V E R I F I E D V E R S I O N

PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into Effective Decision Making for the Successful Delivery of Significant Infrastructure Projects

Melbourne — 22 August 2012

Members

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Witnesses

Mr J. Rice, Managing Director (affirmed), and

Mr G. White, Operations Director (affirmed), CSC Australia.

Necessary corrections to be notified to executive officer of committee

The CHAIR — I declare open the Public Accounts and Estimates Committee hearing on the inquiry into effective decision making for the successful delivery of significant infrastructure projects. On behalf of the committee I welcome from CSC Australia Mr James Rice, managing director and Mr Gary White, operations director. Members of Parliament, departmental officers, members of the public and the media are also welcome. In accordance with the guidelines for public hearings, I remind members of the public gallery that they cannot participate in any way in the committee's proceedings. Only officers of the PAEC secretariat are to approach PAEC members. Members of the media are also requested to observe the guidelines for filming or recording. Please note that these proceedings are not being webcast. I am just reading that because our hearings are often webcast, so just to inform people.

All evidence taken by this committee is taken under the provisions of the Parliamentary Committees Act, attracts parliamentary privilege and is protected from judicial review. However, any comments made outside the precincts of the hearing — that is, outside the room — are not protected by parliamentary privilege. All evidence given today is taken under oath or affirmation and is being recorded by Hansard. Witnesses will be provided with proof versions of the transcript within 15 working days of this hearing, which are to be verified and returned to the committee secretariat within 2 working days. Eventually those transcripts will be posted on our website.

You will have the opportunity to make a brief presentation, after which we will ask questions.

I ask that all mobile phones be turned off or at least switched to silent. I now call on Mr James Rice to make a presentation, if he so desires.

Mr RICE — Thank you very much. I guess at the outset I would like to say that we have come to answer your questions. We do not really have an opening statement, other than introducing ourselves and saying a little bit about the organisation and the roles we hold in it. I thought that might be useful before your questions.

My name is James Rice; I am the managing director of the Healthcare Group of CSC. It is an Asia-Pacific role that covers Australia, obviously, and therefore Victoria. I have held that role since June 2010, prior to which I was the country manager for New Zealand and prior to that a sales director for a previous company. I will give the corporate history in a minute. My colleague, Gary White, is my operations director, but like myself he has held a range of roles within the organisation.

The organisation itself, CSC, is new for us. CSC acquired the business of iSOFT in August last year. The business of iSOFT was the original contracting party with the HealthSMART program. That was two managing directors ago. I was also the managing director of iSOFT before CSC acquired us, so it was not my predecessor but the one before, Nigel Lutton, who signed the contract for the HealthSMART program work back in 2005.

Gary White has been an employee of CSC and prior to that iSOFT for many years. His first introduction into the Australian part of the business was in 2008, and his role was specifically to come and be the project director for the HealthSMART project, which was three years into the five-year agreement that we signed in 2005. Subsequent to that, Gary has been promoted to the role of operations director for the health-care business.

The CHAIR — Thank you very much, both of you, for coming in today. I say advisedly that we are very grateful to those who are delivering projects for government for making their time available because, whilst it is useful and informative to have the perspective of government agencies which are commissioning projects, it is often the insights of those who are actually trying to collaborate with government and deliver the projects that are critically important.

The focus of our inquiry is around issues of accountability, transparency, relevant skills and capacity, and lessons learnt. It is probably in the relevant skills and capacity essentially that our discussion with you today will primarily occur. We are looking for your insight. I know that there will be some questions we may want to put to you that might be a bit sensitive because we will be asking you to comment on perhaps perceived attributes of individuals or groups of people that you have interfaced with, but we are seeking a broad view about your experience in dealing with the government sector.

I will not prejudice what you might say by pre-empting any view at the moment. Certainly over the course of the past two days we have had some very interesting evidence about the skill set and interaction. Would you like to establish the discussion — and perhaps we can have more of a discussion than a Q and A — by making

some observations about the relationship with government as a client and comments generally about your experience in dealing with government and its various arms in relation to this project that you have been involved in for some time now?

Mr RICE — Sure. I might start, and as we draw down I might hand over to Gary. CSC has broad experience in dealing with government agencies throughout the region we are responsible for. In Australia the health-care business has multiple contractual relationships with pretty much every state and territory health department. Generally I have not found the experience of working with Victoria markedly different from the other states. We encounter the same — I guess from the commercial side of the business — frustrations with procurement, probity and all those sorts of things. It is a different style of doing business than with the private sector; you guys would be well aware of that.

My own personal dealings with the health department of Victoria I found to be a satisfactory engagement. I have not encountered any individuals who have appeared to be doing anything wrong or representing the government in a negative way. More recently we have been quite frustrated. You are probably aware that the HealthSMART agreement was for an initial period of five years. We signed a subsequent five-year contract a year and a bit ago now and we are yet to execute any services under that contract, other than the provision of support, which is a feature of the previous agreement. We have not been engaged to deliver any further professional services — in other words, implement more hospitals — which was certainly the spirit of the agreement we signed. There is a degree of frustration from our side that we were resourced up and prepared to do some work that has not actually eventuated.

The CHAIR — Can I ask a more specific question then? Some of the evidence we have had, particularly over the last day and a half of these hearings, has gone to the issue of an informed purchaser in effect. A view that has been strongly led is that we have a skill or capability deficit in the Victorian public sector, particularly in terms of the IT space but probably generally applicable to project management at large, and indeed that evidence was led earlier today. What is your view about that? Is that a valid observation? Do you think that the capacity to backfill with capable and skilled people in the IT area is there to buy expertise in, and, in terms of project management of this particular project, how do you perceive the informed purchaser, if you like, status of the Department of Health?

Mr RICE — My relationship has really been at the management and relationship end, so I might defer to Gary to comment.

Mr WHITE — I would say I started as program director in 2008 to pick up the HealthSMART program, so a lot of my interaction was obviously with the project directors and project managers of HealthSMART. In terms of their capabilities then, I did not perceive that there was any weakness or lack of strength in that area. It was more in relation to the way the contract was set up and the way we had to liaise with HealthSMART for delivery of a certain item, being the statewide footprint, and then our other contract was with the actual implementation direct to the agency.

Under a normal agreement for a company like iSOFT or CSC we normally act as the prime, direct to the client, and/or we work through the prime and just deliver the services enacted. This was a slightly different arrangement where we had a contract to deliver to HealthSMART the footprint but also a contract to deliver to the agencies. The contention in the project management space was very much a three-way, tripartite agreement going on, where you had ourselves trying to deliver to HealthSMART and ourselves trying to deliver to the agency. No three were trying to deliver an outcome. I suppose the issue always is in that situation is that there were always three different opinions and three different drivers from each party. I think that was the biggest issue, but in terms of the capability and skill sets of the government, and HealthSMART in particular, then I thought the people I worked with were competent people.

The CHAIR — Your concern would be around the nature of the structure of the process, rather than the particular skills of individuals.

Mr WHITE — Yes, that is right. HealthSMART was not acting as a true prime. They were not just taking the software from us and then delivering that to the agencies direct through themselves, which is a contract we would normally sign, say, for example with our Asia clients, and/or we would prime it ourselves and just deliver direct to the agencies because we have those skill sets within our organisation. I think the construct of the

contract in terms of that three-way agreement was more of a difficulty in terms of delivery than the actual capabilities of the people involved.

Mr PAKULA — Just for the sake of clarification before we go on, which applications was CSC responsible for in terms of development? Just take us through that.

Mr RICE — The procurement process we were successful in was to provide a patient administration system called iPM. Do you know want to know what a patient administration system does?

Mr PAKULA — So you were not — some of the clinical matters — —

Mr RICE — No, not at all. The strategy from HealthSMART was to separately seek a partner to deliver the patient administration system, which is very much around the patient flow through a hospital — so it is which bed you are in, which ward you are in, in what condition you were admitted and whether you came through ED, your referral from your doctor and all that sort of stuff. It is not the clinical working station that a doctor might use in a hospital.

Mr PAKULA — How many hospitals has that currently been rolled out to?

Mr RICE — In Victoria or globally?

Mr PAKULA — In Victoria.

Mr WHITE — Just to add to the iPM, we were also contracted to deliver some community as well, so it combined community functionality to those agencies that did both acute and community outside of the stand-alone, which InterSystems were actually contracted to do — the stand-alone communities.

Mr SCOTT — Sorry, is that the community health sector? What do you mean?

Mr RICE — What happens is that hospitals usually have a community department, so it is a module of our iPM patient administration system that can manage that community.

Mr SCOTT — So it is community health linked to the hospital acute services.

Mr WHITE — Yes, correct. That is right. Well, not the stand-alone community centres. That is right.

The contract was for 10 lead agencies. I can give you those if you want. They were Northern Health; Peninsula Health; Royal Women's Hospital; Mercy Public Hospital; Gippsland rural health alliance, which came together to implement 10 hospitals because the rurals created an alliance to deliver theirs; Southern Health; Melbourne Health; Western Health; Loddon Mallee rural health alliance; and Grampians rural alliance. They are the 10 that currently have iPM implemented.

Mr RICE — There are more hospitals.

Mr WHITE — Yes. Each one of those is an agency, and then there are the associated hospitals within those agencies.

Mr PAKULA — You are in all 10 of them —

Mr WHITE — Yes, all 10.

Mr PAKULA — and however many hospitals they have.

Mr WHITE — Yes. It is about 54 hospitals, I think.

Mr PAKULA — I just wanted to ask you — I do not know if you are aware of the Ombudsman's report into ICT — —

Mr WHITE — I have read that, yes.

Mr RICE — Yes.

Mr PAKULA — They made some findings. You made some comments about both the original contract and also your interactions. To the extent you able to say, what level of engagement did you have with the Ombudsman in the drafting of the Ombudsman's report?

Mr WHITE — We were not approached.

Mr RICE — We may have been approached and we declined to comment.

Mr MORRIS — One of the features of the Ombudsman's report, picking up that point, was basically right at the starting point a failure to produce a proper business plan — basically a couple of pages, I think was the comment — so that right from the start there were issues with process. You said earlier that the contract arrangements were not ideal. Could you perhaps give us an example of how the process may have been structured to achieve the outcome more effectively?

Mr WHITE — It is easy, I suppose, to criticise large programs of work in health because we do a lot with a lot of governments, so we have done a lot of statewide rollouts in Tasmania and in Asia as well. Inevitably you always come across issues and delays. I think for me personally the thing I picked up with the HealthSMART program was that relationship in terms of there being no prime. There was a three-way contract.

In hindsight, when we do these large programs of work I think there are a couple of things that need to be taken into consideration, from my perspective. The first one is: when you do large health-care IT programs of work, which I think are probably the most complex pieces of work to deliver, whilst the intent is always good, there are always a couple of things we always seem to forget, and that does not matter where in the world I have worked on these large programs. One is that the investment in health care as a program is not just a five-year investment; it is an investment for life. So to think that after five years we are just going to implement what we have contracted for and then all of a sudden it is going to stop is not the case.

We are always developing software, we are always building software, so there always needs to be that investment there to continue to deliver software. If we take, for example, where we finished those contractual obligations June 2010, those agencies have now sat on software which is two or three releases behind where we currently are. You could argue whether the agencies are getting a benefit from that software. Yes, they are in relation to when it was implemented, but we have since gone on and enhanced that product either by ourselves or through feedback from our clients, and we have just not upgraded those agencies for various reasons.

I think there is that first point of thinking 'This is not just a short-term investment; it is a lifetime investment', and that needs to be considered right from the start in terms of funding arrangements, not just for five years but for multiple years. That is the first point. The second point is the concept of HealthSMART program was to deliver a statewide footprint, and that term means it is a common build that can be reused many times. The logic of that was you build it once and you implement it many times. The idea of the cost savings you get from building once and implementing many times is a fair point. I think the reality is that while we all like to think that hospitals and agencies do processes the same way, they do not.

You can take one of these two options. One is to enforce a rigorous change program on the agencies to implement those standard statewide footprint configurations, which was not the case in the HealthSMART program. So I think there is a lack of change management involved in the program, and therefore when we started to implement it in the agencies, we started to come across issues that they do not admit patients that way, they do not discharge patients that way, they do not transfer patients that way. HealthSMART, as an agency, did not seem to have the power to force or implement that change upon the agencies. It was very much the agencies driving HealthSMART. That is where that contractual thing got slightly awkward because we were trying to implement in the agencies something which HealthSMART defined as a footprint, but the agencies were pushing back and were not willing to implement it. So then we were having that three-way party conversation — —

Mr MORRIS — Can I just clarify that: was it a lack of authority to implement it or a lack of desire on their part, do you think?

Mr WHITE — Obviously as a software vendor we cannot say to an agency, 'You're implementing our software'. That is where we look to HealthSMART to do that, and they did not. That is the reality. I am sure there are many reasons for that. You cannot force a hospital to implement something if they do not believe it is

going to meet their needs. So with the concept of a statewide footprint, while the logic is there, the reality is it does not always work, and it is not just here in Australia. I have worked on a national program implementing software in the UK where it has not worked. So you have to do a very large engagement up-front with your stakeholders to say this is the way it is going to be and everyone has to sign up to that, or you just have to accept that there will be favouritism in the statewide footprint and each agency will be different and that has to be considered.

That was the first challenge. The second challenge, as always is, to define up-front the functional specifications in terms of what you are going to build for the department and bring together a set of people to define those functionalities and those specifications on behalf of the Department of Health. The reality is that as a vendor we need something to build, of course, but the problem is there is never a process to continually review those functional specifications. In two to three years time when we build that software and it is delivered, the client will turn around and say, 'It doesn't really meet our requirements'. Then you get into that argument as a vendor of saying, 'Well, we built what you told us to', and the client is saying, 'Well, we now need to pay you more money to rebuild it', and inevitably those people that initially built the functional specifications are no longer part of the program.

That was the other issue as well. I do not think a wide-enough community of the stakeholders was engaged in that up-front defining of the process, and therefore what was perceived as being an inadequate system, possibly by some users, was not. It was just a system which was poorly defined by key stakeholders in the initial stages. I think there needs to be built in that review process, every six months or every year, a continual review of those functional specifications to make sure it meets the needs of the client. That is the second point.

The third point — and this may go to another question that you may ask later — is whether the management of infrastructure should be run by a government agency or whether it should be outsourced to someone who has a specialised skill set. Our traditional model, or any vendor's traditional model, is to work directly with the client in terms of the implementation and support of the software. Most of the feedback from our clients is that they get more benefit that way because they are dealing with the experts directly.

HealthSMART took on the decision to manage its infrastructure itself and to take on some of the management to support of our software. There are two issues with that. Firstly, there is the cross-training of our staff to your staff. It is not easy to cross-train someone in a product with the complexities of iPM in terms of the software. It is just impossible to train someone. The hospitals or agencies are always going to get a substandard service based on that. Also during my time there has been a high turnover of staff in HealthSMART services. There was no continuity in that area in terms of someone staying long enough to learn the system. Inevitably what happened was that HealthSMART was paying us to go in to try to bring down their list of issues. My opinion is that it would have been better for a company — and I am not just talking about CSC, but any company that is in SI — that has infrastructure, that has hardware and that has the capabilities that could deliver a better service at a lower cost, for it to be outsourced to one of those individuals.

Mr PAKULA — In terms of the overall program?

Mr WHITE — In terms of the overall program.

Mr RICE — Management of the infrastructure.

Mr WHITE — Management of the infrastructure and support of the software.

Mr MORRIS — Just a quick supplementary on the first point you raised — that is, the various approaches between the networks. I am not surprised that it is an Australian attribute, or a British attribute, but in terms of other jurisdictions, is that an approach that is seen across Asia?

Mr WHITE — Yes.

Mr RICE — Yes.

Mr MORRIS — It is something that needs to be dealt with or catered for?

Mr RICE — The place where it is less prevalent is in the private hospital groups, which have a more dictatorship-type approach to managing their hospitals. They say, 'This is it. That is what you get'.

Mr MORRIS — This is the Ramsay Health way of doing it, for example?

Mr RICE — For example. Whereas in a public hospital or in a group of public hospitals you tend to have committees that make decisions, so we are talking about standardisation and that can be challenging.

If you do not mind, just to add to your initial question, when you refer to a business plan, I was not around so I do not know whether there was one of not. But typically a business plan would set out the objectives of the project. I am not aware that there has been any of that or any benefits realisation subsequent to the project. The frustration for us — and this part of the tripartite agreement that Gary referred to — is when we develop innovations in our product that have clear value. Just to step back, what we are talking about here in HealthSMART is a standardisation project and that has potential IT benefits if it is done well. Whether they achieve that or not is obvious the subject for discussion, but one of the benefits of standardisation is that you have a core platform so that when you have an innovation you can do it once and apply it to many.

We have had these innovations; we have got lots of them. The agencies want them, but the problem is going through the central body, HealthSMART, as we rely on them to sell it for us, and they do not want to because with the way they have set up the infrastructure they would have to get everyone to want it for it to become available to anyone, because it would be part of the statewide infrastructure.

Mr PAKULA — Just picking up on that, what occurs to me is that whether you are talking about IT or any other kind of health initiative, particularly in the Victorian health system, but I am sure the attributes are common to others, is a difficulty in coming up with any kind of common architecture where there is such a devolved governance framework. It is not just devolved governance but a whole range of different health systems with different IT platforms, with different methodologies, different patients, different services, different clinical applications and different patient admission processes. As I said, it is not just an IT issue. It could be about any kind of common architecture that the Department of Health wants to apply across the network. Going forward for the Department of Health what lessons should they take about trying to apply any kind of common architecture for anything where there is such a devolved governance framework amongst the health networks themselves?

Mr RICE — It comes back to the previous line of conversation. If you are going to do something this difficult — and it is difficult because of the stakeholders and the variable processes — make sure you are clear on why you are doing it and what the benefits are, because the challenges you will face will not equal the small return on investment that IT standardisation gives. You really need to go for common business processes and centralised business processes. With technology these days there is no reason to have certain departments in every single hospital in the state. If you are sharing one system, you can centralise some things like referral management and bookings, and that sort of things.

Mr PAKULA — Patient histories?

Mr RICE — Yes, and I think the benefit of hindsight is great. We are capable of doing more of that stuff now; 'we' as in the sector and ourselves. But at the outset this project — not that I am aware of anyway — did not target any of those sorts of wins. There was not a business plan that I am aware of with a whole range of cost savings from doing things the same way. I am talking about business process rather than just IT stuff.

The CHAIR — I can satisfy your curiosity about a business plan. We are advised that there was not a business plan as such. That is one of the reasons why you cannot measure against the outcomes.

Mr ANGUS — As the chair mentioned at the outset, the objective of our inquiry is to gain some learnings for the future and to be able to put that into our report. You have already commented on some problems that you encountered, and you mentioned one a minute ago in terms of the high turnover of staff and so on. I want to flesh that out a bit more. Would you like to comment on any other unforeseen or unplanned problems that might have occurred during the course of your involvement that could perhaps be better addressed in future projects?

Mr WHITE — It is difficult. It is easy to be critical. There are positive elements of the program as well. I think the things I have just touched on are probably the key areas. Inevitably the management of the hardware infrastructure centrally will always be an ongoing argument about whether it should be done by government or whether it should be done by a specialised company, and whether or not a vendor should be responsible for supporting and maintaining its own software directly with the agencies.

It was evident that there was a high turnover of staff in HealthSMART services, and I think there are probably a couple of reasons for that. One was that it was a high-pressure environment in HealthSMART services, because the time lines were aggressive, especially as we got towards 2008 and 2010. When I joined we pretty much ramped up and took the view that we would do a lot of upgrades, so rather than trying to use the big bang approach we would get them on the base version and then keep going back and upgrading. So generally those guys were working very long hours, because when you are trying to upgrade in a production environment you can only do it after hours, so there was a lot of night work and some weekend work and so on and so forth.

Obviously those guys were coming under increasing pressure, because they were getting their brains filled with us trying to train them on the product as well, plus all the internal pressures. Whereas with people like ourselves, because we come across that every day with our own clients, it is just day-to-day-business, and there would not be that type of pressure or those types of hours that needed to be worked because we are specialists in our own software; it is just a reality. Outside of the tripartite agreement and the complexities that came with that, to be honest I would not say there were any other areas that come to mind at this point in time.

Mr RICE — I will add one. I do not pretend to be an expert in how the funding worked internally, but we did sense some issues in that HealthSMART were our contracting party and then they on-charged our capabilities, our services, to the agencies. That in itself implied there were multiple budgets at play here, and the budget was a problem for the client, HealthSMART, the whole way through the program. That disabled them from taking advantage of our advice and recommendations as we got into the program. There was just no more money, and there was contention. That led to trade-offs that HealthSMART had to make. They had to say no to their agencies, that they could not do things to improve it unless the agencies stumped up the money to make it something that was available to everybody. I think, firstly, centralised funding and have it in one bucket, if you like; and secondly, make sure you have a separate allocation to take advantage of things you learn as you go through the project.

Mr SCOTT — I just want to follow up your comments when you were discussing the issues involved in the project relating to the probity environment in the public sector. I am interested in any comments you would like to make about what the experience for you was of the probity requirements and what impact that had from your perspective on delivery within the project.

Mr RICE — Sure. This is a personal opinion, not a CSC view. We do well out of our relationships with various governments, so I do not want to damage those, and I do not want to appear ungrateful.

Mr PAKULA — What an honest statement!

Mr RICE — My personal opinion is that procurement is not aligned with what the client really wants. The client would normally engage with an organisation like ours because they want an outcome. There is a reason for doing it, but they do not contract us or pay us based on that outcome. It is really task driven. It is, 'You will do all the things in the project plan' rather than, 'At the end we will have a fully working system that saves you money or makes patient flow go quicker', or whatever the outcome you are looking for is. That is the contracting phase.

In terms of actual procurement, what they do is define requirements by committee. As you would know, the nature of the people involved is if you are investing time in this, you want to be heard. You want to make sure that the stuff you put on the table gets included in the ultimate specification. What they end up with is a quite a fat specification of what we have to deliver. Nine times out of ten, to achieve that full compliance, we have to do customisation. The customisation is difficult. The commodity software you will use at home will not be customised at all. You install it on a CD and you use it. It has some configuration options, but you do not ring up Microsoft to say, 'I want an enhancement'.

When dealing with the public sector, you end up doing a lot of enhancement work to satisfy all the people who have contributed to those requirements. The problem is that it is very hard from a single sentence and a tick box where we say we complied to then deliver the software and have them say, 'That was not actually what we meant'. That creates conflicts, there is no budget to pay for additional enhancements and then there is the risk to the project of product enhancements holding up project tasks. If you do not have a stable build, including everything that was due in that build, other tasks have to go on hold until you get that right. The more enhancements there are, the more risk there is to the project running smoothly.

I think at the outset when you are looking for an outcome, surely that outcome is not that we will have all the functionality to give all the users everything they want. That is an unrealistic objective. We end up, because it is driven by a contract, complying with that original RFP or tender requirement, rather than giving them the benefit of what we can really do. It is just the way it is. It does not work

On probity I guess during the process it disables you from being able to engage with the potential client to gain a better understanding of their requirements, or to say, for example, 'We know you said you wanted this. You think you do. We've implemented this a hundred times and we find that this is what actually works'. Because in probity you are not allowed to talk, you do not get to have those conversations and pad out those requirements into something that could be easier to deliver and better for them.

Mr PAKULA — When you say that because of probity you are not allowed to talk, is this up until the tender award, or are you saying it is even after the tender award?

Mr RICE — During. So from the minute the RFP hits the market, and in some cases with some clients it is before then, they might say, 'We've got an RFP coming out next month. I can't talk to you about this', because they are worried that we are going to influence the content of that RFP. Once it is out we are not allowed to talk to that organisation while we put our response together, to the point that even if they tell us that we are preferred — in other words they have selected us — from that time until they sign a contract there are still various probity issues they believe prevent them from engaging properly with us.

Mr PAKULA — That is the period I am interested in. From the time you are declared preferred provider, there is obviously a haggling period when you go from when you have first dibs to contract signed, do you feel that even in that period you do not have a proper opportunity to point out issues, problems and scope?

Mr RICE — Absolutely; we do not. The reason is we are often told by our clients — and this is not a Victorian thing; this is across the board — that any change to the specified requirements would mean they would have to go out to tender again. The extreme example would be they go out looking for a blue one. We demonstrate a blue one and get preferred and then say, 'Actually we have a better red one'. They cannot buy the red one, because they have not given the market an opportunity to propose a red one, if that makes sense.

Mr PAKULA — Is that the triumph of form over substance? I do not want to put words in your mouth, but obviously all of us who have either been in government or are in government for various reasons are incredibly sensitive to these matters. It is not just politicians, it is bureaucrats as well, because it is one of the easiest things in the world for anyone to do, which is to make an allegation of a failure of probity or preferred access. Those sensitivities exist for a reason; if these things are not done properly, they can lead to some really perverse outcomes. Where should government find the balance?

Mr RICE — I think balance is the key. It has to be a bit of both. But I think what you really want, whether you can do it or not, is to say, 'The reason we want this system is because we want this outcome. We need to pick a partner and evaluate them on the basis of whether we believe they can or cannot deliver that outcome but give them some latitude to propose a range of options on how to get to that outcome'.

Mr PAKULA — Without necessarily having to go back to the market?

Mr RICE — Yes, because it is all about evaluation criteria. If the evaluation criteria are to tick boxes against 800 functional items, it does not give any latitude to propose an alternate approach, whereas if it were more like 10 requirements that say, 'We want to see 10 per cent more patients, we want more accurate billing and we want to streamline the health claims process so we have better cash flow', and you identify 10 things and look for a partner who has the capability and experience to deliver those things, the how they do it is something you should work on together. This is an aspirational — —

The CHAIR — It is an outcomes versus an inputs process.

Mr RICE — Correct. I will say it on the record: we are in a situation now with the state of Victoria where we went through a tender process, we were successful in being selected, we negotiated a contract and we have delivered everything in that contract. I do not think we think the customer is getting as much out of the software as they can, and I truly believe the client cannot point to why they did it or what benefit they are getting from it. That, to me, is a consequence of the way it was procured.

Mr PAKULA — It is something that the committee will have to think through carefully because in some respects we have had two pieces of evidences today which are almost diametrically opposite. Kamco was in this morning on a whole other system.

Mr RICE — Sorry?

Mr PAKULA — Kamco, myki; their basic evidence was that, in terms of the original specs, it was too broad and there were not enough specifications. You are saying too many specifications and not enough focus on the ultimate outcome. I suppose we are going to have to sift through those two very, very different perspectives to understand which of those two is better. I say that as an editorial rather than asking a question.

The CHAIR — You are just complicating our lives.

Mr MORRIS — Just on that point — I am not asking a separate question — I think what I heard earlier was that effectively the system that you have provided was basically an existing package which has been modified to meet local needs — whereas in terms of this conversation my understanding is, and Mr Pakula may be able to throw some light on it, that Kamco were hired to build something from the ground up rather than coming in with an off-the-shelf package. That is the way I understood it. I will just throw that in, and we can perhaps come back to it. The point Mr Rice makes is an important one, but if you are essentially building something from the ground up and modifying an existing proven package, they are two totally different things, so the contract approach could well be different in each case.

Mr RICE — Yes. It is about user adoption. If you say, 'I want a system that does XYZ', and we go away and build it from the ground up, it might do X, Y and Z, but your users might reject it. There are things like this. The specification might say, 'You need to be able to produce a report', for example. If your users have to log in three times, go through 10 screens and click 100 things to get the report, it is not fit for purpose, yet it meets the specification.

Mr O'BRIEN — Just drawing that together, one of the things that you identified at the start and that has been identified in this project is the paucity of the business case or the up-front work that a decision-maker of government would need to think about: all the issues that relate to potential specifications, including the purchase of an off-the-shelf product for implementation. I see you nodding there. Is one way that the direction of an ultimate decision can be better informed to have gone through a lot of the up-front feasibilities, business casing and in a sense slowing down the ultimate contractual decision but coming up with a better outcome by taking the time to get that business case right?

Mr RICE — What is relatively normal in our industry is to go through a period of planning, an implementation planning study. What is not good for us during that process is that a client might change their mind. But what is good from the client perspective is that they have an opportunity to delve into the detail and come up with perhaps ultimately different ways of doing things, and they are not really formalising or committing the whole thing until they get to the end of that planning process. There is a bit of a try-before-you-buy kind of arrangement. It is quite normal in our industry to do that. I am not sure whether HealthSMART committed to everything at the end of the planning study — or did they do a planning study?

Mr WHITE — No. What happened was, obviously our iPM has been around for 10 to 15 years so is already quite a stable product. They selected it based on those functional requirements, and then they paid us to do an iPS, which then identified what they called their enhancements to the product. That is going back to that initial stage where they defined the functional specifications.

We sat down with a select group of stakeholders to demonstrate the iPM product. Then gaps were identified as part of the iPS — they could be technical gaps, architectural gaps or functional gaps — and as part of that we created a list of enhancements that then formed the basis of the contract for us to also deliver.

That was great; that was right at the start of the program, and it was by a select group of users. But in two or three years time when that functionality starts to materialise, like James says, because it is very much 800 lines of things, we get to the point where when we go to, say, Melbourne Health and start to implement it, they say, 'We don't actually admit patients like that'. We say, 'We delivered what you told us to deliver', and the people at Melbourne Health say, 'We weren't part of that process'. So we say, 'Well, you know, guys, what do you want from us?'. It is very difficult.

Mr O'BRIEN — To follow on with that point and turning to that outcome, we heard evidence the day before yesterday from the Victorian Auditor-General's Office, and Mr O'Connor did some work, and one of the issues identified was that one of the outcomes or benefits of this program was supposed to be for the clinical application. He gave the example of records being able to be called up instantly rather than having to be couriered over. Unfortunately, I think — and I have asked you to elaborate specifically on what your program does and what others were meant to do or how this could have been put together — we have had the patient admin side of it done but not the clinical histories. At paragraph 290 the Ombudsman says in his report that they:

> overestimated the standard of local infrastructure and the skills of local ICT staff
>
> underestimated the full costs associated with training … nurses …

In a sense you have talked about the three groups, being HealthSMART, you and the various health agencies, but you have the clinical doctors and nurses who are there. I just want to get to the question, because the other thing that is emerging all through this is rapid advances in technology, like iPhones, iPads and so on. Just as an anecdotal thing, when I last went to a GP, I was very impressed by how much they were able to put into the system in terms of the prescriptions or whatever.

Mr MORRIS — They did not pull out your card.

Mr O'BRIEN — There were no physical documents, it was pretty rapid and it did not slow down the treatment. They are obviously able to deal with the IT side of it; it is the network and coordination that has fallen down. Could you get specific for us in terms of those issues?

Mr RICE — Yes, I can, and Gary can feel free to jump in. IT on its own is relatively easy these days. As Gary said earlier, what we are actually talking about here is a change management program. In my opinion IT only exists to automate business processes that have been around for years and years anyway. One should not underestimate the challenges of getting health-care professionals to change the way they work. It is not impossible, but you need to focus on that and give it the right level of attention. We know that better now, so for those who do not know, e-health is what we call our industry. Health care is one of the last industries to really embrace IT, and it is really because of the competition for scarce funding. IT is still viewed as a cost by many organisations.

With something like a PAS — patient administration system — they just know they need it. They cannot manage their hospital without it, whereas the clinical information system manages less business processes but requires more change management because of the people that are intended to use it, because in many cases they just did not use IT before.

Mr O'BRIEN — What was that? Did you say there was a different contract for the clinical side than the admin side? How did that happen?

Mr RICE — Contract under HealthSMART?

Mr O'BRIEN — Yes.

Mr RICE — That is a different vendor.

Mr WHITE — That is Cerner.

Mr O'BRIEN — It is a different vendor. So they separated that out. Is that a fault in the sense that the clinical should have been in there, integrated at the start?

Mr RICE — There is more than one school of thought on this. I think one of the overall issues with HealthSMART as a program is that no one organisation was given the accountability to deliver the whole program. So we talk about our 'tripartite' — we are not even talking about Intersystems or Cerner. Effectively HealthSMART in this instance has operated as an SI, what we call a systems integrator, which usually is, in Gary's words, the prime vendor, which carries through some subcontractors. We have that capability at CSC; we did not as iSOFT, so it was never proposed. But HealthSMART did not engage CSC or a like company to

do that. They decided to build that capability themselves. The other side is that as an outsourcer CSC is the kind of company that can provide an in-between solution, including professional infrastructure management.

In this instance HealthSMART built its own outsource company, effectively, and in hindsight you could easily turn around and say: is that the core business of a department of health, to be a start-up SI and outsourcer in a short period of time? In hindsight that sounds like a challenging thing to do.

Mr RICE — Can I just anecdotally — —

Mr O'BRIEN — Well, I have shared my medical history.

Mr RICE — Just as an analogy, Gary and I cover an interesting region, the Asia-Pacific, so we deal in countries like Thailand, Malaysia, Singapore and most recently Brunei. In Brunei we have a program of work where we are delivering not only a PAS system, a clinical information system and departmental systems for things like pharmacy, laboratory and radiology for the whole of Brunei's public health sector, which is four hospitals and about 80 medical centres. That project, from start to finish, including planning, is a nine-month project.

Mr O'BRIEN — And the cost?

Mr RICE — The cost for that for us is 4 million. I do not know how much it is costing them.

Mr O'BRIEN — Four million?

Mr RICE — The whole project will be delivered for less than 10, and that is Brunei dollars — the same as Singapore and Kiwi dollars, about 8 million.

Mr O'BRIEN — If it were not so serious, it would be funny.

Mr WHITE — That is what we are saying.

Mr RICE — I can tell you verbatim, the Minister of Health there asked me why it takes so long in other jurisdictions. I mentioned committees, and he said, 'Well, I have committees as well, but I am the chair of those committees'.

The CHAIR — I would like to meet him.

Mr PAKULA — He might have some more weapons at his disposal. Metaphorically speaking, of course, Chair.

Mr O'BRIEN — I think he would be at a massive disadvantage.

Mr RICE — But there is a lesson in there somewhere.

The CHAIR — I could not possibly comment.

Mr ANGUS — Just going back to what you said before, in relation to your instructive document, you said you never saw the business case, that it was before your time and for whatever reason it was not in your papers, or whatever. You were working off a contract; is that correct?

Mr RICE — Yes.

Mr ANGUS — So that must have been a very detailed contract in terms of what you have just outlined, was it?

Mr RICE — I can explain how the contract works.

Mr ANGUS — Would you mind, please?

Mr RICE — Sure. What typically happens when an RFP is published in the market is that it will have some preamble about what the objectives of the project are, then it will have some check boxes on required

functionality and then it will have a section where we put a commercial proposition forward. When it comes to the contracting stage, the focus is on the third component — 100 per cent, obviously. It touches on the second component in the requirements, but there is generally no reference whatsoever to the objectives. As a vendor, what we do is we write a nice spiel in relation to the objectives, which is really drawing on our other experiences and delivering those outcomes for our clients. The functional requirements are usually replaced in a contract with something called a statement of work.

What we do in a contract is we have head agreement, which looks after the engagement of the corporations, and we have attachments for software licensing, and that is generally driven by our own desires to protect our intellectual property. That is really our putting some restrictions around what it is we are giving the client. There will then be an attachment for support, which will be a service level agreement that is typically defined by the client and charged for by us. The third attachment to the contract is a statement of work, which is a high-level description of how we will go about delivering on the project, and that sometimes will refer to the requirements at the RFP and sometimes it will not. The RFP typically is used to evaluate a product to get a score, if you like, and then it is usually put away. It is different in every client scenario.

The CHAIR — I think that brings us to the conclusion of this session, which has been very enlightening. I was interested in your penultimate comment about another jurisdiction.

Mr RICE — I said it was anecdotal.

The CHAIR — There are a number of aspects about that anecdote that were useful. Thank you very much, both of you, for coming along today. It has helped flesh out for the committee some of the issues. You will receive from the secretariat at some stage a copy of the transcript for verification and it will then be posted on our website. Thank you very much.

Witnesses withdrew.