THE LEGISLATIVE COUNCIL SESSIONAL COMMITTEE GOVERNMENT ADMINISTRATION A MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE, HOBART ON FRIDAY 4 SEPTEMBER 2026.

INQUIRY INTO THE FINANCIAL AND OPERATIONAL PERFORMANCE OF THE DEPARTMENT OF HEALTH

The committee met at 10.00 a.m.

Tasmanian Audit Office

CHAIR - Welcome, Martin and your team. We appreciate you appearing again before this inquiry into the governance and financial management of the Department of Health. It's really an opportunity to update the committee on where things are at now for Health in terms of the financial performance, particularly, and other performance matters or governance matters you wish to raise with the committee. It is a public hearing. Everything you say will be covered by parliamentary privilege. If you want to make some comments in confidence or in camera, you can make that request, and the committee would consider that. Do you have any questions?

Mr THOMPSON - No.

CHAIR - I invite you to introduce the team at the table and to take the statutory declaration and invite you to make some opening comments.

Mr THOMPSON - Thank you. I will briefly introduce my team. Jonathan Wassell, Deputy Auditor-General and Chloe Bellchambers, Director of Financial Audit Services and the Engagement Leader for the Department of Health.

Mr MARTIN THOMPSON, AUDITOR-GENERAL, **Ms CHLOE BELLCHAMBERS**, DIRECTOR, FINANCIAL AUDIT SERVICES, and **Mr JONATHAN WASSELL**, DEPUTY AUDITOR-GENERAL, WERE CALLED, TOOK THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Thank you.

Mr THOMPSON - In relation to the terms of reference of the committee, I think it's relevant if we go back to the 2024-25 financial audit cycle, particularly our Auditor-General's Report (AGR) report on the results of financial statements Volume 3, where we made a number of specific observations and findings in relation to the Department of Health. In that report we identified across the state sector that there were challenges in terms of budget control, and these were significantly greater, both proportionately and in absolute volume, in the Department of Health.

We weren't sure - and it remains, I think it's probably a combination - but we weren't sure to what extent that was from the setting of unrealistic budgets and to what extent that was not being able to operate within a reasonable budget, as such.

Health had been performing quite poorly against budget for a number of years, as had a number of other agencies, and in Health we just elected to do a deeper dive into their

performance reporting information, with the view of trying to understand whether the performance information that was being reported provided insights as to why the budget performance was so far away from expectation. What we found looking at the performance information was that there were about 403 performance indicators, many of which were difficult to understand in terms of what performance they were measuring, many of which were measures of activities rather than outputs or let alone outcomes. Overall, we found that the public performance reporting was not assisting in understanding the performance of the agency.

As part of that, we did some analysis against the Productivity Commission's, what they call the RoGS or the Report on Government Services. Again, that provided us with no insights into the performance of the department indeed. You know, the costs that were being incurred and the investment of funds into the Health sector in Tasmania were greater on a per capita basis - had more beds, had more hospitals. There was a range of things that would indicate or were counter to the performance. But again, none of that was really definitive. I will touch on that in a moment.

What we were also doing at this same stage was we were undertaking a performance audit of the Human Resources and Information System, which was a project being delivered by Health to revamp a much-needed human resource system or to develop a much-needed human resource information system across Health. Basically, we found that due to poor project management, that project failed. It failed to deliver any of the intended outcomes before it was transferred across to the Department of Premier and Cabinet. That audit gave us - although it wasn't core to the focus of the audit - some insights into issues around procurement that gave us some concern that we followed on and did some more work, which we reported in this year's AGR 1. Basically, we found that in addition to poor budget control, performance against budget, and a lack of performance reporting, there was a lack of compliance in relation to procurement, a flagrant disregard for the requirements of the Treasurer's Instructions, and you know, the statistics on that we've provided in various reports.

That also led us into the Bluegum project. The Bluegum project is a comprehensive IT renewal project across the Department of Health. An estimated cost of in excess of $400 million, I think around $470 million over a 10-year period. Now, that funding is not in the budget at this point in time. So, just to be clear, that's the costings at this stage that the department have prepared for the project, but not what's gone through the budget process. Overlaid, the budget control, the performance reporting, the poor project management, the failure of Human Resources Information System, we were, and still remain, very concerned about the Bluegum project.

We are pleased, despite initially receiving advice from the department that there were no issues in relation to how they were managing their procurement, after subsequent discussions and reporting and, indeed, work by this committee, the head of Health sat down with the head of Treasury and agreed a new procurement framework, which we've seen. And what's been documented does look to be an improvement. It looks to bring a level of probity, transparency, governance, value testing into the procurement process, but -

CHAIR - Is that an available document, do you know? I'm not necessarily asking you to provide it - it's probably not your document - but is it a finalised framework?

Mr THOMPSON - We understand it has now been finalised and it would be potentially something - there will be aspects that are perhaps not on there - but with most agencies, their

procurement framework and policies are made available publicly on their websites. So, it would certainly be something, I think it would be - and again, we haven't got there in our audit cycle at this point - but it would be something that would be interesting to understand how the department's actually rolling that out and how they're ensuring compliance. Because one of the things I would add in relation to the frameworks, the policies, the procedures and practices, it's not enough to simply have the policy and the procedures there. There needs to be a process around compliance and ensuring that that is occurring.

Ms THOMAS - Clear responsibilities for that.

Mr THOMPSON - Clear responsibilities and accountabilities. And that's where there's been a gap in performance at Health, but in other agencies as well, in terms of ensuring compliance with the existing policies and procedures and the like.

Ms THOMAS - While we're just on that, does that new framework apply to all procurement by the Department of Health, or just the Bluegum project?

Mr THOMPSON - My understanding is that it applies to all procurement.

Ms O'CONNOR - Does it have a compliance framework within it that you can identify?

Mr THOMPSON - It does have aspects of a compliance framework but, again, we would need to test the effectiveness of that over time.

Ms GLADE-WRIGHT - What was it in the framework that you were happy with that was a change from previous?

Mr THOMPSON - There is a recognition, for certain IT projects, that there are some challenging specifics around the procurement process. The previous approach was to avoid the steps which are effectively around appropriate oversight, so procurement committees and the like; market testing, so actually going out for a public bid process. And rather than going through those added oversights and market testing processes, contracts were struck below a threshold that enabled them to be done in a non-competitive nature.

The new framework moves away from that and recognises the need for appropriate oversight. It also recognises that, in relation to IT, the procurement process may be more around procuring a range of expertise - individual or collective - rather than procuring of specific goods, which is where it was being problematic in the past. It's where Health had found the difficulties of complying with the framework in the past.

CHAIR - I think some of the evidence we undertook through the Estimates process, too, alerted Treasury to some concerns as well.

Mr THOMPSON - Yes. I think there's a bigger question which we are working on at the moment. We have a proposed audit over the budget oversight process which is in our program for this year, and one of the catalysts for this has been the poor performance against budget in the past. We want to better understand how the budget is prepared, the underlying assumptions and the ability to deliver on those assumptions, and the role of Treasury in relation to that. So, that's a performance audit we've got scheduled to start later in this year. It is actually one of the ones that we don't have funding for at this point in time, but we have a range of

mechanisms available to us to look to deliver that audit. And I think it's really important that we do Health, and the performance has given us an indication of a problem that might go more broadly. Now, Health, obviously, is the largest single agency and the largest contributor to the budget overspend. It is clearly something where action needs to be taken, but I think if we take a step back and understand Treasury's oversight in relation to this role, and the preparation of the budget, that will be useful in informing the parliament in relation to these matters.

CHAIR - So, under a quick search of the Department of Health website, when you're searching for procurement framework, you can't see anything. I can see a design governance framework from last year, but nothing more recent, unless it's buried somewhere.

Mr THOMPSON - It wouldn't necessarily be surprising if it's not updated to the website at this this stage. And again, different agencies apply, you know, different requirements to what they put up on their website.

It probably brings me to, I guess, this year and where we are in 2025-26, and I hasten to say that our audit is continuing. We haven't finalised our audit at this stage, but we are well progressed. Based on the publicly available information, the preliminary financial outcome that Treasury published, I think Friday week ago, again, this year, Health has not performed in line with budget expectations. So, I think it's clear in the preliminary financial outcome that Health has overspent by about $200 million this year.

CHAIR - Which is interesting, Martin, because when we asked the Secretary at our hearing, he estimated a cost of $43.2 million. And I did push him on that a couple of times, so $200 million?

Ms LOVELL - When we asked again at budget Estimates, he said the same.

CHAIR - That's right.

Mr THOMPSON - There may be a difference between additional appropriation and additional expenditure. I think there was a RAF - additional funding.

CHAIR - We don't see RAFs.

Ms LOVELL - Can I ask that question on this? Sorry, keep going.

CHAIR - Yes. Keep going, Martin. I'll come back to you.

Mr THOMPSON - Perhaps I'll just make the general statement that there are multiple ways that you can fund overspend into budgets, and in the previous year, Health received an additional appropriation of $200 million, thereabouts, to fund their overspending. You can also fund overspending through your balance sheet. So, you can increase the amounts owing to your creditors or other suppliers and the like, and that can result in a significant overspend in budget that doesn't require an appropriation. The appropriation's only required when we spend the money. Sorry, the appropriation is required when we make the payment. The expense is incurred, potentially, at a much earlier point in time. So, by increasing liabilities on your budget, sorry on your balance sheet, you can increase the expense incurred, and then you can fund that out of the subsequent appropriation. And that's something that is -

CHAIR - Did you see evidence of that?

Mr THOMPSON - Well, I think even in the publicly announced information in the preliminary fiscal outcome, the overspend that's attributed to Health is around about 200, in terms of staff and supplies, where their big expense is. The only way you can do that, if you're not doing it through additional appropriation, is through the balance sheet, so managing your assets and liabilities. You can run down your assets, and one of the observations we've made over a number of years is that Health has run down their assets significantly. I think we went back two or three years and, please don't quote me, but they had a couple of hundred million in available cash and that's now down to - last year, I think it was down to a relatively - a very small amount.

Ms LOVELL - Thank you, Martin. I want to explore this with you a bit further because one of the things I found difficult to get any sort of meaningful information about through the hearings with the Health department was that - when we questioned them about these overspends and their accounting and how that all works out, and the cash reserves, and supplementary appropriations, all of those things, they, - I mean, and it is very complex and we know it's complex - but they were talking about, you know, there's money that comes from the federal government - like, there's other sources of revenue. There's revenue from the federal government. There's revenue from Medicare. There's revenue from various bits and pieces, and it, it seems -

Mr THOMPSON -Yep.

Ms LOVELL - It was this complex picture of all these different bits of pieces that somehow, miraculously, at the end of the year is expected to balance out. It makes it very, very hard - the way that's reported makes it really difficult, I think, for anyone to really see what the real picture is, with the Health budget and Health expenditure. I'm interested in your thoughts on that situation generally, but also on whether there are improvements that can be made or something that can be done differently to make that clearer for people, so that we can properly understand what's happening with the Health budget and with Health expenditure.

Mr THOMPSON -Yeah. It is complex, but there are organisations out there that do communicate where their income comes from and where their expenditure goes to. I received my annual tax statement recently and the Commonwealth runs through where all of my tax goes and breaks down where it goes and it's a really useful - I mean, I'm an auditor, I wanted to audit it - but it's a really useful way of communicating, you know, you've paid all of this tax and this is where it's been used. I think it is generally recognised that financial statements prepared under the relevant standards are quite impenetrable to non-financial, or non-accountants.

Ms LOVELL - Me.

Ms O'CONNOR - A challenge for you at times?

Mr THOMPSON - Well, I think my challenge is interpretation, so communicating the results and the story that a set of financial statements tells is a little bit of an art form. But, I think it's important to not only look - so, I think there is a role for improving the communication. When we get to our reports on the results of the financial statement audits of the three sectors that we'll be tabling later in the year, part of our process will be trying to

simply communicate what these mean and what risks these numbers enter or that the financial statements are symbolising. With Health, and I'm just looking at their last year's published financial statements, but you're right -

CHAIR - The last year being 2025-26?

Mr THOMPSON - Sorry, 30 June 2025 - last year's published. We've got draft numbers for this year, but I don't really want to talk to those as the audit's in progress. But, appropriation revenue represents about $2.4 billion. Grants, which the bulk of that is Commonwealth funding, represents about $770 million; then sale of goods and services and other revenue is about $350 million. So, they've really got, I guess, three revenue streams: they've got the state appropriation, which is the largest portion; a substantial amount of Commonwealth funding, if I simplify that; and then sale of goods and services to consumers, which is the smallest of those three groups. To an extent, in terms of the operational performance of the department, it doesn't greatly matter where those funds come from.

When we look at their expenditure, again for last year, it was $6 million more than their income and I think that tells you a story. I think when you look at that, you also then need to think about, well, what was the budget? Their budgeted revenue - because I think the budget is really important because that's what they said they would do. Simply put, they said that they would operate on $3.2 billion; they ended up having $3.6 billion in revenue. Of that difference, a ballpark $350 million, about $300 million was additional appropriation. So, if they were operating in line with what they said they would do, they would have required $300 million less in terms of the appropriation. The issue that would have evolved then is that they said they would only spend $3.1 billion, but they actually spent $3.57 billion - so, 3.6. There's lots of reasons, and this is the reason we ended up in their performance information last year, to try and understand why have they spent so much more than they said. We also then went back and looked at 2024 and at the prior years as well - which was a prior year, and that's always really useful because that's what they did last time around. Last time around they spent $3.4 billion, so this takes us back to that question around the budget: if you spent $3.4 billion, was it ever reasonable to have a budget of 3.2? That's why we're going to -

Ms LOVELL - Which they do every year, you can't do that every year.

CHAIR - In that year - was that the year they also reduced their cash reserves right down?

Mr THOMPSON - In that year, their cash reserves were held steady, but the previous year - so, they dropped their cash reserves by that $200 million, and please don't quote me, but it was in that vicinity. So, they thundered their overspend through running down cash reserves. That's just a mathematical -

Ms LOVELL - We asked them some questions about that as well and they said that - because I think it got down to about $11 million or something at some stage - and the explanation we got was that that was kind of a point in time at the end of the financial year and then it would bump straight back up after. They seemed to think it wasn't a big deal and nothing to worry about because there are these other sources of revenue that will come in at various times and bump it back up. What's your view on that, Martin?

Mr THOMPSON - My view on that is, if the cash balance has come down to a low level and their assertion is it's a timing difference, then we would expect that there would be a

significant increase in the receivable balance. Our cash has only come down because we haven't received the money that we're entitled to. That hasn't always - and I apologise, because I am starting to sound a bit technical -

Ms LOVELL - No, it's good because you explain it well.

Mr THOMPSON - If we look at - perhaps a better way than just cash in that argument, is to look at financial assets because they're cash and everything is going to become cash shortly. So, what we're seeing - they do have a high number of receivables and they do have aa high number of other financial assets and that's a little bit problematic.

Ms LOVELL - Can you give me an example of a financial asset in this context, please?

Mr THOMPSON - Most of it's what they call accruals. When they provide a service, either a Medicare-funded service or a private-patient-funded service, which is a lot of that other revenue, if you like, the first thing they do is they'll recognise that revenue and they'll create other financial asset in accruals and then, once they get around to it, they will actually invoice the patient or the health fund or whoever, then they will subsequently collect that cash. So, in accruals before they issue the invoice and then they get the receivable. We have raised with the department, formally through our interim reporting to them this year, there is a problem - there are challenges in the system around the timeliness of this. So, that means that they end up with higher levels of accruals than they should have.

CHAIR - Because they don't bill as frequently as they possibly should?

Mr THOMPSON - Yes. Chloe, did you want to tell the tale of your team member?

Ms BELLCHAMBERS - Yes. So, this was at least 18 months ago. We were having a conversation that she had received an invoice from the department for when she was in hospital and had her son and he was about two and a half then and she was getting an invoice. That is how far behind they are.

CHAIR - That sits on their balance sheet all that time?

Mr THOMPSON - The issues that we've discussed with and we've raised through our reporting process - the timeliness of raising invoices. Our sample testing identified this year, which we would have been undertaken in May or June.

Ms BELLCHAMBERS - April. I think.

Mr THOMPSON - April. Services back as far as March 2024 were being invoiced this year.

Ms O'CONNOR - How does that happen in a functioning health system? I'm sorry, that question is slightly unfair, but -

CHAIR - It's the financial side of the health system, the financial management side as opposed to the service delivery side. The back office.

Ms O'CONNOR - Yeah, but is the back office so hollowed out? What is it?

Ms LOVELL - I think this might be one of the things they've identified as - one of their budget repair measures, is doing this more.

Mr THOMPSON - I think it's a really good question for the department because I think - we've had conversations, we've reported matters around the timeliness of raising revenue. It is a known complex area, both in terms of the raising of invoices and the like, but also in terms of the activity-based funding and the coding of services and those sorts of things. It's a complicated area. It's not uncommon for some delay or lags in that space, but, when you've got stuff going out for services that were provided two years ago that's probably beyond what would be reasonably expected.

CHAIR - Even if they do clear this backlog as one of their efficiency measures or whatever they want to call it, once they're cleared, then the problem still persists, doesn't it? Or the challenge is still there.

Mr THOMPSON - There's two issues, possibly three issues with the delay in invoicing. One is it increases the real likelihood of gaps and lost revenue through failure to invoice at all. They may not - there's a risk that they're not invoicing all the services that are being provided. Equally, when someone receives an invoice two years after service, they're less likely to pay. That leads to an increased level of provisions for doubtful debts and write-offs of debts. A more timely process won't structurally change the level of services delivered, but it will probably reduce the risk that things have just been missed and reduce the risk of non-payment down the track.

CHAIR - Just back to that other point, once - well, let's assume they get themselves all sorted and they get the invoices out and the backlog to the point that they're issuing them in a reasonable timeframe - I'm not sure what that is, say three monthly or whatever, I don't know what that number is - the problem doesn't actually go away entirely. You might get some of the revenue in or the money in from charging, but once it's in, that's it. Then you still have to continue to deliver the services. It's a measure that'll have a temporary benefit if they can manage to collect it, but beyond that, then what?

Mr THOMPSON - Yes, I mean it doesn't change the overall financial equation, if you like. So, we don't know. I mean, we would suspect and estimate that any lost revenue is relatively minor in the scheme of the $3.3 billion budget, so there's no silver bullet there. But, certainly, just improving the cashflow and getting that back into a reasonable level would be a positive, but it's not going to solve the -

CHAIR - Down the line challenge?

Mr THOMPSON - No. I mean, there may be, through reviewing the processes, there may be some efficiencies in there that can be found, but again, it's not going to address the root cause of the department's financial position.

Ms O'CONNOR - I'm just interested to step back a bit because Health is constantly running over budget. The budget is approved by Cabinet, ultimately, and there's an argument that the department is putting up a budget submission that it understands the minister wants to see. So, to get a better understanding, from your perspective, how much of the problem is a structural underfunding and how much of it is inefficiency? I mean, it must be a combination of both?

Mr THOMPSON - So, that's why we're going to do a performance audit on the budget process and we will - so, in Victoria every year the Auditor-General audits the budget.

Ms O'CONNOR - Before or after it's passed?

Mr THOMPSON - In parallel, so that when the budget papers are prepared, there's an audit opinion in the budget. Now it's a negative assurance opinion in the sense that the budget's never going to be the actual result into the future. Now, I hasten to add, I'm not proposing that that's something we would necessarily do on an annual basis, but part of our budget review, our budget audit that we're working with - we're in the very early stages with Treasury - but part of the approach to that will likely be to look at, what are the assurance requirements and perhaps try and apply something along those lines and work with Treasury through the budget preparation process to understand how Treasury ensures the accuracy of information going in, so, the budget bids.

And, ultimately, the decision of the budget committee of Cabinet is the decision of the budget committee of Cabinet. That's the budget that's set. And then, what's the process on the other side of that to ensure that actions are put in place to manage and deliver and operate within that level of funding? So, again, it's important in our work, we're not interested, as such, in the deliberations or the decisions of Cabinet around the budget process, just that the information that goes in is appropriate, accurate, transparent, clear, identifies -

Ms O'CONNOR - Realistic?

Mr THOMPSON - Realistic, yes, absolutely. And then the information that comes out is the information that comes out of that process. But we're interested in, are processes then put in place to ensure that operations are delivered within that funding envelope. If we, again I would ask - I mean it raises the question and I don't have the answer, that when you have an agency that spent $3.4 billion in one year, and a budget to spend $3.1 billion in the next, it raises a question as to what was the process, what were the plans, what were the activities to bring that - it's around about a 10 per cent reduction in what they spent one year to what they spend the next year.

CHAIR - This has been a pattern, though. It's been going on for years. That's one of the reasons I asked for the estimated outcomes in the budget papers, which, by and large, we're now getting, because it does give some sort of indication of what the likely spend is as opposed to the budget, and the whole rhetoric around record spending in Health means nothing if it's actually less than what was spent. So, I mean, it just seems to be a vicious cycle we're in here.

Mr THOMPSON - Yes, and again, this is the objective of our planned performance audit of the budget process, and Treasury's oversight of the budget process is really to provide some information to the parliament about that. We're not going to solve the problem, but hopefully we can shed some light on it, and potentially others can take action as a result.

CHAIR - Martin, last time I think we talked, and we certainly did with Treasury, about what their role is in monitoring compliance, that can take us back to the whole procurement issue with the HRIS and Bluegum. Is it any clearer to you that Treasury does have a role, or is it still a bit murky?

Mr THOMPSON - We have a really clear view that for a system to work, there needs to be a compliance function. In the absence of oversight and compliance, things go wrong. I can take you back to the establishment of the audit office 200 years ago, and it was on the basis of fraud in the police fund. At the time, a naval officer was in charge of all of the income, expenditure and payments of the colony, and there was no segregation, there was nothing. When Lt Governor Arthur was appointed, he had a concern, had someone look into that, and they identified, yes, fraud of £8388 from the police fund over a number of years. That's the equivalent of $1.8 million in today's money.

Now, that happened because of a lack of oversight and a lack of compliance. Two hundred years later, that rule still stays. In the absence of oversight and compliance, things go wrong, so we have a really strong view that there needs to be a compliance and oversight function. What that looks like doesn't necessarily mean that Treasury needs to be the regulator or be the one providing the oversight and ensuring the compliance, but it needs to be built into the system. And there's a multitude of ways that that can be done, through various reporting oversight, internal control mechanisms and the like.

But a constant theme that we're seeing, and certainly focusing on at the moment, is that there's a number of areas where oversight hasn't been adequate: the procurement issue, oversight and compliance. If we go back to our funding of community service organisations - oversight and compliance - there were known high-risk issues there that just weren't being addressed. If we think about the HRIS project, the failing was not the people working on the project, it was the oversight that failed.

CHAIR - So, whose job is this?

Mr THOMPSON - I would say, in terms of the budget process to establish the oversight and compliance function would be the role of Treasury, but whether it's Treasury that deliver that or whether it's elsewhere, there are multiple ways it could be addressed.

CHAIR - On the finance side of it, if we stick with that for a minute, Treasury would get monthly reconciliations of expenditure and revenues from the department?

Mr THOMPSON - The level of sophistication and accuracy in internal financial reporting across the various agencies is varied, so not all agencies - yes is the shortest answer to that question. It would be a good question to ask Treasury as to the consistency, quality, and their perception of the accuracy of that information that they receive -

CHAIR - And how do they assess the accuracy of it.

Mr THOMPSON - Yes.

CHAIR - As far as the risk management side of it is concerned, like, in the community service organisations when there was a huge gap there that actually, from memory, that report of yours said there had originally been 12 risk assessment officers and it's down to two, for example. So, there must be a role within Health for that?

Mr THOMPSON - Yes. There's a financial management compliance framework in another jurisdiction that's really - and I don't always like talking about other jurisdictions - but it's really comprehensive in terms of the reporting structure and forms and requirements. It's

quite a useful framework. It also has a really good compliance aspect to it. It requires a each agency's internal auditors to undertake a review of their compliance with the entire framework on a progressive basis. The results of that review then get fed to the central equivalent of Treasury, which gives them intelligence on the effectiveness of the compliance frameworks of the various agencies.

There's mandatory reporting requirements into Treasury as well. We have - and actually, it's interesting - we had our internal auditors undertake an audit of our organisation's compliance with the Treasurer's Instructions here, and as part of that review, which we passed -

CHAIR - That's good news.

Mr THOMPSON - There were some findings, but we'll work through those. No high-risk matters. But as part of that, we asked the auditors - who are Victoria-based - about comparing the Treasurer's Instructions here and the financial compliance work that they do in Victoria. I think their comments were interesting in that they saw the basis - you know, the broad structure was quite reasonable, but they were a lot less directive and detailed than Victoria. And that may be okay, but I think it's worth exploring.

CHAIR - So, the Victorian framework you're referring to, yeah? So, if we ask Treasury here about that, would they say, 'Well, our Treasurer's Instructions fulfil that function?' Is that how it would be seen?

Mr THOMPSON - I can't say what Treasury would say, but what I would observe is that the Victorian model had a lot higher focus on compliance, and a lot of that compliance requirement is pushed into the agencies and the accountable authorities. But they also have a lot higher level of requirements around reporting to a central agency. So, rather than requiring a central agency to do all of the compliance work, a lot of it's sort of self-assessed, and that gives the intelligence, so that the central agency can follow in, or follow up, where appropriate.

Ms GLADE-WRIGHT - And the cost of that?

Mr THOMPSON - There is a cost. You know, compliance comes with a cost. I think some of the budget performance we're seeing is potentially the cost of not having a compliance framework.

Ms GLADE-WRIGHT - Is there any sense of what it would be in our context?

Mr THOMPSON - Well, I mean, in terms of the compliance - so for us to have an audit done of our compliance with the Treasurer's Instructions as they stand -

Mr WASSELL - I actually don't know. It was less than 30?

Mr THOMPSON - Yeah, definitely. And we're a smaller, simpler organisation, but we're not talking hundreds of thousands of dollars. We're talking tens of thousands to do a compliance review.

Ms GLADE-WRIGHT - Yeah, pretty reasonable. And where would it sit?

Mr THOMPSON - The way it works in other jurisdictions is, the Treasurer's Instructions, or the equivalents to those, set a compliance requirement that the agencies need to do. So, it would need to be driven through, you know -

CHAIR - And Treasury being the central agency here, obviously, with the various agencies reporting into it.

Mr THOMPSON - Yes, that's right. So, Treasury would potentially have a role in terms of setting the rules, and then part of that would require reporting to Treasury on their compliance activities.

CHAIR - That would provide a pretty clear oversight role for Treasury, which seems a little bit ill-described at the minute.

Mr THOMPSON - I think that's a fair definition of the oversight responsibilities at the moment.

Ms GLADE-WRIGHT - Do you think with Treasury, there would be some push-back because they're not wanting their budgets to look so bad?

Mr THOMPSON - I think everyone - you know, I've no reason not to believe that Treasury want to see improved outcomes, and improved outcomes for Tasmania from a fiscal perspective. And I've got no reason to believe that they don't want to deliver the budget that, you know, is effectively set by the parliament. I'm not sure, is my short answer. You know, I think it's a good question for the Treasury as to whether they're apprehensive about having additional expectations around compliance.

Ms GLADE-WRIGHT - They've obviously asked for efficiencies to be found. This would sort of help that.

CHAIR - We're thinking it would stop - well, identify the problems earlier, perhaps, in the first instance.

Mr THOMSPON - Yes. I think it's very hard to identify - we don't currently measure efficiency well. That was one of the observations when we looked at Health's performance reporting. We don't know, at the moment, which agencies are delivering their services efficiently. It's a bigger-level conversation. The Commonwealth has done a lot of work on outcome reporting and outcome budgeting, so really connecting the budget and the allocated revenue to outcomes rather than outputs or rather than activities. At the moment, that's not the framework that we have here. So, when you look at a budget, it's not clear what outcomes the expenditure is trying to achieve. It may talk a little bit about outputs or activities, but it's challenging to know if there is a high level of efficiency or otherwise when we're not even sure what outcomes are being delivered.

CHAIR - We actually operate under an activity-based funding model, which I think perpetuates that.

Mr THOMSPON - In the Health environment?

CHAIR - In the Health environment, yes. It's all about activity - number of widgets. I'll be interested to see and ask Health more about their performance information they're working on. Have you seen that, or you've just heard that that's where they're heading toward?

Mr THOMSPON - We've heard it's a work in progress. We don't audit - which is another interesting point - we don't audit the performance information of agencies. There's one entity in the state sector that subjects its performance statement to external audit, and that's my organisation. We commenced doing that many years ago, thinking that we would lead the sector.

Ms O'CONNOR - Still on your own.

Mr THOMSPON - Still on our own. Look, to be fair, measuring the performance of an audit office is a lot easier in terms of economy, efficiency, effectiveness. Impact is still a bit of a challenge for us, but we've got a lot easier job to measure than some other agencies.

Ms THOMAS - I'm just wondering if any of the analysis you've undertaken through the work you've done on Health has included looking at changes in staffing numbers over time? Information that we received through budget Estimates, through questions taken on notice, showed that between June 2021 to March 2026, over around a five-year period, the number of staff in the Department of Health increased by 2545 FTE, around 22 per cent, and they provided us a breakdown with increases at the clinical operational and non-clinical support role level. I'm just interested if you've done any analysis on that?

Mr THOMSPON - Not specifically, no. I mean, we do analysis on staffing numbers and remuneration and analytical work around that, but not specifically on that, no.

Ms THOMAS - I know last time when you came in we talked about KPIs, have you observed any KPIs around that? Like, in terms of efficiencies and staffing levels and, I guess, the number of staff required to meet demand? You'd hope or perhaps expect that there might be some level of increased demand matched to equivalent increased staffing.

Mr THOMSPON - Yes, there's not a lot in the 403 that relate to the efficiency of allocation of staff. But I think part of the challenge there is that Health is still working through developing their Human Resource Information System, so the ability to get those insights, the data would be very difficult to work through at this stage. So, we don't really have a position on that.

Ms O'CONNOR - I wonder, Martin, if you've had a look at the *Financial Management Act* - I'm sure you look at it reasonably frequently, but whether you believe it's strong enough in parts? I'm looking at clause 34 here, Accountable authority responsibilities, and it sets out quite clearly the responsibilities that relate to many of the matters that we're discussing today as potential deficiencies. What are your thoughts on the act?

Mr THOMPSON - I think the section you referenced is quite clear. I also think it's relevant that the *Audit Act* requires me to bring to the attention of the parliament, through my reporting on the results of financial statement audits, any areas where I believe the accountable authority has not reasonably performed their role. And, as we speak, we're looking at how we do that. I think our AGRs are going to - and we've had some early communication with agencies

on this - we are going to focus much more on pulling those performance issues out and reporting those. I'm not sure Jonathan, whether you wanted to-

Mr WASSELL - No, I think that's it.

Ms O'CONNOR - Okay.

Mr THOMPSON - Again, I think where there's not a compliance function and we're not - our financial audits certainly don't cover all the, you know, it's a very small, in many ways, aspect of the role of an accountable authority, but there is no, as I understand at the moment, there's no compliance activity done on a cyclical basis to assess whether the requirements of 34 have been met by accountable authorities.

Ms O'CONNOR - Across agencies or just Health?

Mr THOMPSON - Across agencies or generally within agencies. There are performance discussions and those sorts of things that occur, but this is another example, I guess, there's a need for a compliance and oversight function because, at the moment, no-one is actively in a proactive, cyclical or ongoing basis assessing compliance with section 34.

Ms O'CONNOR - So, that section says that the accountable authority has to ensure the agency's financial management processes, records, procedures, controls and internal management structures are appropriate. Is that strong enough language in your view? And then the final (h) is ensuring compliance by the agency with this act or any other written law and so, it looks like that part of the act is not necessarily being applied.

Mr THOMPSON - I think the act is quite clear. I think my office has not called out, necessarily, noncompliance that we've come across through our financial audits, and we're certainly changing the way we do that now, but our office alone is not enough to ensure that -

Ms O'CONNOR - To take that compliance function?

Mr THOMPSON - No.

Ms O'CONNOR - No, no.

CHAIR - I'll follow up on that, perhaps. Martin, I'm interested in how - we don't have the compliance framework that some other jurisdictions may have, but we do have audit and risk committees. So, how do you see their role here, particularly in - let's just look at the financial management for a start, beyond the other risk management side of that?

Mr THOMPSON - The audit and risk committees are a really positive part of the overall control environment, if you like. When working effectively, they should be asking questions and challenging and receiving periodic financial information and information that enables them to ask questions and gain satisfaction. They also should be involved in the development of internal audit programs to undertake reviews in areas where risk is greater and, again, that reporting should be coming back to them. Across the sector, I think they work to a varied level. So, we see some that work quite well and do interrogate management and do challenge -

CHAIR - In some agencies?

Mr THOMPSON - In some agencies, yes, it works quite well. In other agencies, they perhaps don't work quite as well. Again, we would note our reports go to audit and risk committees, our findings go to audit and risk committees and they're tracked really well and audit and risk committees will push for the implementation of them and challenge management about it really well in some agencies. In other agencies we have recommendations and they have internal audit recommendations that sit on their recommendations register for a long time.

CHAIR - We're looking at Health. Is Health one that's doing it well, or perhaps not?

Mr THOMPSON - I think it would be a great question to ask Health how they're going with implementing their recommendations from both internal and external auditors.

CHAIR - Do you have oversight of that? You, obviously, send your reports to them - financial and performance?

Mr THOMPSON - Yes, and our team attend and we communicated formally with them recently last, recently - when did we do that?

Ms BELLCHAMBERS - I think it was the July meeting.

Mr THOMPSON - Yeah. So, at the July meeting we provided them with a 36-page report on our outstanding findings. We had -

CHAIR - In relation to their financial or the whole -

Mr THOMPSON - Financial and performance. We have findings in that that go back to June 2024 which was the Access to Oral Health Services audit, which actually was a reasonably good outcome.

Ms LOVELL - Is that a report that could be shared with the committee?

Mr THOMPSON - It's certainly something you could ask - it goes into a little bit more detail than we would normally make publicly available, but it is certainly something you could ask Health to provide.

CHAIR - What is it called?

Mr THOMPSON - This is our Annual Audit Outcomes Report, so each year for each state entity, we provide an Annual Audit Outcomes Report, which summarises all of the open findings - resolved findings across all of our audit activity. We provide a high level of that in our AGR vol. 1. We have a couple of pages that really is a summary of that. That's on page -

Mr WASSELL - 31 of the most recent report.

Mr THOMPSON - Of the most recent report, AGR 1. In that report we do talk about some of the high-risk items. There are a number of issues in that report that go back some time.

CHAIR - Are they high-risk issues that go back some time?

Mr THOMPSON - Well, October 25 is the most recent high-risk item that's unresolved - sorry, the oldest high-risk item that's unresolved.

CHAIR - I assume they provide feedback, based on your -

Mr THOMPSON - Yes.

CHAIR - Have you received that from this most recent outcomes report?

Mr THOMPSON - Yes, yes. Yes, they provide an update to us on where they're at. It's really important to note, we can't enforce - and again, people can reject our recommendations - we can't enforce actions at their end, but with some of the recommendations, the most recent response we might get something like, 'No response and no change, sorry'.

CHAIR - So, no change in relation to -

Mr THOMPSON - They haven't progressed the matter any further. Still, it had been accepted. I think it would be a useful question to ask the department in terms of their response to both our and internal findings and how -

CHAIR - Internal findings from their audit and risk committee?

Mr THOMPSON - From their internal auditors, yes.

CHAIR - Their internal auditors, which is not their audit and risk committee, obviously, that's separate.

Mr THOMPSON - They report to their audit and risk committee.

CHAIR - The internal auditors report to their -

Mr THOMPSON - Yes, and the audit and risk committee would oversee the implementation. It's really important to add that we met with audit committee chairs as part of our work and without - as a general comment, oftentimes audit committee chairs will share their frustrations about perhaps not having the level of action from management on some of the matters that they've agreed need to be addressed. So, again, they're advisory committees, they don't have managerial power, they can't direct, but when they work well, they work well.

Ms GLADE-WRIGHT - How would a compliance framework interact with audit committees?

Mr THOMPSON - An audit committee is part of the compliance framework already, but it could be responsible and aspects of the compliance framework could be moved into the role or the responsibility for oversight by the audit committee. And again, in some organisations, for example, one of the things with departments, with general government sector agencies, is they don't have a board. In some governance frameworks you'll have a board, and so CEO performance, accountable authority performance, would be overseen by the board directly. We don't have those mechanisms, and I'm not suggesting that the audit risk committee should, by any means, be overseeing performance. But there are roles that the audit and risk

committee could take that are perhaps more commonly oversight roles of boards. Again, it's quite a range as to where that could fall. For example, if there was a requirement for compliance attestation on an annual basis where all managers - which happens in multiple jurisdictions. And some agencies do this voluntarily at the moment, where they require their management to attest to compliance with the relevant TIs or standards, or whatever is relevant to their role, on an annual basis. That could filter through the audit committee for review. It creates a level of oversight that's one step removed from the accountable authority, or it can create a level of oversight.

CHAIR - The other matter we did talk about last time was in issues of the fraud management. You haven't found any other examples of fraud or potential fraud in what you've looked at?

Mr THOMPSON - Well, we will be reporting, at the conclusion of our audit, on those matters. I can say our audit hasn't identified any additional items of fraud.

CHAIR - But Health might have?

Mr THOMPSON - Well, we're still working through the finalisation of that process, but it would be something that we would talk to as part of our reporting process again.

Ms THOMAS - Has there been any, or have you seen any updates from Health on how they've dealt with, or responded to, what was previously found?

Mr THOMPSON - They have provided us, as part of the reporting process, with an update. They've developed a draft fraud control plan which, I think, was due for finalisation after we issued the annual audit outcomes report. It's still in draft - and they've indicated -

CHAIR - Is this an updated one? One would assume they had a fraud management -

Mr THOMPSON - They did, yes.

CHAIR - Oh, right, yes. This is a new -

Mr THOMPSON - They were revising it on the back of the recommendations and the findings, and they've advised of some action in relation to the specific frauds. But I think they're still works in progress.

Ms THOMAS - Does the revised framework have some kind of compliance or oversight mechanism?

Ms BELLCHAMBERS - I haven't looked at it in detail, sorry.

Mr THOMPSON - It's a really important point, because the previous framework, in and of itself, wasn't terrible, but it was whether it was being complied with was the issue.

Ms THOMAS - It seems to be a common theme, like, the accountability and oversight across a number of areas in the department. Comes down to culture, doesn't it?

Mr THOMPSON - We made a really important distinction, in our report on community service organisations in the executive summary, we made, I think, the really important point that it was not a problem with systems, processes or people. Indeed, the people that were working in that area were really, I think, dedicated and working really hard. It was a failure of culture. So, the problems were known, the risk was known as high, but there was a decision not to act. That can only go down to culture.

CHAIR - Just to get back to the whole digital piece, like with Bluegum and other digital programs that Health are involved in, I can't recall whether you said you've seen the new framework or whatever it's going to be called.

Mr THOMPSON - The procurement framework.

CHAIR - Yes, the procurement framework. Have you seen it?

Mr THOMPSON - Yes.

CHAIR - Do you think this addresses some of the fundamental problems that we've seen? The concurrent contracts just coming under $100,000, all that?

Mr THOMPSON - Yes, if implemented as written, I think it will go quite a way to addressing those concerns. It acknowledges some of the challenges around sourcing IT resources, but it still requires the key points about a competitive bidding process, with appropriate oversight and management of conflicts and the like, and it takes away the practice of splitting contracts to fit into a threshold. So, if implemented as written, I think it would go quite a way to addressing the procurement issues, but that's really the start of the project.

CHAIR - Well, it is, and also, we hear a lot of things once it's been raised, and Bec's done a great job getting some of the questions out there on the notice paper about this, as well it's been asked in budget Estimates and other forums. There also seemed to be some concerns about conflict of interest, and I mean, Tasmania is a small place, we accept that, but it's how you manage those. That's probably not something that you've actually looked at, but it seems to be an issue that's been raised.

Mr THOMPSON - I think we were concerned about the management of conflicts of interests when the threshold wasn't going through an appropriate process. So, those checks and balances really weren't there. It's probably also worth noting we had some concerns and we've recently reported on the new gifts and benefits policy, which sort of feeds into conflicts of interest in many respects. I think the updated gifts and benefits policy, that's a whole-of-government policy, is a much-improved policy.

CHAIR - But how do we measure the compliance with it? You were obviously doing that in undertaking your audit of the previous arrangements.

Mr THOMPSON - Yes. What we did, which you can't do all the time - well, you can - is we did data analytics or interrogation of selected e-mail files to find words like 'gift', 'appointment', 'dinner'. I can't remember all the words, but a range of words.

CHAIR - Tickets at the box office.

Mr THOMPSON - Tickets, yes: JackJumpers, Tasmanian Devils, you know, cricket. You put all of these words in. I'm speaking about things that I struggle with a little bit, because anything that requires a power point I'm not very good with, but our IT and our data analysts could sort of search for those words. And we found quite a lot, but we were pretty comforted through that report - and again, it was a limited sample of people in higher-risk roles - but whilst we did find some inappropriate issues, it was very much at the lower end of the spectrum. I was almost surprised, pleasantly.

CHAIR - But if you looked at this, Martin, and I don't know whether you looked at the Health Department in that gifts and benefits -

Mr THOMPSON - We did.

CHAIR - You did? Right. I don't know what search words you would use to find familial connections, or other connections to particular contractors so that getting these repeated -

Mr THOMPSON - We didn't touch on it in terms conflict of interest, but I think that is a challenge that, with the low-level procurement running under the - when the procurement is under $100,000, the process could be approved by a manager, really with no formal checks or balances around that. I mean, there are checks around payments and receipts of goods and those sorts of things, services.

CHAIR - Well, once the contract's been awarded, you know, you're obliged to pay.

Mr THOMPSON - Correct. So, all of those questions are really good questions, as to value. I guess our biggest concern was, you know, paying someone $400,000 a year to provide, you know, IT services on three or four contracts over a period would never sound like the best way of procuring those services - both in terms of project risk, so you've only got continuity for two, three or four months, but also in terms of value for money. And it is interesting, other agencies, other state sector agencies dealing with complex IT projects, have complied with the procurement requirements, in terms of going out to market saying we need a range of skills to deliver a project. And they've got multiple competitive bids that have come back. So, we would -

CHAIR - Which ones are those, Martin? Because when I look at the HRTP - that's now with DPAC that's a rebirthed HRIS - it seems that those sort of things are happening still.

Mr THOMPSON - These were outside of the HRIS/HRTP project, these were other IT projects.

CHAIR - Oh, right.

Mr THOMPSON - Now, IT projects are horrendously difficult to manage at the best of times, but it is interesting to note that other agencies had been successfully going out getting multiple tenders for -

CHAIR - For similar sorts of work.

Mr THOMPSON - Yeah, yeah, absolutely. Yeah. Now whether -

CHAIR - Yeah. I mean, you can argue that Health has a much more complicated structure with all the rostering and, you know, when you got a 24-hour, seven-days-a-week, 365-days-a-year service, it's bound to be more complicated than a nine to five.

Mr THOMPSON - Yeah, and rostering concurrent appointments have been a problem or a challenge and a risk that's been identified very early on. Multiple appointments is the third one.

Mr WASSELL - Award interpretation.

Mr THOMPSON - Award interpretation, sorry. They're not IT issues.

CHAIR - No, and do you know if they've, I mean, this probably not a question you can ask, but do you know if they've been resolved, some of those? There's some suggestion that some of them have been?

Mr THOMPSON - Well, I don't know. We haven't gone back.

CHAIR - That's alright. One of the other things I think we've talked about previously, we also talked with the department about, was the vacancy control process. Did you look at that in the audit at all?

Mr THOMPSON - No, we don't look at the vacancy control process per se. We obviously understand numbers, employee remuneration and the like, but we don't look at the vacancy control.

CHAIR - I don't know how many voluntary redundancies are going to be put through the Health system, but we know in the Budget there was no funding for separation payments and things like that. So, how do you see that as a gap in Health's financial performance? Because it's one thing to have a budget to deal with - we always think about the service delivery side, but you've still got to pay the people to deliver it.

Mr THOMPSON - It's another financial challenge that will make it more difficult - will add to their burden. So, often - when someone's made redundant, obviously, there's a redundancy payment, but also all of their leave needs to be paid out. So, I spoke earlier about, if you load up the balance sheet and increase your liabilities, you can reduce your appropriation by not spending the money.

CHAIR - But that'll catch up with you.

Mr THOMPSON - Well, that's right, and if there's -

CHAIR - It'll just catch up next year.

Mr THOMPSON - If there's a voluntary redundancy program, you're not only paying out there, but you're also paying out the leave and the like. So that will have a significant -

CHAIR - I'm not asking you what's in your financial report, but if there have been staff separated, like in addition to the normal churn that you have in a large department like this, but as part of the efficiency - what are they calling it? Not dividend anymore, but, well, whatever

it's called these days, a measure - will that be evident in the financial reporting about, if it's all stacked at - to try and -

Ms BELLCHAMBERS - I don't believe they've separated it out.

Mr THOMPSON - Yeah

CHAIR - They don't separate it out? So, you won't be able to see that?

Ms BELLCHAMBERS - No.

Mr THOMPSON - In the scheme of the payroll, I don't think it's that significant.

Ms BELLCHAMBERS - No.

CHAIR - You'd only say it in the senior staff that might go.

Mr THOMPSON - Senior staff will get picked up. So, anyone in the senior, in the key management personnel area will get picked up in terms of any termination payments there. But, I don't think it's had a significant impact on their costs to date.

CHAIR - Okay.

Mr THOMPSON - Bearing in mind that there's a significant turnover in Health every year.

CHAIR - That's right, yes, but a lot of that's down the lower level, like, it's the lower pay level.

Mr THOMPSON - Yeah.

CHAIR - This is probably a question you can't ask, but I thought I'd ask it anyway - can't answer.

Mr THOMPSON - It'd be easier if you can't ask it.

CHAIR - Or maybe you can answer this one, perhaps I'll reframe it slightly. Where should we focus most of our attention when we have Health back in to talk about their financial performance, as well as their governance?

Mr THOMPSON - It's a good question. I think, when I look at a set of financial statements, the income statement tells you what they've done over the last 12 months, the prior year tells you what's changed, I guess, to a certain extent, the performance against the budget tells you whether they did what they said they should do and the balance sheet tells you about the position they're in right now. So, I think, if you look at an income statement and they've failed to do what they said they would do, so they've spent more than they had in terms of their budget, then the question needs to be what will you do differently to avoid this happening again. Again, looking at the changes year on year can help you understand, perhaps, where activity or the like has changed and looking at the balance sheet, and I think particularly for a department, looking at the financial assets, which are assets that will become cash at one point in time, and

looking at the financial liabilities, which is announced that it will need to go out the door as a cash payment at one point in time, gives you a really good understanding of where they are from a financial position as of that that balance state.

CHAIR - So, if we get a similar response, as Sarah outlined earlier, that they've run their cash reserves down to a low level and the balance sheets, a point of time, the end of financial year, and, in some respects, logically that makes sense that you've spent the money that's been appropriated to you, perhaps a bit more, which won't be sitting in another part. It doesn't really quite chop. So, that's an easy way to sort of shut down that that question, if you like. So, it's really for us trying to understand how you move past that point.

Ms LOVELL - How do we unpack it?

CHAIR - Yes, what's the next question? They'll have the heads up if they're watching, what we're going to ask them.

Mr THOMPSON - I think if we looked at last year's balance sheet for, say, 30 June 2025, the financial assets of the entity, of Health, came to around about $170 million. So, that's cash that they would reasonably expect will come in the door over the next three to six months, but maybe up as much as 12. It gets a little bit tricky, but when we look at their payables, they've got their liabilities or their financial liabilities, they've got $817 million. Now, admittedly, a big chunk of that is employee benefits which they won't necessarily pay out in the next 12 months but, you know, they got $166 million in in payables, they've got $80 million in leases, $32 million in other liabilities. So, given you're saying it's just a timing difference, based on where you were at that point in time, you had expectations of about $170 million coming in, but you had a requirement - I won't, you can work out the current sort of portion of that - but you have a requirement for around $400-500 million going out, how are you going to fund that without impacting on next year's appropriation?

CHAIR - Without using it?

Mr THOMPSON - Yeah. So, it's almost, if you like, because the appropriation - and it is complicated because there's revenue coming from different sources, but if they had earnt that revenue now, it would be in the income statement. So, there's an argument that, you know, cash balance has been run down in prior years, additional appropriation has been provided in prior years, the balance sheet has been run down. When you run the balance sheet down to the point that your financial assets that you're going to receive over the next little bit are less than the financial liabilities that you need to pay, then you're borrowing from the future year to fund the past year. That, again, is unsustainable. It will impact on - not only do you have to save whatever you've got in your budget efficiencies, you've also got to find the money to pay for the liabilities that you've got on your balance sheet that aren't covered by the assets that you've got on your balance sheet. So, it makes the challenge all the more difficult.

CHAIR - I'm just having a look at last year's, yes. I think I'll just unpack that a bit.

Mr THOMPSON - I mean, it is complicated, and I've been doing this for 30-plus years - a lot more than 30 years now - and you know, it is complicated. Learning to understand the story that a set of financial statements tell is not easy. But at the highest level, again, just looking at the primary statements from last year, the story they tell is that Health needed to go to the

government and have an additional appropriation of about $400 million provided. Even with that, they spent another $100 million more.

CHAIR - In addition to the $400 million?

Mr THOMPSON - In addition to the $400 million.

Ms O'CONNOR - A half-a-billion-dollar shortfall that had to be filled.

Mr THOMPSON - Yes. So, they said with $2 billion, they could deliver a $100-million surplus. They got $2.3 and they delivered a $6 million loss, so for an extra $400 there -

Ms O'CONNOR - A $600 million loss.

Mr THOMPSON - But it's very simple; what they said they could do in terms of the budget, they couldn't. What they did do in the previous year, if we look at the previous year, is not a long way away from what they did. So, the previous year, where they spent $3.4 billion, they then spent $3.5 billion in the following year. You know, that seems to be a good-sounding - Well, what happened in the past you, if you don't change anything, is likely to be what will happen in the next year. The increase in expenditure is, you know, supplies and payroll. So, that tells us that there was a question about the budget. Whether they were ever going to be able to deliver that -

When we look at the balance sheet, again, they said they would end up with $3.15 billion in assets; they ended up with $2.99 billion. Now, the $150 million difference in assets is largely around - it's kind of an interesting one - a big chunk of it is relating to capital works. So, they didn't deliver the capital works that they thought they would. Interestingly, and we talked about revenue and the timeliness of revenue, when we look at their other financial assets in the balance sheet, which is those accruals that I spoke about - so the bit between doing the service and issuing the invoice - they thought that they could get that down to $40 million. It increased to $79 million.

The other telling fact on the balance sheet, which is always of some concern, is that their payables, they said that they could get those down to $104 million, but they increased to $166 million - so, the amount that they owe their creditors. But again, quite similar to where they achieved last year. So, lots of things that they said they could do in their budget that -

CHAIR - Just repeat, don't they?

Mr THOMPSON - And again, this is why we're going to do the big performance audit on budgets - lots of things that they said they could do in their budget but it turned out they weren't able to.

CHAIR - Is some of the challenge, then, hidden a bit, Martin, in that they've now pushed out capital expenditure, and that can be for a variety of reasons. I'm not saying that's the wrong thing, it's just timing, availability of materials, contractors, all the things that might delay that, but does that then hide a bigger problem sometimes? Because we see that not just in Health, we see it in general government.

Mr THOMPSON - I mean, the capital works piece, it may, if an agency is constantly not delivering its capital works budget, there's an argument that potentially their assets are being, or are, deteriorating at a greater rate. That may lead to substantially increased reactive maintenance costs and the like, or it might actually mean that they're not fit for service as well. So, when we talk about efficiency and delivery of services and all those sorts of things, if the capital works, building the facilities to deliver the services, is falling behind, then that may have a push-on effect into efficiency of services and themselves.

CHAIR - I'm sure we'll be told, based on the media today in particular, that there's older patients stranded in hospitals that are preventing - they're not preventing, the situation is preventing flow through the system, and federal government responsibility is 'look over there' and tell them that they need to sort this out. Now, this has been going on forever. I remember sitting on committees years ago looking at this very problem. The same problem occurred then. It's not new. Maybe it's worse now, I don't know, but it was a problem back in the early 2000s when we looked at this, or soon after that. How do we see through that, in terms of - That is a problem, I don't deny it's a problem. It's been a problem for a long time, but that doesn't sort of show up anywhere other than the fact that we perhaps- and this could be the reason - we can't deliver the things we said we were going to in our budget because, you know, we can't get the patients in that we need to get in.

Mr THOMPSON - I guess my comment on that would be that you started that by saying it's been a problem for many years. It's a variable that we need to consider, that needs to be considered as part of the budget process.

CHAIR - So, you don't plan as if they're not there?

Mr THOMPSON - Well, that's right. Plan for the reality that you live in, you know, rather than an idyllic world that you don't.

CHAIR - That's been really helpful. I hope it's helped other people to understand where we need to go. It's handy to have it on the record so that we can go back and refresh ourselves and reread it probably five times to understand it more fully. Is there anything you wanted to add, or close, either you or your other team?

Mr THOMPSON - No. I mean, just to acknowledge it is part of our role, as best we can, to assist in informing the parliament, so we're happy to come along and have the conversations.

CHAIR - We find it really helpful and we appreciate this is not something you're actually funded for. It's off the side of your desk. We do appreciate that.

WITNESSES - Thank you.

Ms O'CONNOR - We really value your work.

Mr THOMPSON - Thank you.

The witnesses withdrew.

The committee suspended from 11.30 a.m. to 1.00 p.m.

AMA Tasmania

CHAIR - Thank you, Meg and the representatives of the AMA. We appreciate you providing a submission to this inquiry by our committee into the financial and operational management and governance of the Department of Health. We have had a number of hearings from the department previously. I'm not sure you've had a chance to have a look at those? You have. We're continuing this because it's an ongoing challenge and we need to understand a little better.

Everything that you say before the committee is covered by parliamentary privilege that may not extend beyond the committee. It is a public hearing. It is being broadcast and transcribed and will form part of our public record. If there are matters of a confidential nature you wish to share with the committee, you can make that request and the committee will consider that. Otherwise, it's all public. Do you have any questions before we start?

Dr CREELY - No, thank you.

CHAIR - I will ask each of you to take the statutory declaration and if you could then introduce yourselves and make some opening comments and speak to your submission further.

Dr MICHAEL LUMSDEN-STEEL, FORMER PRESIDENT, **Dr MEG CREELY**, PRESIDENT, and **Ms LARA GIDDINGS**, CHIEF EXECTUIVE OFFICER, WERE CALLED, TOOK THE STATUTORY DECLARATION AND WERE EXAMINED.

Dr CREELY - I'm Meg, I'm the current President of the AMA. Michael Lumsden-Steel is our immediate past president, relatively immediate last eight weeks or so. Lara Giddings, who probably needs no introduction, is our CEO here at AMA Tas.

Thank you for the opportunity to present. It's an area that we're obviously really passionate about, but I suppose our core message around this is that when we look at our health system, we have used - I've been doing this role for perhaps eight or nine weeks and every week I have used the word crisis. It appears on our television screens, and we use the word crisis, but it's become a word that used to mean something and now we kind of go, 'another day in health'. And, it's not because of our clinicians, it's not because of people that work at the hospital are not trying as hard as they can. The commitment is there from every single person who works there, but the system that surrounds our healthcare system is failing. We have, overall, an excellent healthcare system in this country and in this state, but if we don't continue to work at it, if we don't work out where the way the bits that have fallen are down, we're not going to continue to have that excellent health service into the future.

Michael next to me used one memorable and particularly pertinent word to describe our health system and that's 'constipated'. We like it both because it's medical and because it's a really good description of where it is. We've got people who can't get into their GP, so they call an ambulance. The ambulance goes to emergency, it gets stuck at the emergency department - they can't put them into the emergency. A transfer-of-care protocol, as we've seen proposed, doesn't fix the solution if they're just going to move into a corridor because we don't have the ED bed because the ED is full of patients waiting to go to the ward, and you keep going through the system like that. A lot of that constipation is, how do we get people out the other end, topically, today. We know there's a lot of discussion around aged care, but also NDIS. We very much think that that is the core part of the problem. What contributes to that?

There are elements of where does decision-making happen? We very much see a health system at the moment that is command control. Clinicians working where we work, directly involved in patient care, provide feedback and experiences and ways of doing things differently. It goes up multiple levels of bureaucracy until it gets to the top. At the top, a decision gets made and instructions get handed back down. That's the model, where it's not involving clinicians who work with the patients, who we would argue are not the only voice in making decisions around models of care and how health care works, but they are a voice and they are a critically important voice that has been lost in the way we are doing our health system now. Look, you may hear that there used to be a structure where every man and his dog made decisions. That was not, perhaps, the right way to do it, but we've since swung so far through that we have very few people at the top and very few clinical decision-makers.

The two last points before I ask Michael to, perhaps, touch a little bit on what he sees, working within the hospital. We think we need a state health plan. We currently have a whole lot of different plans that are made and they're excellent and there's really good work that's been done into them. There are high-level frameworks, there are clinical, say, cancer services, radiology, sort of individual statewide things, then there are clinical profiles north, south, north-west. But they don't necessarily draw together the focus of demand where we are now. What have we got from a demand perspective from our patients? Where are we going to be into the future? As we know, our baby boomers are turning 80 and they're going to keep turning 80 en masse. What is that demand into the future? What is the infrastructure that we need to match that? What is the workforce we need to match that? And how do we bring that all together rather than in - I don't dare count how many hundreds of pages - within all the others and bring our clinicians along for that, so that we know where we're going. It takes a long time to train doctors; it takes a long time to train nurses. So, should we be surprised if in 10 years' time we're still sitting here saying, 'Well cripes, those locum costs are high' and be surprised by it, if we haven't done that work to look at that future planning, and that's not what we see happening currently.

Michael might like to perhaps talk about what he sees from an anaesthetist's perspective working within the health system and some of those barriers and, perhaps, some of those solutions.

Dr LUMSDEN-STEEL - Thank you, Meg. So, I work in public and private. And I've been associated with health service since I started medicine back in 1995, medical school, and I have worked briefly outside of the state with military. Back when I was a junior doctor, patients would come into the emergency department and the doctor would go out and get the handover from the ambulance crew as they came into the Department, on the stretcher, for a handover. Patients would stay in the ED overnight and there'd be no bed issues because they'd stay there because they'd seen us, we've done the team, there was no bed pressures and the flow was not even an issue. Surgery was not being cancelled because we didn't have beds. The only reason surgery got cancelled back in 2000 was because the Health budget had run out, so they decreased activity, but there were no bed flow issues.

I think that it's fair to say around the country what we've seen since then is that as our activity has increased, as we continue to diagnose and treat more chronic disease, as we live to be older, that's put more pressure on the system. And we do more and more and more, because we can diagnose it and we can treat it. It might be fair to say that going back 20 to 30 years ago, if you were a certain age, you wouldn't be offered certain surgery, whereas now we do. But, that requires resources and what we haven't seen since 2000 is the resources increased to

match it. I think beds is a critical thing. So, as an anaesthetist, quite rightly so, we get involved with patients when they're referred for emergency surgery or they come in in a resus - from literally when they arrive in the hospital in the emergency department right through to then getting them through to theatre, and then managing those patients on the way home.

We also see the patients that come back to the hospital for emergency surgery that have bounced in and out of the health system a few times, haven't been able to be seen, diagnosed, or waiting for investigation. So, I think critically, the system is constipated and it's become very slow because the critical pieces that make it work haven't grown to meet demand. Beds is the first thing. The next thing is - and this is one of the most critical things within our paper - is when we now work up patients we do investigations - that's things like doing X-rays, CTs, MRIs, ultrasounds, or the other big thing is looking at patients' hearts with the cardiac echo. The current wait time, for public echoes in Tasmania, in Hobart is now about 12 months for an elective look at someone's heart with an ultrasound to see how the heart function is.

CHAIR - Even a pre-op echo?

Dr LUMSDEN-STEEL - A pre-op echo.

CHAIR - 12 months?

Dr LUMSDEN-STEEL - 12 months.

Dr CREELY - We send them privately instead.

Dr LUMSDEN-STEEL - Exactly. As Meg has quite rightly said, the workaround has increasingly been in the public system that, if it's urgent, they then go to a private service to have their echo done. The public system simply is not keeping up with demand. Now, Hobart has more resources than the north and north-west, too, so, if you compound the problems that you have if you're up the north or north-west, these patients are often potentially having to be referred to Launceston from north-west or to Hobart for their surgery. And you can imagine the impost for public patients that are then referred to Hobart, travel to Hobart, then they're the ones having these delays for their echo, et cetera. So that's a component. We've talked about beds, we've talked about diagnostic services to support diagnosis. The critical thing here is that, as our hospitals all have an emergency department, there's competition at our hospitals for beds for patients from ED to get into the hospital and patients for elective surgery or elective procedures, so at the moment the only thing we turn off is the elective surgery pipeline, so patients who have been referred for their procedure are the ones that get cancelled.

We've made a mention in here about knee joint replacements and about TAVI. TAVI is the new valve replacement technique that we can do. I was just speaking to the cardiologist today, and it's become so bad that patients who would normally be able to be managed by their teams and control their beds in the hospital, and, for example, talk about cardiologists - they do a lot of their work for patients on a day basis. If you have a dodgy heart, you're sent in to the cardiologist. He or she wants you to have an angiogram or do a procedure on you that day, but you need to have beds for them to go in post-op before they then go home. In the old days, those units would have control and understand what their flow's going to be and manage those beds themselves. With this four-hour rule to get patients into hospital - and the focus has been on ramping times and flow out of ED - the units have effectively lost all control over their beds. That means that the work they've got scheduled is often cancelled. Now, the cancellation rate,

I was told today, for cardiology for their angiograms and other procedures, that might be putting a stent in, et cetera, is up to 70 per cent at the moment in Hobart, because they can't get the beds post-procedure.

Ms LOVELL - That's for all cardiology elective surgery?

Dr LUMSDEN-STEEL - No, cardiology is not surgery, it's a procedure. Obviously cardiothoracics would say it's surgery, so that's, obviously, replumbing the heart and putting the valves in. Cardiology are doing the angiograms -

CHAIR - It's invasive but not surgery.

Dr LUMSDEN-STEEL - Yes, invasive procedures, and it could be diagnostic and/or actually fixing someone who has a known lesion in their heart that if we don't stent it, they're at risk of having a heart attack.

CHAIR - Then they are in the acute centre.

Dr LUMSDEN-STEEL - Well, they do. That's why, in our paper, when it comes to cardiology we've made reference to TAVI. TAVI is, basically, you go in the groin and you go up to the heart and give them a new heart valve - literally place it where the old valve is and you expand this new valve in their heart. TAVI, so it's transcatheter aortic valve implantation service - that's on page 6. It's amazing. Patients can go home the next day after having a valve replaced. They don't go on bypass surgery; they don't go to ICU. The only thing stopping them from going home the same day is that we're just a bit cautious about literally sending them home the same day.

The expense in this type of procedure is having the lab, the skilled expertise and the valve to go in, so it's not cheap to put one in, but the patients love it and they recover really well. That's an example, and I know in the notes - and I'm just making reference back to that because the key point about that service is that when it was set up, it was set up around numbers of 100 a year, but that then was not a defined budget or cap, but it's been used by the service to define how many we can do a year, not based on demand. So, as an anaesthetist working in the system, getting back to that point from the patient's experience is that we know demand is growing every year by about 6.5 per cent in our presentations to ED. That's what we know. We're not seeing an increase in bed capacity by that per year, so the only way that we can manage that flow into the hospital is by delaying elective procedures, and that's managed by outsourcing elective surgery, if they have that capability. That's one thing the state Health service has done.

If we go back about 10 to 15 years ago, and people might recall at one stage Tasmanian patients were being flown to Melbourne for surgery, that got turned off. What we have never done since then is looked at that money we've outsourced for health care and structurally tried to build the services and capacity in our hospitals to meet that demand. So, we still have to outsource. I'm not saying we shouldn't do it, but the goal should be to try to get there, but to strategically invest in meeting the demand, so trying to get back to what Meg was saying: what is the demand? Our number-one concern is, we don't think that we are honest and transparent about the demand, so that means that patients, when they're making the decision, should I take out health insurance? Should I wait 12 months to be seen in the specialist outpatient clinic before I even know what I'm going to have done to me? It's very hard for patients to be informed to navigate our health system, and health literacy is another part of that navigation. If they truly

don't understand what the wait times are going to be and what their pathway is going to be, because honestly, we can't define it that well. Our dashboards don't sort of paint a clear picture. We don't always treat in turn. We don't, unfortunately, also outsource in turn.

And I just want to make this point that we look at a health system being for patients. Not everyone can afford private health insurance. We know that. The public healthcare system should be for everyone. Those that have capacity to go private should be able to make that choice, but not be forced to. And I think that's the point that we're trying to make is, we keep hearing time and time again, and I work in private and you see patients that have said, 'I've had to literally take out private health insurance so I can have my knee replaced, because I've been waiting two years.' It's not uncommon. So, that's unfortunate. The anecdote that I give, that I see, it's patients that don't have money, they're on a pension, they're low socio-economic. It's not like they're going to Bali or they've got all the toys. These are patients that have actually been let down by the system and, you know, they've been able to find inadequate no-gap service, or doctors often look at those patients, provide them with a no-gap service because, you know, they're realistic. But likewise, you know, our system fails patients that don't have the health literacy or understand what they can do to try and get their care in another manner. They're relying on the public system to do it for them.

So, from an anaesthetist's point of view, it's frustrating when you see patients having these delays, because there's the delay to see the specialist to get booked for the operation. They see the specialist, they can't get the investigations that they need to clear them for surgery. Then when they're finally given a surgical date, you know, there's been a plan to manage that patient's medications. They might have come down from the north-west, or they've had someone fly in from interstate to care for them. Then on the day, they get cancelled, because there's no bed. And I think it's not uncommon to try to make the cancellation rates look better. We know there's been some directives to book less people from the north-west and from other areas, because they're the ones that were complaining the most when they were cancelled, quite rightly so, because they've come the furthest. So, rather than doing the most or the maximum activity we could in a day, we were peeling back what we were planning to do because it's highly likely we will cancel people - which is not a good way the system should be running.

CHAIR - And if there is a gap, you know, there isn't the need for cancellation, then you haven't used the time effectively.

Dr LUMSDEN-STEEL - Well, I just want to make a point about efficiencies. So we talk about the Health service needing to find efficiencies in savings. One of the things that you can't measure is that when a service starts to become inefficient because we're always on standby, we're slowed down, we actually become inefficient. As individuals and teams that are doing less activity, you know, the emphasis and the efficiencies that we can find to get through six cases in a day, over time dilutes, it gets watered down, because you're only ever doing four. I work in private. I can start work at 8 o'clock and finish at 6 o'clock and with an efficient surgeon, we can do maybe six or eight major cases. In public, you would struggle to do 50 per cent of that. You might do 60 per cent of it - and there's reasons for that, but one of the other things is the inefficiencies in the system. But the system itself has become inefficient because it's not actually operating consistently at a high pace. Everyone's just slowed down a bit.

CHAIR - So, do you think that the activity-based funding model is part of this problem?

Dr LUMSDEN-STEEL - I think activity-based funding should actually reward you for doing more activity. But there's two points to that activity-based funding. I think, first of all, there's concern that the activity-based funding never actually represents the cost in today's real terms. You're probably aware that the national efficient price, or the IHACPA price, is calculated around about 18 months retrospectively. So they don't actually know what our cost and activity has been done until it comes through our Health reporting systems back to the central repository. Then they work out, 'Actually the cost of the activity 18 months ago was this.' So we're always getting, we're always running, if you like, at a cash negative balance. We're not actually getting funded with that projectively increased.

The next thing is that activity is fine, but we actually can't do the activity because we haven't built the capacity. I think if you go there, and you can just look at the recommendations, which Meg will talk to, which says we think these things need to be addressed so we can actually do the activity. And I think the other thing is a single-funder model at the moment. We've been calling for Tassie to be a trial site for that, because there is this inherent tension between the Department of Health and the federal Health minister versus the state about actually who's responsible for the hospital, who's responsible for aged care, the NDIS issues that causes a hundred patients in your hospitals every day that shouldn't be in there waiting for placement or aged care. And the other thing is, that big gap that Meg knows so well about, that primary healthcare patient, that GP, preventative, out-of-hospital space, is funded completely separately to - that's not ABF. But increasingly the state government, we know, is diverting more funds into supporting primary health care, because it has to invest in keeping patients out of hospital and keeping them well, that preventative primary health care to stop them coming into hospitals, but that's coming out of our state budget money, as opposed to being funded properly by the feds.

CHAIR - Michael, I'm having these terrible flashbacks and deja vu because we've had these exact - Lara will remember them from years ago too - exactly the same conversations sitting across the committee table, exactly the same solutions being put forward - single-funder models, a whole range of dealing with the challenge with the constipated system with not being able to get patients out the other end, with aged care. NDIS is a more recent problem in that it contributes to that challenge. We've been having these same conversations for years, so what are we going to do differently to stop it?

Dr CREELY - I think one of the factors that has arrived that is different is both the COVID pandemic and our use of technology these days. I think we've seen that enable us to move care more outside of the infrastructure of the physical hospital walls to be able to move more care back into the community. And, as Michael touched on, we are seeing state health dollars spent more on ideas and ways of treating people that happen outside of hospital walls. We've seen Hospital in the Home, Care@Home, Virtual ED that is coming, and then obviously primary care and preventative care. And, I think when you look at that from a cost-effectiveness or a value-based care, whichever way you want to look at it, they are good models of care that we perhaps haven't had as easy access to, or as much ability to do, as we have over the last period of time where we have been talking about the same things for so long. So, I think from our perspective, and we touched on it in our submission, that sort of subacute community - delivering health care in the community at people's homes is one of the ways that we should be looking towards moving.

To finish, perhaps one of the last things to make a point of from our opening - the recent operational efficiencies, so the $700 million that we're going to see cut essentially matched by

the contribution from the NHRA is something that we are incredibly concerned about what that means for patients because you might not cut frontline staff, but if you cut the support services behind those, who make the frontline staff work, that helped to collect the revenue from private patients within public hospitals, then it does impact our patients and their care.

Ms O'CONNOR - Can I check on something, one of your recommendations here, and it sort of flows through what you've been talking about, No. 6, is: any savings programs prioritise low-value, duplicative or poorly targeted spending before measures that we can call hospital operations and patient care. Give us an understanding of what 'low-value, duplicative or poorly targeted spending' is, so concrete examples.

Dr CREELY - Yes, I will. The best example is looking at that community space, ED avoidance. We've seen a lot of both media and political attention on our Eds - they're the canary in the coal mine, they're easy to look at. Then we see programs looked at ED avoidance. How do we use Hospital in the Home? How do I, as a GP sitting there, refer to Hospital in the Home instead of ED? How do we use Care@Home to keep people out of hospital, Virtual ED to keep them out of hospital? The problem is Hospital in the Home tends to sit under medicine in the department; Care@Home sits under something else; primary care sits over here. We're all trying to do the same thing but there is an element of crossover. Care@Home does chronic disease management; general practice does chronic disease management. The two do not talk to each other, so how do we -

CHAIR - Why is that? Why don't they talk to each other?

Dr CREELY - They don't talk to each other because the system's not well set up to allow it. So, as a GP, I can't - I rely on a discharge summary and the rate of completion of a discharge summary - and it's also at the end of an episode of care, so it doesn't give me a representation of what's going on during the time. It gives me a representation of the last six to eight weeks, if the discharge summary arrives. Patients leave a hospital system and are told to see a GP, but they come to see me a week or two later and I don't have a discharge summary. I don't know what they've been told to come see me about. We make the best -

CHAIR - Why isn't it sent the day they leave?

Dr CREELY - It's probably to do with resources. It's often the junior doctors who write it. They're busy, they're trying to look after patients; it's not seen as a priority. We're hoping things like the electronic medical record as part of Bluegum will make a difference. There is - at least, we have heard that there is that functionality to allow the system for the outside primary care to be able to see in and reduce some of that duplication - I order bloods one day and ED orders the same bloods the next day.

Ms GLADE-WRIGHT - What about the My Health Record?

Dr CREELY - It's improving things. Pathology, there was a change in July this year to say that by default you have to upload pathology by default, you have to upload it. That is helping, I will say; and we hope EMR takes it that next step. EMR is still a long way away. There are still a lot of factors like a budget and the cost to get through before we get there. Again, we really want to make sure that the clinicians who use that system are able to have a voice in how that looks and that we don't get an 'EMR Lite' version without that functionality that we need to actually do patient care.

Perhaps to finish on your point around the duplication: what we often don't see is an evaluation of those. So, where services are introduced either through an election process where it's been a promise around - this is something that we're going to try. We're very good at introducing these new services, Care@Home, COVID@home, et cetera. Tassie Docs was the service around flying in the GPs, flying in a service to be able to sort those. We're very good at introducing those services. We don't seem as good at evaluating where the crossover is, how they work together, what is delivering cost-effective, value-based care and shutting them if they're not and using that money for something else.

CHAIR - Or how they can be improved to make them work perhaps.

Dr CREELY - Or how they can be improved. We don't do that well. We're really good at introducing. We're not so good at, not politically, perhaps appealing to take away a service, but sometimes we think that's a conversation that just needs to happen.

CHAIR - If it's not efficient or effective and it's costing us more money than it should, surely, we should be having those conversations?

Dr CREELY - Yes, exactly, we agree.

CHAIR - I know a department we could talk about, but we won't.

Dr LUMSDEN-STEEL - On that, just bringing it back to the patients: I've tried to touch on the patient experience in our THS. I think one of the most underutilised resources that we had to have some of these tough conversations about what our Tasmanian population expects is the health senate. There's been some very good people I know that have worked on the health senate or been a part of it, but they've come away a bit upset or dismayed that it felt like it was effectively a briefing bottle. Now that might have changed in the last 12 months, but it was almost like a briefing vehicle and this is our message and this is what we want you to go and spread as opposed to the health senate coming back to provide robust patient, health system, I guess, commentary and putting pressure back on the government to say, 'Actually, we know there are some hard conversations to be had, but can we be part of it and can we actually give you feedback from a patient and from another outside perspective?' I think coming through, our overlying message for here, though, is we actually want accountability. The crisis that Meg's talking about, it's become normalised and patients are coming into EDs and accepting they might wait eight hours, you know, it's acceptable. It's challenging.

One of the things that's frustrated the AMA is that - an example where the government's made a priority is actually trying to create the state government investing in bulk-billing GP clinics, as an example. The state government - look, we support particularly the focus on women's medicine, access to IVF, but we've just thrown money at IVF that is not means tested, for example. IVF is obviously a critical service to provide and public patients, if they couldn't afford it, they just literally couldn't go down that pathway. We've now provided a subsidy, which is great, but it's not means tested. I suspect the reason for that is the process to actually administer such a process would cost too much. My point, though, is, if you're looking at value for money, maybe someone's crunched numbers and said it's all too hard to means-test and implement, but I'm just giving you an example of investing.

But, demand, let's get back to what the demand is. We know demand is exceeding what we can provide. We need to be honest about what the shortfall is. We talk about the shortfall

because what I think this state government needs to do - and that's all politicians - is we need to start pushing back very hard on the federal government. The federal government is the largest collector of tax in Australia. They are the ones that make the big decisions and the state politicians need to work with federal politicians because we have a revenue problem. We are spending more on health care. The expectation is we'll provide more services. We don't mind if you're 85 and you've got a bowel obstruction, having emergency surgery and all that, we're doing that care now, but we weren't doing it 20 to 30 years ago. So, as we do more, our system hasn't been funded and resourced for this extra work we're doing, so that means that we're rationing. We're rationing in the sense that people wait for time, or they wait 12 months for the private health insurance policy they've just taken out to get in there.

CHAIR - Perhaps in a lay person's timeline. What I'm hearing you say is that back in the day, I worked in the system too, like you would take the conservative approach to your bowel obstruction for a person in their mid-80s, but now you do surgery.

Dr LUMSDEN-STEEL - You tend to, but there are a couple of reasons for that. I think there's no doubt that patients are actually living longer, we know that. The average life expectancy has gone up -

CHAIR - Isn't it the reality though, that we've still basing the funding model and the staffing and planning and that, on the system that was, you treat these people conservatively and you wouldn't take them to surgery. Is that the problem?

Dr LUMSDEN-STEEL - No, I think the reality is that the Health budget is actually being determined by the Treasurer. You'll get 2.2 per cent, which doesn't even cover the wage increases that they give to all their staff every year, and it doesn't match the 6.5 per cent growth in services we provide. The Health budget is completely made up in terms of what the demand on the services actually is. So we talk about, we want accountability for the shortfall, because -

CHAIR - If there was a total state plan, then there'd be an argument then to link the budget allocation to the plan, which would no doubt have a service delivery plan as part of it. Then there would be a clear connection between the plan and the budget. Well, there should be.

Dr LUMSDEN-STEEL - Correct.

Dr CREELY - You would hope you could use that and then the projected demand over time, that workforce over time. Again, coming back to accepting that locums will always exist in our system, but being able to factor that in, and then the numbers that we sort of know around health inflation and what we see go up every year, it does seem to be something that, while you can't say it's definitely going to be this year in year out, it seems to be something that is at least a known - it's going to be in this ballpark figure. So, when we see the budget come out in each successive year is going up by tiny little fractions that we know is not going to meet it -

CHAIR - It's effectively going backwards.

Dr CREELY - It's essentially going backwards.

CHAIR - So, if you were to design a new - you had a clean sheet - you were going to design the governance framework for - not so much primary health because that's sort of with

the feds, notionally. But let's look at the governance framework of our acute health services that we're responsible for delivering as well as placing funding. What would that governance framework look like?

Dr LUMSDEN-STEEL - I think our framework actually isn't terrible, but the real reality is that, having spoken to many clinicians within the system, their budgets don't match the reality. So I think you've got a governance framework that ticks all the boxes for governance. It does. It says we've got processes, we've got people, we've got pathways. They all break down when the department tries to micro-manage and control things. Our concern is that between a clinical director signing off on something, there seems to be this black hole where things go into. It was taking 120 days for HR to put our contracts for people that have been offered a job. Now that's coming down, but that's just appalling, so we just continually lost people from our system because they were - but that's an example of processes that weren't responsive to what conditions were asking for.

CHAIR - So, is there too many levels in there, Michael?

Dr LUMSDEN-STEEL - There's levels within the Health department that can be deleted almost straightaway.

CHAIR - What would they be? I mean, for us to actually -

Dr LUMSDEN-STEEL - Well, there's the department processes. So the number of people that seem to be involved in the sign-off process would be a very clear example.

CHAIR - Sign-off for employment?

Dr LUMSDEN-STEEL - Yes, or any decision-making. So, the secretary structure took a lot of autonomy delegations for spending money, for making investments, for signing off on employment, have been taken off the - it was a CEO of a hospital, and now they're called general managers, I'm not sure what they're called now. But the leadership team in a hospital was shrunk. Those resources were pooled into a department, because the department hasn't trusted the hospitals for what's been going on. Now, we've had some terrible things, and Launceston's been hammered because some bad things have come out of Launceston. What the department saw was that the hospitals can't be trusted, so we'll do everything. So they've done that, they've centralised everything. But the trouble with centralisation is that the people that become faceless, that don't have a name, an email, whatever, when you've got a problem with the system, you can't get an answer out of the system. Whereas, in the old days - and I'm not saying this was perfect - but the people that were making decisions would be in the hospital or the building, and they'd be a known face. If you had a problem, you'd go and speak to them, say, 'Look, what's the hold-up?' Whereas now that process is delayed. I know I'm side-tracking slightly, but I think getting back to what we need to do, I think the hospitals need to run the hospitals. The department should not be running the Health service; they should be seeing the strategic goals and requirements, not running the hospitals, which is what we've had done. We've had a dep sec for hospitals sitting over top.

CHAIR - I thought this is what, when we set all this up, that was how it was supposed to work, but maybe I've been delusional?

Dr CREELY - That is how it's supposed to work, but if you look at, say, the executive of hospital at the moment, you've got four or five people. One of them is a doctor, one of them is a nurse, but that's it. And we have executive directors of medical services (EDMS). They're excellent clinicians - they're a specialty unto their own right - but they're also not the people seeing patients. So, we think that one of the ways in which we could add more of a clinician voice into how hospitals themselves are run is to have - whether it's an elected member or something - raise another clinician, equal nursing/medical, into that executive run-in. Not go so far that it is every head of department there and you get, you know, a room full of people. But how do we introduce that back in? We think there's flow-on effects around culture, around people being listened to. We have so many doctors come to us and say. 'We've got these ideas around how we could do this, but I feed it up to the department and I just get knocked back as 'No'.' And I think having that allows people to test some ideas to feel like this is their Health service, that they can help, you know, change models of care. That is one of the ways we see that executive governance structure being -

CHAIR - Clearly that needs to work right across outpatient clinic, you know, the acute patient, inpatient stuff.

Dr CREELY - Yeah. So, there's that level of, sort of, executive sitting over each hospital, but then underneath that, each area has a clinical director or head of department. And at the moment we hear from some heads of department, they don't know what their budget is. If they do know what their financial delegation is, it's so - perhaps to make it clear, I'll give you my groceries as an example. I know how many people I need to feed, I know what I want to do with them, I know the outcome: healthy fed, and I know what my budget is. I'm pretty efficient at going to the supermarket and getting my groceries. But if you know how many people you need to look after, you know the outcome you need, but you have no idea what your budget is, or even worse, you can buy one packet of Tiny Teddies, but anything else you need 12 levels of approval to be able to do, then how do people - how do clinicians run a department of which they are the head of? How does that work?

CHAIR - Being the devil's advocate, Meg, perhaps, is that you see - you have doctors run amok. That'll be the headline, because they've all decided they want to do things their own way. You end up with, you know, 'I like this hip replacement joint', 'I like that one' - and we have had trouble with that in the past. So, how do we stop doctors running amok?

Dr CREELY - Yeah, I agree. It's a really good point. So, I think the point is not that you give entire control to the doctor; it is that you just add that voice in, because at the moment the voice is lacking. But you also have a business management, a procurement person. You know, it's that balancing act of everybody plays to their strengths. But at the moment in a Health system, we've lost a clinician voice, and I think our nursing colleagues would probably agree.

Ms LOVELL - It comes back to what Michael was saying before, too, about it. That what we're doing is based on the budget we have, not the demand or the need.

Dr CREELY - Yeah.

Ms LOVELL - And there's no kind of meeting in the middle of that.

Dr CREELY - It's tricky, though. I mean, we can have an aspirational budget and we can have the budget that we've got and that we have to face. So how do we, and it's again,

perhaps in those hard conversations, what can we provide people? Where can we provide it? We cannot do, you know, the tiny little sort of nuanced types of neurosurgery in the north-west, for example. So, I think that's a conversation that needs to be had, and that's what we think the state health plan might better address.

CHAIR - It might also help people on the north-west say, 'Well, actually no, I'm not going to be able to have that there. I will have to go to Hobart.' And we do get that up there, you know, funnily enough, but -

Dr CREELY - Yes. That understanding, yes.

Dr LUMSDEN-STEEL - The most recent example was, I think, I don't know if he's a councillor or councillor-applicant in the north-west who was banging on about cardiology services in in the north-west. There's a clear plan that they need to be managed by a cardiology inpatient ward. So, if you are having a heart attack or severe heart problems, you should be at a cardiology unit. That's the standard of care in 2026, and it was a few years ago. The problem has been, it's become very clear that patients have been stuck at the Mersey Community Hospital because of bed block. So, Launceston has got probably a much worse bed block issue than the Royal Hobart Hospital actually does. And they're actually using their endoscopy unit to have patients staying there overnight. It's a real problem. But that meant the cardiology patients - now, even if you got to the LGH and they didn't actually do much, the difference was that a cardiologist has been aware, you've been referred to a service, you get plugged into the cardiac nurses, you're in the rehab, all that stuff happens because you've gone to the right unit, and then you get set up for a successful recovery pathway and follow-up. So, you know, and that's because we simply don't have the resources in Australia, to be frank, let alone Tasmania, to staff more than, at the moment, two proper cardiac centres in Tasmania. And the new redesigned cardiac health hub, when it's finished in Launceston, will be phenomenal, because that deals with half the state's population, where we actually know cardiac disease is most prevalent - where? In the north-west.

That's a clear example. But that's whereby we've got to educate the community and support them, and the politicians need to make some really tough decisions when it comes to if they're going to build new hospitals or where they're going to be. Is it actually based on a clinical service plan that we've decided how we're going to allocate and provide care to patients? The right care for the right patient at the right time, but it has to be at the right place, too. And so we've only got -

CHAIR - But the right place could be that you have access to get there, not necessarily in your backyard.

Dr LUMSDEN-STEEL - Correct. Exactly, one hundred per cent. And that's whereby, you know, we've made a lot of investment in our ambulance service. We've got a retrieval service, we've got the choppers, we've got the helipads. But we can't dilute services down, because there's only finite resources in Australia. If you don't do something well, you're not set up to run it 24/7, you can't do things like that piecemeal.

Sorry, Cassy, you were going to say something before?

Ms O'CONNOR - Well, going back to my need for a concrete example of something, you've explained there's multiple layers of bureaucracy and approval and one solution perhaps

was to get a clinician within that structure, but isn't also part of it to enable clinicians to have a little bit more autonomy because they are, obviously, the experts. What sort of decisions are requiring that 12 layers of approval?

Dr CREELY - Perhaps if we talk about how you hire somebody, is perhaps a good example. You might have a department, and you've got a budget of four FTE. You have three filled, so you want to have one more, so you put in a job card. Once you've put that in, there's perhaps five other people, including the business manager, who have to approve that and that takes time. As Michael referred to, it was at over 100 days to get somebody. So then, as the head of department, even though that's part of your allocation, you still have to have that job card approved, it has to go through vacancy control - again, that sits there until vacancy control meet - then it goes up online. And then, you hope that somebody applies, and even once they apply, there are still the processes - and some of these are due processes around how you hire somebody and making sure you've got a panel of people that do it. So, there are some processes that have to happen in there. If they're permanent, there needs to be a two-week review period as per the *State Service Act* and then nothing happens in that time period. They're those sorts of layers involved in, we need a new respiratory physician, we have somebody willing to do it, but there's all these layers in between that are actually happening and you lose them to somewhere else.

CHAIR - Lose them to somewhere else who has a much more streamlined system.

Dr CREELY - Yes.

Ms O'CONNOR - So, are clinical decisions having to go up through this?

Dr LUMSDEN-STEEL - Clinical decisions largely not, but the trouble is that the clinical care for patients is being triaged by bed block. I'll give you a clear example. The team that's planned for the activities that week, they'll know their patients, but they've also prioritised their workflow to be the most efficient, and it might be that someone else that's come in with a skill set to assist what's happening that week. But then what happens is the bed-flow decisions are made by people that sit in the hospital. It used to be the operations command centre of the hospital, and they just look at the number of beds and go, 'Right, well, we're just going to put a line through all these things without understanding all the other moving pieces'. And so, you create these cancellations and efficiencies when things have been lined up. Every time you cancel something, as you know, that has a domino effect in the wait line and you basically, particularly with cardiac disease, someone just sitting around with a narrowing of the coronary artery is at high risk of having a heart attack or an adverse event. So, the clinicians have lost a bit of control in managing their use of their beds and their teams based on the bed-flow capacity issues. That's a real-life example of inefficiencies because you're paying - in a cath lab you might be paying for 12 staff to safely deliver care for each patient because you've got so many moving pieces. It's an amazing team to watch do what they do and they do it well. But then they sit around doing nothing for two or three hours. That's two patients that haven't had a procedure done in a system that's got a massive waitlist. And that's coming back down to, I think, our structures in our hospitals due to the lack of capacity due to constipation.

Another conversation you need to have is how the state can find a rapid plan to get these 104 patients in our acute care beds out of our acute care beds. Where are they going to go to? The problem is, I reckon, that's only going to be a short-term fix to the problem because we're going to fill those 104 beds pretty quick if we're doing the elective surgery and other things we

haven't been doing, which would be great, but it's not without the other solutions fixing the problem, you know what I mean?

CHAIR - You've got to create places for them to go, even when the next 104 or whatever come in.

Dr LUMSDEN-STEEL - I think that's why the federal government's decided to remove the private health insurance rebate for over 65s, isn't it, because they said they're going to put it into the aged-care beds. Now, we don't trust them that they're going build those beds at all. So there's your next big problem, we've just told you we've got an ageing population and now you've got the over 65s losing their health insurance rebate. If you look at all the graphs on activity based on age, where does it start to explode? 65. And so between 65 and 85, about 50 to 70 per cent of elective surgery and cancer treatment and stuff is happening in that population because that's when those things are at their peak and we know that with our pressures on our hospitals, if you suddenly put more pressure into our public healthcare system - you've seen the dashboards.

CHAIR - By removing the healthcare rebate.

Dr LUMSDEN-STEEL - Yes.

Dr CREELY - I suppose we don't see a huge amount of impact in - you can't prescribe that drug to that patient.

Ms O'CONNOR - Or order that diagnostic test, for example.

Dr CREELY - Yes. It is more the system structure that stops us being able to provide care. The clinical trials unit was one of the other specific examples. It sounds like it's just trials and research, but it's not, it's how a lot of our haematology and oncology patients access treatments that are - novel is probably not the right way, but that are still in that phase - and it's the only way they can access certain ones of these drugs. And the funding was pulled for that for non-clinical staff, but those non-clinical staff went out and found those patients and brought them in and supported them through that process, so then the patients missed out on that aspect of care.

CHAIR - One of the other things - you were talking about this earlier, Michael, about patients have 12 months' wait for an echo. But, back in the day, we'd have quite unwell patients who would not - I mean, an echo was a very specialist thing, mostly for medical patients, not for pre-op surgical patients. So, we are actually doing different things. Is that because we've got older patients who are a lot more likely to have cardiac disease?

Dr LUMSDEN-STEEL - You're 100 per cent correct. There are two components to that, and this is a bigger problem up the north and north-west of the state because their public capacity is very tight. It's always been very tight. You have trouble attracting sonographers and specialists to regional areas. But in Tasmania we've also become overwhelmed, too. And I think there's been a bit of a shift from patients that would have been happy to potentially pay for it in private versus billed services in public. Now, the most frustrating thing we've seen in Hobart is we've had very entrepreneurial doctors who have tried to grow the public system. They have, and they're cardiologists who work in the public system. But, because they've kept asking for the funding resources to employ more sonographers, the business cases have not been

supported at a certain level in the bureaucracy, so they've gone and been able to set up, effectively, bulk-billing services. So they end up providing a service, Medicare bulk bill for patients in public, you can get your echo within four to six weeks - the Medicare card pays for it, so we're paying for it. But that takes resources potentially from the public system because the sonographers are being well paid, they're busy, they're happy - actually healthcare workers are really happy and don't complain when they're just able to get on with doing their job and caring for patients.

Ms O'CONNOR - They feel valued.

Dr LUMSDEN-STEEL - They feel valued, they go to work, they've achieved something, they're happy. They haven't sat around frustrated with the system that - we've used the word constipated. So, I'm just giving you an example there, whereby - and I can't nail down who said 'No', Cassy - as to why the system wasn't effective. But when we've tried to say we need to increase our capacity of cardiac echo, the public hasn't built it. It's been done in private. But the problem is that the public patients are now waiting 12 months in Hobart to have that echo and that means that -

CHAIR - You've lost the sonographers over to -

Dr LUMSDEN-STEEL - Partly, but we need to train more. So the final thing, you get back to demand. Workforce. We know we need to train more healthcare workers. Tasmania produces excellent healthcare work graduates, how are we employing them, how are we keeping them in Tasmania. You know, to be a radiographer now you can't train in Tasmania. You can through universities interstate, but the University of Tasmania stopped training radiographers, so a lot of them have gone interstate and they may not come back. Now, you can do some placements down here. So, I think, strategically keep people in Tasmania that want to be here. Offer pathways, but we've got to employ them. And we actually know that we haven't increased our bed capacity for the ageing population. If you look at the line of beds per ageing population is going down, not going up, it's not matching it. So we've got the workforce in Tasmania, we've got the school leavers, we've got the university, but we're not providing the training opportunities or working collaboratively as well as we could be with the universities. But also the final point to make here is, actually, it's the state hospitals, the state Health department that employs the staff that get further training and specialist training so -

CHAIR - Have you talked to UTAS about the radiographer training?

Dr LUMSDEN-STEEL - I don't know if they've got an appetite for it because it's a business decision for the universities and I think most radiographers are doing it through other universities on placement. There's always politics around a relatively low volume training program being effective. The key thing is how we're providing incentives to support people here because it's a shortage. But I think we can train more nurses, we can train more pharmacists - I mean, pharmacists are a big challenge in our public hospitals - we can train more doctors. But we need, obviously, to provide the pathways because once they leave Tassie we know that we have challenges getting them back. If they can't train in Tasmania. It's a challenge. Sorry, I know we're getting towards the end, so times -

Ms THOMAS - I'm interested in, you talked before about who's at the head in the executive team of the department making the decisions. I'm interested in whether you, the AMA, has a view on what it should look like if it was to be more functional and effective?

Where I'm going further with this is, we got some information through questions on notice at budget Estimates about increases to the workforce over the past five years with a breakdown of clinical, operational and non-clinical roles. Overall, in the clinical space the workforce has increased by 26 per cent over the last five years. Operational workforce has increased by 26 per cent over the last five years. Operational workforce has increased by 13 per cent, and the non-clinical health professionals, administrative support, et cetera by 18 per cent. The total health workforce data provided tells us that 22 per cent are support roles of the whole department, not clinical or operational but what I'm hearing is the executive team doesn't reflect that workforce breakdown. Does the AMA have a view on whether it should?

Dr CREELY - I think it perhaps goes back to what is that demand, so clinical workforce growing by 26 per cent I think is good but what does it need to grow by? Have we got the right people in the right places going along? Do we have, you know, respiratory physicians in the north or north-west? We have one, to the best of my knowledge, and I don't know that we're training any more. So, I think there's that element of it. It's really difficult to know with non-clinicians how many of those are linked to clinical roles and provide that support that we absolutely need to do our job. How many of those sit in roles that, as I think Michael perhaps mentioned very quickly at the outset, could be cut tomorrow and no one would notice? I don't think we have that visibility, but we would certainly like to see clinicians have a voice - to see the demand mapped out and worked towards that to make sure that our workforce reflects efficiencies as much as our patient care does.

Ms THOMAS - Did you have a view on what it would look like at the executive level?

Ms GIDDINGS - We're actually developing a governance model, so we don't have a set version of what it should look like right now but we're looking at what it could look like. At the moment, as Meg said, there are five on the executive of the hospital. There's a CEO, or there's an executive general manager now; the CFO, the financial officer; the COO, the operations officer; the EDMS, the Executive Director of Medical Services is one doctor; and an EDON, who is Executive Director of Nursing, so they're your five people on it. That is insufficient.

Ms THOMAS - That's the executive of the hospital though, not the department.

Ms GIDDINGS - That's the executive of the hospital but that's the critical part for us. The general manager feeds into the executive of the department but whether or not they have sufficient, say, around that table as one voice for that one hospital is probably not going to make a big difference but our issue is we want to get the hospital executive stronger. We don't want to go back to the old model where you had every clinical director of a stream and their nursing clinical director sitting on the executive of 16-18 people; far too big. But we're looking at do you keep your five, so you have an efficient executive, but underneath that you have subcommittees or do you use what we have in our system now with the MAC (medical advisory committee) which are doctors who are the stream directors who at the moment exist in these MACs. They meet monthly in most hospitals, quarterly at the LGH, which is far too infrequent. And should those doctors on the MAC be advisory to the executive or in fact be like a subcommittee of a board of directors where you can make recommendations that ultimately the executive then vote on as to whether they'll accept that recommendation or not?

At the moment they're purely an advisory body that the EDMS who sits on the executive goes to the MAC and says, 'This is what the executives are intending to do', and it becomes a

one-way-information-sharing back to the doctors who don't actually have much say. They don't get to recommend and vote on recommendations. We definitely think in the governance of the hospital, there needs to be a strengthened voice of doctors and nurses who do know exactly what's going on the floor and how best resources can be spent.

The Cancer Clinical Trials Unit is a prime example. That has been a unit that has in fact been profitable for the hospital for many years. Recently with changes to how cancer research has been funded, it went into the negative and the hospitals had to subsidise it because of that. And I can't remember the exact figure, but it's like $100,000 subsidy or that sort of figure; it might be slightly higher than that. The hospital have said, 'We can't afford that; we're cutting it', so a potential revenue for the hospital has now been reduced because they don't have the staff, they have 50 per cent of the staff they used to have who can attract that research dollar into the hospital, so you say, is that actually a good use of taxpayers' money or not because the people working in the unit believe they could get back up to a profitable status.

There are some of those decisions where I think if you had the right clinicians with a bit more governance power making those decisions, you would get a better outcome over what's happening with the Cancer Clinical Trials Unit, for instance.

CHAIR - What's the timeline for doing this work?

Ms GIDDINGS - Well, the CTU's had its budget cut already, so it's 50 per cent less than what it used to be. They've had a number of staff already -

Dr LUMSDEN-STEEL - You mean, our governance, sorry.

Ms GIDDINGS - Our governance? Oh, our governance works - so ours has to go through our state council. So, we're developing a paper and working on that right now, essentially, we had a meeting on a couple weeks ago. So, it's probably about three months away before we would be ready to launch our version of what needs to happen. Happy to share it.

CHAIR - Yeah, we're still on - that would be great if you could send it through once it is a finalised document.

Dr CREELEY - We'd really like to. Yeah. I'm really aware of time. Can I quickly, when we talk about big picture plans and state health plans - we've looked, I suppose, at other states, NSW and ACT, where they've had both an independent inquiry and the special commission of inquiry, and that's been that acknowledgement that every single one of us, we wouldn't be here if we had a functioning health system without any problems. The government has problems, the Department of Health has problems, clinicians - and so that's been a way we think of being able to not lay blame, but say how, where are the issues? How can somebody from the outside look in and give us that direction forward from our colleagues who, in New South Wales there does seem to be some movement, because we all don't want another something that sits on a piece of, you know, on a shelf, lovely bits of word on a paper and doesn't actually get implemented. But our colleagues in New South Wales have found it to be a really a constructive process, and the next steps that are coming out of that, in terms of a preventative roundtable, because that was its number one recommendation out of that was that the state itself focus more on prevention. So, we think there is sense in looking at something like that for Tasmania. Again, being really -

CHAIR - So, who undertook that review, do you know?

Dr CREELY - So, the NSW, that was a special commission of inquiry, Yeah. And then the ACT one was an independent inquiry and I can't remember who -

CHAIR - With a focus on? What were they actually focusing on? The governance or the -

Dr CREELY - New South Wales looked at the whole health system, ACT looked at the majority but did have four or five areas it was mainly focused on. But was that sort of overall view of where do things happen, sort of, you know, what we've been talking about from a state health plan, but in more depth around where does that happen now, what services: private, public exist. It's a very long document, the NSW one, but it's a really great document.

Dr LUMSDEN-STEEL - I'd have to say it's a sentinel paper that actually applies to every jurisdiction. If you actually look at the framework and bones and areas -

CHAIR - So, do we need to reinvent the wheel here?

Dr LUMSDEN-STEEL - Well, the question is, you don't need to necessarily need to reinvent the wheel, but that paper, when that was published around Australia we all looked at it and said, 'This is actually articulated'. Because they literally did all the work, and they broke it down and the doctors thought, 'This is a doctor's witch hunt', and then they gave the feedback to the shape and what the inquiry looked into, and it looked at the health service. It wasn't a witch hunt. It was transparent. It looked at the patient, the healthcare workers, the funding, the infrastructure, and it's a sentinel paper that outlines - it's consistent with every state, pretty much, because we've all got the same issues which is a system that's never been designed to meet demand, and therefore funded to meet demand.

CHAIR - Funding hasn't matched up with the service delivery model.

Dr LUMSDEN-STEEL - Yeah, and the design hasn't changed because we haven't been funded to actually achieve outcomes that are measurable. And you hold the minister accountable to. But the minister can only be accountable with the budget that they're given, which is something that the Treasury just decides they're going to get arbitrarily.

Ms O'CONNOR - Well, I mean it goes to Cabinet.

Dr LUMSDEN-STEEL - Oh, sorry. I meant Cabinet. That's fine. No, but that's also because our state government's spending $3.3 billion out of 10 on healthcare - where can the state find another dollar to put into healthcare when you've got all the other expenses that you've got? I mean, we've got a -

Ms O'CONNOR - Well, you could cancel the stadium.

Dr LUMSDEN-STEEL - Well, you could do lots of things, but that wouldn't fix the healthcare service. That's a $1 billion one-off saving, that's not fixing the fundamental actual revenue shortfall, which is why - actually, sorry to take over for Meg for one second - but the federal government not being accountable for actually supporting - I think they're part of the

NRHA because they haven't been meeting their commitment - which I didn't make that point before -

CHAIR - If the department had better outcomes-based performance measures, then we'd have something to hang our hat on, to say, 'Well, this is what we need you to deliver in terms of patient outcomes'. But there's hardly any that measure that - and apparently they're working on it. The Auditor General told us that they are working on a document or other advice because we didn't have a bit of a crack at the last hearing about that.

Dr CREELY - Because even with the KPIs, you know, there's an annual health services plan with a huge number of KPIs in them. But are they relevant? But where are they reported? There's a few in budget paper 4 but they're really - they really don't.

Ms GIDDINGS - The sad thing too is that there isn't any vision in terms of the future around infrastructure and how this will help. We're actually building inefficiencies. We are building costs into our health system as we speak with redevelopments like the emergency department at the ED, that's going to be over three floors, that's going to cost a fortune. Which if you had a brand new Royal you would not have that.

Ms O'CONNOR - A brand new Royal, that would be amazing. It has to happen. I mean, the government is not going to be able to delay the reality of the need for a new Royal for very much longer.

Ms GIDDINGS - A little more controversial for the north-west route, of course, is a single hospital for the north-west too. We are building inefficiencies by spending millions of dollars, hundreds of millions of dollars in trying to redevelop the Mersey Hospital and the Burnie Hospital, both of which have reached their use by date. But there is no vision from this government about tackling those issues around infrastructure and looking at efficiencies into the future.

CHAIR - I'm just conscious of the time. Is there anything you wanted to close with? We do appreciate you coming and we may have further questions for you at a later time, but is there anything you want to particularly close with?

Dr CREELY - Look, I think we've covered what we really were here to cover. We hope we've offered some solutions and not just moaned too much. We thank you and on behalf of the members that we represent for your time and input.

CHAIR - Thanks for your time and we appreciate the submission, it's quite detailed and that's really helpful.

Dr CREELY - Thank you.

The witnesses withdrew.

The committee suspended from 2.03 p.m. to 2.15 p.m.

Martyn Goddard

CHAIR - Welcome, Martyn. Thank you for your submission and your appearance before the committee. As we're prying into the financial and operational performance and governance of the health department. We appreciate your use of expertise in areas related to health funding and those related matters. This is a public hearing. Everything that you say will be covered by parliamentary privilege while you are before the committee - that may not extend beyond it. It is a public hearing. If there's anything of a confidential nature you wish to share with the committee, you could make that request. Otherwise it will all be public. Unless you've got any questions, I invite you to take the statutory declaration, if you wouldn't mind, and then introduce yourself, and I understand you have some papers you'd like to table straight up.

Mr MARTYN STUART GODDARD WAS CALLED, TOOK THE STATUTORY DECLARATION AND WAS EXAMINED.

Mr GODDARD - Now, may I table these? Some of you have seen these already, but there's that which is about what we could do in terms of infrastructure to make the system work better, and that's basically a business case for notionally spending $2 billion over five years on health and hospital infrastructure. That's just really by way of background. The bottom line of that business case, of the discounted cash flow analysis, is that the benefit-cost ratio on the base case, taking into account some pretty conservative assumptions - I've really not stretched the assumptions at all to try to make a case, just the reverse - and that benefit-cost ratio works out in the base case of 2.06. Which means that for every dollar you put in then the benefit to the community is about $2.06. Now you compare that with the stadium and it's about what, 0.45, 0.5? So, if we're going to spend a couple of billion dollars, making people well, stopping them dying wouldn't be a bad idea.

CHAIR - Sorry, before you go any further, would you mind just introducing yourself in terms of what brings you here, so we've got that for the record?

Mr GODDARD - Yes. My name is Martyn Goddard. I'm described as a health policy analyst, I'm also a journalist - that's just my professional background. I came into health policy in Sydney at the end of the 80s when I found myself in the middle of the AIDS crisis in Sydney and I was editing the Sydney Gay Community newspaper. I found myself in the middle of that with a lot of people dying around me, so I got involved in that at that time. I kept the interest up because it's something that the community, the consumer, isn't well represented always. It's not a level playing field between the supplier and the consumer. I was health policy officer at the Australian Consumers Association, Choice, for a bit over a year - I was filling in for somebody else, but that was in Sydney. Since, I tried to look at what down here, there doesn't seem to be anybody else still doing this stuff, outside of government. So I kept on looking at this stuff, because nobody else is, and because you can't just allow the government, the department, the Treasury to feed you your only source of information.

CHAIR - Thank you.

Mr GODDARD - Here's another background, you can table that. That's a partial argument on why living in a smaller jurisdiction is no excuse for such high costs. If that was the justification, then we wouldn't have got to the national average in terms of the cost per patient, as we did in 2015, briefly, because that wouldn't have been possible. The other part which is in that argument is if a smaller organisation, smaller jurisdiction, smaller anything, if

the disincentive of scale really existed then you would expect larger institutions to be more cost effective, cheaper per weighted patient than smaller ones. It's not the case; there's no relationship at all across all of that.

So, the arguments that the government's putting forward that the department tends to put forward are on why we are expensive don't stack up, in my view. The key graph is that one, that graph, in 'How Much Money?' The cost? We're treating an average acute hospital patient in this state, that trend, that relationship with the national average, from about 2011-12 to 2015, follows the pattern of decentralisation of decision making, devolution, delegation from the central administration to the people, as far as possible, in the hospitals; people like the Director of Surgery at hospital and the Director of Medicine and so on. Those sorts of people were allowed to make decisions which they weren't before and aren't now. If you talk to some of those people, you'll find that they say, many decisions that I've made - and I have talked to them - now I have to go to the bureaucrats in the department. Now, the department, as I understand it, has gone in that time, over the course of the current government from two floors to nine. It's impossible to find out. I think I said to you in an email that it's impossible to find out what that means in terms of FTEs or people. There's nowhere you can find that out: how many more people are employed in Elizabeth Street, in those extra seven floors -

CHAIR - Since when, sorry, Martin?

Mr GODDARD - What happened was that under the previous regime which existed under the Labor government, coincidentally really, but was due to the leadership of Michael Pervan, who was the secretary of the Health department. Michael knew that decentralising decision makers, delegating as far as was reasonable, would be more efficient for everyone. Everyone would be happier, including the Treasury. When the government changed, and my impression is that a lot of this push came from the then treasurer, Mr Gutwein, they wanted more control - centralised control, so Mr Pervan was removed suddenly with a five-sentence letter from the premier, with no announcement, no phone call, nothing. He just fell over when he got that letter.

His replacement, Catherine Morgan-Wicks thought it would be, and agreed with the government, that it would be preferable to have more centralised decision making. And so, we went from having a delegating system which might have actually gone below the national average, that's where it was hitting. There's nothing amazing about the national average. When he was defenestrated and the centralization started, coincidentally, the costs went up.

Ms O'CONNOR - Can I just check on that with you because on this document you've given us, it says a clear point here where decision making was centralised at the beginning of 2016, I guess or 2015 and then you see these costs climb and climb. Is it your contention that primarily this growing gap between the cost per patient here and on the mainland or the national average is in large part due to inefficiencies through central decision making?

Mr GODDARD - I'm not aware of any other thing that's happening. I mean, what else could it be?

Unknown - The AMA were saying that as well, weren't they?

CHAIR - Are these weighted costs?

Mr GODDARD - Yes. The particular mix of case doesn't matter. It's about treating a case mix weighted value of one. You're talking about like with like.

CHAIR - Because the argument that is often put, Martyn, and you'd be well aware of it, is that we have an older demographic.

Mr GODDARD - Doesn't matter. Yes, that means the total amount may be higher, but the cost per patient shouldn't be. They're two different things. The demand, yes, the demand is affected obviously by a somewhat higher age group. Not as much as we sometimes think. One of the things that causes some confusion is that it's forgotten that a very large proportion of lifetime hospital costs are in the last two or three years of life. Just because somebody turned 65 or 70, doesn't mean that they're suddenly more expensive. If costs were going up in the linear way from 65, you'd have a very different bottom line than if you're only going up at the end.

We will go to page the second page. The amount of money this is drawing from the National Independent Health and Aged Care Pricing Authority figures, which only go up to 2022-23 at the moment. Coincidentally, the CEO of the Pricing Authority is one Michael Pervan now. Just in acute, we're $260.5 million over the national average. Whereas in 2015-16 we were $4000 better off than the national average. With emergency, it's the same pattern, but there's less cost there. The cost we have in acute is very substantial, very substantially higher than it should be.

Ms O'CONNOR - What do you think's happened here then, Martyn? So, that second graph on the first paper you gave us also has the collision point between Tasmania and, I guess, the national average on emergency department presentation. Then you see here where we cross over in 2014-15 and emergency department costs keep climbing. How much has that got to do with central planning and how much of it has to do with emergency department infrastructure that wasn't - still not - fit for purpose?

CHAIR - And you can't get patients out.

Ms O'CONNOR - And you can't get patients out and into beds

Mr GODDARD - That is the problem. I mean bed blocks, largely. There's a few things involved. One is that we're not getting patients through. Another one is centralisation, that's built into these costs too. Administration is built into these costs, at least to some extent.

My basic point is that we could we could do the same job for very much less and that if we extrapolated - I don't know whether this sort of centralisation and this sort of financial effect is happening across the board, across the budget. If it was, if you extrapolated that $400 million deficit from the national average across the budget, then it'd pretty much wipe out the operating deficit. Health is about a third of the budget, by three. I don't know whether that's happening, but I wonder whether other areas like education have also been centralised, whether there's an increase in bureaucracy and numbers in head office there as well. I'd suspect that there might be.

CHAIR - It would be a safe bet to expect it was in State Growth too.

Mr GODDARD - Yes. So, if I'm right, we are borrowing to pay for the cost of a government policy of centralisation and command and control.

Ms O'CONNOR - And so in terms of the $400 million that you talk about, is it your contention that the way the health department makes these efficiencies is to remove central command and control, that means remove jobs in the department, or would those jobs go back into the hospitals, or how does it? What's your contention here?

Mr GODDARD - We didn't have those jobs before.

CHAIR - They're not clinicians we're talking about.

Ms O'CONNOR - No, I know. So where would you put them if they went back to the hospital? I understand that.

Mr GODDARD - In terms of now, you've got people in the system, you've employed them, you've employed extra people, yes, there's a big problem about what we do with them. The chances are that they will stay somewhere. It's going to be very difficult to get down again, having gone this far. But going from two floors to nine, what do you do with an extra seven floors of people?

Ms THOMAS - So, on that, you mentioned that it's difficult to get data on increases in in numbers.

Mr GODDARD - Well, it's not there.

Ms THOMAS - We did ask some questions - if this is along the same lines, just correct me if I'm wrong - we asked some questions in budget Estimates about increases to the Health workforce over recent times and they provided on notice a response that shows a breakdown by employee category from June 2021 to March 2026. So, over about a five-year period there is an increase of 2545 staff in the Department of Health over that five year period. Clinical roles have grown by 26 per cent or 1858 people; operational roles - cleaners, environmental health officers, food services, technicians, dental assistants, orderlies, attendants - have grown by 13 per cent or 221 staff; and non-clinical health professionals, professional administrative support functions, non-clinical management like payroll, hospital, admin, policy, regulatory functions have grown by 18 per cent or 466 people. So, is that what you're talking about?

Mr GODDARD - Well, I'm glad you got that, but those figures aren't obvious, otherwise publicly.

Ms THOMAS - So, what's your take on that breakdown, because what the data also shows is that, of the health workforce, 22 per cent are support roles, they're not clinical or operational roles. Do you have a view on that as a proportion of the workforce?

Mr GODDARD - Yes, why? I mean, just because you've got more doctors in the system doesn't necessarily mean you need more clerks to catch up. Why?

Ms THOMAS - Have you ever looked at what the breakdown of those employee categories are in other jurisdictions?

Mr GODDARD - No, I haven't. Just getting comparable stuff around the country is almost impossible. It would be a huge task to do that sort of thing.

Ms THOMAS - Yes, okay.

Mr GODDARD - The best state system is the New South Wales Bureau of Health Statistics, which really does independently keep an eye on what's happening in that area and they are -

CHAIR - When you say keep an eye, what do they actually do?

Mr GODDARD - They gather the statistics, all the statistics. They do so independently across health and they are very accessible to journalists, for instance, and to members of parliament. We don't have such a thing here that's independent of government, which is a shame.

CHAIR - Well, it's a little bit hard to get the information out of the departments at times, too.

Mr GODDARD - Yes, and when you do, there's no comparison. They don't compare it with anything. Don't compare it with what happened a few years ago. Don't compare it with what happens elsewhere.

CHAIR - So, we'll have Health back in front of us again, Martyn, at some stage, we haven't settled the date yet, but we've just heard from you, we have heard from the AMA that a lot of this increase in weighted average cost per patient has occurred concurrently with a decision to take it more command of control arrangement and rather than allowing clinicians and see, I suppose, more involved at the coalface, if you like, to have some decision-making capability and manage the flow of their unit, the hospital unit, not the individual ward or the operating theatre as such, but the whole, because it's all interlinked.

Mr GODDARD - Yes.

CHAIR - So, is it likely that the Health department will give us some other reason for it that you could think may be plausible?

Mr GODDARD - No. No.

CHAIR - No?

Mr GODDARD - I mean, why were we able to do it then and not now? Every state has got bigger - I mean, New South Wales and all the others have got much bigger than we have. There's more demand - more population, more demand - we have -

CHAIR - A younger population, but that said, when you look at their decision-making governance framework that enables that, does it look like ours, or does it look different, or does it look like ours used to? Do you know? Have you looked at those other jurisdictions, particularly in New South Wales, for example?

Mr GODDARD - Not deeply, except in comparison with us. The centralisation has got a lot to do with this. Let me just read from an email from a senior insider.

> All recruitment was centralised at the behest of the Treasurer and his deputy as a cost saving measure. As a result, it took so long for a ward, for example, to go to a vacancy in the system, get it approved by head office, advertised and filled, it took so long that good candidates were often lost as they took up other offers for the same money for want of waiting. The other irony is that locums would be approved to fill the gap. The gap would become indefinite and we learnt of some locums who had been in Tas Health for five years or more because of the mess of the centralised system.
>
> The other problem is the high number of locums and the processes to replace or extend them. The consequence of that is that hospitals, HR people, fill their days recruiting and contracting locums, and just never get around to filling the job substantially. Salaries and conditions are the same, if not, a little better. The process of central control gums up the works, triggers good applicants to consider alternatives, and very clearly saves no money.

CHAIR - Where were you reading that from?

Mr GODDARD - An email. I can't share the - but I can tell you privately, but I can't put it on the public record. So, the extraordinary cost of locums and agency nurses in our system is one which has not been justified. That tells you at least part of the reason. So that's basically gummed up works.

But we are, I think I've seen in one of these submissions, that we're spending an enormous amount of money on temporary staff who effectively become permanent. Now, a clinician in senior medical staff, which will be earning between $2000 to $2500 a day, in emergency, it'll be probably $500 more than that. There are similar sorts of discrepancies with registrars and so on. And we have quite a lot of those. Now, I don't know why, I can't see where why that would be justified. And there's no comparison. There are no figures comparing us with other states. I imagine to some extent that's happening here, but you could put down, I think, a good deal of the very high per patient costs to temporary staff being paid an enormous amount of money. By no means all of it, but certainly some.

Ms THOMAS - The other issue, you mentioned in your submissions, is you know people staying at hospital when they're no longer needing acute care, but they might need some nursing care. So, we've seen, in response to try and address crisis levels and emergency departments, federal and state governments invest in urgent care clinics to address that end of the problem but at the other end we're not seeing a response to address getting people out of hospital when they're no longer needing that acute level of care. Is that a big part of the problem?

Mr GODDARD - Well, talking anecdotally, because that's what we have. Nobody's ever done an audit, which they should, but, anecdotally, senior clinicians will tell you that we have somewhere between 25 per cent and 30 per cent of patients in any one day in an acute bed who don't need that level of care but there's nothing else; we don't provide that other level of care for them.

Now, some of those people, but not a huge proportion, are waiting for residential aged care. For residential aged care accounts, it's probably about 2 per cent or 3 per cent of total patient days. The state likes to like to point to that because it allows them to blame the Commonwealth but in fact, if that was totally solved, we'd still have the same problem.

Ms THOMAS - Do you have any idea of what the proportion would be of people who aren't necessarily at the level where they need to enter residential care but also can't live without some level of support?

Mr GODDARD - No, I don't. I haven't seen any figures. I've seen some probably rubbery figures about the residential aged care thing.

Ms THOMAS - Because I feel like there's a gap also in the middle where -

Mr GODDARD - Absolutely there is. The in-home care stuff?

Ms THOMAS - Yes.

Mr GODDARD - That's putting some people in there too but nevertheless, there's no evidence that I'm aware of to show that that's a major problem -

CHAIR - A barrier to discharge? We're talking about barriers to discharge, aren't we?

Ms THOMAS - Yes.

Mr GODDARD - Yes, broadly.

The people who aren't candidates for age care and who can't go home yet, some older people for instance who certainly don't need residential aged care -

Ms THOMAS - Or don't want it.

Mr GODDARD - Yes, or who are candidates for more care than they'd be able to get at home but not as much as you get in acute. That middle area is missing. We don't have it.

This is in some of those background papers I gave you. If we were able to provide that step-down-care as residential, it would be nursing home standard but again talking to clinicians you would need a bit more medical care and a bit more nursing than a nursing home but not that much. You'd need more allied, but not cripplingly. It would cost, maybe, a quarter per day but nobody seems to have thought of it. And I put this to people and nobody said it's not a good idea but nobody does it.

Ms THOMAS - Has there ever been, that you are aware of, anyone look into, not just an audit of that element but also of the proportion of people who return to hospital?

Mr GODDARD - Readmissions?

Ms THOMAS - Yes, readmissions, because they go home, there's not the level of care that they need, therefore, they end up returning?

Mr GODDARD - Those figures are in the AAHW diagram. Off the top of my head, I haven't looked at those recently enough and I certainly can't tell you how they compare with the rest of the country.

The 28-day readmission is a serious thing. I don't think that tells you what the problem is. I think the problem is that we have 25 per cent of patients in any given day who don't need that level of care but do not have an alternative.

It's not the readmissions. That would mean that we are discharging people sicker and quicker than we should.

In terms of average length of stay and its effect on overall cost, that's had a big effect on acute costs. The way that hospitals around the country were managing increased costs, but reducing their expenditure was by reducing length of stay, but that happened over many, many years and this happened nationally, around about 2015, aligns with this. It happened here a little quicker than it did in most other states because we were more crowded to begin with, but it really happened all at that same time. Stephen Duckett's done work on this. There came a point at which you just couldn't reduce length of stay anymore.

Ms O'CONNOR - Safely.

Mr GODDARD - Do it safely, no, and so we got to the point where if we'd continued down, then the 28-day readmission rate would have started going up seriously. We stopped before we got there but what it means is that we've now got an increasing number of people in hospital, and bed numbers that haven't been catching up. So, that's been the case for many years. We've managed that gap by reducing length of stay, but now we can't and for the past 10 years, we haven't been able to.

CHAIR - On that - and I might be devil's advocate, of course - people are going to hospital sicker, they've been waiting longer, so they're sick and they've got more underlying health conditions - all the things that mean their stay will be longer.

Mr GODDARD - Absolutely. Absolutely.

CHAIR - Part of it is that you're creating some of the problems.

Mr GODDARD - As an example, somebody I talked to ages ago, who needed the hip replacement and she couldn't get a hip replacement in the public system couldn't afford to go private. So, because walking really hurt, she didn't walk much.

CHAIR - Yes, lost her fitness.

Mr GODDARD - She put on a lot of weight, developed diabetes, had the problems that you get when you get diabetes and ends up costing the system very much more. That's the sort of example you're talking about.

Ms THOMAS - Exactly.

CHAIR - Which we've been hearing about for a very long time.

Mr GODDARD - Yep. Yep. What's being done about it?

CHAIR - I noticed, just to get onto perhaps a more forward-thinking approach, you gave us a paper that you've tabled, a new deal in health, and they've talked - I've only had a skim, obviously - about what could be done. So, do you want to speak a bit more to that?

Mr GODDARD - Okay. At the moment and historically, we have regarded a hospital bed as a hospital bed as a hospital bed; they're all the same even though the patients aren't all same. Patient's needs aren't all the same. So, we provide this very expensive hospital accommodation without taking into account, duly, what the community needs. If we were able to, as I said, for instance, produce and put up aged care standards for nursing home type facilities with a bit of extra stuff and you'd save, by my calculations, around about three quarters of what you're spending per day. That's one thing that we really do need to look at. It would save a lot of money. It would treat people very much more effectively. Staff and patients would be working in a place where it was more appropriate. As I said, the saving would be substantial.

We can save a lot of money in health. If we can save that money there, where could we spend it? We could spend it on a couple of things. One is much better mental health care. Talking to people like Richard Benjamin, the public sector psychiatrist, who gave me a lot of help with this. If we had centres of excellence, as he would like to call them, in mental health care in Hobart in the north, potentially in the north-west.

CHAIR - We are just about building a new mental health precinct in Burnie.

Mr GODDARD - Yep. One of the problems is that's been done without much of an overall plan.

CHAIR - Part of the north-west had a master plan.

Mr GODDARD - Yeah, but for mental health. That's one thing we could spend some money on. A general hospital is not a good place for mental health patients. Putting people through emergency departments, those loud, chaotic emergency departments, is not good for somebody who's having a psychotic episode.

But what else can we do with them?

CHAIR - In Burnie we send them to Spencer Clinic, which is not the best place either, even though it is a mental health ward.

Mr GODDARD - The other thing we could do is that we could build specific public elective surgery centres nationally. Two-thirds of elective surgery is done in the private sector.

The proportion of people with private health insurance nationally is about 50 per cent. Here in Tasmania it's a bit less than that. Again, that doesn't add up. What that leads you to worry about is that there are large numbers of people, particularly in the lower income ranges, who are not going to get their so-called elective surgery, even though elective surgery, as you know, is a very broad serve. It means anything that can be scheduled. Now you can schedule a cardiac artery bypass graft; that's elective.

CHAIR - It might be urgent, but it's still elective.

Mr GODDARD - Yes. It's not an emergency case.

CHAIR - Not that you have to right now where the patient does not survive.

Ms O'CONNOR - Are there any places that have specialist centres for elective surgery?

Mr GODDARD - Basically no. Well, hang on. Yes, of course, yes. One of the standouts was at The Alfred in Melbourne. About 20 years ago they built an elective surgery centre in what had been a car park. The rate that people were bumped from their appointments went from - by separating elective from emergency, because emergency always trumps - but by separating those out and having your own centre with its own staff - that's quite separate from emergency. They got their rate of cancellations - hospital-initiated postponements - down from 21 per cent to 7 per cent, and then basically to nothing.

CHAIR - When you do that -

Mr GODDARD - Here, I think, the last time I looked it was about 16 per cent.

CHAIR - you'll clear the backlog of patients who are less complicated because the complicated ones won't go through those centres, with multimorbidities and things like that. So then, I think, there has to be an expectation if you do that, that your elective surgery in our hospitals, which will still need to perform a range of elective surgeries, will have less number. They'll be looked at as less productive because their cases are more complicated. So you need to perhaps set realistic expectations.

Mr GODDARD - Only if you don't weight the patients; if you don't put a weighting. If you put a weighting on the patients, then that doesn't happen.

CHAIR - But the dedicated elective surgery centres was something that the Labor Party talked about when Lara Giddings was the premier. The discussion was around making the Mersey Hospital a dedicated elective surgery centre; that was thwarted as well.

Mr GODDARD - I haven't really looked at what the economics of that would be. But certainly if you look at the broader economics, the benefits to the community, it would be substantial.

CHAIR - I think one of the challenges here, perhaps, is that because if you do it in a standalone - with The Alfred they put it right beside the acute hospital, which is a large hospital, so if something did go wrong, and it can go wrong, all manner of things can go wrong with a straightforward planned elective surgery, that there was a quick transfer to the major centre.

Mr GODDARD - I had a conversation on this some time ago with Kath Berry, who was then the CEO of Calvary, and she said, 'Well, that's really what we're doing with St John's and Lenah Valley. St John's is the kind of place we're talking about as for elective surgery. It's up to, and including, hips and knees. It's low to moderate, low to medium acuity. It's not the bypass grafts. They stay where they are. The complicated stuff, the cardiac stuff, for instance, stays where it is. The neurosurgery stays where it is. But a lot of the other stuff, a lot of the orthopaedics and so on can be done separately. What Kath said was that at St John's - and we're talking about a similar sort of operation, maybe the same sort of size - they have, probably an average of about one patient every six months who needs an ICU unexpectedly. They get an

intensive care ambulance in and take them there. That's two a year, and it's managed there. Calvary manages it. We don't manage as well in the in the public sector. We could, I mean, that shouldn't be a huge barrier.

CHAIR - Well if we have to build a new Royal -

Mr GODDARD - We can't have hospitals and stadiums, can we?

CHAIR - If you do, then these are the sort of things that should be considered in a design.

Mr GODDARD - Of course it is. Look, did I ever send you the *Medical Journal of Australia* (MJA) paper on The Alfred Experience.

CHAIR - You might have done a very long time ago.

Mr GODDARD - I will send it to you again.

CHAIR - I mean, the thing is, in our hospitals now here there will always be emergency caesareans and they come into the same theatres that the general surgery is going on. And it always disrupts.

Mr GODDARD - That's right, and if you have an elective surgery centre without its own staff, that's still going to happen. You're going to have surgeons and surgeons, and so on going backwards and forwards and they're not going to like it. It's not going to work. You're going to have, not only the centre, but also the staff who are going to be dedicated to that. When you do that, the patient pathway is marked more predictable and this is what they found at The Alfred, that you can run the patient pathway from admission to discharge on the basis of a protocol, so that everybody knows where you are along that way.

It's very efficient. You can't do that with emergency for all sorts of reasons, because you can't allow emergency patients, but to fit a protocol - yes, we should look at these things. We should be dealing with them. There are plenty of examples. I mean, the Irish systems doing this are great. They've done great work.

CHAIR - Which one?

Ms O'CONNOR - The Irish. What have they done that's distinctly good?

Mr GODDARD - It's just the benefits of separating the two broadly. I mean, that they've gone a long way down that path.

Ms O'CONNOR - So, the system, their whole health system, is separating them?

Mr GODDARD - Well, pretty much, yes.

CHAIR - Well, not necessarily completely separating them, but having dedicated, elective surgeries-

Ms O'CONNOR - Separate staff.

CHAIR - So, all the ones that are likely to be pretty complication-free go through this system.

Mr GODDARD - And patients stay where they are.

CHAIR - I, and I'm sure the committee members, do, Martyn, appreciate the information you've provided here. It is something we can certainly follow up with the Department of Health because we've said for years that we can't keep throwing more money at health, but we've also got to measure some outcomes to know whether what we're throwing is actually delivering on the outcomes that we've expected.

Mr GODDARD - The question is how we save money, how we go about saving money. Now, the way we went about saving money from 2015 or 2014 onwards was to try to reduce expenditure where you could see it, to get more control over everything. That, as we've seen, doesn't work because all it means is that you've got more of your money going to administration.

CHAIR - And fewer decisions being made, probably.

Mr GODDARD - Well, not only decisions being made -

CHAIR - Remote to the patient, yes.

Mr GODDARD - Talking to a senior, director-level hospital clinician, it might take two-and-a-half days to get a decision, right, that he used to make by himself.

CHAIR - Like, on whether he should do this particular investigation or not?

Mr GODDARD - Well, it's not clinical stuff; we're talking about a director of surgery, right? There's a substantial administrative element to that job. He's not just cutting people open, he's running units, running a large unit. So, having to make a decision about, for instance, whether you have replaced someone. When somebody goes on leave, what do I do? That sort of decision should be able to be made there. You shouldn't have to get escalated to management; that person knows what is needed, knows how to do it, should be allowed to do it.

CHAIR - Like, for example, a surgeon turns up in the hospital to do a list, surgical list, and finds that her anaesthetist has just rung her to say she's sick. So, does the surgeon then need to go through up some chain of command to say, 'Well, I need another anaesthetist, can I call him?' And then - is that what we're talking -

Mr GODDARD - That particular situation? I don't know, but I, would strongly suspect that yes. I mean, what would happen is that procedure would be, that list would be cancelled.

CHAIR - Which seems extraordinary. But anyway. Unless there are seriously no anaesthetists.

Mr GODDARD - But I mean, there are just so many minor decisions.

CHAIR - So you're saying, Martin, then that even decisions, and I would call that basic. You know who the anaesthetists are, you know who's in the operating theatre next door. So, you're not going to call them. But you do know that this anaesthetist is on-call for this evening and maybe we put another anaesthetist on-call for this evening and just bring that one in early. Those sort of decisions, you think, possibly are being delayed, or a list cancelled because of those sort of things.

Mr GODDARD - All sorts of decisions, Ruth. I mean the example in here about the truck in 2012, when things were still centralised, going up to us to deliver five pens.

Ms O'CONNOR - Pens.

CHAIR - You've got to deal with the amount of the expectations -

Ms O'CONNOR - Oh, you mean actual pens?

Ms THOMAS - Yeah, pens.

Ms O'CONNOR - Oh see. I read that a few times and thought there was some cage that you put people in, or so, I work it out like biros. OK, thanks. Wow, that makes the story actually extraordinary. Right. Thanks.

Ms THOMAS - Thank you.

CHAIR - All right. Well, yeah, pretty much out of time so, but thank you. And thanks for the information you've provided to us. It's really helpful and we appreciate your time. Thank you.

The witness withdrew.

The committee suspended at 3:13 p.m.