long waits. As I already said, we have given a commitment to this committee that we are aiming to reduce that by at least 50 per cent by this time next year.

Mrs MILLER: Thank you.

CHAIR: Member for Bundamba, we are at time so unless there is a follow-up question, we will need to move on.

Mrs MILLER: No, it is okay.

CHAIR: Thank you. We will move to government questions and call the member for Ferny Grove.

Mr SHUTTLEWORTH: Thank you, Chair. Minister, with reference to the $8.2 billion in employee expenses referred to on page 27 of the SDS, can you please inform the committee about the number of employees who, since November 2013, have signed up to the payroll self-service system in order to repay amounts where they were overpaid by Labor's failed health payroll system?

Mr SPRINGBORG: Thank you very much. This is a very important question because we do have a very dedicated workforce within Queensland Health and just as we recognise the need to redress circumstances where employees have been underpaid, we also recognise that it was not the fault of employees that they were overpaid but nor is it their money and there is an obligation to recover that. Of course, we cannot forget the fact that under our predecessors, they not only caused this debacle but also they brought in a moratorium that saw some $30 million worth of overpayments walk out the door with employees who separated, with very little hope or opportunity for us to recover it because some of those people have moved interstate or overseas and are refusing to repay. However, we are continuing to pursue them.

We have been working diligently through the list to contact the highest value overpayments first and to put in place arrangements for the repayment of that. That has been largely successful, as I indicated earlier on. When we came to government, there were around about $90-odd million worth of overpayments. That was getting worse at around about $30 million a year, so it would have been around about $150 million. We put in place automatic recovery and we also lifted the moratorium on the collection of overpayments, which has been of great assistance.

What we have also done is worked with our clinical workforce to encourage them to pay back the pay date loans and other repayments. To date, we have had 15,000 Queensland Health employees payback their pay date loan. We did that when we shifted the pay date. Also, there has been 5,000 registered plans entered into in addition to that, as of today, since November last year, for a total of $9,309,858. That is 7,787 repayment plans by 5,907 employees. The largest single repayment which has been committed to was $14,058 and the largest overpayment committed to for repayment is $48,671. To date, $3,055,866 has been repaid. I am happy to table that. It is straight off the presses.

CHAIR: Minister, we need to get approval from the committee. Can members indicate? All those in favour? Thank you.

Mr SPRINGBORG: I also want to address some of the interesting statements that have been made by the opposition shadow minister today and also her leader around Dr Anthony Lynham, who is the Labor candidate, and reinforce the fact that there was no such fretting when thousands of Queensland Health nurses were on the breadline and seeking charity just to pay their bills or put food on the table. Also we have heard some wrongful assertions from Dr Anthony Lynham or from the opposition leader on his behalf in recent times out there in the media. I want to reconfirm that the media approached us, I think around Monday of last week, asking us to confirm an amount of an overpayment for the Labor candidate. We refused to do so because of his private information. Later in the week, the opposition leader indicated that she would raise these matters at the estimates committee. In preparation for that, I asked the director-general to secure information in case we needed to actually refer to that information here today. That request I think went in on Friday from my office. It may have reached you over the course of the weekend. That has not been released in any way whatsoever.

One of the great disadvantages that we have in my job, and the shadow minister would probably be aware of this going back to the time when she was an assistant minister and her predecessors, is that you do access information from time to time on patients to try to respond to something, but you are unable to use that. There are lots of things that are said out there that are quite erroneous and absolutely wrong. We are at a significant disadvantage, of course, because of respect for privacy.

There has been an assertion made that Dr Lynham was told do not do anything as a consequence of his first letter, a letter that was received on 28 June 2012. It certainly did indicate that in the case of his overpayment—and everyone received a similar letter, who had an overpayment, so it is a very similar letter. It said, 'You do not need to do anything as a result of this letter'. That is true. But it also says, 'If you would prefer to begin repaying your overpayment now, please contact the state-wide hotline on this number and we can arrange processes which will assist you in that repayment'. Also, he received another letter subject of a pay date loan, which most Queensland Health employees—or pay change loan—shift received later on 17 October 2012, which basically indicated, 'You do not need to complete the enclosed form if you have requested a repayment plan for the transition loan'. But it goes on to state that as a part of the process that 'in repaying your transitional loan you have three options to repay your transitional loan: when you leave Queensland Health, early repayment via a single lump sum or early repayment through payroll deductions'.

As I said, 15,000 people have chosen to do that already. Another almost 6,000 have signed up voluntarily to repay. The Labor candidate was not one of them. Indeed, I am informed that we have cleaners out there who are earning a fraction of what the Labor candidate earned—he was a part-time employee—who have actually arranged to pay back more substantial amounts and have already done that. The bigger question here is, why didn't he disclose these facts and why have many of his colleagues who were paid much less actually already arranged to repay those particular pay date loans and also to repay matters that are outstanding. They have done that; some 20,000 of them have done that and the Labor candidate was not one of them. I think that is a very important consideration as a part of this and it is something that probably he should have been talking about justifying that in context.

CHAIR: Thank you, Minister. Minister, with reference to the LNP's establishment of the state's inaugural Office of the Health Ombudsman, can you please advise about the level of complaints processed and other activities undertaken by this office since its inception?

Mr SPRINGBORG: Thank you very much. We are very proud of the establishment of the Office of Health Ombudsman, the first such office in all of Australia. Indeed, I know that other jurisdictions are looking with great interest and they have hit the ground running. Indeed, if you look at the context around the establishment of this, before we embarked upon this journey there was up to six years that matters were waiting to be properly identified and investigated by the Queensland medical board and the Medical Board of Australia. A whole range of issues were behind time with regards to AHPRA. Also the Health Quality and Complaints Commission, despite their best efforts and they did a pretty good job, were finding jurisdictional blockages from AHPRA because there was not a single line of responsibility around who was supposed to deal with complaints. That has been clearly addressed by the establishment of the Health Ombudsman. The Health Ombudsman may wish to make some comments around this.

Mr Atkinson-MacEwen: Thank you for the question, Mr Chair. In relation to the activity since I arrived in Queensland on 28 January, obviously we have spent a lot of time with a small team building the office. That includes going through an extensive recruitment process, both through open merit as well as suitability assessment, to bring on board what is now a staffing level of 85 full-time equivalents. In addition, we have put in place a number of IT systems to support those staff to ensure that they can do their job very, very effectively and also very productively.

As of 1 July we saw 288 matters transfer from the HQCC to my office. Of those 288 matters 69 were in what the HQCC called the triage stage—that is, they were complaints where information had been requested from a complainant and had been received just prior to 1 July and no assessment had been undertaken or no referral to assessment or resolution had occurred prior to 30 June when they closed. Some 69 matters were in triage, 148 matters were in the assessment stage whilst under the HQCC Act, 14 matters were being sought to be resolved with complainants and practitioners or health service providers, 31 matters were in conciliation and there were 11 investigations. At the same time, there were 15 applications for review of existing HQCC complaints—that is, a decision had been made but the complainant disagreed with the decision and sought a review. Those matters have all transferred to my office and are being dealt with under my legislation.

As well, as of the close of business yesterday—so a full two weeks or 14 days since we started—we have had a total of 118 new complaints come in the door, which has been quite a tick higher than the average the HQCC used to have. We have been taking those complaints by phone, by email, via an online complaint form and by mail. We have also had 143 inquiries about those existing HQCC matters that have transitioned. We have had about 230 general inquiries about the way the act works, how to make a complaint et cetera.

The staff have been very busy. They have been very excited. There has been quite a buzz in the office as a result of the start of the act. We have also been looking and working with AHPRA to determine what matters on foot with AHPRA should transition across to my office. AHPRA has 28 days under the legislation to advise me whether or not matters that have currently been dealt with by the various boards are in their view serious matters that might be transitioned to me. We have been engaged in an information gathering exercise with AHPRA to determine in advance of those 28 days what matters they have on foot that might actually transfer to us. That will continue for the rest of the month. By the end of this month we should have a very good idea of those matters which are best left with AHPRA because perhaps a hearing is underway or is about to be underway at the Queensland Civil and Administrative Tribunal or alternatively matters that are serious matters that ought to transition back to me because action needs to be taken to accelerate the process of determining them.

CHAIR: Thank you. I will stay with the Health Ombudsman, Minister. I have another question. With reference to the establishment of the office, minister can you provide us with an update on the transfer of staff from the HQCC to the Health Ombudsman?

Mr SPRINGBORG: I thought you were going to go straight to the Ombudsman. Sorry, I misheard your opening remark. I will make an opening statement and then I will go to the Health Ombudsman. We were very keen with regard to the establishment of the Office of the Health Ombudsman that he had the opportunity to be able to construct his office the way he saw fit. We were not going to say to him, 'You must take these people or these people.'

A number of people transitioned into the Office of the Health Ombudsman and other people chose to accept voluntary redundancies. Before I throw to the Ombudsman, can I just indicate my appreciation of the work of Associate Professor Russell Stitz. He did an absolutely fantastic job as the chair of the Health Quality and Complaints Commission. I indicate my appreciation for the work of Dr John Rivers after him. I indicate my appreciation for the work Cheryl Herbert did in the transition process. They handed it over in a very healthy state and with resources which could be applied to assist the Health Ombudsman in what he is required to do. This is an indication that you should not just measure inputs with regard to the way you establish an office. You should basically construct of the work program and the way you go about doing it. I think the HQCC's legacy files transitioned quite well. I now throw to the Ombudsman.

Mr Atkinson-MacEwen: Thank you, Minister. Some 29 FTEs transitioned from the HQCC to my office. Some 33 FTEs actually expressed an interest in being assessed as suitable for transfer. We only had 30 positions that directly matched those position in the HQCC, but we also had another 52 position that were out there for open merit selection as well.

Of the 33 staff at the HQCC who expressed an interest in being assessed as suitable, all 33 were found suitable. As I said, there were only 30 positions. One of those FTEs was offered a role and declined. Three others were offered interviews in the open merit process and declined and, as the minister said, took voluntary redundancies.

CHAIR: We will go to non-government questions now. I call Dr Douglas.

Dr DOUGLAS: Minister, we were at this point earlier on today. I am concerned about some answers provided this morning about this $13.6 billion business which pays $7.2 billion in wages after superannuation and pays tax of $1.6 billion on the numbers in the SDS at page 11 and following. There are 72,795 staff. I could not get the answer on the percentage of payments to the Commonwealth. I acknowledge that you said that you would take some of those answers on notice, and I have submitted those. This is on the tax payments alone. You then said I was going to privatisation. This business earns a 13 per cent return to the Commonwealth alone out of the tax payments.

CHAIR: What business—

Dr DOUGLAS: My question is: why have you not pursued a better return on the capital provided from the Commonwealth on the scale of this business?

Mr SPRINGBORG: I think the budget that we are talking about for the next financial year indicates employees' expenses amount, and you referred to it yourself, to some $8.28 billion—you can put the $161,000 on the other end—up from $7.839743 estimated actual for 2013-14. I indicated to the honourable member that we do have a significant obligation with regard to employees' expenses. With regard to capital, as far as I can comprehend the honourable member's issues around that, we are trying to far better understand and amortise the real cost of running healthcare through the national efficient price and all of the processes that go around that to allow us to be able to provide the best quality, best value for money health service. That is why we can tender certain things to market.

The SDS does actually account for the amount of money we get from the Commonwealth. That is right there for everyone to see. I do not have the page open at the moment. I think it is around $3 billion-odd. I am not actually sure we make calculations around the amount of tax we actually pay and how the amount returned to the state overall is really relevant to any of those sorts of things.

Dr DOUGLAS: Well, it is. You talked about business efficiency this morning. We are actually talking about efficiencies. That is what my second question relates to. If you want to go straight to that, I will give you my second question. This is an efficiency question. You actually said this morning that the average cost of a patient treated in hospital through the A&E was $400 yet the average cost in other Australian hospitals is $270. It is actually $130 more to treat the same person in an equivalent hospital in Queensland. Minister, this is a question about the efficiency of running this business. That is what this discussion is about today. You were talking about privatisation well before this business was actually found to be running efficiently.

I have calculated the tax payments on the numbers that you have outlined. I have calculated the average wage to be $92,910. The tax payable on that amount is $22,275. You then multiple that by 72,795 staff. That is a 13 per cent return. This business is not being run correctly. That is the problem. You were talking about going to privatisation before this was discussed?

CHAIR: Dr Douglas, can you get to your question. This is an awfully long preamble.

Dr DOUGLAS: Why is it costing $130 per person more in our hospitals, based on your numbers?

Mr SPRINGBORG: I would have some contention with the propositions from the honourable member for Gaven. This morning when I was answering a question I volunteered that it costs us significantly more to treat a GP type presentation in an emergency department. I indicated at that stage that it cost around $400-odd. My understanding is that for category 4 and 5 patients presenting to an emergency department it is around about that mid-400 mark. For higher acuity patients in categories 1, 2 or 3 it is up over $600. They require a higher level of working up and attention through the ED process before they are either discharged or admitted. With regard to the Queensland efficient price which is basically our efficient price adjustment, it is $4,676. The 2014-15 national efficient price is set at $5,007 which was up around $14 on the year before.

We do not actually assess ourselves against this. It is independently assessed. As I understand it, virtually every hospital and health service is now performing their category of service below the national efficient price. I understand that we are now performing exceptionally efficiently. Maybe one day the honourable member might reach his aspiration to be able to show his genius with regard to these sorts of things, but I cannot find anything here that indicates what he is actually saying.

Dr DOUGLAS: I can take you to it, Minister. I want you look at the first paragraph on page 8. It reads—

The QEP is equivalent to the National Efficient Price (NEP), adjusted to reflect differences in the Queensland Activity Based Funding (ABF) model compared to the national ABF model. It is projected that cost per QWAU—

the Queensland Weight Activity Unit—

as a whole will be below the QEP.

Mr SPRINGBORG: I have information here which indicates that the national emergency department average for category 4 and 5 is around $400. The indication that I have for treating the same patient in a Queensland hospital is $410. That indicates to me that it is slightly better than the honourable member for Gaven would seek to assert here. If I can also point out with regard—

Dr DOUGLAS: We were talking about average costs. Rather than category 4 and 5, we were talking about average costs. What is your average cost?

Mr SPRINGBORG: The average cost that I understand here for us is around about $410 to treat a category 4 or 5 patient in a Queensland hospital. It is around $440 at a national level and it is also projected that the cost for a Queensland WAU for 2013-14 as a whole will be below the Queensland efficient price. So we are actually working pretty well in this area. If we actually look at the cost per Queensland waited activity unit, or QWAU, for ABF facilities, in Cairns and the hinterland the budget was $4,145 in 2013-14 and the actuals were $4,054. We estimate that it is going to be $4,243 this year. We can keep going through that and virtually all of our hospital and health services are performing exceptionally well against the benchmark, whether it be our own benchmark or the national benchmark.

Dr DOUGLAS: But you cannot tell me what the percentage is of this payment back from the Commonwealth to the state albeit that I know you have taken it on notice, but that is an important part of running this business, isn't it?

CHAIR: Member for Gaven, the minister has taken it on notice and you have asked that question already. Unless you have another question, we need to move on.

Mr SPRINGBORG: Are you talking about payroll tax, which we do not actually pay anymore as far as the—

Dr DOUGLAS: No, it is income tax.

Mr SPRINGBORG: How does that actually relate to anything?

Dr DOUGLAS: It is a measure of efficiency of a business. This is a business. We are actually talking about budgets here. It is a health discussion but it is about budgets as well. This is the biggest thing that the state provides.

CHAIR: Dr Douglas, are you talking about how much income tax is submitted to the ATO on behalf of employees?

Dr DOUGLAS: The ATO receives on my calculations $1.6 billion annually, with an uplift factor. In fact, I have calculated it. It is a three per cent pay increase. Of that of the average wage that will go up from $92,910, 35 per cent of it will go to the Commonwealth.

Mr SPRINGBORG: Pay as you go is something which is a normal sort of thing that goes to the Commonwealth. Through changes in accounting processes here in Queensland, we are no longer liable for payroll tax. It used to be a book entry in and out. That is not the situation now in that that liability is not on the books as it were. I am not sure that our health ministerial colleagues both here or around the rest of the country have actually caught up with this erudite presentation about this new calculation methodology, honourable member for Gaven, but if you can point out where others are streaking ahead on this process that you have outlined I would be more than happy to be informed on that because it really is news to me that that has been a part of the calculation. We calculate our Queensland efficient price against the national efficient price and that methodology is something that we generally have agreed to. It was a process laid down by the previous federal government and state and territory health ministers and until it is changed some time in the future it is something we are committed to and we endeavour to work within that and under it. Pay as you go tax, I am sure, would be calculated and utilised by every health department as a normal part of process, not for calculating the efficiency of activity.

Dr DOUGLAS: In health you are actually measured by other measures as well. I could go to those but for the brevity of time. Certainly, outcomes are weighted as well and costed for what—

CHAIR: Dr Douglas, we need to—

Mr SPRINGBORG: We do know, Mr Chairman, that there are different adjustments. No-one is arguing that. I think there is an adjustment as well for 10 per cent for isolation and six per cent for the Indigenous nature of—

Dr DOUGLAS: That is right. Yes, there are variables.

Mr SPRINGBORG:—presentations to our hospitals. So we understand all of those, but they are agreed calculations along the way. I am not aware that income tax has been a measure that we have to look at, but maybe Shane Solomon, who is the chairman of the Independent Hospital Pricing Authority, might be able to elucidate and might be able to educate me on that, but I have never seen it come up before.

CHAIR: Dr Douglas, I think you have some questions on QIMR.

Dr DOUGLAS: No, not at the moment.

Mrs MILLER: In relation to page 49 of the SDS and following up a previous answer by the minister in relation to the letters that were sent out to Queensland Health employees who were overpaid, Dr Lynham being one of them, how many employees ticked the box on the letter that they would pay any amount owing at the end of their employment? As you have pulled Dr Lynham's personnel and payroll records, can the minister confirm that Dr Lynham—like cleaners, wardsmen, other doctors and nurses et cetera—ticked that particular box, returned it to HRM and no further action was taken?

Mr SPRINGBORG: I cannot confirm that, but I am happy to get that information if the honourable member wants. I am happy to discuss a whole lot of information if the honourable member gets the consent of the Labor candidate for Stafford.

Mrs MILLER: As a follow-up to that in relation to page 49 of the SDS, if Dr Lynham, the member for Stafford, complains about the process—a formal complaint—of his—

CHAIR: Member for Bundamba—

Mrs MILLER: In relation to SDS—

Ms BATES: Point of order, Mr Chair.

CHAIR: Member for Bundamba, if you are talking about the SDS, I need you to talk more generally and talk about process and procedure.

Mrs MILLER: Yes, that is fine. Okay, I will talk about process and procedure. If any person—

Ms BATES: Point of order, Mr Chair.

Mrs MILLER: I have not even opened my mouth, Ros.

CHAIR: Just a second. There is a point of order. What is your point of order?

Ms BATES: Point of order, Mr Chair. 'If' is a hypothetical and this is probably about the fourth or fifth time the same question has been asked, so I ask you to rule on 115(b). 'If' remains a hypothetical and it is not appropriate for the minister to have to answer a hypothetical question.

CHAIR: I agree and that is why I asked you to reword your question.

Mrs MILLER: I refer to the policies and procedures within Queensland Health, and I refer this question to Mr Ian Maynard, the Director-General. Should any employee write a complaint letter about any person seeking information about their personnel or payroll files, do the policies and procedures of the department include investigating that matter and a potential referral to the Crime and Corruption Commission?

Mr Maynard: Each complaint would need to be taken on its merit. It is very difficult to come up with a general answer to that. We have processes whereby employees can complain about a number of things. If it pertains to their own personal information, that is generally provided to them. That would not constitute a matter that would be referred on to the CCC.

Mrs MILLER: Could you provide me—

Mr SPRINGBORG: Mr Chairman, if I may say something, because the honourable member asked me a question before and then did not let me answer. She also hypothesised by saying, 'If Dr Lynham, the member for Stafford'. If Dr Lynham is the member for Stafford, that is the last time the honourable member for Bundamba will grace us with her presence. So, Mr Chairman, the first question to me after lunch by government members elucidated the point that some 20,000 Queensland Health employees, regardless of their personal financial circumstances, a significant part of the cohort with overpayments, have already elected to start a repayment plan and they have either repaid it or largely repaid it and some of them are not of the same means as the Labor candidate for Stafford. All I was trying to say is that it is wrong to assert and say that there were not other options that were provided to the Labor candidate for Stafford or other employees. You could either wait till the end, or under Labor when they were in government you did not pay it at all. There was a moratorium. You walked out the door and did not pay it at all. So you could either do that or you could elect to go for a repayment plan either arranged or self-arranged, and the Labor candidate for Stafford was not one of those people.

Mrs MILLER: Mr Chair, I want to follow up in relation to page 49 of the SDS. Would the director-general please provide the committee with the policies and procedures of the department in relation to such a formal complaint by any person within Queensland Health? You can take that on notice.

Mr Maynard: I am happy to take that on notice.

CHAIR: Sorry, Mr Maynard, but the minister actually needs to take that on notice, not you. So it would be up to the minister to determine that.

Mr SPRINGBORG: I am sure it would be available if any employee wants to find out about it, but at this stage we only have an assertion from the opposition leader that a complaint has been made. If a complaint has been made by the Labor candidate for Stafford, that will be properly dealt with in accordance with process. I do not think the process is overly complicated. Any employee can make a complaint and that will be investigated in an appropriate way.

Mrs MILLER: Mr Chair, my request was for those particular policies and procedures to come to this committee so we can have a look at them, and it is in relation to page 49 of the SDS.

CHAIR: The request will be up to the minister to determine whether they take it on notice or not. I am struggling, member for Bundamba, to see how this relates to our examination of the budget.

Mrs MILLER: It relates to page 49, which is in relation to expenses and employee expenses.

Mr SPRINGBORG: There is a process if an aggrieved person is concerned that their rights are protected under the Information Privacy Act and if a person is aggrieved, but the greatest level of grief at this stage appears to be from the opposition leader and from the putative health minister, whose career will be short in this place and elsewhere if Dr Lynham is successful this Saturday. But if an aggrieved person wants to, they could complain to the information commission and they could investigate that under the Information Privacy Act.

Mrs MILLER: So you will not give us the information?

Mr SPRINGBORG: This is amazing. This has been a real conversion, because the shadow minister has never been about giving information around secret co-payment plans, secret deals with Mater over outsourcing and a whole range of other things. I am more than happy to provide information. I have just given a pathway forward there.

Mrs MILLER: Good.

Mr SPRINGBORG: And the policies are on the Queensland Health website.

Mrs MILLER: Mr Chair?

CHAIR: Just give me a second. So—

Mr SPRINGBORG: I am just saying that it is all publicly available—the processes. Today we have more transparency than ever before. More information is released than ever before. It is actually available to all of our staff. It is on the Queensland Health website and information about how to make a—

CHAIR: So the complaints process is publicly available on the website?

Mr SPRINGBORG: Absolutely.

CHAIR: I think that is your answer, member for Bundamba, that the process is publicly available.

Mrs MILLER: This is a specific complaint—could be a specific complaint about specific issues that are very rarely complained about. I think you will find—

Mr SPRINGBORG: Has the honourable member got the consent of the individual to actually even be making these things, because to date we have not seen—

Mrs MILLER: I am talking generally. I spoke generally.

Mr SPRINGBORG: So the honourable member is talking generally about a specific complaint?

Mrs MILLER: No, I am talking generally about people who work within Queensland Health. All I am asking for you to do is give this information—

CHAIR: Member for Bundamba, the minister has answered. The answer is that it is publicly available on the website. The question has been answered.

Mrs MILLER: He still will not give it to us?

CHAIR: We need to move on. Will you please ask your next question?

Mrs MILLER: All right; I will ask another question. I refer to the SDS at page 18. Minister, have you or your office or the director-general instructed Queensland Health Child and Adolescent Oral Health Services, previously referred to as the school dental program, to encourage parents to sign over $1,000 worth of Medicare funding for each child over a two-year period to fund the QHCAOHS when the clear intent of the program was to direct this work to private dentists?

Mr SPRINGBORG: I will just make a general comment on this and I would be happy for someone who might have a bit more information around this to answer the specifics of the honourable member's question. What we are very interested in doing with any of these programs where there might be a partnership or an opportunity is to ensure that we get the best possible pathway to treatment for adults and for children. I do not think that is an unusual thing, but specifically about it does someone else have any information? Does anyone from Metro South or anyone out there want to come up and have a say or Dr Cleary? I am very happy to have anyone to have a go, but other than that we will get the information and come back to you.

Mrs MILLER: Thank you. So you will take that on notice?

Mr SPRINGBORG: I am very, very happy to go fishing with you.

CHAIR: We are going to go to government questions.

Mr KRAUSE: Minister, with reference to the projected delivery of mental health services by the department as referred to on page 20 of the SDS, can the minister advise what measures have been put in place to enhance the safety of both the community as well as mental health patients?

Mr SPRINGBORG: That is with regard to absences? I think that would be in relation to the various absences that we have with regard to mental health facilities in Queensland. One of the things that I have been extremely concerned about over a period of time is the number of people who are involuntary patients who have been going absent without permission and I think we all should be concerned about that. Probably many members would have received complaints over a period of time from family members and friends of those who have gone absent without leave or without permission. Of course, that can lead to circumstances where people not only endanger themselves but, in rare circumstance, they might also be a danger to others.

In response to what was a significant number of absences without permission going back to September 2013 where we had 151 absences without permission, we put in place a process where there was a locking of those doors. That is something which I was reluctant to do, but there had been

a process of discussion around this over a period of time and it was getting worse. For me, I see this as a measure which will only be in place until such time as we get a better evidence based approach to dealing with things, because we want to make sure that people are properly treated and properly protected. So it is in response to the concerns raised by staff and raised by families as well.

As I understand it, in June 2014 there were 54 incidents of absence without permission—down from 151 in September 2013—and we have seen a genuine and a general trend down with regard to that over a period of time. But I have tasked our service providers within the HHSs to make sure that we come up with a better way of dealing with these absences over a period of time. These are for people, of course, who are on involuntary treatment orders.

With regard to inpatients, the incidents have declined from September 2013 from 22 down to July to date—as of 14 July—or five for the whole period to June. So with regard to involuntary treatment order patients, the reduction was 151 down to 54 in June, six months to date—the 14 days in July. So we are making progress but this has to be a medium-term solution, not a long-term solution.

Mr KRAUSE: Minister, with reference to the delivery of $1.57 million in the mental health grants program by the Queensland Mental Health Commission, referred to on page 229 of the SDS, can the minister outline to the committee details of the suicide prevention program?

Mr SPRINGBORG: We see suicide prevention as being extremely important. Obviously, we work within our Mental Health Commission. That is one of the initiatives of this government. We understand and we acknowledge that it also had the bipartisan support of the opposition, but we actually put it in place. We see the policy role of it as being absolutely crucial to the future as is also the work of the advisory committee on mental health and alcohol and drugs that it will be providing. It is a very exceptional guiding body under Dr Lesley van Schoubroeck. Lesley may be here. I will ask her to come forward and answer any of the components of this question that she may see fit as well. The commission has been crucial with regard to providing advice to me and the department around how we need to be restructuring the grants to non-government and other service organisations out there to make sure that we not only get value for money but also that we get better outcomes for what we allocate.

Dr van Schoubroeck: Thank you for the question. Most of that money is still money that was novated from Health when we were established. A large proportion of it—nearly $1 million—is still going to the hospital and health services. The other large amount of money is going to Griffith University where they provide some quite good data on exactly what has happened in the last two months. We are hoping over the next 12 months, though, to expand that—to use the information that Health and the Queensland ambulance have about attempted suicides, because if you can intervene in an attempted suicide you are more likely to be able to make a difference.

The other significant component of that is some work which has been happening with the education department for some time and it is going to joint training. That is currently being reviewed at the moment. So we have kept the larger programs that are going as we now move into a stage of what have we learned from that? Should we continue to invest in that space or are there better things to do? That is the priority for the coming year with respect to suicide.

CHAIR: Thank you.

Mr SHUTTLEWORTH: I note on page 231 of the 2014-15 SDS that the QIMR Berghofer will receive $18.9 million from the Queensland government, representing approximately 19 per cent of their total revenue. Could you please outline how many new research teams have been attracted to QIMR since 2012? What will these new teams be achieving for Queensland?

Mr SPRINGBORG: Thank you very much, honourable member. What I might do is to ask Professor Frank Gannon to come forward. He is doing a wonderful job there, obviously, as the director of QIMR Berghofer. I understand that we have attracted 10 new research teams since the expansion phase commenced in 2012. While Professor Gannon is getting ready, can I just indicate in relation to an earlier answer around absences without permission that it is a policy which has been overseen by the director of mental health, because that is where the power and authority actually exists to make sure that those appropriate lockdowns happen. It is not my ministerial power, but a concern that I have raised and they have acted upon the concerns which have been raised.

Prof. Gannon: Thank you for the question. I think it is a very pertinent one, because it shows the transition that is happening within QIMR that I think is very positive. We have attracted, as the minister has said, 10 new teams in the last year and a half. We are continuing to attract and discuss with others who are going to strengthen our activities.

The areas that we have attracted them into are of relevance to our three research areas that are mental health, just as was mentioned there, infectious diseases and cancer. I think that examples that might be important for the committee to be aware of from this is in the area of infectious diseases. We have recruited a new research group in the area of mosquito control, which is a major problem and one that will continue to grow within Queensland. This is important for all of the diseases that we are aware of that are near to us. Our major approach there is trying to exclude them by ridding us of those mosquitoes. In doing so we have very specific facilities that are unique in Queensland and, in fact, very rare elsewhere in the world that allow you to work with very dangerous mosquitoes under very controlled conditions. We work with colleagues in this who are part of the Queensland Tropical Health Alliance, which is run from the James Cook University. So we work with our colleagues as required. That is one example.

Another very spectacular example is in the area of immunology. Immunology may seem like a fairly oblique area to be discussing in this budgetary context, but it is of total importance for health care and also for economic benefits. The two groups that we have recruited in that area bring with them insights that are attracting worldwide attention, because the new armoury that is available in the treatment of cancer is immunotherapy in addition to surgery, radiotherapy, chemotherapy. Immunotherapy stimulating the immune system to do better is a major area and understanding how cancers and, indeed, infectious diseases obviate that control is at the cutting edge and we have the best people doing that. So I think that is a very important area.

Another person who we have recruited is in the area of metastases. Cancers are dreadful, but very often can be managed if detected at an early stage. The worst part is when they come back and we have a very prolific group working in the area of metastases and how that occurs. I could go through the 10, but it would get a little bit boring. It just gives you a flavour of what has happened there.

CHAIR: Thank you, professor. I think all of us would say that what is occurring at QIMR is truly fantastic. Would you please take that back to the team and let them know that we do not just oversight it; we actually see it and we truly do appreciate the effort that is being made there.

Prof. Gannon: On behalf of the team, I really appreciate that.

CHAIR: Thank you.

Mr SHUTTLEWORTH: On page 232 of the SDS it is stated that in 2013-14 QIMR Berghofer launched one of the world's biggest studies of vitamin D's role in health. Could you please explain what this involves?

Prof. Gannon: I think it is a very good example of our engagement with the needs of the community, which is one of the reasons we get support, and we appreciate it, from the department. Vitamin D is something that everybody worries about, but they are not quite sure what the right thing to worry about is. What is the right level of vitamin D to take? If we have it too high, does it mean that we have had too much sun and we are worried about our skin cancers? If it is too low, is it going to cause other problems? It is one of these things which is on the border of popular information that is not scientifically based.

So our researcher, Rachel Neale, has funds—and again, it is an example of leveraging the funds that are provided to bring in much more funds from the NHMRC, the National Health and Medical Research Council—to perform an analysis of 25,000 individuals who will be monitored for the consequences of them taking a controlled dose of vitamin D. That is the way to go about these things. At the end of this, we will know at the right level what is expected—heart disease goes up or down, cancers go up or down. All of these things which often fall into the area of marketing rather than science will be clarified.

It is an example that goes along with the line with other things. In ovarian cancer there is a study going on where 1,500 women who have had ovarian cancer and who have been treated are monitored for whether they exercise or not and what are the outcomes of that. It feeds immediately back into the population, which is essential for this. It also is another example of where we have studied what have the effects been of Gardasil, Ian Frazer's wonderful vaccine. What has that done, in fact, on the ground for the individuals and has that shown that the level of infection of the HPV has diminished? These are very practical studies that have an immediate feed into the community.

CHAIR: Thank you. We will move to non-government questions. Member for Bundamba.

Mrs MILLER: Thank you, chair. I refer to page 146 of the SDS, the answer to question on notice No. 490 and also the previous evidence given by Malcolm Stamp, the CEO of Metro North. Minister, is the outpatient waiting list equally as bad in Metropolitan South HHS? Is this the real reason the PA Hospital does not report its performance data in the same manner as other reporting hospitals?

Mr SPRINGBORG: I might ask Dr Richard Ashby to come forward with any detail that he has with regard to the first part of the honourable member's question. As I have indicated, we are this year planning to do far more first occasions of service for outpatients in Queensland. I think we are getting up towards four million or more outpatient visits each and every year. So it is quite significant. The performance data issue again, as I understand it, predates us. It actually goes back to a system which was implemented I think around about 10 years ago at the PA. What it does is that it collects, as I understand it, the data on a different system than what do most other hospitals throughout Queensland and it can be extracted and it can be reported. But again, the honourable member should know, because I suspect that, if it goes back around about 10 years, the honourable member was probably the assistant minister at that stage. So she should be right across this. Dr Ashby maybe can elucidate us on those facts.

Dr Ashby: It is true that the waiting lists in Metro South are in a similar situation to Metro North. In other words, there are a lot of people waiting for outpatient appointments. Specifically at the PA, for example, there are 30,482 people waiting.

Mrs MILLER: Can you give us the different categories, please?

Dr Ashby: I would have to take that on notice to give you the precise number.

Mr SPRINGBORG: I am happy to take that on notice, Mr Chairman.

CHAIR: Thank you, Minister.

Dr Ashby: The vast majority are in category 3. So, for example, ophthalmology has a wait list of about 3,900. Of those 3,900, 3,700 are in category 3. The minister has previously discussed addressing that waiting list. The issue of the information provided in that answer, it was simply, I believe, a human error. Our data is not suppressed in any way. It is on a different system called the Outpatient Scheduling Information Management System, or OSIM, that we put in 10 to 15 years ago at the Royal Brisbane and the PA and that data is freely available and has been previously reported in RTIs, for example to Channel 9 only a couple of weeks ago, and it is certainly available to anybody who wants that data.

Mrs MILLER: Is it on a website, Dr Ashby?

Dr Ashby: I haven't looked at the website in the last 24 hours but I believe it normally is and it has been reported previously.

Mrs MILLER: Can it go on a website if it is not?

Dr Ashby: Yes, it can, and I will ensure that that occurs.

Mrs MILLER: Thank you.

Mr SPRINGBORG: Can I just say on that also that there was no regular reporting of outpatient waiting list data until we came to government. It started in 2012. I applaud the shadow minister's conversion to openness. It took a while, but we have got there.

Mrs MILLER: Cheeky, cheeky. Dr Ashby, we obviously haven't had any information on the PA for the last two years, so I thank you very much for indicating that you will put it up on the website which was since this minister has been the Minister for Health. Can you give us a general indication in relation to the outpatient waiting lists? I know you said it is very similar to Metro North. Are there any particular specialties at all where there are difficulties?

Dr Ashby: Yes. Through you, Chair, as I said, ophthalmology is one of the largest. Orthopaedics does have a heavy waiting list. In part that is because of the subspecialised nature of the orthopaedics done at the PA. We receive referrals from all over the state for upper limb, lower limb, spinal surgery and so on. Gastroenterology is another one, and ear, nose and throat. But like Metro North, we are throwing a whole raft of clinical re-design strategies at it and just last week opened the central referral hub in Metro South to streamline referrals from GPs to ensure that patients go to the shortest waiting list. In some cases patients are actually referred to four or five waiting lists in Metro south. In the future such referrals will go to the shortest waiting list to ensure the patient gets seen as quickly as possible. That is one of many strategies that are in place.

CHAIR: Dr Douglas?

Dr DOUGLAS: Thank you, Chair. My question relates to breast screening in Metro south. I see that Dr Richard Ashby is here. I am not saying specifically that he may have to answer this, but it may be helpful if he does. The breast screening program has been dismantled throughout Queensland. Basically it is now the responsibility of the health and hospital boards. There is a loose reference to cancer on page 143 in the SDS and there is also the fact that the Metro South strategic plan reflects other parts of the state. Breast cancer is a very common illness affecting one in seven women. There is more emphasis in a lot of the other plans that have been presented in the budgetary documents, the breakdown of those documents. Can you tell me what is going on in Metro South with regards to breast cancer screening services for a very significant part of the population?

Mr SPRINGBORG: Before I throw to Dr Ashby, Mr Chairman, I just want to make the point that this government is investing very heavily in breast screening. It is a fantastic program and it is something which has been a part of our mass screening program for a large number of years. Indeed, Queensland's participation rate for 50 to 69 year-old-women is the third highest rate in the country. I think it is around 57, 58 per cent. The national participation rate is 54 per cent. In 2011-12 there were 228,733 breast screens performed. That rose to 232,991 in 2012-13 and 241,600 estimated to be performed when these figures actually come out at the end of this year. With regards to the Metro South Hospital and Health Service, as I understand it, the 2013-14 service agreement with the Metro South Hospital and Health Service outlined a contracted activity target of 56,200 breast screens and as of 30 June 2014 there were 46,340 breast screens, so they met their contracted activity. One of the things that we do is, whilst we raise awareness amongst women, we want to actually get more women to take up their opportunity for breast screening. And a real challenge is that whilst it is voluntary and we appreciate that, I had a look at situations in Scandinavia only recently where they have a more robust process of pre booking women, which I am not sure our women would actually react as well here as what they have become used to doing in a place like Finland, but, however, it actually puts the onus back to at least respond to that pre booked appointment. So I am interested in trialling that in some place.

Dr DOUGLAS: That is all great information. I really appreciate it. How do those numbers compare in Metro South to, say, Metro North in terms of the number of people screened, the number of the target population and the results? We have had problems in breast screening in Queensland before. There is historical significance to this question.

Mr SPRINGBORG: I think I said 56 before. I meant 46,200 in 2013-14 for Metro South and as of 30 June 46,340 have been done. We contract with our hospital and health services right across Queensland for a particular amount of activity. It is probably a bit unfair to ask Dr Ashby because it wouldn't be his service agreement, but I am very happy to get the Metro North. But basically it is based on population and we increase it each year. I think there may be a slightly larger population in Metro North. The budget is a little bit similar to yours, it is just slightly under, so I imagine it would probably reflect upon that.

Dr DOUGLAS: Minister, could I then ask you in view of that, could you take that question on notice with regards to giving us an idea of those statistics?

Mr SPRINGBORG: We might even have the information here.

Dr DOUGLAS: The percentage of the target population that has been screened, there is a magical number, which Dr Ashby and a number of medics would know, you have to screen to get a target result. That is where I am leading with this question.

Mr SPRINGBORG: I appreciate that. It is published on the performance website and that will probably be some time in the next couple of weeks. We may be able to get that information to you earlier. We undertake to do that. I just again say that whilst we have a target of trying to achieve up to 70 per cent across the country, and Queensland is actually at the upper level of performance, it really is a matter for women to avail themselves of this particular program. We have mobile services, we have fixed services around Queensland. We actually opened a service in DJs I think last year or the year before for the convenience of women and we need to look at different ways of actually increasing that rate and that is why I have said the experiences in Scandinavia are probably of assistance to us. But breast screening is provided in 200 locations state-wide. There is a network of 11 screening and assessment services, 22 satellite services and nine mobile services. I think around about 17 per cent of the women who are screened are actually screened in the mobile vans—over 40,000. But we are happy to get that information to the honourable member, but it will be published on the performance website probably in the next couple of weeks.

CHAIR: Member for Bundamba?

Mrs MILLER: Thank you, Chair. I just go back to my previous questions about the school dental program. I am aware that in the school dental program some of the staff have been asking the parents of the children whether or not they do have the Medicare funding and that they are pressuring the parents to sign over that funding to the school dental program and I ask, in relation to SDS page 18: has this duplicitous fundraising strategy cut out private dentists in low income communities like my own from accessing these federal funds?

Mr SPRINGBORG: I understand, Mr Chairman, that the parents must be involved and give their consent as part of a process, but I just say around the issue of transparency we are probably far more transparent than our predecessors, as the Auditor-General pointed out recently around doctors' contracts and other examples where the previous Labor government set up processes to diddle the Commonwealth. Alex Scott basically told us, from the Together Union, that the right of private practice arrangements were put in place to 'rip off the Commonwealth'—quote unquote—by the previous government. So I don't accept the assertions made by the honourable member in any way whatsoever. But I will ask Dr Michael Cleary, who is the Deputy Director-General, to edify us with whatever knowledge he may have on this issue.

CHAIR: Dr Cleary?

Dr Cleary: Thank you, Minister. Michael Cleary, Deputy Director-General of Health Services and Clinical Innovation within the Department of Health. Thank you very much for the question. The Child Dental Benefits Scheme is a new program that the Commonwealth has introduced and it was introduced this year in January. As a Commonwealth program, they have indicated that they would propose to review that program within 12 months to determine how well and I guess how effective it is in terms of delivering services to children. Under the terms of the scheme it is allowable for both private and public sector organisations to claim the rebates under that particular scheme. That is different to the old Chronic Disease Dental Scheme that was in place and that this to some degree supersedes. The other thing to say is if a public service does access the scheme then they have to bulk bill the patient as opposed to the private sector where there may be a co-payment. In terms of the forms that you alluded to, the forms are prescribed by the Commonwealth Department of Health and they are the forms that are used across the state by our oral health services when they obtain consent from their clients to provide the services, and those forms are ones, as I indicate, that are prescribed. There are some minor changes to the forms which are used in Queensland in some health services really to make them locally applicable, but those changes have been approved by the Commonwealth so they are not changes that we have done or undertaken unilaterally. In terms of the program, it is something that is run locally, so the hospital and health service boards are looking at how they can use that program to their best so that they can support their local communities. I guess in terms of the key things that relate to the question, firstly, public services can access the program, and that is outlined on the Commonwealth website that relates to the Commonwealth Dental Benefits Scheme, and, secondly, the forms that are referred to are forms as prescribed by the Commonwealth, and the Commonwealth is particular about the use of those forms in the care that is provided by the public health services to the patients.

Mrs MILLER: Just as a follow-up question to the minister or to Dr Cleary, whoever, are you aware that in some HHSs, particularly in South-East Queensland and other areas of Queensland, that when the parents sign over this $1,000 that those children are jumping the queue?

CHAIR: Minister, the question is to you.

Mr SPRINGBORG: Can I just say when it comes to queue jumping I think we should actually look at the Auditor-General's report going back a few months.

Mrs MILLER: No, this is serious.

Mr SPRINGBORG: I know it is serious, but it is interesting that the honourable member is now interested in queue jumping.

Mrs MILLER: This is kids.

Mr SPRINGBORG: I don't accept the contention you are putting forward. There were kids involved when your right of private practice was being rorted and the Auditor-General actually said that private patients being treated in a public hospital were actually queue jumping public patients in public hospitals to their disadvantage. I just think you need to be a little bit careful there.

Mrs MILLER: I am just asking a genuine question.

Mr SPRINGBORG: Yes, and you have become more genuine in opposition.

Mrs MILLER: So will you when you get back there.

Mr SPRINGBORG: Can I just say I am not aware of this, but Dr Cleary might be able to assist.

Dr Cleary: Thank you. I would make two comments. Firstly, the forms are really to provide financial informed consent to the patients and their families. That is so that they are aware that when they access the public dental services that a component of their $1,000 will be drawn upon for the services that are being provided. So it is really a way of making sure families are aware of the impact of accessing those services through or under the Child Dental Benefits Scheme. In terms of the waiting list management that is in place across the state, we have, over the last four years, been very active in putting in place a program or a process to manage the dental waiting lists across the state and patients who access the Child Dental Benefits Scheme are treated under that scheme or under that management framework. It is the same framework that we have used in terms of the outsourcing program using the dental voucher system and it was one of the requirements that would underpin an effective outsourcing program because the waiting list management arrangements have to be such that those people who have the most urgent need or have waited the longest period of time are seen in priority order. So the programs that are in place are really there to make sure that patients access services either on the basis of their clinical urgency such that emergency patients are seen before non-urgent patients, and within each category obviously those people who have waited the longest period should be treated earliest.

Mrs MILLER: So there will be no dental student places as a result of this?

CHAIR: Sorry, Dr Cleary, that is to the minister.

Mr SPRINGBORG: I am happy for Dr Cleary to answer.

Dr Cleary: Thank you very much. The question relates to dental student placements?

Mrs MILLER: Yes.

Dr Cleary: Queensland has a very long and significant history of working with the universities in Queensland to support oral health programs. We provide quite significant funding to the universities that provide those programs. Part of that funding is to allow the universities to train oral health students. Queensland graduates, I think—I would have to look at the specific numbers—but I think we graduate almost 40 per cent of the Australian dental workforce now and that has been really because of the partnership that we have had with the three major universities, and there has been a significant growth in dental graduates in Queensland as opposed to other states. In terms of those programs, the undergraduate component obviously is undertaken within the universities and the post or the later years program is undertaken either in facilities that the universities have on site, and I would make note of the significant facility that Griffith University has put into the Gold Coast and that James Cook has put in up in Cairns and Townsville and obviously the University of Queensland which Mr Stamp mentioned before, so there is significant capital infrastructure being developed, and then students obviously have placements throughout the state and that includes not just metropolitan areas but quite significant programs now where students are able to work in regional and rural Queensland. And I think there were some facilities opened recently in Stanthorpe and out in Warwick. And there is work being done up in Torres Strait. So there is quite a large student support program in place.

CHAIR: Thank you. Our time is up. The committee will now adjourn for afternoon tea. I just remind people that the video from this morning is up on the website if you want to access that. The hearing will resume at 3.30 pm when the committee will continue with the estimates for the Department of Health and the hospital and health services.

Proceedings suspended from 3.02 pm to 3.29 pm

CHAIR: Welcome back, Minister and officials. The committee will continue examining the estimates for the department of health and the health and hospital services. I call the member for Mudgeeraba.

Ms BATES: Thank you, Mr Chairman. Minister, in relation to employee expenses of the Queensland Ambulance Service, the QIRC recently handed down a determination in relation to the remuneration of paramedics. Are you aware of any paramedics losing up to $40,000 a year in meal allowances, as has been publicly suggested, and what increases have there been to the salaries of paramedics?

Mr SPRINGBORG: I thank the honourable member for the question. We actually value very much our paramedics in Queensland and that is why we are investing more in them. But the important thing, of course, is that we want to ensure that our system performs at a high level. There is an interesting statistic that the commissioner has around the performance of our service over a period. There has been some quite erroneous statements made in recent times that are absolutely inaccurate and I will ask the commissioner to specifically address that in a little while. What I will say is that our paramedics have been let down mostly by their union, which refused to negotiate and arbitrate in good faith and actually delayed the pay rise and the backdating going to our paramedics. If they are looking for someone to blame, it has just been the way that they have carried on their union in a very unprofessional way for what is a growing professional organisation and actually delayed our hardworking paramedics getting the pay rise that they should have got. Indeed, it probably cost them money as a consequence. Commissioner, you might want to answer the specifics of the question, thank you.

Commissioner Bowles: Thank you, Minister. I suppose what might also help here is a little bit of history and just some of the key issues associated with the issues, especially around the issues of meals that, as you say, has been getting some publicity in recent times. Meals were introduced or the penalty against the organisation was introduced in 1999 and it was a much smaller workforce. Basically, what was introduced was that for any shifts greater than 11 hours—we basically work 12 hours in QAS—there are two windows that we had to feed staff during the day. As a workforce grows, the actual ability of the organisation to feed people within a defined window becomes mathematical; harder and harder. What compounds that is that we do not control the way the patients come into the system. If the patient comes into the system when you are on a meal and that patient has a heart attack or something like that, we do not apologise for sending the closest car. That breaks the meal and puts paramedics on to meal time overtime, which is basically their hourly rate plus time again if it is after the end of the first window. One of the things that the arbitration commission said, the QIRC, in their deliberations—and we put this evidence forward also—is that it is a small window, we cannot control the input into the system, and it is appropriate in an emergency to send the closest car.

But there has been a lot of comment about how we have removed meals or how the Industrial Relations Commission has removed meals and that is just not correct. What they have done is they have widened the window so they have taken what is currently a two-and-a-half-hour window and opened it up to a four-hour window. There are now two four-hour windows that exist within the shift. There is a change to the way in which the mealtime penalty is paid. In addition, paramedics also used to get, for every broken meal during the day, an allowance of $13-something to replace the meal, on top of the meal time overtime. They have restricted that to one within each window. To say that they are gone is simply not right, or what has been proposed in the decision and that determination will get handed down soon, and the amounts as have been referred to.

I can give you some state data: if you take the amount of money we pay to a cohort of the workforce, for example, the advanced care paramedics. On average if you take all advanced care paramedics throughout the state, it is about an average of $4,000 for each one that we pay. For intensive care paramedics, it is about $4,500 as part of a salary of about $106,000 average across the state for that cohort of workers. I suppose, put simply, the maximum that someone could earn was six hours double time previously within a shift period and now it is down to about three, but our ability to manage it, because the windows are wider, has been significantly improved.

CHAIR: Ms Bates?

Ms BATES: Minister, page 18 of the SDS refers to the percentage of patients transferred off stretcher within 30 minutes. Can you provide the committee with an update on improvements that have been made in this area of front-line service delivery?

Mr SPRINGBORG: Thank you very much. As I indicated earlier, there have been significant improvements right across the system. The QAS in many areas has been an absolute standout. They are quiet achievers. They are highly professional and they are a very vital part of how we go about addressing the challenges in our emergency departments and dealing with hospital avoidance as well. I might ask the commissioner to address the question specifically.

Commissioner Bowles: Thank you, Minister. As I stated previously, there were 15 recommendations that came out of the MEDAI, which is the Metropolitan Emergency Department Access Initiative. Two of them were directly related to the Ambulance Service and another four we assisted the department of health with. One of the more important, to us as an ambulance service, is the ability for the Ambulance Service now to load share. We actually load share amongst a network.

One of the key drivers of being able to load share is that no hospitals, after 1 January 2013, were able to go on bypass. What we do, through a 24-hour room, is we actively distribute patients amongst the network based on two criteria. The two criteria are quantitative, so how many each facility has at any one time, and clinical. So if a patient should go to a certain type of hospital because that is where the speciality is, that is what we do. The other recommendation directly related to us was the review of the hospital liaison officer role. It used to be stuck, I suppose, in a location. We have been able to make sure that that role could go to whichever hospital the issue was at.

I will touch on some of the outcomes since the introduction of the MEDAI recommendations. Patients off stretcher within 30 minutes: if you look at that first quarter of 2012 and compare it to the first quarter of 2014, we have had a 6.9 per cent improvement. At the 90th percentile for the same time dates, there is a 13-minute improvement. When you are talking about a metropolitan area, while 13 minutes does not sound like a lot by itself, when you talk about hundreds of thousands of cases it is a lot of capacity that comes back into the system and that is recognised here. We have had a reduction, if you compare the two quarters, of 298,000 minutes, which basically equates in that quarter to putting 415 shifts back on the road. Hence we have been able to achieve the performance that we have. If you have that capacity and you then do some of the clinical initiatives that we are rolling out, whether it be the prehospital thrombolysis or the high acuity car or things like that, it bodes well for patients and patient care. That is pretty much off stretcher in a nutshell.

CHAIR: Thank you. Member for Beaudesert?

Mr KRAUSE: Minister, as part of revitalising front-line services referred to on page 99 of the SDS, can you please advise if this has resulted in any improvement to renal dialysis in the Darling Downs HHS?

Mr SPRINGBORG: I might ask Dr Peter Bristow to come forward and answer that question. I commend him, the board and the HHS for the wonderful work they have been doing with regards to investment in services right across the Darling Downs and also, of course, their reduction to zero on the long-wait dental waiting lists and also the wonderful work they have been doing with regards to surgical long waits. Dr Bristow, you might care to answer that. I know, from my electorate's point of view, they are very appreciative of your investment in renal dialysis.

Dr Bristow: Dr Peter Bristow, Chief Executive, Darling Downs Hospital and Health Service. Thank you. The renal dialysis unit in Kingaroy has been expanded from 12 patients a week being treated—three times a week they are treated—to 18 a week at this point in time. That was made possible by additional funding from the department, Aboriginal and Torres Strait Islander branch. A large percentage of the in-patients who are treated at the Kingaroy dialysis unit are actually Indigenous, coming from the Cherbourg community. In addition to the service that we have been able to increase in Kingaroy, we have also, to help with transport and decrease the burden on the ambulance service at QAS, moved to have a shuttle bus, a mini bus, transport some patients between Cherbourg and Kingaroy to access their dialysis. It is about a 30-minute journey. Previously, those patients would have had to transfer. They would have had to go by ambulance for two to two and a half hours a day, backwards and forwards, from Cherbourg to Toowoomba to access dialysis. This is a significant localisation of the service, which the board is very supportive of. It wants to localise more services in the South Burnett where possible, but it also decreases the burden on the ambulance service of these transfers.

The dialysis service in Kingaroy was established previously, but progressively in 2011 we expanded the service and then we have been able to expand it further. As increasing amounts of diabetes in our community and chronic disease in our community continue, I would anticipate there would be further need for further renal dialysis services in the South Burnett. We are trying to work by improving the capability of the service locally. We have a renal nurse practitioner and we are trying to deal with the community to actually increase the ability of self-sufficiency and the ability to provide dialysis perhaps more easily in Cherbourg.

CHAIR: Thank you. Member for Mudgeeraba?

Ms BATES: Minister, page 111 of the SDS refers to the percentage of specialist outpatients treated within recommended times in the Gold Coast HHS. Can you update the committee on outpatient wait times and long waits on the Gold Coast?

Mr SPRINGBORG: I thank the honourable member for the question. The Gold Coast Hospital and Health Service has done some really transformational and very innovative things over the past couple of years in addressing some of the dilemmas that they inherited, whether in endoscopy,

emergency departments and some of the clinical governance issues. Certainly they have reacted very strongly and firmly in recent times to what has been an increasingly disproportionate growth in patient presentations to their hospital or their health service. I have indicated some of those a little earlier on. I would be more than happy for Ron Calvert to come up and take some recognition for the work done by the Gold Coast Hospital and Health Service, because they deserve it. Basically, the HHS is on track to achieve the target of reducing the wait time to less than 12 months for all our patients. There has been a 73 per cent reduction in patients waiting longer than 12 months to be seen in outpatients. This has been achieved from 9,200 to 2,471 patients. That is a really good result. Ron, you might want to tell us how you have gone about achieving some of those things and what you have around the corner.

Mr Calvert: The outpatient waiting list and our long waits reductions have been considerable. We started the year with 22,620 patients on our list. We have had a 20 per cent rise in referrals to the hospital. So you might ordinarily expect that the long waits would go up by 20 per cent as well.

As at the end of the financial year, we had 18,185 patients waiting on the list, which is a significant reduction. As a subset of those waiting lists, of course, we had people waiting over 12 months and in some cases stretching back years. We have made a big effort to reduce all of those. We have gone from 9,200 patients waiting more than 12 months down to 2,471. In all bar, I think, five specialties we have that down to less than 12 months. We are on track to get all of those specialties reduced to below 12 months by the end of this calendar year.

In order to deal with that we have invested $8 million. The bulk of that money was made available because we had an underspend last year. That was the community dividend reinvestment that the minister asked us to deliver collectively.

There will still be some long wait patients coming on to the list because there are a number of patients who are not ready for care and when they are ready for care again if they have already exceeded 12 months then technically they will be recorded as breaches of the 12 month wait. To all practical purposes, we are on track to get it down to 12 months by the end of the calendar year.

CHAIR: We will move to non-government questions now. I call the member for the Bundamba.

Mrs MILLER: I refer to the SDS at page 18. I ask the minister: are HHSs across Queensland, but particularly Metro South, restructuring public dental services to increase own source income from Medicare? Does this restructuring include fewer service locations and staff cuts?

Mr SPRINGBORG: I thank the honourable member for the question. I think it is quite amazing that when we came to government in Queensland and we looked at the list—as much sense as we could make out of what we were left—we had about 62,000 people waiting longer than two years for routine dental check-ups. The recommended time was two years. Some people were waiting up to 10 years.

A crucial part of what we have done is redesign our service with a stronger focus towards a partnership with the private sector. We should do that because it helps us actually treat more people in a timely way. It also provides us with a benchmark to better increase the productivity and performance of our public oral health services, and we are doing that. Some of our dental chairs were frankly not seeing enough people go through them, vis-a-vis the private sector. That has been extremely important. I think that we have recalibrated and based ourselves in such a way that we have the confidence that we can see patients in time in the future. Some 62,000-odd down to zero in 16 months is quite amazing.

We have invested in more facilities around Queensland. In the Wide Bay area, for example, there are new oral health facilities in Hervey Bay and Bundaberg. We have also employed more dentists. We have put in place a robust service agreement arrangement with the universities around the training of dental students so that we get more activity through them.

I have absolutely no problem whatsoever with hospital and health services looking at the consolidation and improvement of efficiency in their systems. If the honourable member is on a fishing expedition with regard to what may be happening with Metro South, I point out that I understand that Metro South is looking at consolidating their dental services into a new, modern facility with the same staff to deliver enhanced services for people. We need better investment in new, modern facilities which are more effective and more efficient.

We have actually set a new benchmark in the delivery of oral health services across Queensland, whether it be our own employees who have done a great job with further investment and further productivity focus or our partnership with the private sector. We are not going back on that. Unless Dr Ashby wants to clarify anything I have said, that is the only circumstance I am aware of. If other hospital and health services want to go about enhanced efficiency arrangements, collaboration or consolidation, I have no issue with that because it is all about the patient.

Mrs MILLER: Minister, in relation to the SDS at page 18 will you release all documents detailing any planned restructuring of public dental services by individual HHSs?

Mr SPRINGBORG: If hospital and health services are actually looking at restructuring hospital and health services in their area then they can because they are independent and focussed on services. Obviously they will be developing those plans locally. They may make me aware of what they are planning to do, but I do not get in their way every single day of the week. They are focused on patients. We have an expectation around that. Obviously, I always ask them to be cognisant of the needs of the community—the patient comes first. They need to ensure greater efficiencies.

I have already given you an indication of the one that I am aware of where there is some consolidation of services. I am not aware of any others off the top of my head. If they do come to my attention I do not have any issue with that. We do not hide those things like used to happen in Queensland previously—maybe before 25 March 2012.

Mrs MILLER: So, Minister, you do expect job losses.

Mr SPRINGBORG: I never said that at all. The job losses happened vicariously as a consequence of the previous government's absolute negligence around the payroll issue and affected some 15,704 Queensland Health staff—helped by Swanny along the way. As I have indicated today, we are expecting further investment in additional Queensland Health jobs this year at the front line—almost 2,100 of them. That does not necessarily indicate what the honourable member is saying.

I have always said that we have to make sure that we are efficient. Under your government or our government we will continue to do those sorts of things. We measure outcomes not inputs. If hospital and health services want to continue to go through processes of restructuring as they have done, do and will continue to do, that is a matter for them.

Queensland children's health services are going through that at the moment. They are trying to fix up the loose ends. There are lots of loose ends after the consolidation of the Royal Children's and the Mater Children's into the Lady Cilento Children's Hospital. They are actually having to deal with the reality of redundancies that come from that. They are normal parts of restructuring and no-one should be surprised.

Mrs MILLER: I am glad that the minister is talking about job cuts. I refer the minister to page 12 of the SDS which indicates an overall increase in staffing for 2014-15. I table a list of the job cuts. How many of these positions are people rehired from the 4,379 positions identified in RTI requests made by the Queensland Nurses Union as job losses since 2012?

Mr SPRINGBORG: Mr Chairman, I think a moment ago I said 15,000 job losses relating to the payroll issue. It is 1,574 or thereabouts. I think the figure was the late 1,500s. As I indicated, our hospital and health services have been reemploying people at the front line. That is what we should be doing in the state. We do not employ people for the sake of it. The previous government went through redundancy programs. They actually earmarked 3,900 people for redundancy under a 'you have been identified as surplus to requirement' process. Some 900 or thereabouts of those people went.

There will always be changes in jobs within Queensland Health. That is not going to be any different at any time. As we refocus our support services at a head office level there are going to be changes over a period of time. Contestability in itself will lead to more efficiency and may potentially lead to outsourcing. The big difference is that we will tell people about it. We are not going to hide that from people.

Mrs MILLER: I refer the minister to the SDS at page 42. Minister, you have said, 'The transfer of staffing power from Queensland Health to local health and hospital boards could lead to job losses in the department.' How many jobs do you expect to be lost from the department of health in 2014-15?

Mr SPRINGBORG: The big difference is that when I am asked about the potential of things I do not step away from it. The previous government would always deny something and we would find out afterwards that it was 100 per cent the opposite. That was the legacy of the former government.

They covered up and denied everything. The unions, when they came to see me just after the election, said that they were concerned about Labor's secret process of outsourcing. I said, 'We are not secretive. We will tell you if we are going to do it.'

I will give you an indication. Under Labor I think there were 4,570 separations between July 2011 and 25 March 2012. There were redundancy programs within head office that led to a whole range of people moving away. There may be people who have come back into the system, but we have standard processes with regard to times that they are separated from the department.

Can I indicate that we make no apologies whatsoever for actually reducing the size of our corporate effort around a more efficient framework to reinvest that into front-line services. I was simply asked a question around as we move to transfer more power and responsibility to independent HHSs is it likely that will bring about changes. Yes it will. You would not need to be a rocket scientist to work that out. It will actually mean that some of those resources will be transferred to HHSs. That is logical as they pick up more and more responsibility. But also as we become more efficient internally we should look at the whole reason that we exist as a central agency. That is to support patients and hospital and health services.

As we go through that remodelling over time there will be positions that move to hospital and health services. As people retire or resign from within the system we will clearly look at whether we need to backfill those positions. As we know from the efficiency within Queensland Health's corporate office, the work we did in 2012-13 liberated $96 million which we invested in places such as Metro South, Metro North and Cairns and into things like the mobile surgical facilities and a whole range of other things. That comes from being more efficient. No-one should be surprised by that. The big difference is that we tell people about that. Those sorts of things will happen as a natural part of evolution within a dynamic organisation.

Mrs MILLER: I would now like to ask the director-general the question because the minister did not answer the question. Director-General, I refer to the SDS at page 42. How many jobs do you expect to be lost from the department of health in 2014-15?

Mr Maynard: Thank you for that question. As the budget document outlines, there will actually be growth in numbers of employees within the department. We are focussing very strongly in the department on a significant cultural change. As the minister has indicated, services and activities and responsibilities have transitioned across to the hospital and health services. 1 July this year saw a number of HHSs pick up prescribed—

Mrs MILLER: Can I butt in here. I am talking about the department of health and not HHSs.

Mr Maynard: I am talking about the department of health. As responsibility and accountability shifts to the hospital and health services the need for those activities to be undertaken within the department shifts as well. For example, as the responsibility of the prescribed employer moves across to a hospital and health service the department's focus moves on to supporting and facilitating the HHS. It is possible with those transitions that employees will be offered opportunities within the hospital and health services.

Mrs MILLER: Can I just ask a question in relation to the SDS at page 24. The minister spoke just before about people retiring or resigning. Does that mean that if you have a position with a position number that is vacant that that position will be frozen and not automatically backfilled?

Mr Maynard: There is a range of options that are available to managers when a position is vacated. The position could be used as a training opportunity under higher duties for an up and coming leader. The position might be abolished if it is no longer required. It could be filled on a temporary basis. It could be filled on a permanent basis depending on the position.

Mrs MILLER: Director-General, could you tell me how many positions in the last financial year and how many you expect in this next financial year to be filled by higher duties?

Mr Maynard: On a case-by-case basis, that is a decision that each manager will take.

Mrs MILLER: I am aware of that. I know how the process works. I am a former public servant. Do you know how many?

Mr Maynard: It is impossible to say at the start of the year what positions will be vacated. Positions are vacated, for example, as people take maternity or parental leave. They are—

Mrs MILLER: What about the last financial year?

Mr Maynard: The last financial year?

Mrs MILLER: You should have that information.

Mr Maynard: I do not have that information.

Mrs MILLER: Can you provide it? You can take it on notice.

Mr SPRINGBORG: He cannot, but I can. If it means so much, I am happy to take that question on notice.

Mrs MILLER: That is good. Again referring to the SDS at page 42, you cannot tell me how many jobs you expect to be lost—you cannot tell me how many you expect to be lost—but you expect some to be gained?

CHAIR: Member for Bundamba, the minister and the director-general have both answered the question. Unless you have another question, let us move on.

Mr SPRINGBORG: Unless we find a magic pudding somewhere—and you have probably got one in your handbag or somewhere else—we will continue to restructure. We have to deal with the realities of efficiencies in the Queensland Health service, and we will.

Mrs MILLER: All right; thank you.

Mr SPRINGBORG: The expectation is that we will become more efficient and service oriented, and that does not mean that we actually maintain the effort that we have always done in the same way. The honourable member can refer to the SDS on page 12 because it basically indicates that we expect in head office to have around about an additional 100 employees during the course of the year. There will always be changes with regard to the way in which we deliver services. Everyone understands that. It is logical.

Mrs MILLER: Director-General, in relation to the SDS at page 12 and page 42—and you can take this on notice—how many people within the entire health system, including head office and the HHSs, have requested assistance from the Employee Assistance Service?

Mr Maynard: I will—

Mr SPRINGBORG: We will take that on notice and someone else can find that information during the course of their afternoon and if we have it before we finish here I am happy to read it into the record. Is there a particular reason of concern that the honourable member feels is being unaddressed by the assistance service?

Mrs MILLER: In relation to the SDS at page 42, Minister or Director-General, were the clinical nurses responsible for the follow-up of women with abnormal pap smear results among the 300 positions that were cut from the Office of the Chief Health Officer?

Mr SPRINGBORG: Mr Chairman, I think as we indicated earlier to the honourable member and as the Chief Health Officer has indicated publicly, the reason that that was not sent out was because an error in the coding that sent those particular letters out to people. When that was identified, we went about finding and tracking down those people and providing particular information which was necessary. It was not in relation to anything to do with jobs. It was an IT issue. It was actually nothing to do with jobs. Indeed, we are operating far more efficiently internally.

Mrs MILLER: Mr Chair, the minister has not answered the question I asked. Director-General, were the clinical nurses responsible for the follow-up of women with abnormal pap smear results—and not only the nurses; I am talking about the directors and executive managers of that area—among the 300 positions cut from the Office of the Chief Health Officer?

Mr Maynard: As the minister has outlined, the recent issues that we have discussed at this hearing relate to an IT system issue, not an issue of resourcing.

Mrs MILLER: No, I am aware of that. I am asking whether or not there were positions cut—whether they be nurses, executive managers or director positions—that were cut from that particular area, the registry area. Were any of those positions cut in the last two years? I know it is an IT problem. I want to know whether there were any officers cut within that registry area.

CHAIR: Member for Bundamba, I am going to seek some clarification on the question because I am a little confused. Which office are you talking about, from whose office?

Mrs MILLER: I am looking at the Chief Health Officer's office and within Queensland Health there is also a registry office. I want to know if any people were retrenched, sacked or whatever, and there were 300 positions cut from the Office of the Chief Health Officer. I want to know whether any of those particular positions were cut from the registry area.

Mr SPRINGBORG: Mr Chairman, if people hypothetically were, it had absolutely no bearing on this issue. It was a coding issue, as I understand it, and nurses are not responsible for that.

Mrs MILLER: No, I am aware of that.

Mr SPRINGBORG: We can look at the 3,976 people who received a letter which you were not worried about in government that said they had been identified as surplus to requirements, a range of those in population screening areas. So, Mr Chairman, I am not going off on that fishing expedition, particularly when there is nothing with regard to staffing that impacts upon this issue—

Mrs MILLER: So you are being secretive. You are being secretive. All I want to know on behalf of the women of Queensland is whether any staff were cut from that particular area.

Mr SPRINGBORG: The greatest conversion to transparency we have ever noticed has come from the honourable member for Bundamba. We provide a greater degree of transparency than ever before. I am very interested in—

Mrs MILLER: Except now.

CHAIR: Member, the minister is answering. Please let him answer.

Mr SPRINGBORG: Mr Chairman, it is a coding issue. It is not related to positions within the Office of the Chief Health Officer or Clinical Innovation, the clinical service division.

Mrs MILLER: Mr Maynard, I ask you again. This is the third time I have asked the question. Will you be able to tell me as director-general in charge of the department whether there were any people retrenched—put out to pasture—in this particular area that deals with abnormal pap smear results?

Mr Maynard: I do not have that—

Mrs MILLER: Or the registry.

Mr Maynard: I do not have that detail.

Mrs MILLER: Are you able to find that detailed information? I am asking the minister: will you take it on notice?

Mr SPRINGBORG: Mr Chairman, no, I do not intend to because it does not relate in any way to the services provided to those women around an IT coding issue. But to assist the member in the area of transparency, I want to respond to a question she asked earlier today for information about the circumstances at the Redlands, Prince Charles, Caboolture and PA Hospital between June 2013 and July 2014 as to how many level 3 escalations have occurred with the QAS. At Caboolture Hospital there were 14 level 3 escalations, Prince Charles 17, PA six, and Redlands Hospital 28 for a total of 65. I think there was a secondary question as well for the longest period of time an ambulance has ramped at the Prince Charles Hospital. There was a vehicle which was delayed at the Prince Charles Hospital on 23 June for 206 minutes for a patient with a low-acuity complaint and the hospital average of an off-stretcher time of 33 minutes for the day, which was very good. There was another question around how many ambulances have been redirected to another hospital under load-sharing arrangements. The MEDAI report introduced 15 interdepartment recommendations, and one of the key recommendations for QAS was to introduce load-share arrangements to ensure patients are distributed appropriately across the network. So that was something we did as a result of that. With regard to the other question asked by the honourable member around the trauma truck, which is a term that nobody around here knew we used, at 1200 hours today—that is, midday—there are currently in excess of 100 acute ambulance crews staffed by advanced care paramedics working in the greater Brisbane region who are supported by critical care paramedics in a single responder pod. Each paramedic unit is ably trained and capable of responding to incidents, so they are the only reference we think we have for trauma trucks.

Mrs MILLER: I relate this question to the SDS at page 12.

CHAIR: Member, this will be the last one.

Mrs MILLER: Okay; that is fine. Will the minister provide details of all department of health and HHS functions that are being considered in contestability processes that may lead to outsourcing or privatisation?

Mr SPRINGBORG: We have had some interesting examples of privatisation or outsourcing under our predecessors, most notably the arrangement between Mater Health Services and the government of the day, and of course other arrangements which they were considering at the Sunshine Coast University Hospital. Indeed, Peter Beattie sent around a flyer saying the great news

was that we are going to privatise and outsource a whole range of services, and I know the honourable member hangs off the Blueprint for Better Health Care in Queensland. In February last year I indicated at that stage there would be a whole range of things that we would look at in the area of contestability as well as including central pharmacy; telephony; paging; messaging; Health work space, including managed desktops; smart devices and a range of things; group linen services—this is not new information; medical equipment services; medical imaging; pathology services; and PTSS. So it is all a part of contestability. Contestability does not mean outsourcing. Contestability means that if we want to keep it in-house we need to at least be as efficient as another provider. I think everyone understands that, because the previous government's own budget action management plan said they needed to be more efficient—that was in 2011—and their pathology utilisation management plan said that there was 30 per cent overordering or overservicing in the area of pathology. So that was the previous government. We are addressing all of those sorts of issues. Indeed, Peter Beattie sent this little corker around when he was the Premier saying there would be new partnerships with the private health system, including new radiation therapy services at the Sunshine Coast. So we are doing a range of things, but you should not actually consider that that is going to automatically lead to outsourcing but it is certainly going to lead to more efficiency. It has been reinforced today that it is a matter of public record and we will keep pursuing that agenda.

CHAIR: We will move to government questions.

Mr HATHAWAY: Minister, page 120 of the SDS informs us that the Mackay HHS commenced home based renal dialysis services to the local community earlier this year in January. Will this new and expanded service continue over the 2014-15 budget period?

Mr SPRINGBORG: As I understand it, yes, and I think we need to acknowledge the great work of HHSs. I am very happy for them to sing their own achievements, so I ask the acting chief executive from the Mackay HHS to come forward because she would be very happy to answer that question.

Ms Hornsby: Thank you for your question. We have been delighted this year in Mackay Hospital and Health Service to open our brand-new service for renal home therapies treatments. Previously patients have needed to travel to Townsville to receive services in relation to home dialysising. Home dialysising is an option that we give patients with significant renal failure in order to give them choice in where they want to have their renal dialysis done. Home dialysising is considered best practice by our medical experts in terms of giving choice to patients who are appropriate for care in their own homes and gives patients access to better dialysising options at a time which is convenient for them and fits in with their lifestyle and family commitments. We opened our services in Mackay Community Health this year and are delighted to announce that we now have 21 patients who have now trained for home dialysis in Mackay and we have 35 patients dialysising in our renal units. We were able to reallocate savings and reinvest those at a local level with board approval at a local level to reinvest those efficiencies back into our local community for better services for our patients. We reinvested $1.3 million into this service and we opened that in January this year.

CHAIR: Thank you. Minister, I refer to page 132 of the SDS regarding the Metro North HHS's introduction of a Central Patient Intake model in the 2013-14 budget period. Minister, what results were achieved under this model and shall it be continued over the forthcoming budget period?

Mr SPRINGBORG: I understand that we are already seeing some great results coming from that. I am very happy for Malcolm Stamp to come forward and to answer the question in detail.

Mr Stamp: Thank you for the question. I touched on the Central Patient Intake model before in answer to an earlier question. It gives our patients access to a full suite of speciality services across the whole of the Metro North, so it is not just site specific.

It does that in the most timely and equitable way whilst providing our referrers with a single point for all external referrers to specialist outpatient services. Our focus has been on these external referrals. As you know, being a specialist tertiary centre, we have a lot of internal outpatient referrals as well. The central intake model does not extend to those referrals to date.

It is estimated that around about 156,000 external referrals are received each year. We are at, as I reported earlier, around about the 70,000 mark already in terms of picking those up on our current performance. We have a GP hotline provided for GPs and other referrers to inquire about the referrals and where they are up to. Referrals may be made by a facsimile to a single number or mailed to a single address, simplifying the process for GPs. I believe that you can see the evidence of that with our primary care partners. We are committed to continue the funding of this project, at least for the next two years.

CHAIR: Thank you, Mr Stamp.

Mr KRAUSE: Minister, page 143 of the SDS refers to Metro South HHS's oral health services. Minister, what has been achieved in this area to date and what is the 2014-15 budget expected to deliver in terms of dental services?

Mr SPRINGBORG: Thank you very much, honourable member for Beaudesert, for the question. There have been extraordinary achievements in the Metro South Hospital and Health Service with regard to oral health over the last 16 months or so. Indeed, this is something which is reflected right around the state. We have seen increased efficiencies with the Metro South oral and health service and, engaged with the private sector, has seen the Metro South HHS waiting list for public oral health care cut dramatically. As I indicated with regard to the long waits, we now have zero long waits in that area.

Also, in 15 months the health service has cut the general care waiting list by an outstanding 40 per cent—from 19,296 to 11,468. What that means is, basically, even though we have reduced, we have brought everyone back into the standard waiting times. Even within the cohort of people who are waiting, we are seeing greater improvements. So people are waiting less and less time for their particular services as well. So even within the general accepted wait time, we are getting through those very, very quickly. So 11,213 patients waiting two years or more in February 2013 have all received the treatment they needed with the long waitlist now reduced by 100 per cent. So that is an extraordinary credit and something which has also been reflected in other areas. An additional $8.2 million in funding from the state and federal governments for the 2013-14 financial year as part of the national partnership agreement for adult public dental services has resulted in more patients being seen in a timely fashion.

Also, in the last 15 months, 102,054 vouchers were distributed across Queensland, with 22,935 of those vouchers claimed in Metro South for treatment. The other thing, too, which is important to consider as a part of the processes which have been redesigned for oral health in Queensland is that, whilst the Commonwealth has made a contribution—and we welcome that contribution—it is one-seventh of the overall contribution that we make to investment in public oral health care in Queensland. So of over $200 million, I think around about $30 million of that came from the Commonwealth.

It is not just about the money; it is how we have redesigned the system. This has not been rocket science. The partnership with the private sector is something which our predecessors had a real aversion to. We have broken that down. It has actually been about working in partnership. So we will continue those partnerships this year across the state where it is necessary and will also be continuing in investing in efficiency and innovation externally. Obviously, with regard to the Commonwealth's child dental scheme, we will be making sure that, as a good and honest partner, we continue to be involved in that process as it is rolled out as well.

We have the highest level of eligibility of all populations across the country. I think around about 40 per cent of our population is eligible for free public oral health services, including those on particular concession type cards and, of course, children as well. So your area and other areas will be advantaged by this investment in good oral health care over the coming year and beyond that. But very, very importantly, if you can improve this, it means that we get better outcomes in general health as well.

We can skill people in doing this. That is also a part of what is happening across the state—teaching people basically how to look after their teeth. For many of us, that is something that we just do. But for a lot of people, they do not do it. So whilst we can invest in making sure they have better oral health through our interventions, it really does come back to teaching them good preventative techniques as well.

Mr SHUTTLEWORTH: Minister, page 9 of the SDS notes that the government has committed $30.9 million over four years to establish a rural telehealth service, including the establishment of dedicated telehealth coordinator positions across all the HHSs to support the implementation of telehealth-enabled service delivery models. How will this impact on services provided to the North West Hospital and Health Service?

Mr SPRINGBORG: Thank you very much, honourable member, for the question. I know that your committee has a very strong interest in telehealth and I acknowledge that and thank you very much. It is not a new initiative. It is something that was significantly invested in by our predecessors—at least in the capital acquisitions required—but there had not been a sufficient investment in changing culture to utilise telehealth or the coordination or the reliability around that.

Indeed, I think over the last eight months or so we have seen around a 40 per cent increased uptake in the utilisation of telehealth. We are investing in it. We are making sure that we have that reliability out there and it becomes part of the culture of the delivery of the health care. It is also something that has been done under the Statewide Rural and Remote Clinical Network in the state to ensure that we can expand services, whether that be in paediatrics, mental health and a whole range of other areas. But it not only reduces costs; it reduces the tyranny of distance and just the sheer stress on families having to travel so far.

I might ask Sue Belsham from the North West to come forward and give us a bit of a quick overview of some of their achievements and about how they see it as well. But it is operating exceptionally well and we want to continue to promote its uptake.

Ms Belsham: Thank you, Minister. Yes, certainly telehealth has been a fantastic initiative for us here in the north-west. We have a lot of people, particularly in our Indigenous groups, who have a lot issues with children particularly being sent for long periods of time to the children's hospital and families are very dislocated. Telehealth has been a fantastic initiative to keep them close together. Particularly in Normanton as well, with our renal patients there, telehealth has been the link for them and for their carers.

We have been doing a lot of telehealth but lately we have found that people are more relaxed about it, particularly when they think about the journey and the travel that they have to do to get down to places like Brisbane to go to see a specialist. It is wonderful to be able to see them face to face in their own home area. So it is a great initiative and, indeed, and we welcome it.

Mr HATHAWAY: Minister, the committee is aware of the model of service delivery in areas such as south-west Queensland that have traditionally had a high reliance on locums. In relation to the increase in staffing seen in the South West HSS on page 167 of the SDS, can the minister advise the committee about the appointment of regular doctors in the area?

Mr SPRINGBORG: Yes. I will also ask our acting chief executive, Glynis Schultz, to come along and maybe give us an update from her perspective as well. They have been very successful in their recruitment process in recent times. Only recently I travelled through that area and I can say that they have an exceptional medical cohort in that part of the world providing great services and confidence to the people of south-west Queensland. Not only that, they have been doing a lot to take responsibility for primary care services which used to be with NGOs and have now fallen back to us for responsibility as well. But it is pretty good news.

Ms Schultz: We have just employed four advanced rural proceduralists to be appointed at Roma with one further to follow. We have a sound medical workforce at St George. We are still working with recruitment in Charleville and have not quite secured the workforce there, but we are working with the Queensland team, which is Queensland Country Practice, to look at our medical workforce model with a view to recruiting to the areas that we have not recruited to so far.

CHAIR: We will have one more question from government members and then we will move across to non-government questioning. Member for Mudgeeraba?

Ms BATES: Minister, page 6 of the SDS refers to the significant service expansions in a number of HHSs during 2014-15, including at the Sunshine Coast HHS. This includes expanded services such as endoscopy. Can the minister provide the committee with details on the endoscopy procedural unit at Nambour?

Mr SPRINGBORG: Yes. I will also ask Kevin Hegarty from the Sunshine Coast Hospital and Health Service, the longstanding chief executive there, who has a very good story to tell with regard to the performance of that hospital and health service. But certainly, there is a great story in endoscopy. They are getting great results in their cardiac catheter lab, which has been opened in preparation for the new Sunshine Coast Public University Hospital and also a new orthopaedics outpatient service, which has commenced at the Nambour Hospital and which I think has basically cleared the waitlist there by around about 70 per cent. So there are significantly good results coming through on the Sunshine Coast. But specifically around that, Kevin you might like to tell us your story.

Mr Hegarty: Thanks very much, Minister. You have almost showcased what I was going to showcase, because you know our operations so well. What the minister has alluded to is the deliberate ramping up of services on the Sunshine Coast ahead of the opening of the university hospital in late 2016. The procedural suites have allowed us to do approximately 3,000 more scopes per year. Probably the showpiece of our ramped up service is the cardiac cath lab. Previously, residents of the Sunshine Coast would be admitted to Nambour Hospital before transfer to Brisbane

for stenting. Now, that all happens on site and with cooperation from the local QAS we actually have a 24-7 service where anyone experiencing a cardiac event is brought into Nambour, the labs are activated, as I say, 24-7 and that care is provided straightaway, whereas in the past that care would have been delayed and we would be, as I referred to, holding the patient waiting for transfer to Brisbane. So the outcomes for patients are dramatically improved.

The minister also alluded to some of our innovative practices in outpatients. From the March quarter last year to the March quarter this year, we had a 70 per cent increase in the number of referrals to outpatients just for orthopaedic patients. We have a musculoskeletal clinic that is obviously staffed by physios and other allied health to make sure that people join the right queue rather than just a queue, sometimes as low as a 16 per cent conversion of people referred into an orthopaedic outpatients through to a surgical model. So we are intervening with more appropriate care early so that those patients get access to care that makes a difference to their quality of life. Thank you.

CHAIR: Thank you. We will move to non-government questions. The member for Bundamba.

Mrs MILLER: Thank you, chair. I refer to page 20 of the SDS. Minister, I ask this next question with the permission of the family of Talieha Nebauer, specifically Talieha's mother, Nichole, who has given me a letter asking me to ask this question. I table the letter. Will the minister ensure or help the family have a coronial inquest into the circumstances of Talieha Nebauer's death after she was transferred out of the Barrett Centre?

CHAIR: Sorry, just a minute, Minister. I just need to clarify something here. Minister, you can only answer this as it relates to Health and not to the Attorney-General

Mrs MILLER: That is right. I accept that and I understand that.

Mr SPRINGBORG: Mr Chairman, can I indicate that any death of any person is a tragedy. It is a double tragedy if it is the death of a young person. Mr Chairman, I understand that the circumstances outlined by the honourable member have or are being subject to a root cause analysis. The root cause analysis ultimately, or may be reviewed or referred to the coroner. So that is the normal process. So the coroner may very well be involved in this and, of course, we take the direction of the coroner. Can I also indicate that when it comes to the issue of Barrett, that the previous government had a plan to close the Barrett adolescent mental health facility for a range of reasons.

Mrs MILLER: And rebuild it.

Mr SPRINGBORG: And also there was a range of reasons why it was and should have been closed. As the honourable member would know, there were some issues, that it is not the best environment to actually keep young people in. There were some serious issues there in recent times with regards to even abuse of patients by others, by other patients, which I have previously referred to in the parliament. And also, if you look at the best advice available to me and others, young people should be actually supervised if need be on a 24-hour basis in the community with the support and in many cases close to their own family. We had adolescents that were transferred from right around Queensland, as far away as Cairns and beyond, to this particular facility and we are now trying to accommodate them in their own environment. Also, Mr Chairman, I think it is very important that we understand that a person is normally only kept in Barrett until they are 18 years of age. Now, after 18 years of age then there are alternate pathways for young people as well. And we should stop jumping to conclusions about whether we can control all circumstances in someone's life. We are dealing here with young people who are very, very troubled, with very complex care needs. If we go back and look at some of the circumstances here in Barrett when Barrett was operating, within the facility itself there were 24 suicide attempts between 2010 and 2013 and 195 reported incidents of attempted self-harm. There have also been a number of examples of where people who have been patients and cared for in Barrett have actually taken their own life after they have actually left that facility over the last 10 years or so. Those sorts of things are great tragedies. We can only house a person in a facility like that while they are an adolescent up to the age of 18. I understand in the case of this young woman she was no longer in that age bracket and a care plan was actually devised under recommendation. But we will wait to see what the coroner may or may not do out of that. But I think it is absolutely wrong for us to draw any conclusions around what may or may not have been able to have been done given the history of very troubled young people who have been resident at that facility over a period of time, the records of self-harm, both in and outside that facility, and the circumstances around many of those young people when they have actually left the care of that facility into other care environments in the community, including up to and taking their own life.

Mrs MILLER: Minister, Talieha's mother is asking for help to get answers, but I will now move on.

CHAIR: Thank you.

Mrs MILLER: I would like to call Malcolm Stamp, please, through the minister.

Mr SPRINGBORG: While Malcolm Stamp is coming up here, Mr Chairman, we want answers as well to a whole range of things. We have no issue with the coronial inquest. The coroner is an independent person. The information will be made available to them and they will consider that based on the evidence within that root cause analysis.

CHAIR: Thank you.

Mrs MILLER: Mr Stamp, I refer to page 132 of the SDS. What functions in the Metropolitan North HHS are being considered in contestability processes and do those considerations include the outsourcing of pathology services to the new Sullivan Nicolaides laboratory across the road or close to your hospitals?

Mr Stamp: The chairman and I recently met with the whole of the trade union leaders of pathology and we confirmed at that stage that pathology was not on any contestability list within Metro North. We made it clear that that doesn't mean to say it wouldn't be at some stage in the future. And the organisation you just mentioned, I'm sorry, I've never heard of.

Mrs MILLER: Never heard of Sullivan Nicolaides?

Mr Stamp: No, I haven't, sorry. I lead a sheltered life.

Mrs MILLER: Okay. Can I please call up, Chair, Len Richards, CEO of Central Queensland HHS.

Mr Richards: Len Richards, Central Queensland HHS.

Mrs MILLER: Thank you, Mr Richards. I refer to SDS page 132. Mr Richards, has the Central Queensland HHS outsourced management of the Yeppoon Hospital to Vanguard Health Service and I would like to know what the cost of that is and I would also like to know is Vanguard also managing the outsourcing of medical imaging services in the HHS, again at what cost, and just finally, while you are thinking about it, does Vanguard actually provide clinical services at Yeppoon Hospital or is it simply just a subcontracting agent?

Mr Richards: In terms of Vanguard, we have outsourced the procurement or recruitment of medical staff to provide emergency services out of the Capricorn Coast Hospital which is Yeppoon Hospital. That is a contract that will run over three years. The cost of that is 12.9 million. It is to provide a seven day a week, 24 hour a day service, something that I think—well, certainly we have been unable to provide in the past. It has been a difficult recruitment area, which led the board to this course of action. At the end of the three years the service then transfers back to Central Queensland HHS.

Mrs MILLER: What about medical imaging? Is Vanguard providing that as well and at what cost?

Mr Richards: Vanguard have sourced, or are in the process of sourcing some medical imaging to be provided out of that hospital. That will be at no cost to us as an HHS and that will be for the same period of time as the contract. The reason they are doing that is there wasn't medical imaging provided out of that hospital previously and they feel that that is a barrier to the recruitment of medical staff to work within the A&E department there. So they have sourced that imaging or are in the process of sourcing that imaging, we haven't got a provider yet, but that is coming towards the end of the process.

Mrs MILLER: Just as a follow-up, will Vanguard be providing any other services within your HHS region in the future, do you think?

Mr Richards: So, we work closely with Vanguard. We have got another program underway at the moment which is about the provision of ophthalmology services within Rockhampton Hospital. We have re-established, with the help of Vanguard, the ophthalmology service. That started six months ago. We are increasing the scope and the range of that service over the course of this year and again part of the remit of the contract is to get a service established and then hand that back to Central Queensland HHS. And in terms of ophthalmology that is at the end of this year.

Mrs MILLER: What is the cost of that ophthalmology component roughly?

Mr Richards: The cost of ophthalmology is 1.8 million.

Mrs MILLER: I would now like, through the Chair, to ask the minister in relation to SDS page 17. Minister, how many cases of mother to child transmission of syphilis have been reported in the past two years and what measures are in place in this budget to eradicate this third-world disease in Queensland?

Mr SPRINGBORG: I will ask for that information for the honourable member, but as I understand it there are some particular areas of challenge around the state with regards to syphilis. I think there may have been some issues in the north-west in particular that we have been trying to deal with over a period of time. We are very, very concerned about that. There are, unfortunately, a small number of diseases which we would prefer not to have amongst us in our population. The reality is that we do. HIV is one of them, avoidable eye disease is another one of them. There are a whole range of things. But as I understand, there were 324 infectious syphilis notifications in 2013. That is a 16.5 per cent decrease from 2012. In the North West Hospital and Health Service district they were reduced in 2013. There were 48 cases compared to 75 cases in 2012 and it remains stable in 2014 to date with 39 cases. This was data extracted as at May. So we will keep working with the community and the population around this but we are right to be concerned about it. Of course, often the disease can be quite advanced by the time it is detected and of course it can have significant issues for an infant as well. But as you can see, honourable member, we have made some progress with regards to reducing the reported incidents of syphilis in this state, but of course we will keep working to reduce that even further.

Mrs MILLER: Just as a follow-up in relation to that, would you be able to find out or advise me or take it on notice how many of those cases that you have just said are mother to child transmissions?

Mr SPRINGBORG: If we can easily access that information I don't have an issue around that. I am happy to take that on notice.

Mrs MILLER: That is good.

Mr SPRINGBORG: Or in the next 20 minutes if someone is able to extract that information.

Mrs MILLER: Thank you. Through Mr Chair I would just like to ask the minister will you provide details of all consultants and contractors engaged by the Department of Health and by the HHSs, including the name of the consultant and the cost of the consultancy and contract? That should be readily available.

Mr SPRINGBORG: Within the bounds of what is normally made available around those things I do not have any great issues. I would imagine some of this information is probably already reported. If I can just give a bit of an overview to the honourable member, with regards to the top nine categories of consultancy in 2013-14, the spend in relation to the department's system manager, which is our central agency function, amounting to 92 per cent are grouped below: $4.8 million for Health Service Information Agency or HSIA; $2.59 million for review and advice into private practice reform and remuneration of senior medical officers; $1.45 million for payroll and HR related activities; $.98 million for health service support agencies; $.72 million for Pathology Queensland review and initiatives; $.72 million for support for establishment of Health Ombudsman; $.63 million for contestability review into payroll function; $.63 million for advice in relation to legionella water testing; and $.61 million for advice in relation to SAP. They are just some of them. I think the honourable member would agree that some of them are reasonably crucial. Our hospital and health services have done a very good job this year in continuing to reduce their reliance on consultants. We will put together some data for the honourable member.

CHAIR: We will move to government questions.

Mr SPRINGBORG: In relation to the honourable member's earlier question with regards to mother to child syphilis transmissions, as I understand it there have been three.

CHAIR: Thank you, Minister. Is anything else you want to update at this point?

Mr SPRINGBORG: No, that is basically it, Mr Chairman.

CHAIR: We will move to government questions and I call the member for Townsville.

Mr HATHAWAY: Minister, page 201 of the SDS outlines the operating surplus for the Townsville HHS for the years 2012-13 being reinvested in initiatives to improve patient outcomes including commissioning of an additional operating theatre to reduce wait times and acute surgery access times and additional Surgery Connect activity. Can the minister provide this committee with further details on what this has meant for my constituents and those of North Queensland?

Mr SPRINGBORG: Thank you very much, member for Townsville. Certainly the Townsville Hospital and Health Service has done a remarkably good job. They have followed the trend across the state with regards to the reduction in the dental wait list to zero and, in the last month or so, they have reduced their surgical long waits to zero as well. They are providing some great programs and services. Also, the other day when I was there I saw their investment in Ayr with regards to their hospital and health service. I have already talked to the chief executive and the chair around the re-establishment of birthing in Ingham, which I know the local member, the member for Hinchinbrook, would be very keen to see. I invite Julia Squire, the Chief Executive of the Townsville Hospital and Health Service, to come forward and to tell us the great story of her hospital and health service and the reinvestment of their hard work. Prior to the hospital and health service taking over the operation under the auspices of the board, in the last three financial years before us coming to government, I think their accumulated deficits were in the vicinity of about $12 million or $13 million, so there has been a significant turnaround. Now we are seeing really good financial management and great investment back into services for people in your home town and in the entire district.

Mrs Squire: I am Julia Squire, the Chief Executive of the Townsville Hospital and Health Service. The operating surplus from 2012-13 has been reinvested into the provision of additional activity to reduce our waiting times across the HHS. This would include around 500 additional surgeries and around 3,000 additional outpatient attenders. We have also managed to invest in capital and infrastructure changes, including to improve the health of Palm Islanders by commissioning a mobile health van and building staff accommodation so that the island relies less on fly-in fly-out staff. We are also investing in community hospitals and in other initiatives around the Townsville hospital as well. This year's operating surplus will also be reinvested in capital and additional activity, and it will also be invested in investor save measures to further improve our efficiency, which has improved quite significantly over the past two years.

CHAIR: Thank you. I call the member for Ferny Grove, please.

Mr SHUTTLEWORTH: Minister, with reference to maternal and child health services being delivered by the newly formed Torres and Cape HHS as outlined on page 183 of the SDS, can you update the committee on the rates of Indigenous childhood vaccinations?

Mr SPRINGBORG: Thank you very much, honourable member. Again, I think we have a reasonably good news story up there. I would like to ask Kerrie Freeman, the Acting Chief Executive of the hospital and health service, to come forward and tell the story. There has been a really great process of integration as the two hospital and health services have been merged into one, the Torres Strait and northern peninsular and Cape York. Bob McCarthy, who is a very able chairman and a former director-general in Queensland, has done a great job of bringing that organisation together as well and working with all the staff. We think it will bring a greater critical mass and a greater alignment with the Cairns hospital and health service. Of course, that will improve health outcomes in that particular area as well. Certainly, as I understand it, we have nearly 96 per cent of all five-year-old Aboriginal and Torres Strait Islander children living within the Torres and Cape HHS fully immunised in 2013, which is quite an enviable figure. Kerrie, would you like to tell us?

Dr Freeman: Thank you, Minister. I am Kerrie Freeman, Acting Chief Executive, Torres and Cape Hospital and Health Service. As the minister said, we were very pleased to let you know that Cape York has achieved the state's highest percentage at 94.5 per cent of vaccination coverage for Indigenous children aged 12 to 15 months in 2013. This result exceeds both the state average of 86 per cent and the national average of 85.1 per cent. In addition, the Torres Strait and northern peninsular services achieved above target at 90 per cent coverage for Indigenous children aged 24 to 63 months over the same period. Just to give a bit of context around the newly formed HHS, out of a population of just over 25,000, around 63.7 per cent of our population are Indigenous, with around 85 per cent of those in the Torres Strait and northern peninsular region and 51 per cent in the cape.

CHAIR: Thank you. Member for Beaudesert, please?

Mr KRAUSE: Minister, page 212 of the SDS refers to the West Moreton HHS achieving oral health targets. What has been achieved in this area to date? What is the 2014-15 budget expected to deliver in terms of dental services in the West Moreton HHS?

Mr SPRINGBORG: I thank the honourable member for the question. Again, we see a very strong trend with regards to oral health services in West Moreton, with zero patients waiting greater than two years for general dental care. Also, the number of people waiting greater than two years on the general care waiting list was reduced from 3,512 to zero. Those are the overall figures. To give you an indication, national partnership agreement funding of $2,754,000 or thereabouts was provided

to address the 217,000 waited activity occasions of service. Of course, we were able to assist with resources from within the normal vote from Queensland Health as well. I will ask to come forward Lesley Dwyer from West Moreton Hospital and Health Service to provide an update. While she is doing so, I thank them for the work that they have done. In June 2014, there were zero long-wait patients on their surgical wait lists in all categories. Well done with regards to that.

Ms Dwyer: Thank you, Minister, and thank you for the question in regard to our oral waiting lists. As the minister said, we now have zero people waiting for longer than two years. Our focus for the next 12 months is to really concentrate on those patients who are waiting for treatment. However, that is less than one year. Currently there are about 2,600 patients who are waiting. We run a large dental service. We have mobile vans and we are very interested in actually increasing those numbers, particularly around our school dental programs. We also have a dental van that is permanently based at the University of Queensland at Ipswich, which again is actually helping us work in partnership in training dentists of the future. We are looking at innovative models around having dental hygienists and dental assistants. We have been very proud of what we have been able to achieve.

CHAIR: Thank you. Member for Mudgeeraba?

Ms BATES: Thank you, Mr Chair. Minister, page 222 of the SDS informs that in the Wide Bay HHS there has been a reduction in the waiting time for an endoscopy from more than two years to eight weeks over 2013-14. Over the 2014-15 budget period, is this achievement going to be improved upon?

Mr SPRINGBORG: I thank the member for the Mudgeeraba for the question. This has been a most extraordinary turnaround with the endoscopy waiting lists. I think it is absolutely remarkable as we know the sooner that we are able to address and identify people who are required to have an endoscopy, the quicker we are able to address a malignancy or a condition worsening. That has been very much the strong focus of the hospital and health board up there. Adrian Pennington is the Chief Executive of the hospital and health service. I will Adrian to come forward. He has been strongly focused on this. Certainly if you look at the reduction basically from two years down to a few weeks, it has been absolutely extraordinary. No doubt it has saved lives and pain along the way.

Mr Pennington: Thank you, Minister. Adrian Pennington, Chief Executive of the Wide Bay Hospital and Health Service. The board of our organisation actually made a conscious decision during the strategic planning process to look to invest community dividend in specific target areas where they thought they could best add value for money and improve quality of service. The outcome of that was their perception of what was a catastrophic wait for endoscopy patients, exceeding two and a half years. They chose to exercise their right as a hospital and health service board to commit the community dividend and take the opportunity to, if you like, live their dream and opportunities within the health system. They targeted a four-week wait, which we managed to achieve after a second blitz. Currently it is waiting between four and eight weeks, but the board now has made a further recurrent allocation of an additional half-time surgeon both in Fraser Coast and in Bundaberg, so we expect that to be maintained and sustained on a long-term basis. In addition to that, we are now looking to extend that for cystoscopy within the urology pathway, with a view to delivering an eight-week pathway by Christmas.

Mr SPRINGBORG: That is a real achievement of local area management and focus priority, Mr Chairman.

CHAIR: We have time for one question. I am going to throw that to the member for Gaven. I just remind the member that we have very little time left, so please ask your question.

Dr DOUGLAS: It is a fairly simple question that relates to page 19 of the SDS, the targets for ambulatory care patients, categories 1, 2 and 3. The numbers are identical to the target estimates of 2013-14. I ask the minister: in view of the fact that he has been running this campaign on meeting the targets, spending an enormous amount of money on it and claiming all these things, why would those targets be the same as the ones in the previous year if the expected improvements were as he stated? Minister, can you explain those numbers?

Mr SPRINGBORG: I thank the honourable member for the question. Targets are often a reflection of what we know that we can actually achieve, based on the history of presentation and also what we suggested we may need in the future. Of course, we always aim to improve our performance. We report certain targets. We set certain things for ourselves to be able to achieve.

What we have here are established national targets, as I understand, as well. We will do our level best to continue to meet those targets and improve upon them. I do not think there is anything sensational around that.

While I have the honourable member here, can I also edify him. He asked a reasonable question earlier on around breast screening in Metro North and Metro South. As I understand it, in Metro South their target was 46,200. They achieved 46,340, so 100.3 per cent of activity which is a little bit more. In Metro North, their service agreement target was 39,300. As I understand it, the reason that they had a slightly lower service agreement target is based on the demography of those areas and the cohort of women and their needs. That can happen based on age profiles and those sorts of things. They achieved 41,120 or 104.6 per cent of activity. On the Gold Coast, their target was 32,000 and they achieved 32,690, which is 102.2 per cent of activity. I hope that edifies the honourable member. Chair, if you want me to provide some other information to the committee which was asked about earlier on, I am happy to.

CHAIR: If you would, Minister. We have a minute or two.

Mr SPRINGBORG: I was asked by the honourable member for Bundamba about those who have rung up regarding the employee assistance scheme. In 2012-13, new employees: 2,519. Rather than break it down, the overall total is 3,402 in 2012-13; in 2013-14 it is 3,460. Basically, it is about the same. I will also dig up previous figures, so that the committee can have a true comparison. I will provide that in writing to the committee.

CHAIR: Thank you, Minister. The time allocated to consider the estimates of the expenditure in the Health portfolio has expired. On behalf of the committee, I thank you, Minister, the director-general, the chief executives and officials for your attendance. The video broadcast of the hearing will be available on the parliament's website soon and a proof transcript of proceedings will be published by approximately 8 pm. The deadline for answers to questions taken on notice and any clarifying material is 5 pm on Friday 18 July.

That completes the committee's hearing today. The committee will meet again at 9 am on Thursday 17 July to consider the proposed expenditures in Appropriation Bill 2014 for the portfolios of the Minister for National Parks, Recreation, Sport and Racing; the Minister for Aboriginal and Torres Strait Islander and Multicultural Affairs; and the Minister for Communities, Child Safety and Disability Services. On behalf of the committee, I thank Hansard staff, the secretariat and attendants for their assistance. I declare this public hearing closed.

Committee adjourned at 4.59 pm