THE LEGISLATIVE COUNCIL SESSIONAL COMMITTEE GOVERNMENT ADMINISTRATION A MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE, HOBART ON THURSDAY 23 APRIL 2026.

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

The committee met at 9.00 a.m.

Department of Treasury and Finance

CHAIR (Ms Forrest) - Thanks, Gary and James, for appearing before the Government Administration Committee A Inquiry into the Governance and Financial Management of the Department of Health. We heard from Health a little while ago and appreciate you being willing to provide some evidence to the committee, particularly on the financial management, not so much the governance perhaps, but, I assume, the financial management.

This is a public hearing. Everything you say is covered by parliamentary privilege, unless there are matters of a confidential nature you wish to share with the committee, in which case, you could make that request and the committee would consider it.

I'm sure you don't have any questions before we start, being a frequent flyer as you are. I'd invite you both to take the statutory declaration, and if you want to make some opening comments, Gary, you're welcome to do so.

Mr GARY JOHN SWAIN, SECRETARY, and **Mr JAMES CRAIGIE**, DEPUTY SECRETARY, DEPARTMENT OF TREASURY AND FINANCE, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Thank you. Gary?

Mr SWAIN - I wasn't going to make much of an opening statement, other than probably go over what I think you'd be very aware of. Generally, Treasury has an ownership role in relation to the financial reporting framework. Some of the issues that have been raised by the Auditor-General are in a space where Treasury sets up a whole-of-government framework. Procurement is a key example. But we're not sort of pseudo-managing in the agency, so we don't take an active role in a day-to-day sense of, are those frameworks being complied with?

All the reporting that you're aware of, all the quarterly reporting, the TAFRs (Treasurer's Annual Financial Reports), the annual reports, Treasury sets up those frameworks. We are very engaged. I have to say I've observed and understood more since being in the role the extent to which Treasury's proactively involved in talking to agencies about how those frameworks work. So, procurement is talking to people all the time. The budget branch is talking to people all the time about how things should operate under the FMA (*Financial Management Act*) and other frameworks that we set up. So, there's a lot more of that than perhaps is visible.

But there also is a role for the Auditor-General doing exactly what's happened here: doing a review of performance, financial performance, or otherwise, where that tracks through into a report, which then ends up in a process like this. To me, that's the system working. That will

go to, then, the agency's level of focus - whichever agency is subject to the audit, the agency's level of focus on the issues that are raised. I think that's also happening here.

One thing I noted from the Auditor-General's Report -

CHAIR - The AGR report?

Mr SWAIN - Yes.

CHAIR - He has done a couple. There was also the one into community service organisations which goes to a governance and culture matter too.

Mr SWAIN - I was going to say that probably where I do very much agree with him, he's made some comments in a couple of his reports that you can't - a rulebook can't substitute for culture. So, the culture of an agency is really managed by the executive leadership of that agency. I don't think there's any getting away from that. You can have frameworks that assist, you can have reporting that adds transparency, but you still come back to the culture of the agency. That's probably all I want to say.

CHAIR - One of the areas I wanted to talk to -

Ms LOVELL - Can I just follow up on those opening comments before we move on?

CHAIR - Yes.

Ms LOVELL - Gary, you said that there are whole-of-government frameworks around particular areas like procurement but that Treasury doesn't play an active role in ensuring compliance. Is there an active role for anyone in ensuring compliance with those frameworks? Or is, as you alluded to, this process the more appropriate way for that to be scrutinised?

Mr SWAIN - Some of it's built into the framework design, and James might want to add to this. For example, agencies will have their own procurement committee, which is a requirement under the TI They should have their own internal processes in terms of making sure that the requirements of the framework have been followed. Usually, you have a committee that's not forming a view as to whether the right provider has been selected; they're forming a view as to whether the right process has been followed in the - some of that's built into the framework itself, or the frameworks that we develop. But there's also all the standard measures like, you have management reporting in agencies that should be going through to their executives that will meet weekly. And they should have an internal audit function that's complemented by the external audit function. So, there is a range of other mechanisms that go to compliance that are already in play.

CHAIR - Where I was going to go, slightly around that point as well, Sarah, is that Gary, you said you were proactively involved in how frameworks should be used under the *Financial Management Act*. Let's just focus on Health. I assume a similar process is taken with others, but Health is a very large department - soaks up over a third of the budget, all those sorts of things. How does that work in action? What do we see?

Mr SWAIN - If there are things that are slightly unusual, that will often turn into inquiries of the relevant area of Treasury, and interaction between Health or whoever it is in

Treasury, in that framework. I didn't mention, which I should have in the opening statement, there's also budget committee reporting. There's now monthly reporting that has been in place for a couple of years that tries to track where an agency's at in terms of all its expenditure relative to budget.

CHAIR - Let's just talk about the Department of Health - that provides a monthly report to Treasury on how they're tracking against budget. Is that what it does?

Mr SWAIN - Yes. It will give a report on expenditure. James can talk to this with more authority than me, but it will talk about expenditure and expected end-of-year. And it is, of course, a process that depends on the quality of what's put in by the agency.

Mr CRAIGIE - I think the Secretary of Health and his attendance at this committee a week ago made reference to the budget committee reporting process. There's a monthly report that Health and all agencies provide that is by output, and it has the budget by output, the year-to-date expenditure by output, and a forecast of the full-year expenditure, then a brief commentary. That is compiled by Treasury and discussed at budget committee at its regular meetings.

CHAIR - How often are the regular meetings?

Mr CRAIGIE - Well, budget committee tends to meet monthly, but it doesn't meet every month of the year, because the budget process generally disrupts that frequency.

CHAIR - How close to the budget process - because that sort of attention - not stop, I wouldn't say, but alter - like you said, it doesn't happen every month of the year. It happens monthly, but not every month. If you can tell us what months it does, perhaps it might help.

Mr CRAIGIE - The budget committee would meet more frequently than monthly during the budget development process. It's not a fixed timetable. It's really at the discretion of the Treasurer of the day and how the budget process is managed. Outside of the budget development window which, to be fair, is a reasonably long period of time, there is regular reporting by agencies to budget committee on year-to-date performance. Typically, budget committee has a rotating agenda where agencies come in, so you wouldn't have Health at every meeting, because you have eight agencies, but Health would come regularly and other agencies would attend regularly to talk about their performance.

CHAIR - One of the things that's been perennial, if you like, is the overspend in the Health budget. I'm sure you've seen or heard the evidence from the Secretary and the minister last week. They claimed, I think it was $43.2 million overspend they are predicting this year. Are you confident that that's the figure, looking at all the information you've had access to? Because it would be quite a reduction in previous years.

Mr SWAIN - I have been talking to the Secretary of Health on an ongoing basis. We have interactions at various levels through James and budget branch and Government Finance and Accounting Branch (GFAB). I think there is a very concerted focus this year. Obviously, there's a heightened awareness of budget pressures, for a variety of reasons. I think all agencies have to try to grapple, having been in [inaudible] agency for a number of years, with optimism bias, that when you go to the various areas and say, 'Do you think you are on track?' The answer

will usually be 'yes'. So, there is always a risk around February, March, where there's an internal narrative which becomes less -

Ms O'Connor - Certain.

CHAIR - Certain, yes.

Mr SWAIN - Certain. I think there's a sort of natural- that's particularly the case with big, lumpy expenditure like capital. So, I can say that I think there's been a concerted focus - and I've certainly been discussing with the Secretary of Health things like their vacancy management approach and some of the initiatives they're progressing to seek to manage both the end number and their level of understanding of their own budget. Do I think it'll be perfect? No, there'll be some variation from what they're predicting, but I'm hoping it's a lot less than we've seen in some previous years.

Mr CRAIGIE - Another feature of this year is that the Health budget got a material supplementary funding from prior year, and so they've got a funding boost. You would expect that would assist them in terms -

CHAIR - It also ran down their cash reserve significantly in prior years, yes. I mean, capex is one thing, you can push back. We see that happen in all departments, particularly infrastructure, in DSG. In Health it can be done too. But you were saying that the reporting is on output groups, of outputs, so if we just focus on the opex from the output groups, because that is the operating, what confidence do you have, then, that we're going to see Health come in within a close margin of their budget, or are we going to need a Request for Additional Funds (RAF) or a supplementary appropriation this year - which it doesn't leave us much time to do that, I appreciate that?

Mr SWAIN - Yes, the Treasurer has been very clear that he does not want to go down the supplementary appropriation road, and he set those expectations early with all secretaries and all ministers. I think that is sharpening the focus within agencies that, you know, in past years, there has been - in the post-COVID environment - there's been an assumption that if we just need a 'supp', there'll be one. We've certainly been engaged with the Treasurer on how you manage so that that outcome doesn't occur. I mean, I can't say that there's no scenario where we could get a surprise, but I don't think we'll get a surprise that's huge in magnitude. I'm sure that the predictions will not be right. They are predictions, and there'll be information that comes in and we might have to use the normal tools of the FMA to move money between outputs and potentially across areas, across whole departments, but -

CHAIR - It's always on after the fact, though, or reported after the fact.

Mr SWAIN - That's done after the fact. And there is some uplift in revenue that goes to the Treasurer's Reserve, which means the Treasurer's Reserve is supplemented above what parliament appropriates. So, I think between those tools and tighter management by Health, we should be able to manage without a supplementary appropriation.

CHAIR - So, do you feel fairly confident, then, Gary, that the estimate or projection of $43.2 million overspend is pretty reliable, or do you think that's probably a little bit of optimism bias?

Mr SWAIN - I think there's a risk of optimism bias. There will be variation from it, I'm sure, but I think the order of magnitude, I'm hoping, is a lot less than we have seen in some past years. And my understanding of the way they've been managing more aggressively their own budget, which I think you've sort of heard about, in part, when Health presented, is, I guess, part of that view.

Ms LOVELL - On that, Gary - in previous years, when we have had a much bigger overspend, when has Treasury become aware that that is expected? Has it been that there's been sort of optimistic projections until a point where it's just blown out suddenly? Or has that become evident earlier on in the financial year?

Mr SWAIN - Well, in the time I've been here, and James might have a view, that's probably what I've observed, that the information - let's put it this way - gets better as you go through the year. So, in the period pre-Christmas, you know, normal environment, there's still that optimism bias to some degree, and then it gets clearer as you move into January, February.

I guess the other thing in the Treasurer's position on the supplementary appropriation is agencies have been asked to actively manage to their budget and, to the extent they can't, to look at how they can self-manage any issue, like by appropriately drawing down on their SPA.

Ms LOVELL - And that hasn't - that idea of actively managing within your budget, hasn't been encouraged in previous years?

Mr SWAIN - No, I think it definitely has. I think absolutely it has, but I just think - I mean, my impression is the State Service collectively was a bit slow to return to normal after COVID. During COVID budget was less important and it was more about urgency and making sure that there were the responses that were deemed to be needed at that time. It's taken us a while to get back to the normal processes of budgetary discipline.

Yeah. That's also included - getting - if you look at the policy and parameters statements - well, I have looked at them since I've been in the job - they've gone through the amount of variations in year that is 'policy versus parameter' is shifting and has in the last couple of years. There's more parameter, less policy than in my first year, for example, where there was a lot of policy and not too much parameter.

CHAIR - You could argue about whether some of those are categorised correctly on that.

Mr SWAIN - You could.

CHAIR - Yeah.

Mr SWAIN - I'm not saying that's definitive, I'm just saying that there is - I mean, you know, I'm not wanting to make excuses for the government, but I think, again, Tasmania's not Robinson Crusoe, we've seen that through a lot of that same dynamic - a change of prioritisation and emphasis during COVID and a - collectively been a bit slow to return to normal operations.

Ms LOVELL - Yeah, thank you.

CHAIR - Okay. You said you want them to, you know, the agencies - Health in this case - to be able to - rather than look for more money, to draw down on their provisions in their

special provision account, or their SPA. We know that Health drew down significantly on those reserves over previous years. Do you monitor the balance of that, because I don't think there's much headway there, is there?

Mr CRAIGIE - There's a quarterly process where agencies provide updated SPA revenue and expenditure estimates for endorsement by the Treasurer, so we get quarterly updates.

CHAIR - What is Health's SPA at the moment?

Mr CRAIGIE - I mean, you have to be conscious that the balance is a point in time and the flow. In the case of Health the balance is small - like, you know, order of magnitude $20 million, but the flow is significant. In the 2025-26 Budget they're forecasting in round numbers about $1.3 billion of revenue and $1.3 billion of expenditure through that account, so the flow gives them a lot of capacity, whereas the point in time balance might suggest there's not a lot of capacity.

CHAIR - They've drawn down on that in previous years, as well as needed extra money and here we are, they don't - they've been told no more money - you know, notionally - the SPA is low, compared to what it has been in the past, so they don't have a lot of room to move.

Mr CRAIGIE - Their current forecast balance is low, but there are significant ins and outs that do provide some flexibility. I think the point I made earlier, they have a significant uplift in their funding for 2025-26 compared to 2024-25, so that's - they've got a bigger base to operate with and, hence, they are forecasting a lower variation.

Mr SWAIN - I believe there are some major payments to come in from the Commonwealth. I think there's a couple between now and the end of the year as well.

CHAIR - There are, yeah. Do you have an expectation about how much should be in their SPA? Not just Health, but all of them, but let's focus on Health. Do you think there's a prudent level to have in there?

Mr SWAIN - I haven't turned my mind to that explicitly yet. It's a conversation James and I have had quite a bit, about how the SPAs move, and whether they should. There was a process that started in 2024 that kind of went back through and reviewed all the purposes which SPAs could collect and use money. I think the backdrop is there now to probably think about that, because before there was a rollover of arrangements that to my understanding was partially reviewed when the FMA was set up and not fully reviewed and now that fuller review has been worked through, so the definitions and specifications of SPA are [inaudible]

CHAIR - Some of them were extraordinarily high for a period too, which I don't think is good either.

Mr SWAIN - They were and, I guess, some of the compliance in practice is - comes through, how can I put it - softer means, so the fact that all agencies know the Treasury is progressively going through and looking at definitionally, what can be -

CHAIR - Funds can sit in -

Mr SWAIN - used from a SPA, means that every finance team across the State Service knows that's happening. Then the SPA balances are being managed progressively to a lower, tighter base. They definitely were very high at a period and need to be a lot lower than that and the remaining - you know, the principle, that if they're savings they should be returned to the public account - is what should occur because it's the public account that manages all the downside risk.

CHAIR - I'm not sure that Health will ever have a lot of savings.

Mr SWAIN - No, but, you know, I mean -

Look, the reason I'm hesitant to answer your question is obviously the number's got to be scaled to the size of the agency and the agencies are so varied in size.

CHAIR - That was my point, Gary. It's been very high at times - possibly too high, some could argue - and now you could argue that perhaps it's a bit low to deal with the ups and downs, to be able to pay their bills as and when they fall due. Acknowledging the ins that'll come in from the Commonwealth, you know, I don't deny that at all, but I'm just trying to understand whether there's a - for the Department of Health, whether [inaudible]

Mr SWAIN - I'm not being flippant saying I haven't turned my mind to that because I think there's also then, the extent to which you - you know, there's the demand management - there's the extent to which you can manage demand and the extent to which that's material to what percentage of your opex - I mean I think you'd have - to think about that in a disciplined way is quite a complicated task and, as you know, we have had a few other pressing issues in the last couple of years.

CHAIR - That's why I'm not in charge of it too, Gary, because I couldn't do it.

Ms O'CONNOR - Thank you. This question goes to demand because, although it's pretty clear that the way the Department of Health manages its finances could be significantly improved and the Auditor-General has made that pretty clear, it's a fact, isn't it, that the health system - particularly here with the oldest, fastest-ageing population, highest level of disability, highest chronic disease burden - the pressures on the health system each year are going to inevitably increase. And, it's how that's managed both by government and by the Health department, presumably with some oversight from Treasury, not just this year because Health, as we've heard, got a top-up of funding. How does Treasury see, and at some level manage, those increased demand pressures and, therefore, the need for extra funding? Because when the Treasurer says no RAFs, well, that could mean a cut to services within that financial year, which would impact on people.

Mr SWAIN - I want to be careful not to be too - to make comments on the run when perhaps I haven't had all the discussions that would need to support them and I'm not necessarily aware of everything that's happened in the past. But, where my mind goes, in answer to your question, was we could actively engage with Health, or more actively engage with Health, about some of their budget methodologies - how they factor in those demographic changes in their demand forecasting, which should then support the budgeting process - so that's an ongoing conversation that we could have. But, you do also have an actual tension between any government that wants to hit improvements to its budgetary position and there's, I guess, a judgment call to be made between what puts manageable pressure on an agency that

it can deal with and what is optimism in setting the budget, which the Auditor-General has also raised in one of his reports.

Ms O'CONNOR - And what is realism in terms of meeting demand.

Mr SWAIN - Yes. There's a lot of judgment in that and that, ultimately, comes to the government of the day's view.

Ms O'CONNOR - The Auditor-General has found that the Health department's administration of its finances is fundamentally flawed, and we've heard here at the Table that Treasury has a quite limited capacity to help Health be less fundamentally flawed in the administration of its finances. Are there system and accountability improvements that could be made to help Health deal with some of what the Auditor-General has identified as cultural issues in the way it deals with public money?

Mr SWAIN - You've characterised it in a particular way. I would say if - what's a good way to respond to that - if we are systemically seeing across all agencies particular outcomes, then I think you would go to say, 'Have we got the system right?'. If we're seeing it in some agencies but not others, that naturally takes you to the implementation of those arrangements in the agency.

Ms O'CONNOR - Which is a culture question.

Mr SWAIN - Yeah, culture, or systems or processes or training. It could be a whole range of different things you could look at as the executive team of that agency.

But I guess that's the way that, in discussions in Treasury with my own team, that's how I'm looking at this. Is this a single agency or one or two agencies? Or is this all agencies? If it's all agencies, maybe we need to look at the system or the process. There's a lot of that going on.

So, in procurement, there's a progressive review of our arrangements. There's been increased engagement in the property side in response to another audit that raised our role in relation. I think there's an ongoing need to look at those systems. They'll never be perfect and they can always be improved.

But the focus in my mind is, are we seeing systemic outcomes - in which case we have to look at the behaviours that the system is generating? Or is it an agency-specific thing - in which case, in part, that will be the minister who's responsible for that agency responding to the scrutiny budget committee and the parliament?

Ms O'CONNOR - Do you have a view on that: whether it's systemic or there's an agency or two or three that lie a bit outside what would be an ideal financial management approach?

Mr SWAIN - Like in any capability across the State Service, you've got different capabilities in different agencies, but also different challenges in different agencies. You can't ignore the fact - and a number of them were raised by the Health Secretary in this forum, I don't think you can ignore the fact that Health is a third of the budget, so the challenge is huge. I also think there are genuine - I'm sure Dale would agree with me, there's room for improvement in both Health operation under the financial management arrangements, and there is undoubtedly things that we can look at to improve those arrangements.

There is a fundamental challenge also with the Commonwealth's involvement in this.

Ms O'CONNOR - What's that? Do you want to flesh that out a little bit?

Mr SWAIN - If you look at the recent health agreement, it's definitely a significant improvement and will lead to additional funding to the state where additional activity occurs.

But it's also true that the Commonwealth's contribution over time has been reducing as a percentage of cost. And I think the national arrangements for setting efficient price, which are under review, my anticipation is that they will conclude in a year or two that the current efficient price advantages those jurisdictions with big urban settings because they've got economies of scale that you couldn't really expect to get in a smaller jurisdiction. None of that is saying that Health can't be more efficient than it is, but I do think there is the funding mix component here.

Ms O'CONNOR - Is Treasury, or what level is the Tasmanian government involved in negotiating with the Commonwealth about that sort of equitable fair price allocation of health funds?

Mr SWAIN - Very. There is a branch in Treasury, the Intergovernmental Financial Policy branch, one of the key things it does is it has a key role in revenue and GST management. But it also is involved in all the major funding agreements, the five major agreements. In this case, that was a close working relationship between DPAC, which also has an intergovernmental function supporting First Ministers forums, Treasury and the Health department. It has to be that way because a lot of the detailed understanding at portfolio level is in Health, so the central agencies can't do it without talking to Health.

But yes, I think that is a bit like the GST. There may be many things that we could have, in our respective roles, differences of opinion on, but health funding is one where it's likely that Treasury, DPAC and Health will all agree.

Ms O'CONNOR - Yeah, good.

Ms LOVELL - Great.

Mr SWAIN - There's a role in prosecuting a case for Tasmania.

CHAIR - On that, Gary, I want to go straight into that. It's probably more a question for Health, and I have put it to Health as well: The current funding arrangements that are part of the agreement do fall short for Tasmania - even the extra millions of dollars provided through the most recent announcement, reward activity, not outcomes. That clearly benefits major centres, as you've alluded to. Is the model wrong for a small jurisdiction like Tasmania? The Northern Territory would have the same argument. I bet Northern Territory is saying exactly the same thing. Is this the problem: that we have a dispersed population, a demographic, as Cassy's outlined, and the funding model promotes activity without promoting outcomes?

Mr SWAIN - I'm not sure I've got a view on that. Conceptually, I agree with you. I know this has been something you've had an interest in for many years, the performance indicators that the government works across, being they're more outcome-focused and less input or

activity-based. It's not that I disagree conceptually. I just don't know how difficult that is to operationalise in Health, whereas the activities, they can obviously operationalise that.

CHAIR - You can. But just creating activity doesn't improve health outcomes. You end up doing things that you don't necessarily need to do, or you do this thing today, that thing tomorrow, another test this day, rather than treating the whole patient. My view is that the model doesn't work for a society that is not post-war, where it was all about almost transactional health care. It's about treating the whole person with comorbidities or multi-morbidities, with a whole range of different health challenges. We're stuck with a model that rewards activity - someone comes in, you can fix them with one treatment, off they go. That's not the case any more.

Mr SWAIN - Yeah, what I'm saying is that, conceptually, I agree with you entirely. But I don't have enough detailed understanding of health to have an informed view on that specifically around health activity.

CHAIR - In Treasury's role in negotiating the health agreements and providing advice, I assume you provide advice to Health? Or are you actively involved in the negotiations?

Mr SWAIN - It depends on the different - usually there's an agreement through Cabinet on how that will work, who will be the lead minister. The Treasurer has varying degrees of involvement, depending on that process. This process was initially led by first ministers. I'm trying to remember if it was throughout or it was a baton change partway through from the health minister to first ministers. It certainly ended up - no, actually, it was really first ministers all the way through because the current health agreement stems from the November '23 agreement of National Cabinet. So, there was a large role for premiers all the way through this one.

But treasurers were still involved so -

CHAIR - It's really important, then, they -

Mr SWAIN - That will mean that Treasury, working with Health and DPAC, will still be giving advice to the Treasurer on the way through and feeding -

CHAIR - And to the health minister?

Mr SWAIN - Yes. There'll be engagement at officer level between the three departments. Health might do some modelling or Treasury might then compare that with how our budget numbers are looking. If there's a difference, we'll try to understand what's going on. Is that difference -

CHAIR - But if you lifted this back up to the activity-based funding model and the efficient pricing that's being reviewed at the moment, which may or may not result in the benefit to Tasmania. In fact, it's unlikely to result in the benefit of Tasmania because you've got all those big states and there's more of them than us.

Mr SWAIN - As I'm sure you are aware, in the last round of that - I can't remember exactly what month it was, but the Commonwealth was surprised when the efficient price

increase came out at 12 per cent through the independent body. That kind of derailed the health negotiation for a period of time because I don't think they were expecting that result.

Now, that was under, as you say, a methodology which arguably doesn't account for small jurisdiction costs. Even without accounting for that, what it said was that the previous cap under the formal agreement of 6.5 per cent was inadequate. I think the recent Health agreement is definitely an improvement, but there is still more work to do. In particular, that methodology review that's underway around the way the efficient price is set is a key piece of work.

CHAIR - Did Treasury have any direct input into that, or is that left with the Health minister?

Mr SWAIN - No, we will be involved in that. The treasurers, through CFFR and the [inaudible] -

CHAIR - CFFR being?

Mr SWAIN - The Council for Financial and Federal Relations. It is interested in that issue because for every Treasurer, it is the biggest budget risk, really, looking at the year-on-year growth rates and health costs. The situation in Tasmania, which has been a key challenge for the budget here for a long time, is mirrored everywhere else. Every Treasurer, when the treasurers get together, they all have that same challenge.

CHAIR - They can benefit from the activity-based funding more, except for the Northern Territory and the Australian Capital Territory, perhaps?

Mr SWAIN - I think the Northern Territory, Australian Capital Territory and Tasmania have more closely aligned interests in that regard.

Ms LOVELL - I am sorry we have moved on a little bit, so I want to take you back to what we were talking about before, around the difference between there being an issue with systems and issue with implementation, in terms of the budget management and the systems that Treasury has in place. How confident are you that the systems that are in place now are the right systems, given those comments?

Mr SWAIN - I suppose I have a philosophical view on this: that no organisation is ever fully efficient and no system is ever perfect. All I'm saying is, I think that the arrangements that we currently have in place have a lot that's right about them, but I think the day that a management team thinks that nothing can be improved in the agency they're in is the day they should all go.

Ms LOVELL - But you've not identified any major systemic issue with the systems that you have in place at the moment?

Mr SWAIN - I have a couple of areas of interest; I will put it that way. One of them, which James and I have talked about a little internally, is I am interested in where employment and budget decisions are being made, at what level they're being made in an agency. I am specifically interested in - if budget decisions are made here, and labour - like, how many people you're going to have on the ward, et cetera, are made further down the organisation - it seems to be very hard for those two things to talk to each other. I am interested in that

relationship across agencies, and it's something I've just started informally talking to a couple of the secretaries about.

Ms LOVELL - It's a good point, given that there have been vacancy control measures and things put in place. Can you talk a bit more about how those processes work at the moment, and is that consistent across departments or agencies?

Mr SWAIN - I think it's different agency by agency. In some agencies the business unit needs to very much be responsible for its own budget and key decisions, and that's enabled and supported by the financial management accounting functions. Other agencies may manage that more centrally or at a higher level. My kind of working hypothesis is not that there is necessarily a right way to do it, but I am interested in understanding better where there is a difference. You are not doing it at the same level, because I struggle to see - If somebody is making a decision around employment - and employment, as we know, is pushing 50 per cent of the opex of the State Service - I struggle to see how you could effectively manage your budget if those decisions are being made at very different levels, without a very strong connection between the decision-making processes.

Ms LOVELL - I guess it's hard, too, because an agency like Health needs to be fairly agile because it has a lot of movement around its staffing. Do you have a view of, or have you put much thought into, how that can work in a more effective way without becoming something that's too restrictive, in terms of them being able to respond to the needs of the agency?

Mr SWAIN - Well, I guess at a conceptual level, there is a fundamental need for good data. I guess I don't have full visibility on health systems and processes. I know that -

Ms LOVELL - I don't think anyone does, really, from the answers we were getting.

Mr SWAIN - I guess, conceptually, the world's got more complex in the last 10 years. We've moved to more flexible working arrangements, which is a great thing. You know, one of the things I learnt coming back into the Treasury, having been there 10 years before and then coming back, was Treasury has very much embraced flexible working arrangements, which I think is a really good thing. But it does also make that challenge a bit more complex.

CHAIR - You can't work from home when you're a nurse on the ward.

Mr SWAIN - No, what I mean is in offering that flexibility, then you have a more fluid set of employment arrangements, which means that the challenge of making those decisions tracked through in real time, into your budget management, requires very good data. Now, I know that there's a lot of work that's been going on around the Human Resources Information System (HRIS), and that I think Health are very keen on some aspects or some capabilities that may come out of that, like around rostering.

Ms LOVELL - I think we're all very excited about that, actually.

CHAIR - This is HRIS?

Ms LOVELL - Yes.

CHAIR - I mean, seriously, that's been used as an excuse for not being able to provide data to committees for years.

Mr SWAIN - I'm not going to talk to that system, because I don't - but I think the notion that you can't manage without real-time data makes a lot of sense to me.

CHAIR - Particularly in something as demand-driven as Health.

Ms LOVELL - Well, and when it's having such a huge impact on the budget and on the operating expenditure of the agency, it's pretty extraordinary.

Mr SWAIN - Anyone who's been involved in any kind of operational delivery - you know, it sounds an easy thing to know exactly where your establishment is at any one point in time and how that relates to your budget. Every organisation I've ever been in finds that an ongoing challenge. Now Health is, of course, a very large organisation in Tasmania's context, so that is a bigger challenge for each of them.

CHAIR - Doesn't that make it even more critical to make sure there is a level of connection between your budget and your service delivery?

Mr SWAIN - I think so, yes. I think that's right. If you were talking nirvana, you would tracking back -

CHAIR - I live in Utopia, more often than not.

Mr SWAIN - No, you would have outcome-based performance measurement that was then supported by -

CHAIR - Your budget.

Mr SWAIN - Well, budget and employment arrangements that talk to each other - but easier said than done.

CHAIR - So HRIS won't deliver that? No?

Ms O'CONNOR - I have a quick question on employment. What's Treasury's expectations? We've received some information in the lower House on various agencies. Part of that - I don't have it in front of me - was about employment control measures. What's Treasury's expectation of how employment levels in the Health department itself - if there's a pretty tough vacancy control program in place, presumably that'll impact on staffing numbers in Health. Is there an understanding of what that looks like?

Mr SWAIN - Broadly, yes. I think if you look over the last five or eight years, which we have done, under processes like the preparation of the financial sustainability report, the budget in Health and the number of people employed in Health has grown rapidly over the last five years. You can't, I think, manage Health's budget without managing the number of people in Health, because it's too big a proportion of their cost base. It's just not possible to do that. I take some comfort from the focus that Health is putting into that vacancy management, and specifically I know that they are very interested in the use of locums. I think it's -

CHAIR - We did ask a lot - we have a lot of detail on locums.

Mr SWAIN - I think the Treasury view would be that the first priority is managing the budget. Being aware of, and keeping an understanding of, where your headcount is at is a subset of managing the budget, if I can put it that way. If you don't know where you're at on headcount and FTEs, it's unlikely that you'll be able to manage the budget. At the same time, the way that the *Financial Management Act* is set up, which has the accountable authority being accountable for the effective and efficient management of resources, I think that is best done at the agency level, is my view. The monitoring of FTEs is an indicator, but ultimately, the accountability under the FMA is around your budget management.

Ms O'CONNOR - Is there an understanding in Treasury of what the reduction in FTEs in Health will be to achieve the salary savings that have been identified?

Mr SWAIN - The way that works, is the agency will work out how best to achieve any budget improvement and then they'll factor that into the way they allocate resources and code that into the budget information management system. So, yes, broadly, I think if you're going to have a reduction in growth across Health you will see reductions.

Ms O'CONNOR - A drop in FTEs.

Mr SWAIN - The reason I'm hesitating is - the way that's implemented, whether you do that through admin staff, bands 3 to 6 -

Ms O'CONNOR - Which would be a pretty blunt instrument.

Mr SWAIN - Yeah, I mean, yeah. I understand why the political debate often focuses on frontline versus non-frontline.

Ms O'CONNOR - Very hard to define the difference.

Mr SWAIN - Yeah. But, I think the reality is very complex, as you just alluded to.

CHAIR - Can I go to the Auditor-General's report of May 2025 in regard to the Department of Health's funding of community service organisations? Treasury provided quite an extensive response to that report, which is good to see, that there was a comprehensive response, sometimes there's no response, so it's great, it's really helpful. But, I note, and we've talked about some of this already, Gary, but page 51 of the report includes the response, and you talked about this earlier, 'Treasury regularly assists agencies in understanding the financial management framework and the Treasurer's Instructions.' It goes on to explain that a little bit further:

> On this basis, Treasury is concerned that there is limited evidence offered to support the assertion that guidance was sought from Treasury, and Treasury did not provide the clarity requested. Treasury maintains comprehensive records of advice requests. Treasury does not have a record of a request from the Department of Health regarding this matter.

Mr SWAIN - This is the grant versus procurement issue - is that what we're -

CHAIR - Yeah. There were bigger problems than that in it, when you read through the report. There were a number of challenges. For example, the staff they had assessing the risk of any particular grant was reduced from, I think, 12 to two over a period of time, which makes it more difficult for those risk assessments to be undertaken.

You said that you do keep track of advice sought. Since this report's been tabled - and the government - like the minister of Health agreed that they would implement and develop a new strategic DoH framework for commissioning of services with CSOs with associated controls. Has advice been sought from the Department of Health on these matters since then?

Mr CRAIGIE - I think those comments were in relation to some specific comments the Auditor-General made in his report about Health asserting how much engagement they have with Treasury and we have a slightly different view and expressed that to the Auditor-General.

CHAIR - Which is what I read out, basically.

Mr CRAIGIE - That's right, and because the report wasn't changed, we put those comments in our response. Gary alluded to earlier in our procurement branch, we - this is an embellishment, but we effectively provide an advisory service. If there is a procurement task in an agency and the procurement officer is unclear of how to navigate the procurement Treasurer's instructions, they will contact Treasury and we'll assist them into interpret the TIs and how to apply them to a specific procurement they've got to do.

CHAIR - Since this report has come out in May last year, like it's almost - well, close to a year, have there been requests for advice, particularly around the funding of community service organisations and the grants that are provided through Health that you can recall?

Mr SWAIN - I can't answer that directly, I might have to take that on notice, but what I do know we have done is - there was a discussion where we wouldn't probably fully agree between ourselves and the Auditor-General on the level of clarity in our current guidelines between procurement and grants, and there was a review of those guidelines and some further clarification, which I'm - I just need to confirm this -

CHAIR - So the guidelines are being updated?

Mr SWAIN - I think I've written to all secretaries advising that the guidelines been updated and bringing that to their attention. So, in that way we have responded to that process, but I'm not sure I can answer your specific question about how we cycled back to Health on there. I mean, of course, Health is doing a huge number of procurements all the time. So, I don't -

CHAIR - But, if there's a problem in one - and this goes back to the cultural problem - if there's a problem in one area, there's always a concern that there could be problems in others. In terms of a cultural problem, as you said at the outset, whatever rules you have, they have no effect if the culture's not right.

Mr SWAIN - I mean, I guess off the back of the Auditor-General's report and me writing to a secretary with an updated guideline. I mean, I would at that point think that that might be a matter for either of the Health executive or their internal audit function to consider.

CHAIR - So how did the guideline alter in that?

Mr SWAIN - I think it was just trying to add clarity between, you know, when you're in a grant process, when you're in a procurement, what are the signals? If you're not clear, what things to look for to help you make that judgment. There were a range of changes across the guideline. I can't remember all the specifics, but that was the focus, how to better help agencies delineate between those two things because there had been a bit of confusion in Health, but it had also come up in another context.

CHAIR - Can you provide a copy of the updated guidelines to the committee?

Mr SWAIN - We could provide one, I think. I don't see why not. I haven't got it with me.

CHAIR - That's fine. We'll write and request that. We'll also follow up with if you've had any requests for advice, acknowledging that it may not be necessarily an easy thing to track, but you did say in your response to the Auditor-General's report that you do -

Have you got it?

Mr CRAIGIE - I've got a copy of the letter that the Secretary sent to accountable authorities.

Ms O'CONNOR - Can I just check: was there any sort of Treasurer's instruction attached to that or any other direct -

Mr CRAIGIE - There's already a suite of Treasurer's instructions that deal with procurement and malpractice guidelines, and there's a policy on grants as well.

Ms O'CONNOR - Did any of those Treasurer's instructions change in response to the Auditor-General's report on Health's management of CSO funding?

Mr CRAIGIE - I'm not - I mean -

Ms O'CONNOR - Or were they tightened up, or -

Mr CRAIGIE - I need to take it on notice. I'm not sure because we review them constantly and there are small adjustments made regularly and, occasionally, there are larger adjustments made, so I'd have to check.

CHAIR - The thing with Treasurer's instructions are they're altered by Treasury, but there's no visibility of the change except if you go to look for them yourself.

Ms O'CONNOR - As you've seen the previous one.

CHAIR - Yeah. They're not something that comes through the parliament at all.

Mr CRAIGIE - No. They're communications to agencies because it's agencies that are bound to use them.

Mr SWAIN - Just on that letter, I'm just confirming that, so I did write to accountable authorities on 29 January, in relation to the guidelines.

CHAIR - January 2026?

Mr SWAIN - Yes.

CHAIR - Just drawing their attention to the new guidelines, not the changes?

Mr SWAIN - Providing the revised guideline as an attachment to the letter and effectively saying if you have any queries and here's a contact point to understand what the changes might mean for you.

CHAIR - Okay. It'll be helpful to receive a copy of the guidelines later. We will write to you. We're nearly out of time. Has anyone got any other questions you'd like to put at the moment?

Ms O'CONNOR - Well, maybe just some clarity around - if we've got a little bit of time - the papers that were tabled in the Assembly the other day; there's a section there on the Department of Health budget efficiency dividend by output and the total year to date savings for Health are put at $33,713,000 and a lot of that's come out of admitted services. Is that - I'm just trying to understand, so Health has apparently made these savings and they've also had a top-up of funding -

CHAIR - $700 million, I think, wasn't it?

Ms O'CONNOR - Yes, so what's Treasury's understanding of, in the Health context, are pretty significant savings that have been made in year to date - how the Health department's achieved them? Just for the layperson.

Mr SWAIN - I, at a very high level - well, first, the savings, they're significant in dollar terms, but they're small in percentage terms against a $3.5 billion budget. But, a whole range of different efficiencies, no single measure. From memory - I'm trying to remember if it was Ernst & Young - but they had one of the major consultancy firms do a review of their operations and come up with a whole range of different savings measures. So, they have implemented a range of those, in addition to tightening their management, particularly of their vacancy management and sort of recruitment processes. So, I'd say that I'm aware and we're tracking how they're going against their savings target through budget committee, but I can't talk to the detail of the savings.

CHAIR - We have asked Health for a breakdown of the $33.7 million because they've got it in their document provided to the House of Assembly, there's a great long list. We've had some information around use of locums in the hearing, so we're asking for that.

So, that review that was done, did you see that? Sorry, we finish at 10.30 a.m., sorry. I need to put my glasses on to read the agenda properly.

Mr SWAIN - I think so. I think I saw a copy of that, or at least an excerpt from that and we, again, at that stage, would have been more interested in, 'Was it happening, are you actively managing?' than the specifics of it.

Just in reference to, and I think James touched on this before, there was the significant adjustment across the budget forward Estimates for a demand - for demands, generally. I can't remember the number, but I think it was something like $880 million across the budget forward Estimates. So, there was a significant step change in 2024-25, I think, in terms of the funding for demand related pressures. So, there's always lots of moving parts in the budget, so that was on - that was coming in, if you like, but then on the other side there was an efficiency or a savings requirement, which is based on a methodology applied through budget committee across agencies.

CHAIR - So, that review that was done, Health didn't, from my memory, I mean Sarah might remember, it wasn't referred to, the review they'd done, was it, to look at this?

Ms LOVELL - No, I don't think so.

CHAIR - So, can you just outline, again, what the review was seeking to achieve?

Mr SWAIN - I think they commissioned some work to identify some savings opportunities, which is not - you know, that's sort of what you'd expect them to do in an entity scale of - you know, in a very small entity, you might be able to do that entirely through your own management team, but in something the scale of Health, it's not surprising that they would get some external advice around that. I think they - I can't remember its exact scope, but it was to assist them to identify potential opportunities so their management team could then make some decisions about what they would pursue.

CHAIR - Okay, and you wouldn't know how much it cost to do? I'm not - it's only a small part of the of the $3 billion budget.

Mr SWAIN - I don't know.

CHAIR - Okay.

Mr SWAIN - But, in a sense, from a Treasury point of view, the fact they're doing - they're commissioning that work would be a good thing because it'll throw up matters for them to investigate.

CHAIR - Do you want to go any further with that, Cassy?

Ms O'CONNOR - No, not at the moment.

CHAIR - Did you have any questions on the culture thing? I said we were going to come back to you, or have we dealt with that?

Ms O'CONNOR - We've dealt with it. The take-home message here is that Treasury has a limited capacity to reach into the health system and deal with the cultural issues that have been identified by the Auditor-General and, ultimately, it comes home to the Secretary and the minister.

Mr SWAIN - Yes. I mean, I think we have a role to play. Some of the stuff we've been discussing, like the guideline discussion we just had, I think Treasury can add more value through continuing to improve and update some of those framework arrangements than we

could ever do trying to reach into an entity the size of Health, which wouldn't be appropriate under the way the FMA is set up anyway, but it's also where you get the biggest bang for buck from Treasury which has a whole-of-State Service role but is quite a small entity of itself.

CHAIR - That said, it's a critical role of Treasury to ensure that departments and agencies are fully cognisant of what the expectations are in terms of reporting and financial management. Do you see there is any broader monitoring role other than the monthly reporting that you get? How can you have confidence that what you're being told - like, 'Yeah, we're only going to have a $42.3 million overspend this year. That's what we project.'?

Mr SWAIN - Yes.

CHAIR - I don't know what you were told in past years, but certainly that - you know, how do you make sure that you have a level of confidence there? Because, ultimately, Treasury is the one which has to try to set the next budget. It all comes back to you.

Mr SWAIN - Yeah. I mean, there's probably a few things - in reality, it's probably also more complicated. If you went around Treasury's branches and functions there will be information exchanges; so, you know, the property team in understanding and managing leases is getting updated information about space requirements and status of thinking in agencies around property needs, and the procurement guys are getting information to put on the Treasury website. So, it's a bit more nuanced in reality as you go around the different functions of Treasury where we have a whole-of-government function.

There is quite a lot of informal stuff. I know that whenever something tricky comes up in the budget space, often Eleanor and James will get pulled in by the finance teams of the other agency going, how do we treat this? Not all the time, but quite often it'll be, we have something that's not plain vanilla; how should this be treated? There's a lot of that that happens.

What we don't do is send a team in and say we want to go through all your procurements and we're going to form a judgment on whether you're following the framework or not.

Ms O'CONNOR - That's the job of the Auditor-General, in a way.

CHAIR - I'm not suggesting that you do that, Gary. What I'm saying is that Health is the biggest portion of the budget. It has a history of overspending. Surely, of all the departments, it would be one that you might take a particular focus on when their reports come to you to give you a level of assurance that that actually looks reasonable; they can back it up with evidence to say, we're not having a handout for supplementary appropriation this year to an order of magnitude.

Mr SWAIN - When James talked before about that role in rotating appearances at budget committee, that does have regard to risk and performance. If we have either a budget reporting process or we've asked for an update in relation to SPA balances and there's any anomaly in any of the information that comes into the questioning that happens through budget committee - 'You've said this number, but it doesn't appear to align with this. Can you explain that, please?' - all of that stuff is going on. But -

CHAIR - I guess the question is - you say there's a rotating process of agencies coming in, but do you spend a bit more time on Health because of its size, because of its history?

Mr SWAIN - I think you're always going to look at the agencies with big spends probably with more detail.

CHAIR - How often would Health rotate through this process, then?

Mr SWAIN - I mean it's - that'd be tailored. Again, James has been involved in more of these than me. But it depends on the circumstance you're in and the treasurer of the day's views and interests. I don't mean interests in -

CHAIR - I'm sure the Treasurer would be interested in Health every day because there's such a big drag on the budget.

Mr CRAIGIE - I think budget committee, I would paraphrase it as they take a risk-based approach. So, yes, Health are very regular attendees because they have the largest slice of the budget pie. But there are other risks across agencies that have become systemic risks. Those agencies also get invited in, and budget committee gets a chance to prosecute with the relevant minister and the accountable authority the 'why' and 'what are you doing about it?', and 'how we're going to trend back towards budget', and negotiate or prosecute the appetite or need for supplementary funding. You've only got to look at the budget risks section to get a sense of what some of those are. You've also got to look at policy and parameter statements over time, or RERs (Revised Estimates Reports) over time, to see where supplementary funding has been provided. And you'd be very well aware of what some of those categories are: prisons, out-of-home care, workers comp, et cetera. There are a range of risks, but - and my view would be -

CHAIR - I hope workers comp wouldn't feature that much this year, though, because we've had an increase, or some money put into the TRMF.

Mr CRAIGIE - I'm talking about across time, but yes. The Treasury and the treasurer of the day would agree the budget committee agenda, with input from other budget committee members as to who they want to see and when they want to see them, and what the particular items are for discussion.

CHAIR - In the last financial year, how many times has Health been looked at in that process?

Mr CRAIGIE - I'd have to go back and look at agendas. They don't come every month because we haven't got the capacity, but they're regular. In prior years, when they have had forecast or actual above-budget expenditure that's more material than this year, they would have had a greater focus.

Mr SWAIN - Just following up for that, because it just made me think of something important. That whole risk assessment through the budget process does inform effort and focus across other Treasury branches. An example of that: if we know that there's a significant major project occurring like North West Transmission, then we might have a particular focus through the energy capability of Treasury on working with TasNetworks to understand those risks.

Picking up the workers comp one, if I was asked, in talking to the branch that manages the TRMF, should we be involved, supporting Justice in looking at what the causal drivers of that are, and is there anything we can do about them? Then we'll get involved in that policy process.

Again, as you say, we're not seeking to do the Auditor-General's role, but we use the information that comes out of the budget process to inform where Treasury applies its effort in a policy sense. And one of the advantages of Treasury being relatively small in size is that's a conversation you can have at the exec, where everyone is highly informed about the key issues, because it's manageable to maintain an understanding of that across the exec.

CHAIR - If I can just go to the Auditor-General's Report No. 7, 2025-26, which is the General Government Sector (GGS) and Treasurer's Annual Financial Report (TAFR), in pages 32-33, there's the Department of Health report. The Auditor-General reported on two frauds that had occurred in Health. They were predominantly picked up internally before the Auditor-General reported on them. I'll identify them to you. We heard more detail on this in an in-camera session, so I'm not going to go to that detail. But was Treasury informed of these frauds when they occurred - when they were identified through the internal audit processes, not through the Auditor-General's work?

MR SWAIN - Not that I'm aware of, but I -

CHAIR - Would you expect to be?

Ms LOVELL - Yes, is that something you would expect?

Mr SWAIN - I suppose it depends on the magnitude of it. If there was a systemic issue and systemic learning, then I would hope, probably as my colleagues would, that at sec-board that might get some discussion: 'Hey, this has been an issue in the agency, and people might want to', you know. But of itself, with an agency the size of Health, I would imagine that they have a whole range of ongoing challenges around identified fraud risk. In the same way, they'll have cyber risk. They'll have a whole range of things going on, and I wouldn't expect to hear about them unless they were very significant in scale or there was a systemic problem, and the agency head was saying, 'Hey, there's a systemic problem that we need Treasury's help to address because it goes to the framework that we're operating under.'

Ms O'CONNOR - And that didn't happen in this case, is that correct?

Mr SWAIN - Well, I don't think this - I'm not -

Ms O'CONNOR - These cases, sorry.

CHAIR - They weren't material in amount, as such, given the size the Health budget.

Mr CRAIGIE - If I can use the procurement TIs (Treasurer's Instructions) as an example, if an agency does a procurement and there's a complaint, there's an escalation process. So, the first step is the agency tries to resolve the complaint. If that is not -

CHAIR - A complaint from?

Mr CRAIGIE - A procurement process. So, it could be a person that participated in a tender and didn't win the tender, and registered some complaint about improper process. The first step is the agency's responsible for dealing with that. Then after a couple of steps, it can be referred to Treasury and Treasury can do an independent investigation for that procurement. The *FMA* is a devolved model, and so the responsibility is the minister and the accountable

authority and, in particular, under the *FMA*, the accountable authority. So, Treasury's role is a systemic role, not a -

CHAIR - I'm not expecting you to have a management role in this. I'm just trying to understand at what point you would expect to be notified of something like that.

Ms LOVELL - On this particular report and the response from the Department of Health - it's on page 32 of this report in relation to these fraud issues. In the report, the Auditor-General identified that, in their view, the Department of Health doesn't have an adequate fraud control framework in place. The department, in its response, has said that their fraud and corruption plan was in accordance with the Treasurer's Instructions for fraud and corruption control.

Has there been any closer look at that? Any issues identified with those Treasurer's Instructions? Do you agree with that statement that that was in accordance with the Treasurer's Instructions?

I guess, my concern is if Health is saying, 'Well, we've done it in accordance with the Treasurer's Instructions', and the Auditor-General is saying, 'Well, those are not good enough measures in place', has there been a closer look taken to see where the issue is with those two conflicting statements?

Mr SWAIN - Not that I'm aware of. I'd have to check that. But again, I'd come back to, in checking that, my first question would be: 'Are we aware of other challenges in relation to matters dealt with under this TI?', not 'Has there been an individual problem in a specific agency?'

I don't have the detail of the TI in my head, but there's also lots of processes where you can comply with the process but still make bad decisions under it. I'm not saying that is what's happened here, but I'm saying it's not always that the process even hasn't been followed; it could be that you've just -

Ms LOVELL - I guess my question is, if Health is saying it has done what the Treasurer's Instructions require of it and the Auditor-General is saying what you've got in place is not adequate, then the natural conclusion from that is either that what Health is saying is not accurate - they haven't done what the Treasurer's Instructions require; or if it has, that that TI itself is not adequate. There wasn't a closer look at the instructions to make sure that that -

Mr SWAIN - Well, no because unless the finding was that the TI was inadequate, if the Auditor-General had made that finding, we would've known about it and that would've been relayed to us as a finding. I mean, normally I would expect the audit finding to have some comment around causality, and then those things would be considered by the management team, and they would have a remediation plan against the actions recommended by the Auditor-General. So, I'm not disputing Health's comment that they complied with the TI, but I'd need to go through the report and see, were there any recommendations to management from the audit, and have they been pursued? That is a matter for the executive of Health.

CHAIR - We did ask Health about the actions they had taken as a result of this, but I do go back to Sarah's point that the Auditor-General said that the Department of Health does not have an adequate fraud control framework in place, as there were two alleged frauds that

occurred between 2024 and 2025. Then the response from the Department of Health - this is back to the Auditor-General, as you're aware:

> The Department issued its fraud and corruption plan in December 2023 in accordance with Treasurer's Instructions FC-5 - Fraud and Corruption Control. I'm not aware that Audit Tasmania has undertaken any review of the plan or provided the department any feedback on the plan's scope, coverage or adequacy, apart from the improvement opportunity noted in the recent financial audit outcomes dated 30 October 2025.

Which is a report that was done before this one was released, obviously. So, there is quite a conflict here. They're saying, as Sarah said, we complied with FC-5 Fraud and Corruption Control Treasurer's Instruction, and the auditor's saying that the Department of Health doesn't have an adequate fraud control framework. It suggests there that their framework doesn't really comply with that Treasurer's Instruction.

Ms O'CONNOR - Which makes it systemic.

CHAIR - That's the risk, yes.

Mr SWAIN - Yes. Sorry, I am just working through whether those things are causally linked in that way. So, you could have the Auditor-General forming the view that the plan isn't that adequate, the department saying that it complies with the TI. It seems to me that both those things could be true. It could be that the Auditor-General has some concerns with the TI, but I would expect that to be articulated -

CHAIR - I'm not sure that's what he's saying. He's saying [inaudible]

Mr SWAIN - I would expect the Auditor-General to articulate the concern.

Ms LOVELL - That goes back to my original question - that bit is not clear where the issue is, whether it's with Health or whether it's with the TI. That bit is not identified here and not clear. I guess my original question is: has Treasury had a closer look at the TI to make sure that you're comfortable that TI is adequate and the issue is not with that? In which case maybe it's with Health, maybe it's not.

Mr SWAIN - I'm not aware, but I come back to the first thing that - I think there is, if there hasn't been, there's a conversation probably between Health and the Auditor-General in terms of the view that their plan is inadequate in what respect?

Ms LOVELL - And you would hope that if it was an issue with the TI, that would've been identified or the Auditor-General would bring that to your attention.

Mr SWAIN - Any plan - it could be the plan could be inadequate relative to the requirements of the TI, it could be inadequate because it's too easy to navigate, if I can put it that way, or it's not been applied properly. I am guessing at which one of those things it might be.

Ms LOVELL - Yes, and that was my original question, as to whether Treasury had done anything proactively to look at that.

Mr SWAIN - No, not that I'm aware of. I can say generically that - because we get copies of the Auditor-General's audits and we do look at them. I've had a number of discussions with different members of James's teams and other parts of the agency about, is there something in this that we need to have regard to?

CHAIR - Well, that's the question, I think.

Mr SWAIN - I mean, we do look at the Auditor-General's - well, many of the reports that come out, because they'll often have some degree of relevance to Treasury, but we wouldn't necessarily go through and say we're going to have an action one-for-one with everything raised.

Ms O'CONNOR - Have you talked with the Auditor-General himself?

Mr SWAIN - Yes, I meet regularly with the Auditor-General, and we'll work through issues of common interest and concern. I think we won't agree on every issue, but generally it's very productive. So the Auditor-General will have - as he develops his independent work program, he will have areas of interest, and he might just want to discuss those with Treasury.

CHAIR - This report included TAFA, which is right in your backyard.

Ms O'CONNOR - What's TAFA, sorry?

CHAIR - Treasury's annual financial report.

Ms O'CONNOR - Oh, TAFA.

CHAIR - Yes.

Mr SWAIN - We meet regularly with the Auditor-General. We talk about any issues like that. We might also talk about - in going around his work program, is he seeing any patterns that are worrying him, has he got any concerns with the government business enterprises (GBEs) or state-owned companies (SOCs)? We have quite a broad-ranging periodic conversation with the Auditor-General.

Ms O'CONNOR - Oh, good. Well, given that he said in his report into Health's financial management of community service grants that they've known about it for a long time, that these issues in the way grants are administered in Health are of long standing. I don't want you to breach your conversations with him, but I'm sure that came up. It comes back to that issue about, you know, what capacity Treasury has, or where is the real accountability that drives change in an organisation? If there's not some direct action, presumably, the way these community service grants are managed by Health will continue.

Mr SWAIN - I don't mean any lack of respect in what I'm about to say, but a lot of parties Treasury engages with, including the Auditor-General, have a view that Treasury should be more involved with something. It is literally a five-times-a-day issue.

Ms O'CONNOR - Will you fix it? Help us fix it.

Mr SWAIN - So, we are quite judicious, and with all my direct reports I will have a conversation about relative priorities, because we just can't - if every issue that someone said 'it would be good if Treasury could get involved in that' was activated, we would be 10 times the size that we are now.

Ms O'CONNOR - Can I just ask this: in light of the Auditor-General's report, was there a conversation between Treasury and Health about the way it manages community service funding?

Mr SWAIN - I think we had discussed it, but I can't remember detail. Usually when we meet with the Auditor-General we would touch on if there was a live audit that had relevance to Treasury, but I just can't remember a specific conversation.

Ms O'CONNOR - With Health?

Mr SWAIN - No, with the Auditor-General about this one. I think -

Ms O'CONNOR - My question was about - you've got the report there - it says this problem is of long standing and that the administration of community service funding is fundamentally flawed. Is there a conversation between Treasury and Health in light of that Auditor-General report and findings? The worry here is that this report will come out and then it will just float off, and there won't be accountability and not much will change. That impacts on those community service organisations, of course, as well as the administration of public funds.

Mr SWAIN - I don't think I had a specific conversation with the Secretary on that matter, I don't know if there were any discussions at branch level.

Ms O'CONNOR - Okay. I mean, it's okay we're having those discussions with Health, but the role of Treasury is still, to my mind, a slightly open question.

Mr SWAIN - I try to have periodic one-on-one discussions with all secretaries, but it's not a fixed agenda as well. Again, what's running hot at the time is what you tend to focus on.

CHAIR - Let me go back to what's running hot at the time, Gary, because in the AGR No. 3, the one that looks at the general government sector, Auditor-General's Report. On page 11 he goes to the lack of expenditure control and setting of unrealistic budgets. There are two points set up: the budgets may well be unrealistic. That's not Treasury's fault; that's the determination of the Treasurer. But there's a lack of expenditure control. When we look at Health - and this is why I'm a little bit sceptical about the projection for this year: in 2022-23, $396,000,462 over budget; in 2023-24, $522.7 million. Even last year, 2024-25, it was $447.947 million over budget. That's a total of $1.3 billion in those last three years.

Treasury, by comparison, has saved money. They've been under budget. Maybe you need clear focus on what Health's doing. I'll be astounded if they come in at $43.2 million despite the uplift in their budget. There's the flu season, which is often bad and impacts hospitals directly: the operating of hospitals, staff off sick, more patients there with other chronic conditions as well.

Ms O'CONNOR - Plenty of COVID still around, too.

CHAIR - Yes, all of them. That happens before the end of the budget year predominantly. That table outlines really clearly the scale of the problem.

Mr SWAIN - I did go through that document when it came out. I think, at the high level, that the conclusions we support - that you can't have good budget management if expenditure is occurring out -

CHAIR - Outside of what parliament's agreed.

Mr SWAIN - Yes, outside of what parliament has agreed, or not through a process that parliament has approved. You can have variations, as you know. But my memory of that report is there were two drivers of the change that weren't separated. There were both policy decisions in government, which I wouldn't characterise in the same way as just expenditure overruns that were not identified when they should have been identified through reporting processes. And I don't -

CHAIR - So, in your monthly reporting, they weren't identified? Is that what you're saying?

Mr SWAIN - Well, what I'm saying is there are circumstances where governments will make in-year policy decisions and there are adjustments made to expenditure related to that. And they might not all relate to appropriation spending; they might relate to a change in an agreement or something. I don't think that report differentiates between the two.

CHAIR - If you just look at 2024-25 then, that's basically a $448 million overspend, can you give us a breakdown of what was new policy and what was just overspend, or not?

Mr SWAIN - No, I can't.

CHAIR - But you're making the point that that, perhaps, does truly reflect a certain situation.

Mr SWAIN - What I'm saying is there might be a nuance that needs to be unpacked underneath that report - that there could be two things going on.

But it doesn't move away from the fundamental thrust of the report: that disciplined expenditure management is very important and you can't have budget improvement if you don't have it.

CHAIR - And parliament approved $448 million less than what the department spent? That's a fair statement, isn't it?

Mr SWAIN - Yeah, I think that's correct. I mean, with someone who has got an economics background -

Mr CRAIGIE - I think there may have been a supplementary appropriation.

CHAIR - There was, yes. But it just shows -

Mr CRAIGIE - In the original budget.

CHAIR - Yeah.

Mr SWAIN - With someone who has got an economics background, if you don't put a price on a good or a service, you would expect demand to be unlimited pretty much. I think you have to give some consideration to that, the proportion of health activities that are in that category.

But that would really swing you back to the methodology they used to come up with future forecasts. Does it take into account the demographic changes that are going on in the - yeah.

CHAIR - And a funding model that rewards activity, not outcomes?

Mr SWAIN - Yes.

CHAIR - Anyway, I'll leave that one with you. We're out of time, but thank you. Did you want to make any closing comment?

Mr SWAIN - No, just that I'm happy to follow up on those things that we, effectively, took on notice, including the provision of the revised guideline.

CHAIR - Thank you for your time today. We appreciate it. We know it's a busy time for you.

The witnesses withdrew.

The committee suspended at 10.32 a.m.

Department of Health Audit and Risk Committee

The committee resumed at 11.00 a.m.

CHAIR - Thank you, Yvonne and your team for appearing before the Government Administration Committee A - Inquiry into the Governance and Financial Management of Health.

We note your role as the chair of the Audit and Risk Committee. That was the basis for the invitation to appear today.

Everything you say is covered by parliamentary privilege while before the committee, but that might not extend beyond the committee proceedings - just keep that in mind if you were to make further public comment.

It is being broadcast, it is being transcribed by Hansard and will form part of our committee's report at a later time. If there are questions you can't answer at the Table, we're happy for you to take things on notice and we will write to you with those to confirm once we've established that you're happy to take it on notice.

Everything you say is part of a public process here. But if there were confidential information which you wish to share with the committee, you could make that request. The committee will then have a short deliberative meeting to consider that, but generally those requests are honoured, just so you know. You'd just need to explain why it would need to be held in camera.

Do you have any questions before we start?

Ms RUNDLE - No.

CHAIR - What I'll get you to do is to introduce yourselves and take the statutory declaration, each of you - assuming you all may speak, and then also invite you to make some opening comments about your role, one of the Audit and Risk Committee, if you wish to do so.

The two members of the committee are Sarah Lovell and Cassy O'Connor. You probably know them, and our secretariats, Jenny and Allie, and Hansard recorder Roey.

Ms YVONNE JOAN RUNDLE, CHAIR, **Mr IAN THOMAS**, CHIEF RISK OFFICER, and **Mr ANDREW HARGRAVE**, DEPUTY SECRETARY, INFRASTRUCTURE, DEPARTMENT OF HEALTH AUDIT AND RISK COMMITTEE, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Over to you, Yvonne.

Ms RUNDLE - Thank you, Chair. Just as a way of introduction initially, just so that you know who's with me as well. On my on my left, I have Andrew Hargrave. Andrew is a member of the department's Audit and Risk Committee and his substantive role is Deputy Secretary of Infrastructure.

In his substantive role as dep-sec of infrastructure, Andrew sits on the health board, so if we come to specific questions around health board and interactions between health board and ARC, I can hand over to him.

On my right is Ian Thomas, who is the Chief Risk Officer for the department. Ian is not a member of the Audit and Risk Committee, but he does have a standing invitation to attend our meetings.

Thank you, Chair and committee, for the invitation to appear today. As mentioned earlier, my name is Yvonne Rundle and I appear before the committee in my capacity as Chair of the Department of Health Audit and Risk Committee.

By way of context at the outset, based on departmental records available to me, the Department of Health has had and audit and risk committee, which I'll often refer to as ARC just to make it easier, since at least 2008. Now it's probably gone back longer than that, but certainly the records we were able to dig up go back to at least that far.

The establishment and operation of the Audit and Risk Committee is not discretionary. It's a formal requirement under the Tasmanian Public Sector Financial Governance

arrangements. Audit committees for agencies are mandated through the Treasurer's Instructions issued under the *Financial Management Act 2016*. In the case of the Department of Health, the Audit and Risk Committee is constituted consistently with the Treasurer's Instruction FC-2 Internal Order, which sets out the framework for internal audit and audit committee oversight across Tasmanian government agencies. The department's Audit and Risk Committee therefore forms part of the governance and accountability frameworks supporting the Secretary's responsibilities under the *Financial Management Act 2016.*

Turning to the purpose of the Audit Risk Committee, this committee is an advisory committee established to assist the Secretary of the Department of Health in fulfilling their governance and oversight responsibilities. As set out in the ARC's current terms of reference, and I have a copy of that terms of reference if you'd like them.

CHAIR - That would be great if you were happy to table that.

Ms RUNDLE - There you go.

The committee's role is not executive or decision-making in nature, rather its function is to provide advice and assurance to the Secretary across key areas including financial reporting, internal controls, risk management, governance, compliance and both internal and external audit activities.

Over my time as Chair of the Audit and Risk Committee, the ARC has met generally five times each year. This has tended to be in March, May, July, September and December.

The annual work plan and meeting schedule is established prior to the start of the year. A three-year schedule of committee briefings is established to assist and ensure coverage of key areas over that period. As needed, the committee also considers papers or documents out of session.

When considering the crossover points of your committee's terms of reference and my committee's terms of reference, key areas that you may be interested in are financial performance and risk management and internal controls, as they relate to fraud and control measures. The other areas such as operational performance, budgetary control measures and suitability and effectiveness of KPIs are not specifically covered in our terms of reference but may come to the attention of the committee from time to time as a result of internal audits that touch on these areas. In saying that, I'd say that we haven't really done a specific internal audit on those areas, but you may find that a specific KPI has had an internal audit on it, depending on how that works.

In relation to financial performance, the key responsibility of the Audit Risk Committee is to consider and review the annual financial statements for the Department of Health, including the Tasmanian Health Service and Ambulance Tasmania, and recommend their adoption to the Secretary. We consider significant financial matters relevant to reporting as they arise, and we review all representation letters signed by management concerning the annual financial statements. We assist the Secretary with his determination that the financial statements present fairly the financial transactions for that year and the financial position as at year end. We do not provide advice to the Secretary on the actual financial performance of the department.

In relation to risk management internal controls, the ARC provides a forum for considering the department's control culture and risk management governance and practices. The ARC seeks oversight of the risk framework from a whole-of-department perspective, as well as receiving risk assessments and internal control briefings from various areas across the department.

Specifically in relation to fraud, the ARC has appraised a number of internal reviews undertaken by internal audit at the request of various managers. As a committee, we believe it's important that not only the specific fraud issue identified is addressed, but also that any systemic issues are determined and addressed. We therefore support internal audit by reviewing and providing feedback on proposed internal audit scopes, reviewing internal audit or review findings and, in respect of internal audit findings, monitoring management's implementation of agreed actions.

Importantly, while ARC has broad authority to seek information, engage with auditors, and review significant matters, its role is explicitly advisory. The committee reports to and makes recommendations for consideration by the Secretary. Accountability for decisions and for the operations of the department remains with the Secretary and the executive management.

It may assist the committee if I briefly outline the current membership of the Audit and Risk Committee. As at March 2026, the Audit and Risk Committee comprises four appointed members. I serve as chair of the committee, as an independent member, having been appointed for an initial term from January 2023 to December 2025. This term was then extended to June 2026. I'm a chartered accountant, with over 30 years' experience in public practice and over 25 years' experience as a non-executive director - and they overlap, that wasn't consecutive, just in case. As a non-executive director, I've been a member of or chaired many audit and risk committees for state-owned companies and private companies.

Professor Stuart Crispin is an independent member, appointed for the period March 2025 to March 2028. Professor Crispin is currently working as a consultant and holds the role of director on the academic board with AIEN Institute of Shanghai Ocean University. Professor Crispin is also currently on the board of Regional Development Australia, Tasmania.

Dr Benson Elijah is a Department of Health management representative, appointed as a committee member from December 2023 to December 2026. Dr Elijah's substantive role is Executive Director, Medical Services, Statewide Mental Health Services. He's currently seconded to the Tasmanian Health Service North as senior adviser to the CEO with a focus on process change at Launceston General Hospital.

Finally, Mr Andrew Hargrave is a Department of Health management representative, appointed as a committee member from April 2024 to April 2027. His substantive role is Deputy Secretary, Infrastructure, a role he's held since 2022.

For completeness, and I'm happy to table, if you like, the CVs of all the committee members.

CHAIR - Thank you. That's fine, if you're happy to do that.

Ms RUNDLE - Finally, the committee is currently undertaking succession planning, including imminent appointments of an additional independent member and a new independent

chair to ensure continuity and appropriate mix of skills and ongoing compliance with government requirements.

Ms LOVELL - Just a clarifying question on the makeup of the committee or how the committee operates - you talked about substantive roles, when people are appointed to the committee, is that a full-time position? Are they still working in their substantive role whilst they're on the committee? Is there that crossover?

Ms RUNDLE - Basically the committee is just a function of governance within the Department of Health. Andrew still has his substantive role full-time and he just simply attends Audit and Risk Committee meetings when they're held.

CHAIR - Doesn't receive extra remuneration for the attendance?

Ms RUNDLE - No, no. So, the only - I, for example, get remunerated, so my remuneration is a flat $10,000 a year and the other independent member gets remunerated and I think his fee is about $6000 a year, so not highly paid jobs.

CHAIR - There's a lot of responsibility though.

Ms RUNDLE - There is a lot of responsibility.

CHAIR - Thanks, Yvonne. It's helpful to have that background information. Some of the questions I'm going to go to may be outside your remit after listening to some of that, but feel free to direct us in other directions if we need to.

As part of the role of the audit and risk committee, do you get provided with information regarding risks relating to the department not remaining within its appropriated funds? We've seen over the last few years, according to the Auditor-General's report, significant overspend of the original budget of the appropriated funds in the budget; they've had supplementary appropriation and other top-ups, if you like. Do you receive information regarding risk related to that?

Ms RUNDLE - We haven't had any presentations to the Audit and Risk Committee about overspend of budget or additional appropriations, no.

CHAIR - In the past or currently?

Ms RUNDLE - I can only speak for my time as chair, which is about three and half years, so in the last three and a half years we haven't had a presentation on that.

CHAIR - When you look at the last two years, 2024 and 2025, when there have been overspends of 400 and something, a lot of money, many millions of dollars - the number's actually in the report here somewhere - like last year the overspend was $447.947 million - that's not a matter that comes to the attention of the Audit and Risk Committee?

Ms RUNDLE - It hasn't specifically come to the Audit and Risk Committee. We've not been involved in the budget sort of side of it. We've had, perhaps, a broader more general discussion around financial sustainability of Health and it comes up from time to time,

particularly, for example, in relation to some different audits. We've had a recent audit in relation to medical equipment, and some medical equipment can be extremely expensive and if you don't have long-term planning, how do you actually ensure that you've got sufficient funds to replace some of those expensive pieces of equipment.

It's been raised in those sorts of contexts, but not specifically as, how do you address this risk, because what we've tended to hear back when we've talked about financial sustainability is the fact that the government provides the appropriations, they are meant to live within their means. There is a question around: is the level of cash holding - is the level of reserve that they hold - an appropriate level and I think that's -

CHAIR - Do you look at that question?

Ms RUNDLE - No. I think if you had a finance committee then those sorts of areas would come under a finance committee's remit, but they haven't specifically -

CHAIR - Is there a finance committee?

Ms RUNDLE - No, not as an external finance committee, there is -

CHAIR - Obviously, there's the finance department within Health.

Ms RUNDLE - The risks that we generally tend to look at tend to be at a - there is a risk register that would have probably the top eight risks that the Department of Health has identified.

CHAIR - Can you run us through those top eight risks, then?

Ms RUNDLE - Can I hand over to Ian?

CHAIR - Yeah, being the Chief Risk Officer, he'd be all over them.

Mr THOMAS - We have what's defined as the strategic risk register, so that talks to what the agency's identified as its eight key priority areas that we need to focus on to manage the department effectively. They range from - budget sustainability is one of our risks. I don't have it with me, but there is a risk register, which we could provide a copy of out of session if that was useful.

CHAIR - We'll write to you if you're happy to take that on notice and provide a copy of the risk register.

Ms O'CONNOR - Can I check whether appropriate fraud controls and managing the risk of fraud within the agency has been identified as a risk in the top eight?

Mr THOMAS - It's not identified as a strategic risk, but it's held within - so, when you look at the risks, if I take financial sustainability, the strategic risk itself, then there would be a number of risk areas identified that could prevent us from managing in a sustainable fashion with regard to our budget. Then there's the series of mitigation initiatives that we're aiming to do to stay within that, so it would be captured in that broader scope of what we're doing under that strategic risk. Similarly, there's another risk around infrastructure and providing

appropriate environments for our staff to work in and patients to be treated in, and then that breaks down into all the different components that we do in that space.

CHAIR - And medical equipment, going to Yvonne's point about some very expensive kit we use in Health.

Mr THOMAS - Yes.

CHAIR - That's not necessarily infrastructure, that would be -

Mr HARGRAVE - It does sit under my remit.

CHAIR - It does, does it?

Mr HARGRAVE - It's transitioning to infrastructure, primarily because in the past it's been a little bit disjointed, and what we're trying to do is centralise it and apply an asset management discipline to the management of medical equipment assets - much in the same way we would for build infrastructure assets.

CHAIR - But supplies and consumables wouldn't fall under that?

Mr HARGRAVE - No, not consumables.

CHAIR - [Inaudible] supplies, yeah.

Mr HARGRAVE - To pick up on Yvonne's comments previously, it's really about providing a sustainable framework, but also being able to plan for that expenditure and maintenance over the long term, so that you can forecast when that expenditure needs to hit the books effectively or equipment needs to be renewed, and to maintain that continuity of service within hospitals.

Ms RUNDLE - Part of the problem you get is the mismatch between political cycle and what you would otherwise get as a strategic long-term planning approach to it. In a lot of the infrastructure, you should be looking at 40 to 50 years as you cycle. We know the political cycle is nowhere near that.

CHAIR - It's one year at the moment, every 12 months.

Ms RUNDLE - Sometimes if you're lucky. That is the risk, I really think, in relation to, if you're starting to talk about sustainability, how do you get those two systems to get closer together so that more of that longer-term sustainability can be looked at because, just taking a three- to four-year budget outlook isn't enough. You really need to be looking at 10, 15, 20 years up to 40 to 50 years in some cases, particularly if you're talking about buildings or that type of infrastructure. Some pieces of equipment could be 15 to 20 years.

CHAIR - Is a three-year term for the Audit and Risk Committee adequate, then? You have a level of knowledge from your time there, but it doesn't extend very far back and won't extend - and if it's not - I don't know whether it can be renewed, I'm not sure.

Ms RUNDLE - It can be. It comes back down to what you're actually trying to get out of your Audit and Risk Committee as well. There are both independent and non-independent members from that perspective; three years isn't a long time because you can say you're going to spend the first 12 months coming up to speed - I mean this was my first exposure into a government department. I largely come out of state-owned companies and private companies, and government departments do run differently to other entities. So, it does take a little bit of time to come up to speed with how they operate. So, it's not a long period of time, but at the same point in time, I think there'd have to be a different value proposition put if you want people to spend time. For example, I live on the north-west coast. I travel down; I pay my own travel costs; I pay my own insurance costs; I pay everything - out of $10,000 doesn't go very far. You could say it's a love job that we do it for, because we want to give back, and I think that would need to change if you're going to work for a longer period of time.

Ms O'CONNOR - I'm trying to understand what role, if any, the Audit and Risk Committee had in responding to the issues raised in the Auditor-General's reports, and one was about CSO funding and how that's managed and the other was about blowouts in expenditure and inadequate fraud prevention measures. I'm not clear, from your opening statement and your answers yet, what role the committee has in helping Health to be its best self.

Ms RUNDLE - Let me try to expand a little bit on that and by all means, if I still don't hit the mark, come back to me again. The Auditor-General and/or his representative will attend all of our Audit and Risk Committee meetings. They generally sit through our Audit and Risk Committee meetings; they hear and get the papers for what comes to us. I have a very open relationship with them as well, so I will have regular conversations with David Bond, who is the representative we deal with from Audit Tasmania.

When we have issues like fraud and specific instances of fraud that come through, so if the department has done an investigation into a fraud - and I will be very general, because if you want to be more specific we might need to take it in camera - so if the internal audit has been requested to do a review and undertakes a review and gets findings in relation to that review -

Ms O'CONNOR - Sorry, who undertakes that internal audit?

Ms RUNDLE - The Department of Health has an actual internal audit team. They can either undertake the review themselves or they can outsource it. So, they could use or call on KPMG, Deloitte or Wise Lord & Ferguson, if they want to, or they can undertake the review themselves. Depending on what they've got at the time, what their resources are, and what the issue is, will determine whether they look at it themselves or whether they outsource it. But there is an internal audit team within the Department of Health.

Ms O'CONNOR - I am just trying to understand the ARC's role in responding to, if any - I mean, for a temperate person, the Auditor-General's findings are pretty damning, really, of the Department of Health. How does the Audit and Risk Committee play any sort of role in helping Health respond effectively to those findings?

Ms RUNDLE - Some of their views would have come out from hearing and following what was coming through the Audit and Risk Committee. So, in relation to some of the frauds and other instances that have been detected, the review would have come up to the Audit and Risk Committee. We would then expect to see management's responses to that, and in some

cases, we expect to see not only their responses but how they're going to deal with it from not only that instance, but from a systemic perspective. So, how they're going to ensure that this fraud isn't going to be perpetuated into the future.

Where I think Audit Tasmania has been disappointed - and I can't speak for them, but from the perspective of what they say - is perhaps the slowness to then take action to prevent future instances and/or address the specific instance that may have been identified. Some of these things have taken 12 months, two years, through the process. Even as an ARC member, we have been frustrated with the slowness sometimes to attend and take action on some of these issues.

Ms O'CONNOR - Has the committee identified whether they believe that those instances that the Auditor-General talked about were two-off, one-off, or that there's a systemic problem here within the agency, in terms of prevention?

Ms RUNDLE - In terms of prevention, there has been a reflection on some of these areas that have been identified. I think you could say that some of the areas, there are some trends, for want of a better word, of where you could say, well, we have issues in 'this' area. One of the areas might be procurement, and therefore we then need to do a deeper dive for the whole of the organisation to address procurement and perhaps take action in relation to procurement as -

CHAIR - When you say 'we', who do you mean?

Ms RUNDLE - Department of Health, sorry.

CHAIR - Yes, so the Department of Health, not your committee.

Ms RUNDLE - Not audit risk. No, sorry, I'm using 'we' loosely.

CHAIR - That's alright, I just want to be clear.

Ms LOVELL - What is the role of the committee in that process?

Ms RUNDLE - The role of the committee, which is what I've been trying to say through this, is that we only have an advisory role. So, we can only ever advise the Secretary. Following the completion of every meeting, we prepare a letter to the Secretary of issues that have come out of that meeting, and advise the Secretary of areas that we think they need to be -

Ms LOVELL - So, the Audit Tasmania report, as an example, would that be something that the committee would consider and then provide that advice on those issues?

Ms RUNDLE - Yes, but the Secretary also gets that report. So, things like that report would come both to the Audit and Risk Committee but would also go direct to the CFO and to the Secretary as well. It would probably go to at least three other people within in the department as well as coming to Audit and Risk Committee. I guess our role in relation to that is then to ensure that these things stay on the table and we continue to pursue it until we find that we're happy that there's been an appropriate resolution of the issue. I guess what I'm saying is some of these things have taken a very long time to be addressed.

CHAIR - Can I follow up, then, and if there are matters that you can't discuss in the public session, we can consider going into camera later on. We will try to deal with all the public information first, but do you believe, Yvonne, that the Audit and Risk Committee has been appropriately informed of the matters that were raised by the Auditor-General, and have reports been provided to the committee in a complete and timely manner? It seems perhaps - anyway, I'll let you elaborate on that.

Ms RUNDLE - Okay. Yes, we have been advised of the matters, and that is how Audit Tasmania would have picked up on some of these matters as well, because the matters have come through Audit and Risk and, as I've said, Tasmania would have a representative that comes to Audit and Risk Committee meetings.

Have we been kept appropriately advised? I guess what I'm saying is these things have taken a long time to address, and perhaps there has - I guess there should be better ways of ensuring these are attended to quicker. There's a slowness around attending to actions to address.

CHAIR - Why is that, do you think? From your assessment, why is that?

Ms RUNDLE - I'll come back to the Department of Health's core values, which is care; compassion, accountability, respect and excellence - and that accountability is sometimes missing.

CHAIR - Where do you think the basis for that lack of accountability sits? The Auditor-General, in the report that looked at the fraud matter but also there's the funding of grants related to the community service organisations. He identified a cultural issue there. Is that what we're talking about here?

Ms RUNDLE - Yes.

CHAIR - Can you further elaborate on how that could be improved? Does your committee have a bigger role to play, acknowledging the limitations of it?

Ms RUNDLE - Because we are advisory only, our role really is to try to get heard, I guess, from that perspective, and we have the link with Health board through Andrew as well. So, to that extent, what we have been seeing is a blowout in relation to times to address audit action items, and that's been happening now for a period of time. We've been raising it as an issue and as a result, Ian, through his team and through Health board as well, have been implementing new ways of trying to address and deal with that. It is trying to get people to be accountable for actions that are coming out of internal audits, whether they are reviews or whether they're an actual formal internal audit of the internal audit plan. Ian, did you want to-

CHAIR - It would be good to hear from the Health board perspective here and also from the Chief Risk Officer's perspective, and I note your earlier comment that there is no actual finance committee - is that something that needs to be considered? But I'll go -

Mr HARGRAVE - Well, there is a budget and finance subcommittee of the Health board, so that does exist. In terms of open audit recommendations, they are examined or they're reviewed by the Health board monthly at our Health board meeting. We meet on the second Tuesday of every month. The open audit, or audit recommendations that have not been closed,

are examined and discussed at each Health board meeting. They're very much on the agenda for Health board to try to lift that accountability that Yvonne has been talking about, and understanding that there is a need to close these out.

CHAIR - In a timely manner?

Mr HARGRAVE - Correct.

CHAIR - Just in terms of the Health board - who's on the Health board?

Mr HARGRAVE - If it's okay, I'll just refer to the terms of reference and we could make a copy of this available to you, if you want.

CHAIR - That would be great.

Mr HARGRAVE - Would you like me to read them out?

CHAIR - Yes, if you wouldn't mind.

Mr HARGRAVE - The memberships are comprised of: the Secretary as the chair; the Associate Secretary is the deputy chair; the Deputy Secretary of Clinical Quality, Regulation and Accreditation is the deputy chair; the Deputy Secretary of System Management and Reform is a member; the Deputy Secretary of Community Mental Health and Wellbeing is a member; the Deputy Secretary of Infrastructure, which is my role, is a member; the Chief People Officer is a member; the Chief Financial Officer is a member; the Chief Information Officer is a member; the Chief Clinical Information Officer is a member; the Chief Risk Officer is a member; and then the Office of the Secretary is the secretariat. That's the membership of the Health board. I'm very happy to provide you with a copy, if you'd like, of the terms of reference.

CHAIR - In terms of the finance committee that sits -

Mr HARGRAVE - Subcommittee.

CHAIR - Subcommittee of that Health board, are they tasked with looking at the expenditure that goes beyond the appropriation that we've talked about, that I was asking Yvonne about earlier?

Mr HARGRAVE - I couldn't say, I don't sit on that. I would have to take that on notice. It would feel logical that they would, yes. But I couldn't say for certain because I'm not a member of that subcommittee. But it would seem to make obvious sense that they do.

CHAIR - Clearly, there's been an issue for the last three years. The Secretary said it's less of an issue this year. That's a projection, not a reality.

Yvonne, this comes to you, perhaps, as the chair of the Audit and Risk Committee: would you expect that if there was an expected significant overspend that would be flagged with the Audit and Risk Committee? Or is that just not something that should happen?

Ms RUNDLE - Would it be flagged with us? It would depend on what their discussions with Treasury have been as well. We're not party to a lot of the internal machinations, I guess, at the Department of Health. The Department of Health would have regular meetings and discussions with Treasury and they would be aware of whether or not, I would assume, they're likely to get an additional appropriation or not, or whether it's a major issue. I guess if they saw that they weren't likely to get a major appropriation to cover it, then it might be flagged by the Health board through to the Audit and Risk Committee. But there probably isn't any formal avenue, perhaps, for that to flow in, other than if the Secretary raised it with me. I'm not sure that there's a formal mechanism for it to flow in at this stage.

CHAIR - Do you think there should be? Because it is a risk that the parliament might say no with the supplementary appropriation. A risk that, by way of RAF - it's done, and then we approve it after the event.

Ms RUNDLE - I'll answer that sideways. I'd have to say the risk management system within the Department of Health would have to be considered immature. I think there's a lot of work that needs to be done in relation to strengthening risk management throughout the whole department. There's a lot of work going on in that space at the moment, and Ian can talk to that. But I think what you'll find with the Department of Health is clinical risk is dealt with really well. The doctors face risk every day, nurses face risk every day, and they make the assessment on risk really well. If you said, do they understand risk on a more broader perspective than that -

CHAIR - 'They' being the Department of Health?

Ms RUNDLE - Department of Health. Then that's what I'm saying is immature, that embedding and understanding of risk throughout the whole department would be considered immature.

Whilst there are risk registers there, the process and approach to how they're being updated - so, there are processes in place. But identification of new and emerging risks and the governance process that sits around them, I think, is still being worked through at the moment. Even things like risk appetites are not, perhaps, that well understood throughout the department. There's a lot of work that needs to go on in developing and maturing risk management throughout the department.

CHAIR - It's quite extraordinary to hear this. I appreciate your frankness on this, Yvonne, because this department takes up a third of the state budget and it seems extraordinary that our risk management framework, or system, that sits there is perhaps not mature. It's not a new department.

Ms RUNDLE - No.

CHAIR - Is the Chief Risk Officer able to comment further on that? You must scratch your head and wonder sometimes, perhaps. I'm just trying to understand how we've got to this point where we've got what has been described as an immature risk management system.

Mr THOMAS - I can certainly talk to - I've been in the role about 21 months now and the role was created probably about three years ago. It's quite a new role and a new department

within Health. I think there's been a recognition of the need to have a greater focus at an agency level around risk and its management.

Since I've been in the role, we've done some considerable amount of work to - well, for me as the Chief Risk Officer, but then my department [inaudible] the whole of the department, to go to Yvonne's point, to understand what risk looks like, people to understand what their risks look like and how we best manage risks across the department.

As was mentioned earlier, we've done a lot of work in identifying what those strategic risks are at an agency level. We're flowing that work through each of the various departments across Health. We've done work as well in the internal audit space to establish an internal audit schedule that aligns with those risks. We can't audit every risk all the time, so we try to identify those that are the highest risk or of the greatest consequence if things were to go wrong, and then conduct those audits to help the risk owners understand where those issues are and what we should be doing to address them. We're on a journey of improving the way we understand, identify and manage risk across the department.

CHAIR - You did name up financial sustainability as a key risk. What specific work is going on in that space? When you look at the overspends in past years, plenty of that's a risk. But also we know it's a like an open-ended tube, this one, where demand is met one way or another because we have a universal healthcare model.

Mr THOMAS - In our agency risk register, risk 5 is budget sustainability. Within that we've got a significant number of potential causes that could restrict us or prevent us from remaining within budget, and then a number of initiatives or [inaudible] pieces of work that we're aiming to do to operate within budget.

CHAIR - If you could elaborate on that, that would be really helpful.

Mr THOMAS - I won't read them all out, but I'll just quote a few.

CHAIR - That's fine.

Mr THOMAS - Under potential causes, we've got items such as increased demand for public health services; unfunded FTE growth required to meet demand pressures; significant increase in salary - medical locums, agency nurses, et cetera; inefficient expenditure of constrained resources; inaccurate or complete demand forecasts. They're a number of the causes in our current controls.

We have a vacancy committee that manages our recruitment to try to ensure that due process is followed: If we are recruiting, do we need the role? Is it funded? Where the funding's coming from. The nature of the role that that work will fulfil when those positions are allocated.

Ms O'CONNOR - Can I check whether that is for every vacancy? We heard from Treasury earlier that there's a sort of disconnect between the budget setting and people who are doing the hiring. So, it comes through the risk process and each vacancy is examined? Or is it that you examine a cohort? How does that work?

Mr THOMAS - I don't sit on the vacancy committee, but I can speak from vacancies that I've recruited to. They go through our internal process with the people and coaches, the

HR department, the recruitment element of that, and then there is a key point when each and every one of those recruitment requests goes to vacancy committee to be signed off.

If you go on our internal recruitment portal, PageUp, as it's called - I and Andrew would be the same, you'll get alerts when there's an approval to go into and at the bottom of that it's documented - where they're at, whether it's budget and finance, whether it's with the approving manager, and the last line is vacancy committee.

Ms O'CONNOR - Okay. Can I go back to a question about -

CHAIR - Just let him finish the other bits. He was talking about, steps being taken -

Ms O'CONNOR - Sorry, right.

Mr THOMAS - So, the Secretary has accountability meetings; so, he meets monthly with each of us to go through our performance, including our budgets. There's an analysis of whether we're over- or under-spending and where our budget pressures are and what our initiatives are to address those.

There's, obviously, our engagement with our Commonwealth colleagues to work on what funding is in the Commonwealth space and what is funded statewide. Andrew mentioned it earlier, we've got - as well as the budget subcommittee, there's a financial sustainability subcommittee that's been running to really drill down on what are our non-negotiables that we need to fund to be able to sustain appropriate and good-quality health services, and what might we look at - either doing it a different way, slowing down, turning off or creating different delivery models.

CHAIR - Where does that subcommittee sit?

Mr HARGRAVE - It's a subcommittee of the board.

CHAIR - Okay.

Mr THOMAS - There's a number of subcommittees, which we sit on or chair, that all report into the Health board, so that would be another one of those.

CHAIR - Have you got a governance structure of the board?

Mr THOMAS - I think we can send one through, yeah.

Ms O'CONNOR - The Health board?

CHAIR - Yeah, the Health board.

Ms O'CONNOR - This is what I want to ask a question about, when we get there. Not the structure, but -

CHAIR - Perhaps if you can provide that at a later time. Obviously, there are a number of subcommittees by the sound of it.

Mr HARGRAVE - There are a number of subcommittees, yes. Quite a number.

CHAIR - Do you want to add anything else?

Mr THOMAS - I can leave it there, but as we said earlier we'll perhaps share this.

CHAIR - Share the risk register, yeah, that would be great.

Ms O'CONNOR - Mr Hargrave earlier was talking about the Health board and the makeup of the Health board and the fact that the audit reports are always on the agenda. Then you listed the membership of that board, which has the secretaries, the chair and multiple deputy secretaries or associate secretaries. It strikes me that, well, there's your senior management in your Health system, there are the audit reports, yet there remains an inertia in responding to them. Then we heard earlier from Ian that the Secretary has what he described as accountability meetings, monthly. Are they actually called accountability meetings?

Mr THOMAS - Yes.

Ms O'CONNOR - Interesting.

So, the question is, how can these damning audit reports, or challenging audit reports, sit there in front of a board that's made up of the senior management of the health system, then you've got the Secretary having the monthly accountability meetings and still there doesn't seem to have been, well, by some measure, an acceptable response to the issues that have been raised by the Auditor-General. How does that happen? Is it a lack of political will, because the buck stops with the minister?

Mr HARGRAVE - Yeah, I think it goes to the point, perhaps, that Yvonne made before in the - perhaps you can address the -

Ms RUNDLE - I'm happy. I think the system that both Andrew and Ian have talked about are systems that have been put in in more recent times. If you talk about how long they have actually been coming monthly to the Health board, its not that long. These are systems that have been put in to address some of these issues, as a result of some of these issues not being addressed.

So, the fact that there has been long-outstanding audit actions that haven't been addressed that we've been raising as an issue, as a result of that, some of these things have been put in place to work towards addressing them. They're not necessarily actions that have been there for six months or 12 months, they are more recent actions that have been undertaken by the Health board or by the Secretary to address some of these problems that we've been seeing.

Ms O'CONNOR - Okay. I'm just trying to work out the sort of line of decision-making here, and there's the obvious one straight to the minister, in any Westminster system, but does the Health board itself provide advice or make any recommendations as part of its work? If so, where does that go, and if not, what do you do?

Mr HARGRAVE - So, it does and, certainly, in relation to the open audit reports that are overdue, the Health board does make decisions about closing those out and

recommendations to the relevant deputy secretary, and then this part of accountability goes to working with their business unit to close those items out.

Ms O'CONNOR - And when you say close those items out, it doesn't just mean providing a response from the Health department's perspective, it means actually addressing recommendations and if not implementing them in full, at least finding a way to give effect to the spirit of the recommendations, is that correct?

Mr HARGRAVE - Yes, that's correct. So, the audits, when they're handed down, they provide a list of recommendations. The relevant business unit has an opportunity to review those, as Yvonne's outlined previously, and if they're accepted, there's a timeline that's recommended for the closure of that. Obviously, those open audit - or those recommendations relate to a risk in the agency or the organisation, with a view that they should be closed out in that time. So, that's sort of the process.

Ms RUNDLE - So, some of the issues that we've seen in the past and why there can be some level of frustration from, say, the Audit and Risk Committee's perspective, is that sometimes the responsibility to actually action an ordered action item is not necessarily assigned to one person. It may have been given to a department or it's been given to somebody who's then been seconded somewhere else or who is no longer in the Health department or - any number of reasons why. So, it's coming back to that fundamental accountability question of, when there's an audit action item that's been raised, one person needs to be assigned to deliver on that and they need to be held accountable. They may not actually do the action themselves, they can get multiple other people to do it, but one person needs to be held accountable to ensure that that action is undertaken.

Ms O'CONNOR - Thank you. And that process is not in place at the moment?

Ms RUNDLE - It hasn't been happening to the extent that it needs to be happening. What we've seen, therefore, are audit actions that have been pushed out, that have been deferred, that have had different people assigned to them or - and not actually completing the actions that should have been completed.

Ms O'CONNOR - So, in terms of the work of the Health board, and just looking specifically at the issues raised by the Auditor-General in relation to the question of some instances of fraud, has the specific question of fraud prevention come before the board in light of the Auditor-General's report and recommendations? Whether it's systemic or whether these are one-off or it's just part of the system that needs dealing with.

Mr HARGRAVE - So, the matters of fraud are considered by the Health board, yes. As Yvonne's pointed out, these recommendations or these reports are also provided to the Secretary and that consideration is also given to the Secretary. So, yes, those matters are provided to the Secretary and they're also made aware to the Health board, also via the ARC, so I provide a report to the Health board following every Audit and Risk Committee meeting on the things that we discussed and that we wanted to recommend to the Health board. So, they certainly are presented to the Health board for consideration and discussion.

Ms O'CONNOR - Last question on this line of questioning, thanks, Chair. I sometimes empathise with ministers, particularly ministers of really large departments, because it's very difficult to know everything that's going on within that system and, ultimately, the minister for

Health now is answerable for all failings in the system. So, does the work of the Health board, for example, or even the Audit and Risk Committee ever reach the minister either in a briefing form or is brought up at the regular weekly meetings? Is the minister being sort of kept up to date with matters relating to risk and the work of these two entities attached to the system?

Ms RUNDLE - It's probably a question to ask the Secretary -

Mr HARGRAVE - Yeah, I agree.

Ms RUNDLE - because it's the relationship between the Secretary and the minister, I think, is probably where you're going to, and they would meet, I would assume and I don't know, but I would assume they would meet regularly to discuss.

Mr HARGRAVE - Weekly, at least.

Ms O'CONNOR - Weekly.

Mr HARGRAVE - At least, at least.

Ms O'CONNOR - Yes, regular weekly meeting, at least.

Ms RUNDLE - So, how they format their meetings, I don't know.

Ms O'CONNOR - Okay, so just a final clarifying question: Are matters discussed at the board relating to risks that have been identified that it is agreed or the Secretary flags he will raise with the minister? Or is a lot of this dealt with at that level and so the minister can't know exactly what's going on unless she asks the right questions?

Mr HARGRAVE - Again, I can't speak for the Secretary, but certainly matters around risk associated with the department, I'm sure - but I cannot speak for the Secretary - it would be raised with the minister.

Ms O'CONNOR - Okay, thanks.

Ms LOVELL - I just wanted to, I guess, better understand how the committee reports and who to. It's not part of the organisational chart on the Department of Health website, so it's a little hard to see how that kind of fits in.

Ms RUNDLE - We don't rate a mention? Right. Really not important, yes.

Ms LOVELL - No, I know. Disappointing. You've spoken about providing advice to the Secretary, and obviously there's a mechanism with the board. Does the Audit and Risk Committee report directly to the Secretary? Is it to the board? Is it both of those things? How does that work?

Ms RUNDLE - So when I first came on as Chair of Audit and Risk Committee, the reporting mechanism was direct report from Audit and Risk Committee to the Secretary. That happened via a letter following the completion of our Audit and Risk Committee meeting, so we would draft a letter up. What we normally do is, at the end of the Audit and Risk Committee

meeting we'd go back through the agenda and say, what are the items that we think the Secretary should really be made aware of here? That would then form the letter to the Secretary.

In addition to that, as Chair of Audit and Risk Committee, I would then meet with the Secretary at least four times a year to - and that could be face-to-face, by phone, by video conference, whatever - to have a discussion and allow, I guess, that two-way discussion around, well, what was in the letter? Did you understand what was in there? Was there any further questions you'd like to ask? If there were other issues that I might think the Secretary might need to know, but I didn't think important enough to put in the letter, then I can raise them at that point in time.

That's the formal mechanism that's in place from that perspective. In relation to the Health board, it's only really been the last 12 months or so, we identified that we were doing this work, we were having all these discussions on things, but when the Health board was formed, there wasn't really a level of reporting to or from the Health board, which is when we then implemented into our standard agenda the feedback mechanism.

Again, at the end of the meeting we go through and we say, well, what are the areas that we think we should be advising the Health board of? We come up with that list and then Andrew takes that to the Health board. Then at the start of the meeting, Andrew reports back from the Health board to the Audit and Risk Committee. But that's only been there perhaps for the last 12 months.

Ms LOVELL - And Andrew's on the committee as a management representative?

Ms RUNDLE - Correct.

Ms LOVELL - And Dr Elijah is as well?

Ms RUNDLE - Yes.

Ms LOVELL - I'm assuming that link with the Health board will continue beyond Andrew's tenure on this committee.

Ms RUNDLE - It's not actually specified in our terms of reference that the Health board member is a member of the committee, but I certainly know the Secretary is aware of the benefits of having that connection into there. So I think -

CHAIR - Should the terms of reference be amended to ensure that longevity prevails here?

Ms RUNDLE - I think it's appropriate to get turnover as well. So, at the moment Andrew provides an insight into the infrastructure side of it and -

CHAIR - But a position and a reporting structure back to the board?

Ms RUNDLE - Yes, possibly. Like, whilst we have it as a standard agenda item, it's probably not specifically called out in our terms of reference, so we could amend our terms of reference to pick that up.

Ms LOVELL - You have it as a standing agenda item for your committee. Does the board have it as a standard agenda item for the board?

Mr HARGRAVE - Yes, it does. Well, there's an agenda item in the Health board standing agenda items which is matters for noting and minutes from subcommittees, so it fits within that. There'll be other minutes and papers from other subcommittees of the Health board for the minister to note, and my report from the Audit and Risk Committee sits in that section.

Ms LOVELL - It just seems that's a really fortuitous - it's a good link to have between those two bodies, and it would be a shame if that was only out of good fortune that Andrew happens to sit on both that, you know, that doesn't continue in the future.

CHAIR - That's what I mean - maybe for an amendment to the terms of reference to make it clear - not a person, but a position, and a reporting framework.

Ms RUNDLE - Yes, that could certainly be done. Terms of reference have generally been looked at every two years and obviously are signed off by the Secretary. From that perspective, they're due to be reviewed again at the end of this year, so it would be good timing for that amendment to be picked up. Like I said, it's only been something that we've implemented in the last 12 months. The Health board itself has only been around for how long, Andrew?

Mr HARGRAVE - I think 18 months.

Ms RUNDLE - Eighteen months. So again, to give you -

Mr HARGRAVE - It used to be called the Health executive prior to that.

Ms RUNDLE -Yes, bit of the context of -

CHAIR - So there's a lot of new things, I guess you have to make sure they work to achieve their intended outcome.

Ms RUNDLE - That's right. Yes, before you -

CHAIR - Which brings me to performance information.

Ms RUNDLE - Sorry the?

CHAIR - Performance information, like the KPIs. I think at the beginning you alluded to that not being an area you even look at or consider.

Ms RUNDLE - No, the only times, like I said, that something may be a KPI that may come through via an internal audit, so I couldn't even tell you what the specific KPIs are. I think there are over 100 for the department - 400 if you include all of them.

CHAIR - Yes, if you include all of the various areas.

Ms RUNDLE - Apologies, but I can't name them up. But I think if you looked at, perhaps, where the internal audits have been, you would probably find that there may have been an internal audit in an area where there is a KPI. That wouldn't surprise me.

CHAIR - The majority of which measure output, not outcomes - which is problematic in the delivery of health services. That's a statement.

Ms O'CONNOR - Of fact.

CHAIR - Of fact? Yes, well it is a fact, that's true. Just on that, then, and sort of circling back a little bit, are you aware of how many internal/external audit items remain unaddressed? This is a matter that you've raised - the slowness of adopting them. Do you know how many there are?

Ms RUNDLE - Yes.

CHAIR - How many are there?

Ms RUNDLE - I've got that. Yes, you might be a bit surprised.

CHAIR - Probably not, after this.

Ms RUNDLE - As at 31 March 2026, there were 175 open recommendations and nine recommend - oh, sorry. Yes, so 175 open recommendations as at March 2026.

CHAIR - Are they broadly across a range of areas?

Ms RUNDLE - The open recommendations relate to the internal audits that have been done over a number of years, so some could even go back five years and more. If we've had an internal audit five years ago, and a particular item hasn't been closed out, that would still form part of these open audit recommendations.

Ms O'CONNOR - Does that include the Auditor-General's recommendations?

Ms RUNDLE - I think that number does. Sorry, I can't confirm that. I know, for example, back in December 2025, the report that came to the Audit and Risk Committee back then - and these would've been numbers prior to December 2025, but it came to the December 2025 Audit and Risk Committee meeting - there were 144 internal audit recommendations and nine Audit Tasmania performance audit recommendations that were outstanding.

CHAIR - Alright, so it probably does include them, if that's the case.

Ms RUNDLE - Could well do, but I couldn't confirm that.

CHAIR - The role of the Audit and Risk Committee there - you've expressed some frustration, Yvonne, about them not being closed off in a timely manner or being responded to for a range of reasons you've given. What is the Audit and Risk Committee's role, then, in this? Surely, we want them actioned - all of us?

Ms RUNDLE - Absolutely, yes. What's our role? I guess our role is to advise the Secretary in relation to the fact that there has been not a lot happening in this space, which is where there's then been changes made both at Health board, and also within Ian's area, to try to speed up the approach in relation to this. But coming back to it, it does come back to culture.

It also comes back down to, perhaps, a lack of understanding of risk, from this perspective, across the organisation. What I think is that sometimes people don't understand that the audit actions are really there to address risk, and if they understood and said, well, are you happy to continue to carry this risk, yes or no - would that trigger a different response or a different action? By not responding to the open audit actions - that, in essence, is what's going on - the various areas that have the open audit actions are saying that we're happy to continue to carry this risk, rather than actually address it.

CHAIR - Which should concern us all, if that's the attitude and the culture that prevails. With regard to the two particular frauds that were reported by the Auditor-General, are you satisfied that they've been dealt with?

Ms RUNDLE - We have some more reporting coming to our May Audit and Risk Committee meeting. Again, what we have done is tended to continue to raise and follow through on this. Some of the reporting that we have had has not been specific enough for us, or has not necessarily given us the lens that we wanted to see to ensure that it has been dealt with and finalised, et cetera. So, there is still reporting going on in relation to some of that.

CHAIR - What would you need to satisfy yourself that they'd been adequately dealt with, as a committee?

Ms RUNDLE - Two things. One is to understand the actions that have been taken to address the actual fraud issue itself; and then, systemically, what are we doing to ensure this does not happen again? So, what have we rolled out across the department to ensure that: let's say if it was a procurement fraud or something like that. What systems, what internal controls have we put in place, what systems have we changed to ensure that that same type of fraud cannot happen again? And has that been rolled out?

CHAIR - Clearly, something needs to change. According to the Auditor-General's report, the Auditor-General made the comment that the department does not have an adequate fraud control framework in place. Whereas, the department response said, 'Well, we follow the fraud and corruption plan in December 2023, and in accordance with the Treasurer's Instruction FC-5 fraud and corruption control'. The department appears to be saying, 'Well, we've followed the Treasurer's Instructions', but the Auditor-General has found that the department didn't have an adequate fraud control framework.

From what you've just said, does that mean you are looking for changes within the department with regard to the framework that governs how they apply the Treasurer's Instructions? What would you need to see?

Ms RUNDLE - I think there is an element of - there is a fraud and corruption policy, and there are other policies - conflict of interest and all sorts of things that relate to this area. They exist. There is no doubt that they are there. Like I said, a lot of this does go back to culture. It's about people understanding what this is about.

When we talk about fraud, what do we mean by fraud? Do we all understand? Can it be explained? The example I gave when we were talking about it at our last Audit and Risk Committee meeting was, our policies need to be written in a level that someone in year 8 can read and understand because particularly when we are talking about fraud, it is not just the Health board that needs to understand the fraud policy. It's everybody. It's consultants, it's volunteers, it's everybody across [inaudible] -

CHAIR - [Inaudible] every nurse, everybody?

Ms RUNDLE - Yeah. Everybody needs to understand it. So, are our policies written at a level that ensures that they can be appropriately understood and complied with? Are they written in a way that enables them to be easily accessed and followed? When we talk about framework, do we actually understand framework? I could say, 'Andrew, stand up and draw me what does the framework look like on a whiteboard.' Can everybody do that? Do we understand what the framework is? Do we understand where culture sits? Do we understand where the policies sit, and that sort of framework that sits around it? I think a lot of it's there. The understanding and perhaps application of it may sometimes be missed from time to time.

The frauds that the Auditor-General picked up were actually identified by Department of Health. There was somebody in Department of Health that said, 'Hang on a minute, this doesn't look right'.

CHAIR - It did take some time in some cases, according to the evidence we heard.

Ms RUNDLE - They've been identified, they've been reported, the process then of doing the review has happened. All of that is what you would expect in your framework, in your policy that sits there.

What is then, I think, taking the time, and the frustration that is probably coming in from Audit Tasmania, is the response to it. What are the internal controls that were overridden, were lacking, that need to be implemented to ensure this doesn't happen again?

CHAIR - Surely, that needs to be identified if you are going to correct it.

Ms RUNDLE - That's right, that's part of your process. That element is where the frustration is; it's the slowness of doing that part of the process. That really is no different than not dealing with your open audit actions. It is exactly the same.

Ms O'CONNOR - Coming back to basics, why is it important that people who work within the Health department understand the nature of the risks that the agency is facing? And what is the byproduct of there not being that organisational understanding of risk, and understanding that that risk has multiple layers to it as well? It's a big complex thing for all the thousands of people who work in Health to understand, which goes to your plain English comment. But what is the risk if the department's employees don't understand risk?

Ms RUNDLE - Well, two things. One is: then they're operating outside of the risk appetite of the department. They're doing things that they shouldn't necessarily be doing, so they're exposing the department to negative elements. It could be that their patient care could be impacted, it could be the financial situation could be impacted. There's any number of risks

that they're exposed to if people aren't aware of how you identify and deal with risk within the department.

Having a common language of risk is really important and embedding it throughout the organisation. Again, what we do with Audit and Risk Committee is we'll have different departmental heads come in and talk to Audit and Risk Committee, and tell us what they do in relation to risk. And we have the chance to question them about risk. We get a bit of a feel, 'Well, do you really understand risk?' and 'How are you taking it at your level and ensuring that those underneath you understand it?' And how is that then filtered up? If something's identified four or five or six levels down, how does that filter up through the system to be then identified and recorded and addressed?

Ms O'CONNOR - Given what we've heard and read about the apparent inertia or slowness of the department's response to instances of fraud, doesn't that also elevate another risk? If within the organisation it's understood that there hasn't been an effective response, or it drags on forever, then it doesn't discourage further -

CHAIR - A blind eye.

Ms O'CONNOR - Yeah. It doesn't discourage further misconduct on the part of some people who work within the system. That again creates a risk, doesn't it? Not responding appropriately or efficiently?

Ms RUNDLE - That's right, and to me that goes to culture. Because, again, you need that level of accountability. You need to be seen to be actioning things quickly, decisively, responsibly, so that you're developing a culture that says, 'We don't accept fraud'. By slowness in moving, you're right: it sends the wrong message around that.

Ms O'CONNOR - There's a similar sort of frame when you look at some of the department's responses to matters that came before the commission of inquiry, where you saw some of the most serious allegations being raised, information being provided to senior managers, and this inertia or buck-passing. Some of these cultural issues are longstanding.

Do you have any observations, as someone who's been in state-owned companies and the private sector, about how you might crack that nut?

Ms RUNDLE - It would be controversial if I said it, so -

CHAIR - With a very large hammer.

Ms O'CONNOR - Yes, sledgehammer.

Ms RUNDLE - Look, it's not easy and you've got a number of factors against you, I think. Departments are obviously part of the public sector. The premise behind, I think, anything that happens in the public sector is you afford the greatest of care and the greatest of obligations and chance for somebody who you may want to reprimand or do something with. So, if somebody has not acted necessarily in the right manner, the processes that are there as part of the public service system are long and arduous. It could take you 12 or 18 months to go through a process.

CHAIR - Which was an issue that was picked up in the Commission of Inquiry, too.

Ms O'CONNOR - That's right. There's a tension between natural justice and justice for others.

Ms RUNDLE - That is a really interesting issue: how do you get that balance better? I don't know that the balance is right now. That does go to culture, because you need to be able to react responsibly and quickly, but fairly at the same time. If it takes you 18 months to go through a process, again, what is your culture telling you? That you're not sending the right message quickly enough.

Ms O'CONNOR - About what your priorities are or your values?

Ms RUNDLE - Yeah. So it's not an easy fix. I'm sure if I came back in 10 years time, we're probably going to have the same discussion.

Ms O'CONNOR - Hopefully, you have better things to do with your time in 10 years' time.

CHAIR - And, hopefully, the culture may have shifted in that time, one would hope.

Ms RUNDLE - But it's not easy and, I think, because it's such a big department as well, it makes it even harder and you'll have different cultures within different parts of the department as well. So, your clinical culture will be different to another area, whether it's infrastructure or somewhere else. So -

CHAIR - It's interesting; we had evidence from Dr Toby Gardner -

Ms O'CONNOR - Great evidence.

CHAIR - Yes, but he obviously operates GP practice and the urgent care clinic in Launceston. One thing he did to change the culture in his place, in his practice, was he went around and put a sticker on every item - every single drawing up needle, every administration, every syringe, every alcohol swab, everything - and put a price on it. And, it changed the culture of the way the staff used consumables and he has staff working both the public system as well as in his own practice and it changed them. So, there's one - I mean, that's a small hammer but would it take a lot of time to do? I said to him, 'Are you serious? You put it on every needle?' and he said, 'Yeah'. So, I think, there are ways of doing it, but it takes a lot of effort and it's a massive department. His is a smaller practice, so it's nothing like the Health department.

Ms RUNDLE - It does. And it's consistency of sending that same message. So, it's not just about putting the message out today and thinking that you're done with it. It's that consistency of repetition of constantly doing it and holding people to account for not doing it sort of thing. And that, I think, is the hard part that you find here because, again, so many people come in and go out of the department for various reasons, whether it's secondment or whatever, but you get this flush of people coming in, flush of people going out, and then you get the people who have been here for 25-30 years that think, 'We've seen change before, we'll just sit here long enough and we'll ride it out' sort of thing. So, there are various cultures within there and it's hard to change them.

CHAIR - There's also the hierarchical nature of the medical profession and the pecking order, which makes it sometimes - well, it makes it hard for whistleblowers from down low to raise a matter about someone higher up. Having worked in that system many years ago, you know full well who pays the price in that system.

Ms RUNDLE - Yes, and I think that's where perhaps, again, the Department of Health is in the process of looking at its fraud framework and fraud in policies and things like that and consideration around do you need that external agency or connection into somewhere where you can just make a phone call and sort of say, 'I've got this problem' sort of thing.

CHAIR - 'I'm concerned about this', yeah. I mean, there was also the Auditor-General who can be anonymously informed of a concern as well, which then may flow through back to something like an audit report but -

Ms RUNDLE - That's right, and other things that have triggered reviews or internal audits in the past is, you know, the secretary might become aware of something and he'll initiate himself a review or internal audit of something that he's been made aware of, to review and check into.

Ms O'CONNOR - To your knowledge, has that happened?

Ms RUNDLE - Yes, it has happened. Yes.

CHAIR - Well, thank you. It's been really informative and we really appreciate your time today and the information that you've provided to the committee. It'll really help us inform our future questioning, not just in this forum, but also in budget Estimates and other processes as well. So, it's very helpful. It's part of - like we have the audit reports, we have the committee doing its work and I think it in terms of accountability, this fits right into that and so, hopefully, that will help - help your work maybe as well. But we will write to you with those couple of matters that we agreed that you'd take on notice and provide to us at a later stage and we thank you for your time today. Is there anything you want to say in closing?

Ms RUNDLE - No, I don't think so. I think we've covered sort of a fair, broad expanse, but, I guess just to say, the department is acting on these things. There is a question about how slowly sometimes things move and I definitely sort of say there's frustration levels around that, but it's not like it's not doing anything, you know?

CHAIR - It's not ignoring them.

Ms RUNDLE - It's not ignoring them. It's just the speed sometimes at which these things change or roll out is perhaps the issue that we're talking about largely, yeah.

CHAIR - Thank you very much, all of you, appreciate it.

Ms RUNDLE - Thank you.

The witnesses withdrew.

The committee suspended at 12.17 p.m.

Sphere Management Advisers and Consultants

The committee resumed at 1.30 p.m.

CHAIR - Welcome, Dan, to the Government Administration Committee A inquiry into the governance and financial management of Health. We appreciate you providing your submission to us and quite happy to accept the late submission, because it feeds directly into the terms of reference of the committee.

This is a public hearing. It is being transcribed by Hansard and is being broadcast. The broadcast will be published at a later time on our website, as will the transcript. Everything you say is covered by parliamentary privilege while you are before the committee. That may not extend beyond the room. Just to keep that in mind should you speak publicly about evidence you provide today to the committee. It is public, but if there were matters of a confidential nature you wish to share with the committee, you could make that request. The committee would then consider that and that would then stop the broadcast, et cetera, if that was the case. Do you have any questions before you start about any of those matters?

Mr O'HALLORAN - No questions.

CHAIR - So I'll ask you to take the statutory declaration in just a moment and then speak either to your submission or to speak more directly to our terms of reference. We will probably have questions from your submission, but also perhaps from your opening comments.

Mr DAN O'HALLORAN, DIRECTOR, SPHERE MANAGEMENT ADVISERS AND CONSULTANTS, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

Mr O'HALLORAN - Thank you for the opportunity to be here with you today. I might provide some context to Sphere Management Advisers and Consultants' (Sphere Mac) submission in light of what you heard from the minister and from the Secretary last week. I had the opportunity to look at their submission, and the minister mentioned regarding the need for efficiency and productivity. That is a really important point for the committee to understand, because if we consider policy over the last 10 years, particularly since the National Health Reform 2010, there has been a policy remit of very much looking at technical efficiency. That is what was provided in the attachment, one of the first reports that I actually led when I was at the National Health Performance Authority when it existed. So, technical efficiency primarily looks at the average cost, but it doesn't consider allocative efficiency. That's one of the biggest challenges that the system probably is facing today.

Because it's true to say and fair to say that more activity does not necessarily lead to productivity. If you are doing more activity to deliver the same outcome, it's inefficient and it's also wasteful. It's also important to note that the average cost, or the lowest average cost, doesn't necessarily mean it's better. An example of that is pathology services. You could have a situation where you have more testing being undertaken that may not be appropriate. That more testing can reduce the average cost, but the outcome of that is the overall budget is actually higher than it should be, which will then lead to financial sustainability challenges. So that's what you heard primarily from the minister.

You heard from the secretary, or what I picked up from the secretary, was around the activity cap. Regarding the activity cap, you have to ask the question - why does the cap exist in the first place? You've heard from a number of people that demand is outstripping the ability to provide services. The challenge with that is that there's only so much that the Commonwealth has on the table, and therefore a cap is then implemented to apportion as much as it can be fairly across the other states and territories.

Irrespective of what Tasmania does to become efficient, if the funding model nationally doesn't actually consider the appropriateness of the services that are provided and whether those services provide value, whether the services are cost-effective in the settings where they're provided - what I mean by that is that some services may be more cost effective to be provided in primary care, in residential aged care or in private hospitals. If you're not considering that, and all the activities coming into the public system, you will exhaust the cap very quickly. One of the proposals that Sphere Mac met with a minister back in 2024 was to have an international review that considers how that activity operates across the entire market.

The other thing that's not considered when The Independent Health and Aged Care Pricing Authority (IHACPA) does their costing and their pricing, and I think that's really important, as their function is to look at costs and then price of services, is that service is not synonymous with an outcome. Also, there is no evidence to actually then consider whether those services are cost effective. So, there is no-one actually giving guidance, in a policy setting, on where we want services to be preferentially delivered across the ecosystem. So everything is being drawn into the public system.

If we go back about 10 years ago when activity-based funding was implemented, you actually had a number of viable private hospitals. Since then, a number of private hospitals, particularly in regional communities, have closed and you end up having state governments pursuing private activity very aggressively. Whilst that activity comes into the public system, you then have lower utilisation in your private hospitals. Lower utilisation in your private hospitals will increase the average cost of services in private hospitals, which will subsequently increase private health insurance. As private health insurance increases, you then have a fallout in the market where you have more demand back on the state system. Everything then gets pulled back into a system that then says, 'Demand is outstripping what we can deliver'.

And so, fundamentally what I'm proposing, what was proposed by Sphere Mac back in 2024 to the state government, is we need to consider an international review that looks at a whole-of-ecosystem market. The reason for doing that is that the current functions of the independent agencies do not have that remit to do that.

Effectively, and I can confirm today for the committee that we have commitment from Professor Alistair McGuire, who has over three decades of experience with the London School of Economics (LSE) looking at cost effectiveness, economic evaluation and public private interface and has also been an advisor to numerous governments, the IMF, the World Health Organisation and the World Bank. We've also got commitment from Mark V. Pauly, who used to be the head of the Wharton Business School. Importantly, of those two people, Mark actually did a seminal piece of work back in the early '90s that looked at productivity is more about how you use your labour market. I actually updated that for my dissertation when I did my master's at the London School of Economics under the supervision of Ali. Mark also has a lot of work and advice to Congress regarding their budget concerns in the United States. We also have an agreement from Mike Drummond, who is a leading health economist with York University and

has, in his own work, published two major textbooks and over 700 scientific papers. We have also previously committed to have Jason Sutherland from British Columbia, who recently has been engaged by IHACPA (Independent Health and Aged Care Pricing Authority) on one of their international groups or committees. Our view is that irrespective of being engaged by that committee, given IHACPA's role is transparency, then there should be no reason why Jason couldn't continue to be involved in this body of work.

If we go back and have a look at what you heard from the minister and secretary is that there is a challenge with the [inaudible]. We acknowledge the fact that the state has done a fantastic job in relation to negotiations with other smaller jurisdictions in having IHACPA consider a small state adjustment. However, despite that, we also have to be cognisant that Tasmania is not necessarily comparable to the Northern Territory or the Australian Capital Territory. Tasmania has one of the most disparate populations across a very unique geography. It also has a small population relative to other settings, which means it's reliant on services interstate. We also have to consider that it's an island, which means the cost of actually providing and transferring people to quaternary services is much greater. If you consider the Australian Capital Territory, it's relatively concentrated, and the Northern Territory has relatively only two settings.

Irrespective of that work, I do not hold the view that it will actually fix your financial challenges because it doesn't actually go to the core heart - whilst other states and territories can do whatever service or activity they want, they will always take more money off the table that could have been available to Tasmania.

CHAIR - Because of the nature of paying for activity rather than outcomes?

Mr O'HALLORAN - Yes. Well, fundamentally, if you consider that you have a situation that we've provided in submission around a patient wanting to have surgery because, effectively, there's two doors into a hospital. There's the emergency department or a waitlist. If we consider the waitlist, a person is waiting to say a specialist outpatient. They then get listed for elective surgery and then they have the surgery. In some jurisdictions, you'll find that there have been initiatives undertaken to actually then say, 'Well, actually, we could take people off the waiting list by having them see physios' and that may lead a different pathway. But if you then did an actual cost effectiveness review of that and you found that a large majority of those patients actually then subsequently still needed surgery, then all you've done is added more care - or, actually, more activity - to deliver the same outcome at more cost. Whilst that occurs, you then end up having those states taking more money off the table, which means there's not as much left on the table and Tassie says, 'Where's our share?' And so, that's where Sphere Mac is really saying that it's not just about cost and prices; it's around where in the Commonwealth is there any direction being given around cost effectiveness of services and whether services would be better to be delivered through Medicare, through GPs or private. Because if you don't consider the whole ecosystem, you'll cause distortions in the market.

Ms O'CONNOR - Would it ever be possible for Tasmania, at a Commonwealth level, given those challenges that you talked about - the fact that we've got the highest level of disability, fastest ageing population, highest level of chronic disease - are we ever going to be able to demonstrate cost effectiveness?

Mr O'HALLORAN - When I say cost effectiveness, I don't mean Tasmania demonstrating cost effectiveness. What I'm saying is there is a void in the system in providing

guidance around if care could be given in multiple settings, what is the setting which is most cost effective for the system to deliver it?

What we have is a policy remit that focuses purely on primary care, purely on hospitals, purely on aged care, purely on disability. An example of that is the tariffs that are being paid for EDs are in the order of the hundreds; yet the GP is only getting in the order of less than $100, right? That incentivises complex care to be pushed into the hospital. If you then consider well, maybe some of that complex care could be treated by GPs in primary care, which potentially is more cost effective for the tariff paid to GPs to be lifted because that would be substantially more cost effective than paying the tariff in the hospital.

Also, the challenge - and this is where I talk about the challenge for Tasmania to other states and territories - is other states and territories which have relatively high populations that are concentrated, running ED services. If they're pushing high volume of patients through those EDs, it is highly likely that their average cost is below the tariff, which means they're actually money-making departments. And so, whilst that's occurring, where Tasmania then turns around and says, 'Well, actually, we want to reduce the activity and push patients out into primary care', you increase the average cost. And then someone turns around and says to you, 'You're not doing the right thing'. What we're saying is what you're being asked to do, by purely pursuing the average cost, is not the right thing.

CHAIR - So, the system works against us, from what you're saying.

Mr O'HALLORAN - Correct.

CHAIR - Does Tasmania, based on its geographics and all the matters you raised, need a different funding model that's not activity-based? And what would that look like?

Mr O'HALLORAN - I don't think it's just Tasmania. My view, having worked in regional New South Wales and also being on a board for a local health district in New South Wales, is I believe the challenges being faced by Tasmania are similar to those regions. Often it's to do within markets and it goes back to equity. There is a fundamental baseline of cost to deliver safe and effective care close to where people live because if you purely drive it down to a cost figure, you would close those services and people would be denied fair access to emergency and urgent care. And that's just not right. What we have to do is go back and say, 'What are we actually trying to achieve?'

The idea of looking at the whole premise of an international review is that we actually have people that are not inherently biased or conflicted. Because a lot of people here, domestically, have been architects of the existing system, which mean they're conflicted. There's also a large number - and I suppose you might ask the question, why is Sphere Mac here compared to a Big Four firm?

Ms O'CONNOR - I was going to ask you, why are you here?

Mr O'HALLORAN - Right, yeah. The Big Four firms will make a lot of money out of these costing and pricing studies, right? I grew up in Tasmania, and we will be recently returning, hopefully, to the state. And so, I've seen a lot of challenges within the healthcare system. I've worked in the healthcare system and I've seen bad outcomes from it. I've seen outcomes which I believe are because the resources are not necessarily there - not because of

a decision by the state government, because the state government is clearly putting a lot of money into the system, at 30 cents in the dollar. It fundamentally goes down to, I believe, that the environment upon which the minister and the environment upon which the secretary is being asked to operate in is not fit for purpose. To me, the only way you can resolve that is if you get international expertise on an opinion.

CHAIR - What would it cost to undertake that work, in your view?

Mr O'HALLORAN - A few years ago we did do a proposal for government. I think at that point, we might actually go in camera.

CHAIR - Sure. We'll leave that until the end, then, because there are other matters I'm sure members will want to ask about.

Ms LOVELL - Thank you, Dan. This is really interesting and helpful. I guess my question is: what you can share with the committee around what other jurisdictions in a similar position as Tasmania - what they've done to help deal with some of the challenges around how we provide high-quality care for when we don't have the volume of those episodes of care happening - so particular surgeries, or things like that where it's hard to attract someone to come and work as a specialist in Tasmania, where we don't have maybe a lot going on in their field of specialty, and be able to provide them with an attractive salary and role -

CHAIR - [inaudible] support and all the other things.

Ms LOVELL - Yes, mentoring, all those other things. Have you got any ideas on how other - or what you've seen - around how other jurisdictions deal with that sort of challenge?

Mr O'HALLORAN - I suppose the first thing to consider is that resource follows funding. So, if the funding framework - and if there has been, and there has been an acknowledgement by the witnesses before you - is the funding framework is not fit for Tasmania, given that resource follows funding and performance follows resource, because effectively, the health system is the people that's within it. Then until such time that you resolve fixing the funding, you're never going to be able to afford something which is economically viable or attractive to the market.

If I reflect on my time when I was in Broken Hill, one of the things that I really liked with what the health service did, at that point in time, is it actually partnered with other centres in Sydney. When I worked in the hospital, I was working with doctors that were on a 12-week rotation that basically had an arrangement that if you're going to be employed in one of these major hospitals that you want to in Sydney, you had to spend a third or a quarter of the year in Broken Hill. What that meant is that it actually created a workforce where you couldn't get a workforce in the past. Not only that, it meant the capability of the people that were actually servicing here in the region were equally of the capability that were servicing in the metro areas. I suppose they are simple things when you start thinking about, how can the system operate? How can it partner for what you're trying to achieve? To me, that's just one example, because it comes down to, how do you resolve your workforce? Because what we've seen is just throwing more money at it doesn't necessarily work.

Ms LOVELL - Yes, I like that idea, but there's an additional layer of challenge in that would require Tasmania to partner with another state government. Political cycles, I guess, can interfere with that sort of thing, or put some uncertainty around it.

Mr O'HALLORAN - I think if you look at the Australian Capital Territory, they do that with New South Wales, because it's not viable for the southern parts of New South Wales to deliver full services, right? And you do that on a contract, and if you do it on a contract where people are being appropriately remunerated, then that takes the politics out of it. I suppose it goes down to having actually a reflection on what is it that we will deliver and what is it that we can't deliver that is actually proficient enough, safely.

The alternative is you do similar things to what the Royal Flying Doctor Service does, where they have teams of people that fly out to the different settings, as opposed to saying, 'We're going to establish a service just here'. Because the risk is, and this is what can happen in other larger jurisdictions, or on the mainland particularly, is that a regional service says, 'Well, we're now going to provide this service because we're going to meet the backlog from the last 10 years'. That's okay, they clear that waiting list for the last 10 years. Once that's done, there's not enough demand in the forward outlook, and so that then creates supply-induced demand because if they have to do supply-induced demand, otherwise their average cost goes up, because they have to actually achieve the activity. So, to me, there are a number of things that can be done. The question [inaudible] - you have to actually have a coordinated plan to do that. That is actually whole of system. That includes GPs, private hospitals and other primary healthcare providers.

Ms O'CONNOR - Didn't it used to operate a bit more like that here, where, from my recall, there was quite a lot of cross-pollination, if you like, of clinical staff between the public and the private system? I'm not sure of the extent to which that happens here now, but is it the introduction of the activity-based funding model - and I think you referenced this in your opening - that has reduced that interaction between the public and private system and GPs, potentially?

Mr O'HALLORAN - I can't comment completely. What I will say is that the existence of activity-based funding creates competition, which in my view, has created a negative impact on how we actually use the entire workforce. Because what you're doing is you're creating competition amongst the workforce, which is then leading to an underutilisation of workforce that is there. Then you end up having a workforce which is under pressure where it's all being attracted to, saying 'we can't cope'.

If you wind back to when it was under block funding - I'm not just saying you simply go back to block funding. I want to really emphasise that. One of the things that Sphere Mac proposed to government is you actually have to consider where the country has been basically over the last 20 to 30 years. One of the biggest challenges a state like Tasmania has is that after 1942, you effectively gave up your right to income collection through the tax reforms because of World War II, right? That is a fundamental issue when you don't have the lever to generate more revenue, which then says your only option is to reflect on how do you operate within the market that exists? Because if you try to bring everything into the state system, you're actually incurring expenses, you're incurring work and demand, but you're not actually getting the income.

CHAIR - Is there a jurisdiction where this works well, Dan? What are the differences?

Mr O'HALLORAN - Internationally, Australia is unique. The reason Australia is unique is because of the private and public market. That's one of the reasons why we've suggested Mark Pauly be involved, because of his specific understanding of private health insurance and the implications of that.

If we have a look at outcomes for surgery and pathways, there was work that was presented at LSC that basically looked at data around outcomes, and it looked at particular profiles that for, say, Ruth Forrest, for your condition for different characteristics, people of a similar nature, what was your outcome? That information was then made available to GPs to make better decisions and to actually engage in patients to say, 'Well, Ruth, as someone with your characteristics, this is a likely trajectory of the outcome for you'.

In that case, that then reduces the risk of supply-induced demand, because it's actually empowering the GP, and instead of just saying, 'Here's a referral, go see someone', it's empowering the GP with some information to have a conversation where Ruth may actually say, 'No, I don't want that. I actually may just resolve it by having some medicine', or 'I might do something and modify my lifestyle or my life to manage it'. As opposed to then creating demand for the system. That creates a benefit to everyone else. Equally, you have better outcomes because you've used the evidence to do that.

If we look at insurances, there's other countries that have actually done reviews like the Dekker Review. The Dekker Review was done in the Nordic countries regarding insurances around movement and patients with insurances to then encourage prevention. I'm cognisant of the fact of the work that St Lukes has been doing here in Tasmania in actually trying to push that.

Ms O'CONNOR - It's such good work. Terrific.

Mr O'HALLORAN - You also have to be cognisant around that itself has to sit within a broader policy of a broader response to the ecosystem, because the reality is that if you have people live longer, if morbidity is longer, it costs you more money, so you simply cannot pursue a prevention strategy in isolation of all other reforms, because what we end up identifying is you identify illness earlier. People then live longer, so the cost overall, unless you then do what France has done, where you then increase the retirement age, you're not actually generating income to cover all the costs on that journey that you've created.

Ms LOVELL - Dekker - is that an acronym or a name? Can you spell that?

Mr O'HALLORAN - It's a name.

Ms LOVELL - Is it D-E -

Mr O'HALLORAN - I believe it's D-E-K-K-E-R. It was particularly undertaken on the basis of the risk of people moving between insurance funds - we have this risk in Australia - that disincentivises insurers to actually spend money on prevention.

CHAIR - Don't you also potentially run that risk of you increasing your cost of individual services because - I think you touched on this in your submission - if you spend a lot on prevention, then you're not doing the same amount of activity in the hospital potentially. Which

is a good outcome, but it means that you get less money, because you're not ticking as many activity boxes.

Mr O'HALLORAN - Spot on.

CHAIR - Which sounds like a really perverse outcome from trying to improve people's health and keep them out of the system.

Mr O'HALLORAN - Exactly.

Ms O'CONNOR - In your excellent submission, you suggest that we, or an inquiry, ask this question: If we consider population profiles, age and social determinants of health need, what is the average spend per person across Australia's jurisdictions, and how does that relate to the cost of activity and funding Tasmania is receiving? Operating on the premise that you never ask a question that you don't have some hint to what the answer might be, what are your thoughts on what the answer to that question might be, depending on who we ask?

Mr O'HALLORAN - On the basis that Tasmania is acknowledged to have the oldest population - and we know from other countries that it is primarily people aged 0-4 and over 65 that are higher utilisation and therefore the major cost of healthcare services, and that a very small proportion of the population account for the main costs. Given Tasmania has been operating under an activity base and it is of an equivalent size to only a small health service on the mainland, it is highly likely that Tasmania is not receiving its fair share relative to other jurisdictions on a standardised population. The reason for that is the larger states, who have larger health workforces relative and also centralisation, can where they are able to push more patients through and the average cost is lower than the average price and they're making money out of it, that means they are then getting a larger amount of the activity or the size of the pie going to them, yet they don't have the older populations - relative.

Ms O'CONNOR - We did hear some evidence from Treasury this morning about - and I don't want to verbal them - I will verbal them - about the essential inequity in the current agreement with the Commonwealth. That agreement may take some time to rework and rewrite, and as you make clear in your submission, even if there is an adjustment and we get more money, it doesn't necessarily mean we're going to get better outcomes short of that. While that process is in train - negotiating with the Commonwealth - what are the structural things that we could do here to sort of level out some of the costs, make sure there's a bit more equity and also that the people living in rural and regional areas genuinely have access to the same sort of specialist and clinical services that people who live in urban areas do?

Mr O'HALLORAN - I think the first step is acknowledging the environment that you're in. You heard from the secretary that your costs are basically growing at a higher rate than what the cap is growing at, right? Therefore, there is no room to meet any growth in demand. If you accept that, there has to be, as a consideration, well, what activity does the state system have to push to other parts of the health ecosystem? What I mean by that is: what activities currently being undertaken by the state's public hospitals that should be delivered by primary care, that should be [inaudible] by GPs and other allied healthcare professionals, including pharmacists, and also, what should be delivered by private hospitals?

Ms O'CONNOR - Sorry to interrupt, but is there a risk there that then what you do is you transfer higher costs onto the patients?

Mr O'HALLORAN - So, that is, if you consider it within the copayment arrangement, and that's why I'm saying you have to bring these other players to the party. If I use private health insurance and private hospitals as an example - and this is a big problem with the current framework - is that there is no evidence of competitive neutrality considerations in the price setting of services between the public and private. So, there's therefore an incentive for private health insurers, I believe, to potentially want services to be delivered by the public hospitals because they then don't have to pay the capital component that they would have to pay to a private hospital.

Ms O'CONNOR - Right.

Mr O'HALLORAN - Now, if you then unpack that, some people have argued that you should just then pay all the states and territories the capital component in the service. Issue with that, though, is that we already know that there's evidence of supply-induced demand. We also know that there's low-value care. We also know that there's services that could be delivered in primary care. So it means you then distort the allocation of funding even more. And so, given the state doesn't have the ability to resolve the competitive neutrality and it can only lobby for the Commonwealth to do that, what it can do is it can actively engage with GPs to understand what services could actually be delivered by them if you then started paying them a tariff.

There is an example of this where I did the cost effectiveness review for another jurisdiction that looked at Pathways to Home. That was for the Victorian government, that then said, 'Well, we know that we have this limited cap of money, right, so what activity will we say that we have the capacity and say residential aged care or disability services?' You could actually work out that it was more cost effective for the state government to cover the copayment for those services than it would be for the state government to pay the contribution of the activity being delivered in the public hospital.

Ms O'CONNOR - So, do you want to identify some of the activities that, for example, we might be delivering here at any one of our public hospitals? Let's talk about the Royal, because it's the biggest, that could fairly be delivered in other settings, including private hospitals.

Mr O'HALLORAN - So, with all these cases, it requires consultation and it requires codesign, and it requires it to be considered on a geographical basis, because it is all dependent on what service is available within the geographical footprint within the reach of the hospital. So, what it requires is a tailored response for the North West Regional, a tailored response for the Mersey, a tailored response for the LGH, and a tailored response for the Royal. Because what it then needs to consider is, well, outside of here - and an example, and you heard this from the minister and the secretary around long-wait patients awaiting residential aged care or more complex care. I suppose one of the questions is, or that I would have, for the minister and the secretary, what proportion of them were conveyanced from the residential aged care facility? What I mean by that is, what proportion of those long waits actually were referred to the hospital from residential aged care and residential aged care won't have them back? Because if you identify that proportion, you may find that if you paid a slightly higher tariff by the Treasury paying this, it would be cheaper for the Treasury to pay that than it would be to pay the growth in escalations for the hospital.

Ms O'CONNOR - When you say that, to pay the extra costs to the aged care system?

Mr O'HALLORAN - Correct. And it releases a bed for someone in the ED.

CHAIR - Because they need slightly higher care than they were doing before they came.

Mr O'HALLORAN - Spot on.

Ms O'CONNOR - It's interesting when you talk to some of the clinical staff at the Royal, the stories of, you know, that terrible term 'bed block', which I find offensive. I'm sure I'm not the only one, but patients who are in the Royal who have probably a series of comorbidities and nowhere to go. It is a regular story coming out of the clinical staff there. That goes to some of what you're talking about too, doesn't it, because the public health system catches all these people, then the clinical staff who are making the decisions to do this pathway to home or pathway to where home is, really have very limited options. You hear stories of people who've been in the Royal for many, many weeks.

CHAIR - It is often not the best place for their health and wellbeing.

Ms O'CONNOR - No, that's right.

Mr O'HALLORAN - Or for the system, or for the staff. This goes to my point of looking at the whole ecosystem and then looking at the funding because, as I said, [inaudible] follows funding.

CHAIR - On this, we have seen in Tasmania the government step into areas of primary health where there has been system failure or market failure in that space. We rightly criticise the need to do that. The federal government should be paying enough to deliver primary care in the regions and that sort of thing. But where there is market failure, we've stepped in to ensure that those people have access to that sort of level of care. If you do something like this, how do you avoid the Commonwealth squibbing out of their responsibility? If we're going to pay a tariff to the aged care facility or pay a higher tariff - maybe it's not us, maybe it's the feds that should be doing it. But how do you stop the Commonwealth squibbing out?

Ms O'CONNOR - Again.

Mr O'HALLORAN - To Cassy's question before, is what do you do now and what do you do for the medium- to short-term? My view is that you do something now, which is understanding what activity could you move so that you release some capacity in the system? Parallel to that is you're actually having policy advice from the international panel regarding evidence that you can then use as a state that actually gives you a relatively strong argument. Because at the moment you can generate all the evidence that you like and all the issues that you like, and then it gets deferred to an independent arbitrator, which is IHACPA (Independent Health and Aged Care Pricing Authority), and all their function is to look at cost and price of services. This issue is much bigger than that.

CHAIR - So their remit is quite narrow?

Mr O'HALLORAN - Yeah. The narrowness of that is that there is no entity to look at this which then says I believe your only option is to then go abroad. To your point, as you continue to ask me, what countries? It is not that simple. It is not as simple as just saying go and do what Denmark does or go and do what France does because we have a unique system

where we have a public and private market. I genuinely say, having led the COVID analytics response for Queensland Health, is that I am of the view that because we have a public and private market, we actually fared much better than what we could have done compared to, say, the NHS (National Health Service) because we actually were able to access capacity much quicker.

My view is that we need to look at these other systems, which is hence why I have proposed that international panel, to bring their expertise because it's not just my expertise and my knowledge. There is a point here that I would like us to all consider: those men are not young and so there is only a time-limited opportunity for us to access that knowledge.

CHAIR - Your previous attempt to engage this, with the support of the Health department, was not successful?

Mr O'HALLORAN - I think it is fair to say, given you were in the room, is that there was relative agreement around the challenges. But there's a level of complexity upon which the department is operating with the Commonwealth that maybe the timing was not right given their active negotiations. I think what you're saying and what has been recently acknowledged by your new Health minister and your secretary, is that there is a problem. And until you start going beyond what it is that you do normally, I don't think you'll be able to resolve it.

Ms O'CONNOR - It actually potentially complicates negotiations with the Commonwealth. If the state set out to put in place some structural changes, more utilisation of the private sector, wouldn't that impact on the activity within the public system and, therefore, potentially we lose funds because those other sector components haven't had agreements and won't necessarily have funding arrangements that give them comfort to take up anything the public system can't or won't do?

Mr O'HALLORAN - The assumption, in that case, is that you end up flatlining all the activity. What you hit here or what you've already heard is the demand profile is so high, and also if you're doing prevention strategies and people are living longer, then what is highly likely to be the case is that what you release will be just filled. What you're doing is trying to take pressure off the system to meet the demand that it's not already meeting. It's not turning around and saying, we're going to reduce what the system delivers. What it's saying is we're trying to take pressure off the system and utilise the entire workforce in Tasmania, no matter where it sits for Tasmanians, so that those that don't have the ability to pay a co-payment or don't have the ability to access private care, can access the public system because those that can have.

One of the biggest misnomers is that people think, 'Oh, people have private health care, then that's bad for the public system'. Some people have that belief because they think that the state should just do it all. But by actually having private health care or private health insurance, those that have the means to access it actually provide a benefit to those that don't because they open up capacity in that system for those that need it.

CHAIR - Just to follow on from Cassy's point, which is very valid, I'll go to your third recommendation to the inquiry, which is the last point of your submission. You talk about piloting a value-based, whole-of-journey funding model in Tasmania. But I assume that we couldn't do this until after a full review has been done, as you're suggesting.

Mr O'HALLORAN - Spot on. That's why the recommendations have been sequenced.

Sarah, I don't mean to sound coy by not just giving you examples of other countries. I'm cognisant of the fact that I don't want to presume what the international experts would actually want to provide you. I'm also cognisant that this is being recorded, and then other people just take that advice and serve it back up to the government and charge the government for it. That's why I'm being somewhat reserved.

But to your point, Ruth, there is a sequence of events and, given your question, Cassy, regarding the immediate challenge, I'm probably of the view is the first step is to undertake an understanding or review of, how do you optimise activity across the whole ecosystem?. In parallel to that, you then do the international review around the policy constraints that arms Tasmania with international evidence that you can rely upon around, what are the things or levers that you need to pull or then negotiate with the Commonwealth? Subsequent to that, once you understand that you've optimised the entire workforce for Tasmanians, whether they sit in public or private, is that you're also then considering, what is the baseline funding that's needed for the public system? At the moment, while you have costing and pricing of services, none of that is synonymous with a baseline requirement to provide safe, effective care to the regions.

CHAIR - It has no direct connection with our budget either.

Mr O'HALLORAN - Spot on. Then the third is you can't do a pilot until you get all that done. Because if you rush to a pilot -

CHAIR - Piloting what?

Mr O'HALLORAN - Exactly. Then you don't even know what it is that you're really pursuing.

Ms O'CONNOR - There's an urgency about all of this, isn't there? The evidence that we've received, what we hear from our constituents, the waiting lists -

Mr O'HALLORAN - For the staff, too.

Ms O'CONNOR - I was just going to say the pressure on the clinical staff, the use of locums. I mean, you can see -

CHAIR - Higher rates of workplace injury.

Ms O'CONNOR - stress and leave. It really feels like the health system is just sort of just hanging on in a way. It's a real worry for our communities.

Mr O'HALLORAN - Which there is an urgency to say: how do you utilise every healthcare professional no matter where they sit in the state? Because if we don't do that, then for the people that actually need care, they are being denied access to care.

Ms O'CONNOR - It's happening now. All of us get emails from distressed constituents.

CHAIR - Maybe it might be helpful, and there are some matters that you don't wish to share in a public session, I understand that they're commercially sensitive. I don't know that we

need to have a break in the meeting I think it's a reasonable request so we might stop the public broadcast.

The committee adjourned at 2.15 p.m.