THE LEGISLATIVE COUNCIL SESSIONAL COMMITTEE GOVERNMENT ADMINISTRATION A MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE, HOBART ON FRIDAY 27 MARCH 2026.

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

Tasmanian Audit Office

The committee met at 10.48 a.m.

CHAIR (Ms Forrest) - Thank you, Martin, and your team for appearing before the Government Administration Committee inquiry into the Governance and Financial Performance of the Department of Health. Apologies if we're a little bit vague. We're a little bit tired on this side of the table. This is a public hearing. Everything you say is covered by parliamentary privilege. If there is anything of a confidential nature you wish to share with the committee, you can make that request. The committee will consider that. Do you have any questions about the process?

Mr THOMPSON - No.

CHAIR - Okay. I'll invite you all to take the statutory Declaration. Then I presume you will make some opening comments on these matters and perhaps consider the questions we should be asking the department from your perspective. That would be really helpful.

Mr MARTIN WILLIAM THOMPSON, AUDITOR-GENERAL; **Ms JANINE McGUINNESS**, ASSISTANT AUDITOR-GENERAL; **Mr JONATHAN WASSELL**, DEPUTY AUDITOR-GENERAL; AND **Mr DAVID BOND**, ASSISTANT AUDITOR-GENERAL, FINANCIAL AUDIT, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

Mr THOMPSON - Thank you, Chair. What I propose to do is I'll provide you with a copy of my speaking notes. They will be in two parts and I'll touch on that in a moment. I'll give a bit of an introduction and then we will go from there.

I think the first thing it's important to recognise is that Audit Tasmania recognises and respects the important relationship that we have with the parliament. Our primary function is to report to the parliament to provide some insight. While this is most commonly undertaken as part of our physical report process, providing evidence to committees such as this one also falls within that reporting to the parliament framework.

Audit Tasmania does not have an in-depth understanding of the operations and activities of all of the state entities. However, through our financial and performance auditing activities, we do develop a unique, if somewhat limited, insight into each of the state agencies. The matters that we report publicly are done so through an evidence-based audit or investigation process and are subject to the rigours of the relevant accounting standards.

We do, however, through the conduct of those audits, obtain and have access to a wide range of information from our auditees. All of that information is subject to the confidentiality requirements of the *Audit Act*. However, that place of legislation specifically allows for the

sharing of that information with committees of the parliament. We looked at the legislation which provides us to share that information which we obtain in confidence. My preferred approach in these circumstances is that where information is available currently in the public sphere, we are happy to share that in public, but where we have information we've obtained that is subject to the confidentiality requirements of the *Audit Act*, we would prefer to present that in camera. I propose to provide a brief summary of our recent public reporting and then I would request that we go in camera to provide additional information that we have in relation to the terms of reference of the committee.

CHAIR - Thank you. We will need to have a short deliberative meeting before we go in camera, but when we get to that we can go through that process.

Mr THOMPSON - Perhaps if I turn to our recent reporting in public. The first thing to note is that all of these reports are publicly available and they're available on our website, which we've referenced in my speaking notes.

I wanted to talk briefly about the funding of community service organisations, which was tabled in the parliament on 26 May. The audit was focused on Health's administration of Community Service Obligation (CSO) funding, which is around about $75 million annually, and we found that process to be fundamentally flawed. Troublingly, Health knew this to be the case long before we started the audit. Recommendations to fix this problem had existed as far back as 2009 in terms of the CSO funding, and they've been taken to the Health board on multiple occasions. Again, the grants that are specific recommendations coming out of the 2019 review. In terms of the procurement aspects, there were systematic issues that were dated back to early 2024 pertinent to today's conversation, because it highlighted that the root cause of Health's failings was not a particular system, process, person, team or whole-of-government project. It was the culture within the organisation.

Health knew of the risks. They did not acknowledge them at the right levels, nor did they manage them effectively. So that report specifically found that people in Health had identified the risks, problems and challenges, had reported them accordingly, and nothing was done. So I think that's relevant to some of the conversations we will have today.

In terms of our financial audit activity through 2024-25; all of this information is reported in either volume 1, or volume 3 of our annual Auditor-General's report on the financial statements of state sector agencies.

Amongst other things, that financial audit identified inadequate management of outpatient revenue. There was challenges in that space. This was something that we actually identified in 2024, and again, whilst the department made assertions that they had addressed those matters, our retesting in that subsequent year found that those issues still occurred. Inconsistent treatment of private patient schemes was another area where we saw different and inappropriate treatments between the north and the south.

Again, directly relevant to the committee's deliberations and terms of reference, the fraud framework was clearly inadequate. Significant frauds were identified. Really important to note, again, they were identified initially internally within the department and there was failure to act in relation to those. At the time we finalised the audit, really in relation to the two specific frauds we were looking at, there was insufficient action taken in that space.

CHAIR - On that note, if I can ask, what would you expect them to do?

MR THOMPSON - Perhaps, if I could answer, I have some comments around that which I might answer in camera.

CHAIR - Sure.

MR THOMPSON - In terms of the performance reporting. Sorry, I'll just go back a step. What I can say quite comfortably is we would have expected them to follow their existing policies and procedures in relation to fraud and fraud control. That hasn't, no.

CHAIR - That hasn't?

MR THOMPSON - No.

In terms of performance reporting: the published performance reporting - and again this is reported in our publicly reported - is indecipherable. The key performance indicators, the key performance report, 403 measures, no targets. The department failed to make 249 of those, no explanations. There's no summary of results, there's no context as what all of this information means. Our team's been through all of those indicators, and we still don't know what that means. Again, it's almost impossible, I think, for the public to understand what targets have been set and how the department's delivering in relation to those.

Across the department, but I think across the broader general government sector and the departments, there was a lack of control over expenditure in combination with unrealistic budgets. You know, the Department of Health was the largest single contributor, when we looked at just expenditure over the last three years. The department spent $1.3 billion, almost $1.4 billion, more than what they had budgeted in terms of expenditure. Now that wasn't all funded through appropriation, but that was the total expenditure over budget.

So in summary, public reporting has highlighted many of the challenges that are relevant to the terms of reference of the committee. I would encourage members, if they haven't, to go back and have a look at those reports that we cite, to see that process.

Perhaps now, in the absence of questions, I would -

CHAIR - I have a few questions, as others may have as well. To go back to the inadequate performance reporting. I think it was yesterday, it could have been the day before, the Tasmanian Health Service Annual Service Plan was tabled. In that there's section 4.1, which is key performance measures. They go through all of these. They do have targets. They're basically not less than 100 per cent or other, not less than 5 per cent: just a percentage measure that I think doesn't actually tell you what the outcome of that is. Is that a good measure, how you measure the outcome of that? Have you had a chance to look at that?

Mr THOMPSON - I haven't looked at that version that was released as recently as that. We did look at that previously. What we found was sometimes there would be targets somewhere, but then when we published the results, we weren't publishing the targets. So you really needed to go and actually look at multiple documents to try to bring that together. Some of the targets are difficult without narrative and context, to understand whether a high number is a good number, or a low number is a good number. One of the 403 targets relates to the

number of people who have readmitted, in certain circumstances, within the mental health space. Now, a high number might be positive, because more treatment is being received. Or it might be negative because the treatment they initially received was inadequate. There's no context around that. So even where there are targets, it is difficult to understand what they mean.

CHAIR - Would anyone like to follow up on that?

Ms LOVELL - So in relation to that performance reporting, you've obviously identified this in public reports, has there been any feedback or response from Health around that, or willingness to change the way they're doing things, any further conversations that you've had around those issues?

Mr THOMPSON - We provided Health our reports and they did provide feedback, which we incorporated into that report. That was predominantly in relation to the fraud matters. I think they were reasonably silent in terms of any actions on performance reporting. It is important to note, we made those observations in our public reporting based on what we had seen through our auditing process. We certainly saw that the financial performance was troubling; then we tried to look for the performance information that would explain why; then we found the performance information was troubling. So, we haven't audited any of that performance information, but we've made that observation.

CHAIR - Going back to both your reports, there is a comment, or response if you like, from the Premier in the community service organisations report. There's one from the secretary of the Treasury. I'm particularly interested in the response from the secretary of the Department of Health, because you do say that there have been multiple opportunities when action could have been taken on some of these matters with regard to the community service organisations. I just note the secretary's response. They said:

> Whilst I accept the recommendations of the report, I reject broad characterisations regarding lack of action over recent years. This was a period of time where staff and leadership across the department were necessarily diverted to address the challenges of the COVID-19 pandemic, as well as focused on child safety following the commission of inquiry.

In your comment here, you talk about this being known for some time prior to COVID. Obviously, you get this response back. It says, look we were too busy being tied up with COVID, but there is no acknowledgement that this problem was there beforehand. Do you have any further comment around that?

MR THOMPSON - We didn't place a rejoinder or additional comment in the report. We are legislatively obligated to provide an opportunity for that comment, and to either publish that comment, or a fair summary of the comment in the report. We will go back - and I would note, whilst the response questions or rejects the broad characterisation regarding lack of action, it doesn't reject the findings. So, where we found that reports were made to the Health board identifying those issues and no action occurred, that's not being rejected by the response.

So we tend to accept and publish the response. We will go back, and we're actually in the process of going back now, to assess where the department's at in terms of implementing the

recommendations. We will report to the parliament on the status of the implementation of those recommendations later this year.

CHAIR - In a separate report or in your annual report?

Mr THOMPSON - In our annual audit outcomes report, which is our AGR1, we now include reporting on the progress of recommendations from our performance audits.

CHAIR - There didn't appear to be any recognition that these matters were raised in 2009, 2016 and 2021 - yes, that was COVID, but 2016 wasn't.

Mr THOMPSON - No.

CHAIR - There was no acknowledgement that things should have been done then?

Mr THOMPSON - No.

CHAIR - They continued with the inadequate processes that were around the funding of community service organisations during that period?

Mr THOMPSON - Hmm. There was some work that was being done on commissioning at that stage, but it really wasn't addressing the issues that we had identified, and indeed the issues that they had identified internally.

Ms O'CONNOR - Thank you, Chair. Good morning. You talk about the issues that you've identified in health financial management as being cultural - it's a cultural problem. Is that something to do with the lack of discipline internally around financial management systems? Is it a lack of accountability through the processes of management? What do you think is at the core of the cultural problem?

Mr THOMPSON - There's some comments I can make in relation to that, but I would prefer to make those in camera.

Ms O'CONNOR - Sure. Is there anything that you feel you can say in an open hearing about that comment around culture?

Mr THOMPSON - I think the funding community service organisations audit is really important because that's where we have first called out that this is a cultural issue. I think there is a risk that the cultural issues can spread across an organisation, so we've got a cultural issue as the root cause in relation to this. I think there is a risk that that may be causing other problems.

Ms O'CONNOR - Those other problems potentially relate, for example, to an inadequate fraud prevention framework; is that correct?

Mr THOMPSON - Correct.

Ms O'CONNOR - Thank you.

Ms THOMAS - Thank you. My questions were similar, so I look forward to hearing more in camera. Having identified these issues over a number of years and them not having been addressed, a lot of culture comes down to leadership; is there anything you can comment on in terms of changing leadership in the Health department over that period of time? Is that something you considered or inquired into as part of your investigation? I don't know how many secretaries were there through that time, from 2009 through to 2021, and then now; there has been a bit of change.

Mr THOMPSON - Not directly, but some of the comments I make in camera - information might be of assistance.

Ms THOMAS - What I'm trying to ask, is that leadership a really critical component to culture?

Mr THOMPSON - Correct. It's not systems, it's not processes, it's not technology that drives culture.

Ms THOMAS - The policies and frameworks exist, but they're not being adhered to?

Mr THOMPSON - Our findings in relation to matters of fraud were not primarily focused on inadequate policy framework or inadequate procedures. Indeed, the internal processes identified the fraud and resulted in those being reported internally. It was from that point that we found the action was not in line with what we, and to be fair, what their policy and procedures would have expected.

Ms O'CONNOR - Is it possible that that's an internal resourcing issue where there's perhaps not the capacity within the agency to follow things through according to policy?

Mr THOMPSON - Yes, the capacity can be a challenge in that space. That hasn't been asserted to us as part of our process, but I certainly have a concern about the capacity, so the volume of resources available to ensure appropriate control frameworks are in place in organisations. That is certainly a front-of-mind consideration.

CHAIR - This is perhaps a comment more than a question, but the Integrity Commission reported some time ago about an issue with RTIs being reassessed by the same person who did the first assessment saying, 'yeah, I did a good job, fine.' I mean, you talk about the culture spreading. We've had that from the Integrity Commission, we've had this from the audit office, where it talks about culture and a cultural problem. In your discussions with Health, has there been any acknowledgement that there is a cultural issue here, from the department?

Mr THOMPSON - Not formally, no. We talked to a vast range of people across the organisation, so as you could imagine, from very junior finance people, clinical people, right through to the executive. Different people will have different views in that space.

Just briefly going back to the question of capacity, although not related to the fraud comment. In the funding community service organisations audit, the grants program moved into Health. The history of it is quite convoluted, but I think at one stage there were around 12 people who were involved in administering, evaluating, assessing the grants. Through a number of machinery government changes and reorganisations, that number dropped down to two. So, we've gone from 12 people supporting the $75 million program - it was, to be fair,

less than that - it was about $60 million, I think, early on - we've gone from 12 people supporting that program to two.

CHAIR - So quality and control measures and the risk assessments were perhaps not being done?

Mr THOMPSON - Correct. Risk assessments, monitoring and oversight - in that report, again, a relatively new process for us. Janine led the team. We engaged with community sector organisations, we brought them in, had meetings with them and workshops with them. One of the comments etched in my mind, and it will probably never disappear, is one community service organisation left all of their performance information blank and submitted that return to the department and were never questioned. We have that comment in the report. So that's an indication of the level of oversight that was occurring in that space.

Ms O'CONNOR - Can I just do a quick follow-up on the CSO's report and the feedback from the Secretary of Treasury and Finance to that report? They seem to take some offence to your report and say that the department remains concerned about references that would appear to be inaccurate. They infer a more significant role for Treasury in oversight and compliance with financial management than that which Treasury is given authority under relevant legislation. But they go on to detail a number of paragraphs in the report that they have concerns with and, I mean, effectively, seek to refute some of your findings in the report. What's your response to that?

Mr THOMPSON - In terms of the response from the Secretary of Treasury and Finance, it is fair to say that we have a different take on the oversight compliance role of the organisation that sets the rules. Treasury and Finance set the rules in relation to procurement and the grants process, and received information and evidence that those rules and processes were difficult to understand, complex, and convoluted. We have a view that there is a role for Treasury and Finance in terms of compliance and taking the feedback and perhaps updating guidance. I would note that since this report was tabled, Treasury and Finance have reissued complete, updated procurement and grants guides that are a significant improvement.

CHAIR - Clearer and easier for people to comply with?

Mr THOMPSON - Yes, and clearly articulating that the process of putting procurement activities through a grant program is not appropriate, which was probably one of the major issues that we encountered with the Department of Health. Notwithstanding the comments, we were very pleased with the work that Treasury and Finance had done in updating and issuing new guidance to departments in this area. However, I think it's fair to say we still have a slight difference of opinion around compliance roles for the person who sets the rules - often the department.

Ms O'CONNOR - So the department, Treasury, is playing, would you say, no compliance role with Health right now?

Mr THOMPSON - Our conversations with the Department of Treasury and Finance would indicate that they don't see themselves as having a compliance role. Again, that might be a useful question for the Department of Treasury and Finance.

CHAIR - This is similar but different. Under the CSO area, we've recently had communication in other forms relating to the grant funding for the SHE cancer services wellness centre. I'm interested in your view, as the Auditor-General, as to the process that sees these sorts of decisions being automatically funded, as an election commitment, without what appears to be any proper process of assessment of the value. This leads to what is the culture in the department that says, 'the government's committed this, so yes, that's it'. I'm just interested in your views on that.

Mr THOMPSON - To be clear, our views are that the accountable authority, departmental secretaries, are responsible for complying with the requirements of the *Financial Management Act* and the directions of responsible ministers. The *Financial Management Act* requires that the accountable authority ensures all expenditure is lawful. It also ensures all expenditure is incurred in an efficient and effective manner and that, in complying with that, the risks associated with expenditure for a grant program need to be clearly communicated to the minister as part of the decision-making process, as part of the advice from the department.

Now, the minister is absolutely entitled to take on board that information and ignore it, but our focus is on the adequacy of the advice that is provided from the department around that expenditure. So, even if something is an election commitment or it's a budget amount to a particular organisation, it doesn't step away from the responsibility for the accountable authority to ensure that an appropriate risk assessment is done, value for money is considered and those compliance requirements in the *Financial Management Act* are also met.

CHAIR - There's another example of this in Health in that, regardless of what your view is, the Bubble in Launceston has been provided with significant funding. I know I've had quite significant representation from other general practitioners in the region who have no financial support from the state government at all. Again, this was an election commitment; the money appears to have automatically flowed. It has to go through a budget process, obviously, but I'm interested in these decisions when you talk about a risk assessment. Surely part of a risk assessment should include what the negative impacts could be on other service providers - in the SHE example, the cancer services at the Royal Hobart Hospital and notionally around the state, because we all potentially rely on those. And in this case, the impact on other health providers who also provide women's health services.

Mr THOMPSON - Yes, absolutely, and at a Commonwealth level, where they have a specific entity established for community grants and a separate entity established for business grants, part of the process is that a comprehensive risk assessment is undertaken for all grants. In different jurisdictions they have similar processes and oftentimes they scale. So, if the grant is under $50,000, the process is going to be different than if it's above $5 million, but they would all incorporate a risk assessment process that would ask those questions: does the entity have the financial capacity to do this? Is it in their normal business operations? When we're giving a grant, a capital grant if you like, to an organisation to build something, do they have adequate financial resources to meet their commitments? Do they have adequate financial resources to subsequently maintain that into the future? Do they have reserves that will enable them to meet any potential cost outflows? All of those.

CHAIR - And impact on other services?

Mr THOMPSON - Impact on other - I mean, 'is this the best way to deliver that service' should be a fundamental part of that process of the assessment.

CHAIR - Without doing an audit on those things, are you aware that any risk assessment is done on these? Not just these, there are others that we could name. They are just a couple.

Mr THOMPSON - Based on the outcomes of the funding community service organisations, we found that risk assessments were not being done. We haven't audited either of those two, but if they went through a similar, or same process, then it is possible that there was no risk assessment done as part of that process.

CHAIR - That's a question we can follow up with the department

Mr THOMPSON - Absolutely.

Mr BOND - It is in the report in the executive summary. It does say that the key staff advised that they did not consider it appropriate to undertake risk assessments, or that there was no appetite to assess risk once a commitment had been made.

CHAIR - So the government of the day, or the opposition for that matter, who end up in government, make a commitment. So that's it, we just fund it. Is that what you're saying?

Mr THOMPSON - That was the view of the employees at Health who were doing the assessment.

CHAIR - So you can point to a slight culture problem there.

Ms O'CONNOR - It is interesting, isn't it? Because, well, in a Westminster system, I mean, if a government takes a policy to an election, dispersing money to various organisations is not policy. But if a government makes a commitment, and then wins an election, you can kind of understand why the department would go, 'Well, this is policy now and it is our job to implement -

CHAIR - This is why we need a parliamentary budget office.

Ms O'CONNOR - Yeah, but you know, then all those risk assessment [inaudible] they don't need to assess risk in their minds because it is a promise that's been made. So it has to be done anyway.

CHAIR - I mean, a parliamentary budget office would look at some of this. So that's another inquiry at the moment somewhere else. Does anyone have any questions on the matters we've discussed in open session at this stage?

Okay. We just need to have a quick deliberative meeting about your request to go into camera. So if you just step outside for a minute and just stop the broadcast.

The witnesses withdrew.

The committee suspended from 11.20 a.m. to 11.57 a.m.

CHAIR - Thanks Martin. We appreciate the information you've provided in camera. That will remain confidential to the committee, of course, but if you'd like to make some closing comments that be really appreciated

Mr THOMPSON - Thank you Chair. I will just reiterate the earlier comments that we do see the provision of this information and evidence to these committees is part of our role of informing the parliament. It's been a pleasure to provide that information.

CHAIR - Well, thank you for your time today and the enormous amount of work you've put into providing that information to the committee. It is extremely helpful and absolutely going above and beyond the role that you're funded for.

Mr THOMPSON - Thank you.

The witnesses withdrew.

The committee suspended from 11.58 a.m. to 12.00 p.m.

RACGP Tasmania

CHAIR - Welcome, Dr Toby Gardner. It's really lovely to have you appear before the committee inquiring into the governance and financial management of the Department of Health, predominantly. We appreciate the submission you've provided, which members have had a chance to read. Before we start, though, I just wanted to remind you that everything you say is covered by parliamentary privilege while you're before the committee. That may not extend beyond the hearing. Just to be aware, if you make comments outside of this hearing process, that may not cover you. If there is anything of a confidential nature you wish to share with the committee, you can make that request. Otherwise it is all public. It's been transcribed by Hansard and being broadcast as well. Do you have any questions before we start?

Dr GARDNER - No, I understand.

Dr TOBY GARDNER, CHAIR, RACGP TASMANIA, WAS CALLED, MADE THE STATUTORY DECLARATION, AND WAS EXAMINED VIA TEAMS.

CHAIR - Thank you very much, Toby. So I will invite you to make some opening comments and speak to your submission. Then members will have questions for you to follow.

Dr GARDNER - Well, thanks for inviting me to present to my submission. My name is Toby Gardner, I'm the Chair of the Royal Australian College of General Practitioners (RACGP) Tasmania. We're obviously a membership-based organisation representing almost 50,000 GPs nationwide, and almost 2000 in Tasmania across 200 clinics. We work more so in the private sector, we're essentially small businesses running around the state, although lots of us have a lot of contact with the Tasmanian Health Service (THS), and a lot of involvement with the THS. Some of us work part-time within roles within the THS, and lots of our nurses also work dual roles in our practice and in the THS as well.

We were asked just to provide some feedback on what we think some of the financial, and perhaps operational, inefficiencies in the Department of Health may be. Personally, I leaped to the chance to put a few things down on paper that I've observed, over two decades of being in Tasmania, of things that I think are inefficient within the hospital sector particularly, that I think could be addressed particularly in this budgetary environment that we're looking to

do what we can to make everything more efficient for the better outcomes of the state, and also our patients.

CHAIR - Thank you. I really appreciate the way you've set out your submission, Toby, because it really helps us to focus in on things that you see as potential inefficiencies. I think it's pretty clear, particularly in regional areas, there is a very heavy reliance on locums in both the medical profession, but also agency nursing in our nursing services, and nursing and midwifery. Every time we ask about this, we're reminded about the challenges in recruiting, attracting and retaining. So, from your perspective, what do you see the real challenges are?

Dr GARDNER - Look, I think they're cultural within the hospitals. I mean, I can speak probably to the Launceston General Hospital (LGH) more than anything else, because I'm pretty closely aligned with the LGH, but I was just informed at a meeting prior to this that this year we've had two out of the 20 medical students in the north-west regional clinical school commence internship within the North West Regional Hospital: so, a shockingly low proportion of graduating medical students that we're training up locally to work in our local hospitals, but because of cultural issues that they're exposed to within their clinical time, they're choosing not to pursue training in Tasmania in their sort of intern years. We lose them to the mainland then.

So what happens is we then fill the gap with all these International Medical Graduates (IMG) who come in, who are great and we want to retain in Tassie, but we know that IMGs are less likely to be retained in Tasmania long term. There's some hope in the fact that we've now got an increased number of Commonwealth supported places, particularly in Launceston Clinical School, and in the Rural Clinical School, to grow some of these local doctors. It's been really heartening for me to see medical students come, in their first year this year in Launceston, that I've treated as babies, they've gone to local schools. Hopefully that will lead to retention of these doctors long-term, because they're firmly planted in the community, but if they don't have a great time in hospital, they're not going to stay. The clinicians are fantastic, but it's more the structural supports around them that have led to some of the morale issues that we see in the LGH, particularly at the moment.

CHAIR - Having a son go through the system - I understand some of these challenges.

Ms THOMAS - Can I just ask: when you said only two graduates got jobs in the Department of Health in Tassie, out of how many?

Dr GARDNER - That was a figure from the Rural Clinical School, which has about 20 students go through per year, 20 to 25, so only two of those were retained. When I started at the med school 20 years ago, I would say that 80 per cent of Tasmanian local people who had gone through the whole way would stay here. Of course, the university does rely on international students coming in as well, for financial reasons. I think it's about 50:50 international to local graduates but we were actually able to retain a lot of those international graduates in the past as well. There's heaps who have actually settled down here and are still working as clinicians within the hospital, but we're just not seeing that happen anymore.

Not knowing fully what it's all about, I suspect it's cultural because that's the echoes I hear in the corridors. It's nothing to do with the clinicians; the clinicians are, by and large, fantastic and I count many of them as my friends, but they come to me in despair about the circumstances in which they work all the time, the lack of support, the lack of follow-up for any of their issues

or grievances that they have brought up, the lack of cultural surveys actually going anywhere - they are asked to do them, but I don't know if anyone actually follows them up. In a private business that we all are as GPs around the state, we focus on culture first and foremost because without that, nothing else works. We have high rates of sick leave and workers compensation and all those sorts of things that naturally follow a poor-culture environment.

CHAIR - Toby, to clarify, you're talking about the clinical school in Launceston there?

Dr GARDNER - That's in the north-west. I work at the Launceston Clinical School and I can't remember the actual numbers, but I was told it was pretty disappointing in Launceston as well this year, as far as retaining some of our fifth-years once they graduated in Launceston. It's not that they're moving to Hobart; they're leaving the state altogether.

CHAIR - When you talked about [inaudible] I was going to ask you about some of the factors - lack of support, lack of follow-up and action on the cultural surveys - the other thing that I have heard over the years is the work hours, the lack of peer support, opportunity for downtime, and that sort of thing. Is that something you hear as well?

Dr GARDNER - Yes, absolutely. There used to be this sort of core group of clinicians in Launceston who would do all this sort of after-hours team building and have them as part of the ressies communities and so forth. That was sort of basically disbanded, and everyone's so burnt out with it all now. There's no one really wanting to champion it anymore. It takes a really good, committed group of clinicians to sort of nurture a group of junior doctors. There are little pockets, we have a really effective plastics service up here run by a friend of mine who is the head of plastics in Launceston; he will take out the residents and registrars out to drinks, or to his house, or just do things off his own bat and funded by himself just to try and provide opportunities for people to debrief, talk about clinical cases and provide that team environment that's required. So, certain pockets work really well but then, with respiratory medicine, where we lost a whole lot of clinicians suddenly, the whole thing is just a revolving group of locums at the moment. They're not there for any time, so any trainees that come through are just sort of disheartened by the whole environment.

CHAIR - So, if you had the opportunity to put forward a proposal that you think would be effective in supporting students and encouraging them to stay, what would it look like?

Dr GARDNER - I would sort of look at every department and have sort of a champion within each department within the hospital, so across cancer services, respiratory, cardiology, have people who may be employed to be cultural leaders within that group to ensure that everyone is being looked after, every concern and grievance is being managed in a timely way; also checking in with people all the time, the sort of thing that I do with my staff every day just to ensure that we don't miss anything, and actually listening to them when they have an issue.

We had an Executive Director of Medical Services (EDMS) up here last year who was making Australian Health Practitioner Regulation Agency (AHPRA) complaints against doctors within his own hospital; it's just unheard of. If you want to drive culture down in the hospital, that's how you do it. It was just atrocious to hear. These are people I worked with at med school, and I was trying to support some of these doctors who had come out from Colombia and so forth, who were doing really good work, who are great clinicians and certainly not warranting AHPRA complaints and then having to deal with this. That just makes you think, 'Why am I here? Why am I giving my time to this place?'

CHAIR - Yes, so what you're suggesting is, like, a formal sort of process. Then that relies on the more senior clinicians being in a position where they have time and resources to do it. And we understand the pressure they're under, it's not like they have all this free time. Do you see that as a funded program? I'm just conscious of the pressure on the state budget, but we're also conscious that there seems to be a lot of inefficiencies in Health, and some of this is related to the loss of permanent staff.

Dr GARDNER - Yes. I think that's a small investment in culture to save on the $300 million locum budget, or whatever it is at the moment. I mean, it's blowing up incredulously and really, you just have to invest a small amount at the start to get the return on just the retention. Retention, I think, is the biggest issue at the moment.

Ms O'CONNOR - If we could just zero in on retention a little bit. You referred earlier to losing a whole lot of clinicians from the respiratory service. Can we unpack that a little bit? When did that happen? How many clinicians left? What do we know about why they left, and do we know whether they've been replaced with locums or otherwise?

Dr GARDNER - Yes, the respiratory in Launceston is running on very much a locum group of doctors in at the moment. What that means is our patients who require regular day procedure admissions for infusions, for respiratory issues, for lung cancer and so forth, they're seeing a different clinician each time. You can imagine the inefficiencies in having to go through someone's full case every time they meet someone and starting afresh with a set of new eyes.

We lost out of the system one of our great clinicians, Greg Hoag up in the north, who I've worked alongside for many, many years. He's a fantastic educator, teacher, someone who's been wedded to the public sector for a long time and doesn't really like working in the private sector, because he likes working in that team environment in the public sector. A great teacher, a really good part of the medical school. He was sort of stepped aside, I believe because - we've always known Greg is not ideal with paperwork or getting his letters out to people from clinics, and that's a peculiarity of him, but I tell you what, in the private sector there's an AI solution to that that we would get straight away just to get that information out to the clinicians. It's not a reason to step down a really highly respected clinician who does so much work in the hospital but is also really good for morale. They don't seem to look at what taking out someone who's a key person to that organisation will do to the whole department. As a consequence, the department's just floundered.

Ms O'CONNOR - Can I just check on that? You said he was 'stepped aside'. What does that mean? Did the department, because of some sort of irregularity around paperwork, say to Dr Hoag, 'Off you go'?

Dr GARDNER - Yes. Well, they said, 'You can't do any clinical work. You're going to need to sit in an office and you're going to have to go through and do all of your letters. We're going to have a secretariat there for you to get all of this stuff out to the doctors and the community'. Realistically, if there's someone we're really worried about, we'll just pick up the phone and we talk amongst each other, because we're all senior clinicians in the area. So, I don't feel that I was really missing out on anything particularly, and that was a way to drive morale down even further for him. He loves clinical work. He's great at it. He's got lots of experience. The way he was treated, to be put into a room off the hospital campus, was enough for him to

say, 'Look, I don't know if I really want to come back to this place, if I'm being treated like this'.

You lose someone like that, who's prepared to continue working in the sector - and he's the sort of person who other people want to work under. So, you get a new registrar come in who's going to work under them for a number of years and that's the next person to replace him, essentially. At the moment I don't know who's going to replace someone like that.

Ms LOVELL - Thanks. Toby, I'm sorry to jump a bit all over the place, but under item six in your submission - accountability, performance metrics and governance - you talk about the public health system lacking strong accountability mechanisms for cost containment. I'm really interested to hear a bit more about your thoughts on that, because I guess some would argue that the public sector would have stronger accountability mechanisms and reporting than the private sector because of the nature of the state budget and the measures that we have in place for that.

CHAIR - The parliament.

Ms LOVELL - Parliament, that's right. So, I'm keen to hear some more from you on those comments.

Dr GARDNER - It probably feeds a little bit into the resource utilisation and waste minimisation as well in point four, in that we see - as someone who's been in the private sector for 20 years, I walk the halls of the hospital all the time and see people utilising equipment and throwing it away like there's no cost associated with it. People don't think about cost. No-one seems really aware of cost. I don't see anyone going around and - it's not about saying, 'Your budget is this, you've got to achieve this within an impossible budget'. It's about looking at, 'Okay, this is what you've spent compared to this department over the last six months - let's take that apart and find out where these cost blowouts are coming from'. I see this as sort of business as usual, and I don't know who I'd go to to see where the accountability stops. Like, we watch everything like a hawk in our business, because ultimately it comes back to our personal profitability, and I think there's just that feeling that it's not really our money, it's someone else's problem. That's the feeling I get walking through the hospital.

Ms LOVELL - Maybe, do you think there is maybe a bit of a disconnect between the level of accountability in terms of the budget and budget Estimates and the parliament, but down to that kind of day-to-day operational level in terms of what's actually being used and wasted, potentially?

Dr GARDNER - Yes, the consumables. I did something at our practice 10 years ago and I actually went and put a label on everything - every dressing, every local anaesthetic, every needle, everything our doctors use - and it actually changed behaviour. It was such a no-brainer, I thought it would be pretty easy -

CHAIR - A label stating the cost of it, you mean, Toby? Like, an individual needle - you had a price on it?

Dr GARDNER - Absolutely, yeah, because it's our money at the end. So, it actually changed the behaviour of the doctors. Now, they don't want to waste money. What has been great is that we have a lot of THS nurses that work with us in our private urgent care here. It's

been good for them to learn about things, and they've been able to take things back to the hospital and say, 'You know, every time you open a cannula, it's costing this amount of money. Don't throw it away if you're not going to use it' or 'don't open it if you're not going to use it'. Little things like that, and the costs - anything medical has a premium attached to it. Our supplies are so expensive - the dressings that get used sometimes are perhaps not the most cost-effective ones. So, you'd look at all the inventory, do big stocktakes, say, 'This is going to be the same product for a cheaper price', and really justify your use of it.

CHAIR - One thing that's struck me in looking at the budgets over the last five-plus years is that there seems to be a bit of a lag of the - and I use the word 'mentality' carefully - around the cost associated with delivery of health services, particularly through consumables. I think, to me, it goes back to the COVID period. In COVID it was like, 'Give us what we need, 10,000 masks, 20,000 gowns', whatever, and it was like, 'Yeah, here it is, here's the money'. We understand why that happened; there was a great period of uncertainty, but what we saw in those budget years, around the immediate COVID period, was budget control. They actually spent within the budget they were allocated, acknowledging they got a fair bit more in Health.

Since then, they haven't stuck within their budget and they've had massive top-ups through supplementary appropriation and other measures. It doesn't appear that they've changed that mentality of 'we can get whatever we want, if we don't use it, we'll just chuck it away'. So, you've probably got stock going out of date and all that sort of stuff. Have you observed that, and how do we change that mentality?

Dr GARDNER - Well, you have better oversight of it. You know, I teach simulation at UTAS and I used to go to the pharmacy and pick up, like, $10,000 worth of expired drugs every week, because it was going be destroyed. I'd use it to demonstrate, for teaching purposes, how you open an ampoule, how you draw it up, what you're going to give, fill up my emergency trays. I've got a sort of expired drug cabinet that I use in my simulation rooms at the university. I can't believe it, there's so much thrown away every week. Surely, there's some more accountability of it.

But also just from a doctor point of view, doctors don't know how much it costs to order a CT scan. They have no idea what that costs the state, or certain blood tests. I try and teach this in medical school now. My students in simulation say, 'I'm just going to order this blood panel', and I'm like, 'Why?' And they say, 'For baseline'. And I say, 'Well, that's not a reason to order all of these tests. Most of them are going to be normal. Go looking for things that you think are going to be abnormal, then expand your net after that. Rather than just doing this big net to begin with, just because no one's really paying for it that you consider'. We're much more mindful of it now.

I think all doctors should be audited about the tests that they order. I'd say that some would be, who are a bit more, you know, the more unsure you are about yourself, the more you are likely to order millions of tests at a huge cost to the state. I really think no one has any education about that in the hospital. No one knows the actual dollar figure.

CHAIR - In the dark ages when I was working in the hospital system. I worked in public and private. One of the jobs as a registered nurse on the shift was to check the crash trolley. One of the reasons to check the crash trolley was not just to make sure everything was still there, particularly if it had been used, but to go through all the drugs that were in there and

check their expiry date so that they could be rotated out before they got close to their expiry date, so that they could still be used. Do we need to go back to something as basic as that?

Dr GARDNER - Yeah, we do. We need closer scrutiny of all of this. I mean, we do have expired drugs that we get rid of in the private sector here. It's really annoying for me because I know that they're not really expired. I know the pharmacology of them. It's the drug companies who are controlling that, and that keeps their revenue going. You don't want to make a drug that has no expiry date, because you need to keep things turning over. That's a bigger issue. But you know, I can't believe saline has an out-of-date. I took home all these oxygen masks the other day that have an out of date - on oxygen masks. We can't sort of legally use them. I mean, it's ridiculous, it's totally ridiculous.

This stuff is bought on mass, in big boxes, and a lot of it just sits there, almost sometimes unopened. Then we get all this supply from ICU, all the time, these bags and masks, and all this stuff. Then they're like, 'Oh, we can't use them because they're out of date'. I'm like, 'What is wrong with this stuff?'

CHAIR - Because they don't rotate them through the operating theatre, where they would use it nearly everyday.

Dr GARDNER - Yeah, and they could actually do that. They could, you know, use this stuff. It just sort of seems to sit in one department, for their use.

CHAIR - Until someone probably realises this whole box of oxygen masks is out of date.

Dr GARDNER - Yeah. Take it to respiratory, take it to emergency, take it to where it's actually going to be used.

CHAIR - So a question the department would be what checking mechanisms are there to avoid that?

Dr GARDNER - Yes. Again, I can say there's an AI solution for all of this, Cassy. This doesn't even have to be a person; this can all be checked in through AI that's done centrally.

CHAIR - So obviously, you feed the information in when you receive the stock.

Dr GARDNER - Yes, and where it goes.

CHAIR - So you've got 1000 oxygen masks and the expiry date is x.

Dr GARDNER - Yes.

CHAIR - Then they've gone here, they've gone to ICU, they've gone to theatre, they've gone to the surgical ward, wherever.

Dr GARDNER - Yes. It's because people think of it as small amounts. But it's these incremental things that all add up to huge amounts in the system.

Ms THOMAS - Thank you for your submission and how you've set it out. Because you really set it out as problem and solution, and really concisely and it's really helpful. I guess, the way I see it, is there's three key things to overcome the challenges in the health system.

1. It, perhaps, needs to be run more as a business;
2. Needs to use modern technology, including AI; and
3. Probably at the top, the cultural change.

They're all interlinked. With that cultural change that you've talked about. You've talked about culture surveys, and actually following up on those. If you were to go in and be the top of Health, what would be the most important thing to do in terms of culture. Because leadership is really important and that ownership and leadership across the different levels of the organisation. What do you see as most important from that leadership perspective?

Dr GARDNER - I would probably go out worldwide and look for a really high-paid CEO from someone who's got some experience in the health industry, who has a clear track record, bring them in and ask them to start to clear out a lot of the sort of deadwood within the hospital, because there's lots of it and there is lots of rusted-on people who have existed in positions that they probably shouldn't. Not only are they taking a public salary but they're really damaging the culture which has all these flow-on effects. That's what good, effective businesses do, bring in someone with runs on the board.

Ms THOMAS - There was a worldwide search, I remember the media release, 'Worldwide search for a new Secretary of Health'. That's perhaps a question for the department. Thank you. I think that's helpful.

Ms O'CONNOR - Thanks, Toby. I want to go back and flesh out the statement about deadwood in the department. In terms of the sort of layering of positions in the department: is the issue primarily in middle management?

Dr GARDNER - Yes, probably.

Ms O'CONNOR - So the middle management, and what kind of responsibilities do those positions have?

Dr GARDNER - I think sometimes clinicians have to report to these people in middle and senior management and they feel, if they have grievances, they don't feel heard or it just doesn't seem to go anywhere. It's sort of, 'Leave it with me' and then nothing happens. Then they come to me and say, 'This place is crap, no one is listening to of any of my concerns. They're clearly not escalated'. Again, that was just on cultural surveys. I talked to one of the leaders in one of the departments up here and he said, 'We do cultural surveys, but we never hear about what happens to them. They have middle management and senior management come and ask us what can we do?' These are the people on the ground who have the solutions that they know in their department would help to attract people, to keep people, to be more efficient, but it just doesn't go anywhere.

It hasn't been enabled - we have a pretty ineffective EDMS up here and we had another - I can't remember her name, someone else who has been managed out. I did talk to the minister about this, almost the day she became the minister, because I've known her in her

federal role and she has been committed to try and look at the top levels of management. I said without that the whole culture - culture rots from the head, right? - so if we don't fix those couple of people, nothing else will change. And she's committed to try and improve those individuals. We've got a good CEO up here, but I think she felt a bit hamstrung by some of these other individuals up here who are affecting her ability to do her work. These people need to be managed out or paid out. I personally would pay them out as quickly as possible and then get someone really good in.

CHAIR - Start fresh?

Dr GARDNER - Yes, absolutely.

Ms O'CONNOR - Is it possible, though, that the apparent unwillingness to escalate issues that are raised or complaints that are made, or suggestions for improvement that are made, that that resistance to escalation actually comes from the next layer of management above that because at that middle management level they are also kind of worn down by a lack of leadership from senior management.

Dr GARDNER - Absolutely, and without knowing the actual individuals involved, I absolutely expect that's probably the case. It's somewhere within that managerial structure, that's someone's not really - it's because I don't feel like ownership of the hospital as a kind of business, they just sort of see it as a as a place of work to come and go check out. There's no real vision for the future. If I was there, my vision for the future would be, 'Cut the locum budget. How am I going to cut the locum budget?' That would be the forefront of my mind. I would just do everything I can to work out why we're not retaining staff. Go and talk to every person, and then do something about it.

Ms O'CONNOR - I think it would be a resistance, wouldn't it, to putting on full-time salaried critical staff or nursing staff, because then you've got a rolling, ongoing, recurrent responsibility for that role rather than just paying that bit extra for a locum.

CHAIR - Its not just 'a bit' extra.

Ms O'CONNOR - No, I know, but it's sporadically - the department's obviously made that calculation, but it's ironically -

CHAIR - Have they?

Ms O'CONNOR - Well, they must have, because they keep hiring locums and not hiring enough of our best and brightest. But, Toby, I just wanted to ask you a little bit about how AI works in the health system and what you see as the opportunities and the limits, because there's a system-management question, and so there's efficiencies there, the one we were talking about earlier; but, there's also a concern, or an issue potentially, that looms around role replacement.

Dr GARDNER - Yes, absolutely.

Ms O'CONNOR - So have you got any observations on that? Anything you want to flag with us or warn us about?

Dr GARDNER - Well, it's an existential threat, Cassy. I was in a board meeting yesterday with my national board in Hobart, and I'm extremely worried about where AI is going to replace a lot of our jobs. We talk about it strategically a lot. I think a lot about chronic disease management, and the stuff that can be managed without a clinician doing procedural stuff, will be replaced by AI. There's already big startups and disruptors in the industry. I think medicine is going to change dramatically in the next five years. We're trying to brace ourselves in the primary care sector for where our relevance will be. Funding models are going to change as well. I know that I will be okay, because I'm a procedural clinician, and I'm going to go through come through okay, but I really worry about a lot of my colleagues.

In the hospital sector, I think AI could replace a lot of the managerial staff, a lot of the those middle-management people, and so forth, the reporting lines. The fact that, you know, there's so much that just gets done manually in hospitals still. You have to put in overtime, and then overtime goes through all these different levels of people before it's actually awarded, but generally it's pushed back on. You don't need that to go through the hands of all these other people.

There should be some sort of system that just says, 'Is this appropriate or not?' If you're claiming too much overtime and someone comes down and looks at what's happening in your department, where you don't have enough staff and you have to do all of that overtime, it just triggers those sorts of things. I'm not a techie person, but I'm just forced to think about it now because I'm worried about, existentially, where all my colleagues are going to draw their income from in the future.

Ms O'CONNOR - Yes. We've just had the Premier's state of the state address a couple of weeks ago, where he said that the government is fully embracing the AI revolution, in the same breath as talking about more sort of efficient and effective service delivery. It's all very coded. To your knowledge, where is AI currently being utilised in the health system? Have you seen it have either a positive or negative effect?

Dr GARDNER - Well, in our practice day-to-day, and in hospitals, it's used in transcription. So, it's used just to take out the need to type up notes, and those sort of things. We're a pretty slow mover into an electronic health record, and we're moving there currently, but that's been a very slow process. Once we get an electronic health record, there will be AI all over that, drawing data from here, there and everywhere, to sort of inform decision-making, and so forth.

I see people actually having sort of an autonomous connection with some sort of AI-whatever in the future, helping to formulate a diagnosis and management plan; I see people actually accessing pharmaceuticals and treatments online without any real oversight of a clinician. I'm worried that it's going to happen - that's happening in China at the moment. People want convenience, accessibility, and affordability. If the startups can provide that for people, that's sort of more important to people at the moment, with some quality, but it doesn't have to be delivered by a human at a certain cost. So the world's going to change really quickly in this space and I'm just worried about our survival at the moment.

Ms O'CONNOR - Yeah, agreed.

CHAIR - Back to a topic we're discussing a bit earlier. It goes to the cultural piece and the lack of action, or follow-up on the culture surveys. You made mention of the need for

structured exit interviews. I go back to the medical students that are graduating from the Rural Clinical School: do they have exit interviews?

DR GARDNER - They do. I think Ruth could probably get you that data. I think we do ask why they're choosing to go to certain places.

CHAIR - That's Ruth Kearon, not me.

Dr GARDNER - Yeah, Ruth Kearon. I think we do have some of that data. We're certainly starting to actively collect a lot more of it. It's really important for us because that then helps us feed back into the hospital, 'This is what's happening, this is why our students are feeling unsupported', and it may only be particular departments.

For cultural stuff, I'd also just look at workers' comp and sick leave - you know, it's a red flag when you've got workers comp and sick leave in certain departments. So, just deep-dive into that and find out what has happened. There was an issue here, in the Holman Clinic with radiation oncology and radiation oncologists. It was a bit of a disaster over the last 12 months, and it saw our two senior radiation oncologists go on leave for prolonged periods of time, because of a locum who, as a clinician, wasn't good and made lots of mistakes that required these two senior clinicians to then go and fix, on top of their already growing load of patients - because patients keep getting cancer, that's not going to change. But there had been an almost unwillingness from the Holman Clinic over the years to really employ any extra radiation oncologists. So, there were these two senior clinicians basically running the department, and if one of them was sick it would all fall onto the other person left there. They were crying out for an extra hand for so long; it was sort of like, 'Oh, there's not really anyone available. We've looked'. That's not acceptable to me - you know this group is going to burn out, and then you've got no service whatsoever. So, you look harder, you just go harder. You offer a little bit more, because now, they're relying on locums, of course. It's costing more than it would have in the beginning.

Ms O'CONNOR - Are they still not there, those radiation oncologists? They're still gone?

DR GARDNER - No, they're back, but they feel pretty jaded and aggrieved with how they were treated through all of this.

CHAIR - This extended to the north-west service as well.

Dr GARDNER - Absolutely.

CHAIR - I got the feedback from there about how terrible it was.

Dr GARDNER - Yes, and they were providing that reach-out service to the north-west, so they just didn't want to do it anymore, and were saying, 'Why should we do this? [inaudible] -

CHAIR - That leaves the person up there unsupported.

Dr GARDNER - Yeah, totally.

CHAIR - Are you aware - this may be a question for the department - but exit interviews for some of these people that do leave, are they conducted routinely or not?

Dr GARDNER - I'm not sure. I don't actually know.

CHAIR - My concern is, what I'm hearing is they're done for the medical students. You feed that back; you have the culture surveys - there's no feedback. It's almost like it's a box-ticking exercise, which doesn't help the culture or the sense of being cared about.

Dr GARDNER - Agree. That you're being listened to. Yes, absolutely.

CHAIR - Which then can feed into your fatigue, your mental health and wellbeing. It's all very linked, isn't it?

Dr GARDNER - Yes, absolutely. The other thing is that just, as a profession - and across every profession, you'll be seeing this - that there's a big productivity issue. The average hours worked per week has dropped in the last five or so years. I think you just need to be mindful of that when you're employing people, so we're trying to expand our number of GP trainees in the country, because we know that people are wanting to work part-time. You need to train three people now to replace one person, because no-one wants to work seven days a week like an old-school GP anymore. It's the same in the hospital with these clinicians who are retiring. You need to actually hire a couple; it's not just a one-for-one thing. You need to look at that, because that's the nature of the workforce. The workforce has changed; there's no denying it. I don't think it's going to go back, so I think you need to be mindful of that when you're doing workforce planning as well within the hospital.

CHAIR - In terms of the cost of that, if one clinician who works, like, a squillion hours, which some of them do, and that person gets to retirement or leaves for other reasons - the recruitment of two - in a cost comparison there, we're not talking about paying those two people to replace the same amount individually - as that individual got, we're talking about it -

Dr GARDNER - The hours - you're covering the hours. Some of these older clinicians work longer hours, are paid overtime and so forth because of it, but people are not wanting to do that anymore. It's about just ensuring you have the same coverage of hours when you bring in new clinicians.

CHAIR - So, the overall cost would be pretty similar -

Dr GARDNER - One would hope so.

CHAIR - in employing two and replacing one in that scenario.

Dr GARDNER - Yes.

CHAIR - And possibly less because you're not paying overtime all the time, potentially.

Dr GARDNER - Absolutely.

Ms O'CONNOR - And better value because you're not leading to burnout and a loss of staff and productivity.

Dr GARDNER - Absolutely. People want to job share and do this sort of stuff.

Ms THOMAS - Back to the issue of locums, in your submission you've talked about the workplace culture and the ability to retain senior medical staff. Is part of the issue also that, once there's this culture of locum employment becoming the norm, then there's a resistance by doctors to be employed permanently as staff because they get paid more being locums? Like it's created a monster?

Dr GARDNER - It has created a monster. There's a group of doctors around the country who really thrive on being guns for hire. They know that they can charge what they like because of this issue at the moment. There are GPs like that as well, who I can't get to come work locums because they charge exorbitant fees that would just cripple us. But, that doesn't mean it can't slowly be turned around. It won't happen overnight, but it's slowly - there needs to be caps put on locum payment, I personally think, enforced caps because otherwise it just keeps on growing and growing.

Ms THOMAS - Okay. In terms of the ratio in the department of administrative staff - we talked a lot about middle management. Do you have a view on the balance, in terms of administrative staff versus clinical staff and how that's looking? I mean, we've had these jobs freeze, but I see new jobs advertised the administrative arm of the Department of Health quite regularly in different departments and different areas within the depart, even new areas coming into creation. What's your view on that?

Dr GARDNER - Since I've been a doctor over the last 25 years, I've seen administration staff grow massively compared to clinical staff and I haven't seen any real improvements in efficiencies because of that. So, I would, personally, go around and one-on-one, what is your job? How do you justify your role? Who do you report to? What are your KPIs? And ensure that they can justify why they're actually there. I see a lot of people, when I walk through the hospital sometimes, with open doors, all just sitting down, having coffees, having chats. I'm usually charging around looking for equipment or something like that. They just don't do that at my work. I have a really good admin team, but they're always working because they know that it's money out of our pocket. I just think sometimes they don't really think of it as the taxpayers' money, they just think it's a job - I don't know, I've been in the private sector for a long time, so - yep.

CHAIR - Can I go back to the question - I think you were responding to Bec about putting caps on locum payments. Price caps or anything are problematic because they do have adverse consequences sometimes. That would need to be a nationwide approach wouldn't it?

Dr GARDNER - I think that's a national thing, yes, because -

CHAIR - Otherwise, they'd just say, 'We're not going to Tassie'.

Dr GARDNER - They all go to Queensland because Queensland are paying a fortune up there and that's just dragging so many people out of Tassie, particularly all our rural generalists who go and work up there.

CHAIR - There's another challenge with locums - clinically, it's fine, but it's the 'all care and no responsibility' for locums, so that you don't actually get that ongoing support for your

interns, for your residents, for your registrars. How does that add to the challenge, when you have a locum providing great care - there's no issue with the clinical stuff - it's all the other stuff that a fully employed specialists would provide?

Dr GARDNER - It makes the people under them think, 'Why are you a locum and why wouldn't you want to stay here long term?' Then it sort of makes the locum look appealing to them. Locums in some areas will settle down and find a place to stay, but a lot of the time - the other thing is, although they might be really good, there are things that come in after they leave, and what happens to those results? Where do they go? There's this sort of empty spot where, suddenly, you get things pulled out, and six months later, you're like, 'There was an MRI that came in addressed to this person who's no longer here', and someone followed up, and everyone's like, 'Well, that's not my responsibility'. Suddenly you've got someone who's like really unwell. It's a bad outcome.

CHAIR - Exactly. It's problematic. We're almost out of time. Does anyone have any other questions on the submission? It has been really helpful, Toby. I mean, it's such a huge, unwieldy beast in many respects, but I think one of your key measures was start with the basics and build from there. I hope I'm not verballing you in that, but if you'd like to provide a closing comment around the key message you'd like this committee to take away and where you'd start if you were the main decision-maker.

Dr GARDNER - I think just the accountability for the financial decisions that are being made and actually a proper audit of every department, of every person in every department, finding out who the key people are, and getting on the ground feedback from all the staff about who are the irreplaceable people in this department and who are the people who perhaps cause friction or could be replaced by someone else or not be replaced at all. That's where I'd start, just with interviewing those people on the ground.

CHAIR - Thank you.

Ms THOMAS - Is there anything that you think we should be asking as part of this inquiry?

Dr GARDNER - I would want a good auditor to go through and like micro-audit everything. That's where I would start personally and I reckon you'd find out a whole lot from there, and, personally, I'd go straight to the workers' comp and sick leave.

CHAIR - That would be an internal audit process we're talking about?

Dr GARDNER - Yeah, absolutely.

CHAIR - Thank you. That's a really helpful suggestion.

Ms THOMAS - Thanks so much

CHAIR - Well, thanks for your time. I appreciate it's an hour out of your day.

Dr GARDNER - No worries. Happy to help.

CHAIR - And you're a busy person too.

Dr GARDNER - We need a functional hospital. We need functional hospitals to support us in the community to keep doing what we're doing, so anything we can do - we want to provide advice on.

CHAIR - Thank you so much.

The witness withdrew

The committee suspended at 12.56 p.m.