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**THE LEGISLATIVE COUNCIL SESSIONAL COMMITTEE GOVERNMENT
ADMINISTRATION A MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE,
HOBART, THURSDAY 15 OCTOBER 2026.**

FINANCIAL AND OPERATIONAL PERFORMANCE OF THE DEPARTMENT OF HEALTH

The committee met at 9.12 a.m.

UTAS Health

CHAIR - Thanks, Prof Zosky, for appearing before our government administration committee inquiry into the financial and operational performance of the Department of Health. We received your submission in relation to your interaction with the Department of Health as training health professionals. I note you're in Burnie, where we're doing all things up there now, which is great.

Prof ZOSKY - We are doing lots of things up here, yes.

CHAIR - Thank you for your appearance today. Just by way of explanation, this is a public hearing. Everything you say is covered by parliamentary privilege when you're speaking with the committee. That privilege may not extend beyond the committee hearing, just to keep that in mind. If there were matters of a confidential nature you wished to share with the committee, you can make that request, otherwise it is all public. It's being broadcast and will be transcribed and form part of our parliamentary records.

We've got another member online, Sarah Lovell; Clare Glade-Wright beside me here, and Bec Thomas will be joining us shortly. She went to the wrong location this morning apparently, where we were yesterday.

Professor GRAEME ZOSKY, PRO-VICE CHANCELLOR, HEALTH, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED (via Teams).

CHAIR - Thanks, Graeme, and I appreciate the opportunity to use first names. You can call us by our first names, too. I certainly prefer that.

Prof ZOSKY - I appreciate it, thanks for the invitation, Ruth.

CHAIR - We have read your submission, and appreciate the effort you put into that. I invite you now to perhaps speak more broadly to that, and then we'll probably have questions to follow up, if you'd like to make some opening comments.

Prof ZOSKY - Happy to, and do appreciate the invitation. I appreciate the time that the committee has taken to examine these matters, and very happy to speak on our collaboration with the Department of Health. I obviously can't speak directly to any internal matters in relation to the operations or financial performance of the Department of Health, but we do have a very longstanding important collaboration. That spans decades, and it's really critical for us as a university, but also for the department. It forms a little bit of a symbiotic relationship, whereby we can't train our health professionals without the support of the department, particularly in them offering placements to our students as part of our accredited health

programs. But likewise, we are a critical partner for them in training the health workforce that they need for Tasmania. It's something that we're both deeply committed to.

That longstanding partnership has had a number of evolutions and the most recent evolution of that is framed by the most recent memorandum of understanding, which was signed in June 2024. What was different about this particular MOU was it represented the next step in the maturity of our relationship because it had a really clear governance framework around it, which we haven't had previously. The governance framework for that particular MOU involves a strategic oversight committee, which is called the Strategic Health Advisory Committee. I co-chair that committee with the secretary, and it's really the strategic oversight of our whole relationship across a range of different facets. It's attended by a number of senior executive members from both institutions, both the department and the university.

Underneath that strategic oversight committee, there are a number of working groups and subcommittees across a range of domains, including research and innovation, workforce development, shared infrastructure - which is actually a critical part of our relationship, and people resources, how we support primarily conjoint positions between the university and the department to support some of our collaborative activities. All of those elements and those subcommittees have matured over the last few years and we're really starting to see some results out of that work.

But there are some things that we can continue to do and continue to work on. One of those things is our relationship in terms of placements. One of the things that's probably helpful for this committee to understand is not just the scale of the placements that we have in specific relationship with the Department of Health, but the general scale of our placements at the university. In my role as Deputy Vice-Chancellor, Health, I'm responsible and accountable for all of the health disciplines across the university. Within that, we have just under 17,000 students across all of the disciplines and, in any given year, around half of them are on some form of placement or work-integrated learning, depending where they are in their degree and depending on what type of degree that they're studying.

We have partnership and placement agreements with over 1000 partners, but far and away the largest partner in terms of the volume of hours and the number of students is the Department of Health within Tasmania and all of the services that they offer. On an annual basis, we have around half-a-million placement hours in the Department of Health. Our total footprint in terms of placement hours is around a million hours a year. The Department of Health represents around a half of the footprint of placement hours in any given year. Placements, for us, as I mentioned, are a really critical part of what we do. They're not only a requirement under many of our accredited programs that lead to registration as a practising clinician, and they're required as part of that training; they also provide a really rich student experience. We really work hard to ensure that our placements provide that - not only provide the students with the skills that they need and the capabilities that they need to achieve, but also a rich experience so that they understand the system, and hopefully many of them will enter this system when they graduate, so they can understand the health system and be a really effective practising clinician within that system.

From our perspective, when we think about placements, there's the learning experience, which is absolutely critical, but underpinning the placement, irrespective of what the nature of that placement is - and we have placements across the public sector, across the private sector, we have placements in community organisations, we have placements in sole-trading

situations, but we also have, clearly in this case, placements across really large organisations like the Department of Health. For us, the underpinning theme for all of that is ensuring that students are safe. There's two elements of that. One element is ensuring that students are appropriately prepared to not only make the most of their placement, but also to practise safely under supervision during that placement. We do a lot of work in the lead-up to that, preparing students for those placements, including meeting any requirements for the placement provider in terms of immunisation or onboarding, or inductions that need to occur.

When we track that through the placement process, we also have a fairly robust auditing process of our placement providers. We do site inspections for all of our placement providers, including for the Department of Health, on a regular basis. We also have a really robust system for tracking placement experiences and placement challenges. So, if we do identify a situation where a placement is not going the way that it should, we can track that in our system, implement our procedure to manage any risks associated with that and then ensure that no students are placed in that circumstance until we are convinced that it is a safe space for them to go into. As part of that process and as part of our procedures, it requires a close collaboration with the department, and we have a really good working relationship in that space. All of the students are provided with a handbook and a set of detailed information about how they can get support that is co-produced by both the department and the university. We do that together so it's very clear where a student can go if they're having any challenges or they need any support, but it also allows us to maintain that collaborative approach to placement.

Broadly speaking, from my perspective, with that strategic governance approach in place through our MOU, our collective commitment to getting the right workforce for Tasmania and our collaborative approach to how we manage placements, my observation and experience is there's a deep, shared commitment to ensuring not only a great learning experience so that the students have the capabilities that they need and so they can be a safe practising clinician, but also to ensure that the students are safe throughout that process. In any instances where we feel that they are not safe, we have really clear escalation pathways to manage that situation. Hopefully that helps provide a little bit more richness to the submission. But that's to give you a sense of how it works.

CHAIR - Thanks, Graeme. We've been hearing from various parties in the system in various levels of the department down to the actual delivery of service levels. When you do the site inspections in the hospitals, particularly for your nursing students and medical students, how often do you find students being placed in difficult situations, particularly due to the levels of staffing? In the media we hear there's so many unfilled shifts and there's so much overtime being worked, and all those things. So, how do you assess that and how do you get the feedback from the students about how they feel, because less staff, less supervision, all the things that flow?

Prof ZOSKY - All those things, yeah. There's probably a few layers to that, Ruth. It's a good question. From a formal process, one of the data points we do have is the number of placements that are cancelled and there are a number of - we collect data on the reasons for those cancellations. The primary reason is around what you've alluded to, which is around workforce and supervision capacity. Across all of our placements with the department over the last two years, noting that there's around 1700 or so placements per year, so around 3400 over a two-year time period, we've had 130 placements cancelled. Of those, around 90 per cent of them were cancelled by the agency, in this case the Department of Health, and the primary reason was around that supervision capacity. In those instances where a student is no longer

able to be placed, we immediately find an alternative option for those students. But that gives you a sense of the scale of formal cancellations of placements, so -

CHAIR - So, they're not cancelled for a shift, they're cancelled for the placement period?

Prof ZOSKY - For the duration of the placement, yes. If it's down to a shift-by-shift basis, again, we work with the students and the placement agency to determine what an alternative - I don't have any specific data on a shift-by-shift basis and how often that occurs. The data I was describing represents a whole placement period. The placement blocks for nursing and medicine are several weeks, so it will be a cancellation of a four- to six-week block of placement.

In terms of student feedback and getting an understanding, if it's an issue around student safety, we have formal reporting mechanisms for that. There's kind of two categories of it. One is we have a portal at the university that's called MySAFETY, which any safety incidents, hazards or near-misses can be reported. Students have access to that and can report directly into that, and so do the staff supervising the students at the university. I see every one of those in my role, so every single MySAFETY record that comes through, and I do monitor it. Over the last two years in the MySAFETY system, there have been 80 records of students reporting situations that have either been a hazard or have made them feel uncomfortable. That includes physical hazards as well. It might be a needle-stick injury or they might cut themselves on a glass ampoule, so it includes all those things. So, 80 records over the last two years. A small fraction of those are around the supervision experience or the supervision capacity, or something related to that. And a very small fraction of those are a more serious matter that would require notification to AHPRA or some other registration body.

We have a second system which is part of our response as a university to the gender-based violence expectations. We have a separate system where students can report matters related to behaviour, and we have records around that. In the last two years, there's been around 60 reports across Health. I should clarify that the MySAFETY record that I was talking about and this one that I'm mentioning now is actually across all of Health. It includes everything including non-placement interactions. Again, of those 60, only a small fraction were specifically related to placements and only a small fraction of those were related to serious matters. And there will be overlap between the two things. It depends on the nature of the incident or the hazard. Sometimes they'll be recorded in both MySAFETY and in the student-facing harassment and behaviour system.

Overall, in proportion to the number of placements we have, a relatively small proportion of incidents, only a small fraction of them related to placement, and only a small fraction that are more serious.

In terms of student feedback and their experience, we have a number of mechanisms for tracking that. All students, as part of their placement, are offered the opportunity to respond to a student feedback survey. It's relatively consistent across disciplines in Health. Nursing also engages in a national survey around placement, so we can do a bit of benchmarking. That's only relatively new, so we don't have any comparative data as yet. We also hold - and again, this depends a little bit on the nature of the placement and the discipline, but certainly, for nursing and medicine, and placements in a setting like the Department of Health, the schools run debriefing sessions with the students. So, they have multiple touchpoints where they can raise an issue. They can do it formally through one of our systems; they can do it directly to

their unit coordinator or our placement supervisors, or the placement team; they can raise issues through the survey; and they can also raise issues through the debriefing session. They're also provided information about how they can escalate things within the health service as part of the handbook. We do have a couple of examples where students have escalated outside the system, so, for example, going directly to AHPRA. AHPRA then contacts us and then we manage the situation together. We do also have examples where they've reported directly to the department and then the department has come to us about an incident or an issue that needs to be sorted, and we then work together to resolve it.

CHAIR - All right. It's good that it's being monitored so closely. I know anecdotally, and maybe you can confirm this, Graeme, in Burnie, for example, many of the student nurses there do stay in the region and are employed mainly in one of the hospitals there, the Mersey or the Burnie hospital. Is that the experience that you're finding? You would think it must be relatively positive if they want to go back and work there.

Prof ZOSKY – Yes, and you alluded to this earlier, Ruth. Our intent with Burnie is to do exactly that: to train students from the region in the region because we know that that is, by far, at least from an intent perspective, the biggest predictor of someone staying and practising in that region. We do have data for Nursing because that's the program that's had the longest timeline up here. Some of the end-to-end training for Medicine, our Psychology programs and various other pieces are a little bit newer, so we don't really have data on what the retention looks like. But the Nursing retention is reasonably good. Indeed, many of our nurses do choose to stay here. I do think nursing is an excellent example of the partnership working very well because we do have strong conjoint positions, particularly in Burnie, where they're employed both by the university and by the department. So, they really provide that conduit to not only a safe experience, but a rich and rewarding experience. I think that also assists with that likelihood of staying and being retained in the system.

CHAIR - Members of this committee will be able to have a look at the lab up there in February when we're doing an electorate tour up there.

Prof ZOSKY - Excellent.

CHAIR - Hopefully you might be there. I know Sonia will be there.

Prof ZOSKY - I'd love to. I'll make sure that I am here. I'll try to be here for that.

CHAIR – Yes, it is truly amazing. I know the medical degree only started being done right through this year, starting. How is that going in terms of interaction with the department, too, in this space?

Prof ZOSKY - Yeah, any increase in - so, we've done the clinical year training up here for some time, and you're right, Ruth, the end-to-end training, from year 1, the first years were in it last year, so they're just going into their second year at the moment.

CHAIR - Oh, last year it was? Time flies.

Prof ZOSKY - Yeah, time flies. We've just started first year in Launceston this year. We're also doing end-to-end training there as well.

Any increase in student numbers, particularly in Medicine, we do have to have a direct conversation with the department and the local hospitals around placement because it increases the placement requirements. We do that very early. Our head of school, of the Tasmanian School of Medicine, Ruth Kearon, who used to work in the department, has a really good working relationship in that space. She also sits on a number of the committees within the department to support that workforce development, particularly in medicine, and support strategies for retention of medical students once they graduate. So, it requires a negotiation, but we all have a collective understanding about the benefit of it, particularly in the north-west. As you would be aware, retaining doctors up here is a challenge, so the more we can work together to provide the placement opportunities and then, ideally, ensure that our Medicine graduates have a really smooth transition into practice if they want to stay here, that's one of the critical pieces that we're working on together with the department. We've highlighted that as a priority for this year - for all of our disciplines, in fact, but starting with Nursing and Medicine, to think about how we can ensure that the students have a smooth transition from training into practice, if they want to stay and practise in the public health sector.

CHAIR - Is Ruth's position a conjoint position?

Prof ZOSKY - No, she's fully employed by the university, but she sits on a number of committees as part of our support and collaborative relationship.

CHAIR - She's very good. She's worked in the system a long time.

Prof ZOSKY - She has. She has a very good understanding.

CHAIR - There's obviously less opportunities for the medical students in the hospital, but they also do the placements in the community.

Prof ZOSKY - They do.

CHAIR - But one of the focuses that's been talked about, particularly by the Rural Doctors Association and others, is around the rural generalists. Is the university delivering any of that rural generalist training at the minute?

Prof ZOSKY - We're not directly responsible for specialist training, but we support the rural generalist pathway through our collaboration through the - it sits in a slightly odd space, I would admit, but it's through the Centre for Antarctic Remote and Maritime Medicine. So, the rural generalist pathway is supported, from a university perspective, through that relationship with the leaders of the rural generalist pathway in the department, but also ACRRM, which is the specialist body that looks after that pathway. So, we're engaged; we are not directly responsible for the specialist training as part of it, but we support it. We do have, in Burnie, and we're looking to, funding pending, expand it into Launceston as well. We have something that's called the regional training hub that's based here, which is about facilitating that postgraduate training in medicine to deliver specialty training in place. We don't directly offer the training, but we facilitate it and help and assist through that regional training hub. That's its specific purpose. We've had a few examples recently where we have been able to train a specialist in Burnie and support them to get their registration as a practising specialist, which is really critical for the region.

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That's the other challenge, I suppose. Our focus is on, as a university, because of Tasmania's needs, we do very much focus on a generalist-focused medicine workforce, but we also need to find ways to support those specialty needs as well, and we do that through those sort of postgraduate facilitation roles that we can play as a university.

CHAIR - I wasn't aware you were doing that. That's interesting. So, that person you assisted, were they an overseas graduate that specialised elsewhere? How did they come to you?

Prof ZOSKY - I don't have those details about the specifics of that particular person. But the leader of the regional training hub is a conjoint position, is a practising specialist in the North West Regional Hospital. They also hold a role as the director of the regional training hub so, again, they can straddle the system, support students while they're doing their intern years and advanced training, and then support them into those - it's about us providing support to access facilities to support the training that they need to do, and to stay here and do it.

CHAIR - The colleges deliver most of their training for the specialities?

Prof ZOSKY - Yes.

CHAIR - But you can provide some support and access to resources and stuff?

Prof ZOSKY - Access to resources. Even pastoral care can be an important part of that.

CHAIR - Do you find that when the students come back from their placements - because we're hearing that some of the permanent staff of all our major hospitals are feeling pretty burnt out, they're feeling pretty undervalued, they're working long hours and all that. Does that flow through to the student experience? Do the students report that, or are they sort of shielded from that?

Prof ZOSKY - If a student feels like they are not getting the support or attention they need from the person supervising them in the clinical practice, they certainly provide that feedback, and we do get that feedback from time to time. I'm not aware of any systematic pattern in that. What I will say, though, is they probably are, to your point, Ruth, a little bit shielded from it because of the way that we support clinical facilitation. We have a number of different models. For some disciplines and some circumstances, we pay a fee to support the time of the clinician who's providing this supervision to the provider directly. We also have clinical facilitator models where they're either university employees or placement provider employees, and we provide some of the salary for them to actually spend their time specifically to support students. We also have some regional clinical facilitators, particularly up here in the north-west, that support it a little bit more holistically. Quite often there's a lot of support wrapped around the student. If the clinical supervisor who's an employee of the placement provider is under strain from a time perspective, there are ways we can still support the student.

I suspect it's a bit of both, Ruth. There are situations where the student doesn't feel like they're getting appropriate supervision, and we absolutely hear about that, then we respond in some way. But they are very well supported from a range of different mechanisms to ensure that they - because from our perspective, and as a higher education provider, we have two primary concerns. One is that the students are safe is the primary one. The second one is to ensure that they get the training they need so they can have the capabilities they need and be

able to demonstrate them. If we feel like they're not getting that, then we will find an alternative way to support them through that.

Ms GLADE-WRIGHT - What about follow-up after they've entered the workforce? Do you check back in with them after a year or so, or not really?

Prof ZOSKY - We do have some graduate survey-type things, but they're probably not specific enough to answer what I suspect you're interested in. We do have a sense of where they're employed, how long they stay there and that sort of thing. Medicine tracks their graduates pretty heavily, and they go all over the place, depending on the areas. But we don't specifically capture feedback necessarily on their experience. We only have data on, do they stay?, where do they go? We can only do that really for the registered professions because we can track an individual on the basis of their registration. It does become hard for us to maintain contact with graduates once they leave, because they do go into a range of different places.

Ms GLADE-WRIGHT - Where do they go? We've heard quite a bit that there's no incentives here in Tasmania. Are a lot of them sticking around, or not?

CHAIR - The medical profession, you mean, the doctors?

Ms GLADE-WRIGHT - Yes.

Prof ZOSKY - The doctors do go, indeed, all over the world. I suppose, back to my previous point, our intention of having end-to-end training here in Burnie and in Launceston is to address some of that challenge. Historically what would happen is all the students would have to do their years 1 to 3 in Hobart, so they would already be moving away from their region potentially, and then they might come back here to do their clinical years, or indeed some people who live in Hobart do their clinical years here. That reduces the stickiness and the likelihood of retention. We don't know the answer to whether we've been successful because we've only really just started, but that's really the intent of that.

The other critical piece there, which I did mention before and that's one of the priorities that we have with the department, is to ensure that, if the students do want to stay, that that process is as smooth as possible, so that there are no operational or HR, or appointment barriers to them to make them think that, 'Oh, well, I'm not valued here, where I want to stay and practise'.

CHAIR - Can I go back to the funding you provide to support those placements? How does that work for each of the different disciplines?

Prof ZOSKY - It's both discipline- and site- and placement provider-specific. There's different arrangements depending on the combination of those things, and there's not a consistent approach. That's one of the things, I think in my response, I mentioned. We're at a point where we're renegotiating the next placement deal with the department. Our intention is to bring some consistency to that because it does make it a little bit challenging for us to plan how we're going to resource placements when we have all these multiple different models, even within a single discipline. With the department, we have some variation between sites, and I do kind of understand that, because the nature of the North West Regional is very different to the nature of the Royal Hobart Hospital, so you might need to have a nuance there. But having

more consistency would be really helpful, I think, for the student experience but also for our collective planning purposes.

CHAIR - Do you have an estimate, if not an actual number, for the amount of funding you provide to the Department of Health, and whether you can break it down by north-west region, Mersey, Launceston, Hobart? Do you have that sort of information? We're just interested how much extra money they're getting from outside.

Prof ZOSKY - I don't have that data at hand, but I could potentially find out if the committee was interested.

CHAIR - It would be interesting, because we hear that there are various sources of funding that come in from external sources. Some of it is private patients coming in and that sort of stuff. But we're aware of a number of different amounts or funding sources that are separate to the appropriation in the budget. I'm trying to get an understanding of how much it is because it's a global budget for Health and it's a bit hard to pull it all apart. I imagine the money that UTAS puts in to support their students in various places is in that, but we can't see it, as such.

Prof ZOSKY - There are multiple different financial constructs around it. Sometimes it's just a fee for time, you know, so many students for so much amount of time is a fee per student. Sometimes we directly pay a partial salary of, say, a conjoint position. So, there are a range of different ways. But I couldn't give you an estimate of what the overall number is. Sometimes we wear the cost internally in that we employ the person who facilitates it full-time. A good example of that is our psychology clinics. Clinical supervision for clinical psychologists is very intensive. The accreditation requirements require one-to-one supervision for 130 hours over two years. The only way we can do that sustainably is to run our own clinic and directly employ clinical psychologists to provide that supervision training. That's an area that I completely understand, from a department perspective, is a real challenge. For them to provide that level of intensity of placement supervision is actually really difficult to do and we would need to find a way to support that.

There are all sorts of other funding constructs that make things very difficult, for example, in the private sector. We find physiotherapy placements very difficult because there are rules around what a student can and can't do for a billable activity, which means that students are limited in what they can do during their placement, so it's very difficult for private providers. So, there's a lot of complexity in the placement space that makes it very difficult to manage. I do appreciate the resourcing, from the department perspective, that needs to go into some of these placement arrangements, and we try to support that wherever we can.

Ms LOVELL - Thank you, Graeme, that was really helpful.

Ms GLADE-WRIGHT - Sounds like it's going really well.

Prof ZOSKY - Yeah, from my perspective, it is travelling really well. We've had a very clear approach to retaining. For us, we've always been very proud of - we would, at least, like to hope that we train a really highly capable Tasmanian workforce. We're really trying to lean into how we can get them to stay. There are some things that we can do about that, but the collaboration with the department will also be critical with that.

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CHAIR - Thanks very much, Graeme, for your time and for the submission. Hopefully we'll see you up in the north-west in February.

Prof ZOSKY - I will talk to Sonia and make sure that I'm here.

CHAIR - Do that, yeah. We appreciate you taking the time to appear and apologies for the bit of an IT hiccup at the beginning. We'll leave it with that and thank you for your time.

Prof ZOSKY - Not a problem. Thank you and I hope the inquiry goes well.

The witness withdrew.

The committee suspended from 9.45 a.m. to 9.58 a.m.

COTA Tasmania

CHAIR - Thanks, Jan, for appearing before the government administration committee inquiry into the financial and operational performance of the Department of Health. We have the submission from COTA. We appreciate that. It's pretty extensive and really helpful. So, thank you for that.

I know you have presented before committees before, but I'll just remind you that everything you say is covered by parliamentary privilege while you're before this committee. It is a public hearing; it's being broadcast and will be transcribed and form part of our parliamentary records. If there was something of a confidential nature you wish to share with the committee, you can make that request. Otherwise, it is all public.

Ms **JAN DAVIS**, POLICY OFFICER, COUNCIL ON THE AGEING TASMANIA, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Do you have any questions before we start, or you're okay?

Ms DAVIS - No. In your hands, Chair.

CHAIR - Goodo. Thanks for your the submission and for your willingness to appear before the committee today. I will ask you to introduce yourself and then perhaps make some opening comments in relation to the submission. We'll have follow-up with questions from there.

Ms DAVIS - Thank you, Chair. I'm Jan Davis. In this instance, I'm working with the Council on the Ageing Tasmania, COTA, and I'm their policy officer. My role with COTA is to ensure that the interests and concerns of older Tasmanians - and there are many of us, are represented across government and in any of the conversations where decisions are being made that are going to impact on older Tasmanians.

CHAIR - Before you go on, I forgot to introduce you to members of the committee you may not know: Clare Glade-Wright here, one of our newer members to parliament; Bec Thomas you probably know; and Sarah is online. Apologies for that.

Ms DAVIS - That's all right. I worked it out. One of the things that's been fascinating for me in doing this work with the Council on the Ageing has been the scope of areas of interest and impact of government on decision-making for older Tasmanians. The automatic assumption - and this is a really dangerous one, is that the only things older people are really interested in are aged care and health, and that's far from the issue. Whilst we have the highest population of older people in Tasmania than anywhere in the rest of the country, we certainly have also a large number of older Tasmanians, the majority by a long way, that are not involved in the healthcare system other than tangentially. What we're trying to do is to get people to understand that it's a very diverse population, and the needs and interests are quite broad.

Having said that, this is a health response and I want to make it clear from the outset that our intent in making this submission was not to address actual healthcare issues or any of the complaints and concerns that we see reported daily in the newspapers. Our purpose was to look at how we can get better accountability and visibility from the activities of the Health department, recognising it's such a big proportion of our state's budget. The points that I really wanted to bring home were that expenditure is not the only measure that we need to be looking at because, as we all know, we can keep spending money, but it doesn't necessarily bring better outcomes. If we're going to get better outcomes, then we've got to have more disaggregated data than simply statewide averages and age, you know, not distinction, not disaggregated data for age and regionality because that's where the disadvantage often falls. When you look at an average set of data, you don't see the things that need to be seen.

The second point I want to make is that, as I said, \$1.37 billion is a large proportion of our state's budget, and also in that \$1.37 billion was the largest overspend of any department. It certainly needs to have greater clarity and greater transparency so we can be sure, as a community and, obviously, as a government, that we are doing everything we can to address both the overspend and the spend itself.

The next thing is a saving is not necessarily an efficiency. You can save money and get worse outcomes. And that's something we see often across government when expenditure and activity is siloed. So, you might save money in one space but you end up creating a knock-on and more often more concerning effect in another area. So, we've got to make sure that, where there are savings, they do deliver either efficiencies or better outcomes. And from the data sets that we see, that isn't visible. That's particularly relevant when you're looking at transitional activities within the health system. You might save money in one area but actually create further problems. That is, if you cut expenditure on some service provision - and while the breast-care service wasn't necessarily a cut, it was a reduction for a whole bunch of reasons, what you'll find is you'll create a knock-on worst-case scenario further on where women will not be able to access the service and, therefore, there's a potential risk of cancers being not detected at a stage where they're treatable and you end up with a longer term care and concerns outcome for both the individual and for the system itself. So, it's not just about cutting or reallocating resources; it's about looking at the journey someone makes through the health system from the start to the finish and making sure that we can manage that as effectively and efficiently as possible.

Finally, if we're going to make sure that the outcomes from our health system for our population, whether it be older Tasmanians or anybody else, is delivering the best possible outcomes, we need accountability, we need credible milestones and we need transparent data. That means you can look at trend lines longer term, you can see where there are particular issues that need to be addressed, whether it's a regional shortage, whether it's something like

the breast-care bus or where there is something we can do better. And that's really important. To do that, we think there are three things that the Health department needs to look at within its operational structure:

We need to have a population-based performance framework with disaggregated data, measurable outcomes, credible milestones, and regular and informed decision-making about where there are gaps or where there are things that we can do better. At the moment we don't have that. The second thing we would like to see, and we think is a really good and standard measure for government, is where there are efficiencies planned, we want to see a cost-benefit statement to make sure that this is just not cutting funds and that the implications of those changes are thoroughly researched and understood. The third thing that we think is really important is to make sure that this data and these measures are publicly available so that there can be informed consideration and assessment of the decisions government is making.

The upshot of our submission and our view is that we support sound stewardship, particularly recognising the difficult economic circumstances the state faces. But we want to make sure that reporting frameworks and decision-making allow both the parliament and the community to tell if the resources and the decisions that are being made are actually improving outcomes longer term. Thank you for the opportunity to make that statement, Chair, and also thank you for the invite to attend. I'm happy to take questions.

CHAIR - Thanks, Jan. You covered a lot of the things you're recommending in that. I understand the request for disaggregated data. It's one of the things we often try and get out of the department during budget Estimates, to try and break down.

Ms DAVIS - Oh, I know. I've watched you try.

CHAIR - The best we can get off them is regionality data. But then looking at the breakdown of demographics is another step that is obviously critical in light of what you've said here. In terms of reporting frameworks, how do you think - I mean, the department will argue, and with some justification, there's a lot of push reporting through their dashboard and other things like that. What specific public reporting and transparent reporting needs to be made available so that we have a better understanding of how the money is used?

Ms DAVIS - Chair, that's a really interesting question. I understand the challenges the department faces, although with modern technology it should become easier and easier to break data down into more usable chunks. The two key things that - no, let me go back a step. Nobody expects everything to be done at once, nobody has a magic wand. We get that. But the two key things that are missing at this point to allow any informed assessment are, as you rightly pointed out, regional disaggregations, so not just down to the three, south, north, north-west, but more informed breakup of how those services are allocated and responded to. The second thing - and this is the most important thing, is some sort of age-based disaggregation so that we can see where the needs are and we can see where the gaps are, even if it was a fairly standard 65-plus, 50-to-65 type breakdown, because people's needs are very different at different stages in their lives. With that averaging, you're missing that ability to make those assessments more appropriately.

Look, we don't expect everything all at once, but there should be within the system the ability to do those two things, even if it's something that over time becomes more refined as we understand better how to manage the data and what the appropriate needs are.

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Ms GLADE-WRIGHT - Jan, I've got a question for you around access to, I guess, aged-care facilities after patients have been in the hospital. We've heard a lot that patients can be well enough to not be in hospital but they have nowhere to go. Have you got a comment around that for us?

Ms DAVIS - Quite clearly, I mean the conversation around this is public and energetic, I think is one way of discussing it. This is a national issue but it's particularly acute in Tasmania because of our ageing population. We're not delivering enough aged-care beds to be able to meet those needs. Even things like the Southern Cross-Calvary decision, where we've lost, I think, 90 beds over a period of time, any replacement is so slow that you're never going to catch up on the backlog we've got, let alone keep up with the increasing demand. Part of the reason for that is the fact that we don't have longitudinal forward vision of what the numbers look like. And where there are measures being taken to address that need, they're often concentrated, particularly in Hobart, not in the areas where we have specific regional and rural need. That's the issue. Everybody knows the population is ageing, everybody knows we've got a tidal wave of need, but nobody has the ability to make those quite fine assessments of where that need is and what that need looks like. And there certainly doesn't appear to be the will or the funding to be scaling up the investment that needs to be made to address even the backlog we've got now.

CHAIR - Another point you talked about was some transparency around savings and perhaps having a cost-benefit analysis of savings measures. What we're observing and hearing about a bit in this area is that delays to filling positions where those positions are actually agreed positions that need to be filled to deliver the care that's required, in the hospitals particularly. There's this situation where they are taking a long time to fill for a variety of reasons or they're left vacant for periods of time. And part of this is the pressure that the government's putting on with the vacancy control processes they're using. They did say they wouldn't attack frontline workers, but it seems that maybe that's not quite right. Then that's creating other costs in the system. The money not spent notionally seems a saving, but are we not capturing the money spent that sits alongside that, of the increased overtime, the double shifts, the increasing agency locum staff, that sort of thing. Is that the gap here, do you think?

Ms DAVIS - It's certainly one of the gaps. This is the point I made about you might make a notional saving in one budget line, but push the costs out into another part of the department or another agency. That means that that saving is imaginary because it's creating not only an increased demand now but particularly in the Health portfolio, it's creating an increased demand and subsequent cost as you move further down the path. The longer things get delayed, the worse the outcomes become.

To pick up on another point you made, too, which I think is really important, that the government has made commitments not to cut frontline services, their definition of 'frontline' is quite confusing. The implication that people that are not - even if you accept that definition, that people that are not front-facing are not integral to the delivery of the service is absolutely bizarre. Somebody has to keep the lights on, get the floors clean, provide the equipment, roster the doctors and the nurses. They're not frontline services, but you can't deliver frontline services without an efficient and effective back office, if you like to call it that, that's doing it. This delineation between so-called frontline and not frontline, to me, is spurious and misleading, and certainly not assisting in delivering better outcomes either financially for government or in terms of the service provision for the community.

CHAIR - It's frustrating because you've also got the admin staff who make the appointments, and on the other side there's the billing. If you're not billing private patients and things, then that's revenue forgone.

Ms DAVIS - And somebody has got to be watching all that because part of the Auditor-General's report has been about the management of financial systems within this agency. If you don't have sufficiently experienced admin staff, they're not checking that the bill matches the quote or that the payments are in line with what they should be, and somebody's not overcharging and there's not fraud going on. Those positions are as important to the system, in many respects, as our front line, or so-called front line. I know it's not germane to this particular inquiry, but that definition of 'frontline' and the approach that's being taken is, to me, pea and thimble, I'm trying to think of nice words that won't have to be cut out there. You can imagine what's going through my mind. I'm thinking particularly about the proposed cuts to Service Tas. We're being told that there'll be no job losses for these people. What are they going to do? Sit at the back and make cups of tea instead of having their doors open?

CHAIR - Don't start me on that one, Jan.

Ms DAVIS - Look, I know. And the cumulative and often insidious disadvantage to regional and remote communities exacerbates things particularly in the Health portfolio, where they can't get to appointments, there's no transport, all these things. It's just this constant overlaying of one thing at a time, which individually might not look like it's of significance, but when you add it all up, people in rural and remote communities in Tasmania, particularly people who are elderly or disadvantaged and don't have access to their own support networks, are suffering serious disadvantage that often results in serious health outcomes for them and for the people who need to look after them. It's not good enough.

Ms LOVELL - Jan, in your submission you talk about the risk that arises for older Tasmanians between services or post-discharge, and the lack of data around readmissions and what's happening in those spaces. What is COTA hearing from your members about those experiences and what's happening there?

Ms DAVIS - We get calls every day from people who are stressed beyond belief about falling through gaps in health systems. For example, I spoke to somebody the other day that was facing a health issue that's been diagnosed which needs a succession of appointments. They've had to have radiology, they've had to see specialists. They're now on a - I don't remember the exact number. It's 542 waiting days for an appointment to see a neurologist. They've seen the first specialist. Tick that one. They've had the radiology. Tick that one. If you're looking at individual KPIs, those KPIs for the system have been met, but the outcome for the person is not a satisfactory one. I was talking to somebody the other day that has been waiting, on a repeated process, for a prosthetic leg that they can use. They've had two goes at it, but they've not been appropriately fitted. And that's not unusual for a prosthesis. To keep going through this process, she's now been, effectively, two-and-a-half-years without a leg she can walk on. Yes, she's seen the specialist; she's seen the person who does the prosthetics. So, those KPIs are ticked. But she still hasn't got a leg she can walk on.

Ms LOVELL - In terms of the performance of the system, too, you can imagine those kinds of delays are leading to more expensive, more intrusive types of treatments being required.

Ms DAVIS - Absolutely. Sarah, this is part of the problem, too. Some of this becomes invisible because of the split in service provision and costing between state and federal governments as well. You can lose that visibility in that gap as well as within our own internal Tasmanian systems.

If you look at that woman with the leg - well, without the leg, more to the point, she's now almost exclusively reliant on support-at-home services because she can't get out. That's an increased cost to community. It's not necessarily a state-based cost, but then you get all the issues around, well, because she can't get out, she can't do anything; the rest of her health is declining and that then becomes a burden on our state system through hospital and medical treatments that, had she been able to continue the life that she'd had when she had a leg that worked, wouldn't be an issue for her or for us.

Ms LOVELL - Not to mention the human cost, of course, for her.

Ms DAVIS - Exactly. This is what I mean. Layer and layer and layer of disadvantage results often in insoluble problems that could have been avoidable. And that's human cost, it's financial cost, it's community cost. It's just this unnecessary creation of stress in people's lives, whether it be her, whether it be her family, whether it be the carers, whether it be anybody else involved in the system, that we don't need to create. There are pathways where this could be avoided.

Ms LOVELL - Thank you.

CHAIR - Another point that you raised was recommendation 5, to include patient and carer outcomes. We've had discussions with the Auditor-General and others about the lack of outcome performance information, like patient outcomes, whether the expenditure links to patient outcomes or it doesn't. Not that we can ascertain how it does that. You also explain this a bit further where you said:

Measure whether people understand discharge arrangements, obtain prescribed follow-up care and remain safe and well at home; and whether unpaid care is appropriately included and supported.

I think that's a category of people who aren't captured at all, the carers. Having helped older parents with health issues, often hearing deteriorates and sometimes, myself included, medical professionals talk too fast -

Ms DAVIS - Oh, my word.

CHAIR - Yeah, or have - and this is just a reality, have accents that are difficult to hear for some people even with hearing aids and things like that. So, it makes it hard for that information to be received and understood. It's not that [inaudible 10.24.06] was not provided. And this is particularly an issue, I think, for the older cohort. How do you see that needs to be addressed? If they just then cycle back because they haven't understood which medications they've taken, they take the wrong ones, or they don't go and have the follow-up with their GP or some other healthcare provider, so their condition deteriorates, they circle back. Have you got further views on that?

Ms DAVIS - There are no quick fixes for some of this stuff and, as I said earlier, we don't have magic wands. But in an ideal world, we should be doing better than this. Some of the solutions are more accessible medical care, particularly in the regional areas and the smaller regional communities, with less of a pressure on the medical provider to push people out the door in 10-minute slots. You need to be able to spend the time to be able to have a conversation with somebody who understands your issue and recognises the challenges you might have so that you can, as an older person, particularly an unaccompanied older person, you can be sure that you can trust what you heard and that you can understand it well enough to follow the instructions. That's a multi-layered issue. It's about access to services. It's about doctors and other medical professionals that know the patient, that have some continuity with the relationship. It's about making sure there's enough time to have a meaningful conversation. It's making sure there's enough systemic connection to ensure that follow-ups are actioned, both by the patient and by the system itself.

I personally had a situation not that long ago where I went and had some tests and I never heard anything. I assumed the doctor had heard something and, when I went back, the doctor didn't have the test results, I didn't have the test results, they'd gone off into a black hole somewhere. Fortunately, in this case it wasn't an issue because there was nothing that they needed to do. But had it been something that was of concern, and the fact that I followed up and went back, not everybody has the capacity to do. I don't know. I mean, there's no easy fix, Chair. But there are things that we can do that reflect better outcomes for the individuals and the community that don't necessarily mean a whole bunch of costs either.

CHAIR - So I guess it comes down to -

Ms DAVIS - Sorry, just to pick up on that, that's an important consideration. If, again, you look at government in its entirety rather than siloed, the state government has set preventive health targets and that will require investment. At the moment, we only ever tend to look at stuff when it's become a crisis rather than looking at a pre-emptive preventative investment where we could stop stuff becoming costly and impactful as well.

CHAIR - Just going back to that, I accept that comment, and the previous issue about accessibility. You do talk about healthcare providers knowing the patient and knowing whether they can read, if you're giving them a leaflet to take home; knowing whether they can hear, or hear well; knowing that they've got a level of functional literacy that would mean that if you give them something written, they will be able to understand it. Does there need to be some - well, that can fit across the whole cohort of Tasmanians, but particularly in the older people, who don't readily go online to access information - some do, but there's a lot who I know don't, and don't want to, and they don't trust it for a start, which you can understand why you wouldn't. But is there a need for some other person or intervention in the middle of all of this?

Ms DAVIS - You raise a couple of really good points. The first one is, specifically for an older population, most of us were, from a young age, inculcated with the belief that you didn't question the professional. The doctor knew what the doctor was doing. And that has led, as I'm sure you've all seen and experienced, people who might think not questioning because they don't feel comfortable doing that. We need to recognise that, too, and, I don't know, have some sort of interpretive measures - not interpretive dance, but you know what I mean, where people can feel a bit less uncomfortable about questioning a medical professional.

That goes back to trust in the system, too, because, again, people of an older cohort were used to having a family doctor and they were used to somebody who knew them and had followed whatever the issues were; whereas now, quite often that isn't the case. And there's an assumption on the part of the patient that the doctor knows the history when the doctor might not, and that will lead to not an ideal outcome without that background. That's the first thing. There are issues around that. And there are issues around younger and less community-experienced - so, people who haven't lived in rural and regional communities for a while that are providing medical services that don't understand the context in which that advice is being offered. Like, you know, 'Go and get a test'. When you live out the back of, you know, Marrawah, going and getting a test is not the same as in Hobart, where you can line up and do it without a great deal of drama. Particularly transport is becoming more and more of an issue that we hear about for older people. That's a conversation for a different place, but it is one of the factors.

The second point I want to pick up on that you made, Chair, is a really important one. It's across government, it's not specific to the Health department. It's the propensity we're seeing more and more to push more and more service online, without other alternatives. We had a long discussion with Service Tas earlier this year where their intent - and I believe it still is their intent, although they've been a bit more measured about it, is to push the concessions guide and all of their service offerings online. We know that much of our community doesn't have the capacity to do online stuff, whether it be a literacy issue, whether it be an unwillingness to trust, as you've just pointed out, or whether it be something more basic, like they don't have a computer and they don't have connectivity. There are lots of black holes across Tasmania where even the most computer-literate person has to stand on the roof of a ute to get a signal.

CHAIR - Or they have severely arthritic hands, which makes it difficult to use a keyboard or a phone.

Ms DAVIS - Exactly. And a phone. I mean, I had an issue myself the other day where a banking facility wanted me to use an app on my phone and I won't do it, (a) because I don't like the app on my phone but, (b), I simply can't see well enough to be able to do something as important as transfer money on a phone, so I won't do it. And I'm fairly computer-literate, don't have a lot of the challenges that other people have. There's all this hidden barrier that we all subconsciously recognise but isn't accounted for anywhere in the systems, that we need to bring out into the open and take steps to address. Some of these things are not expensive and some of them are not difficult, and some of them simply require us to recognise that change engagement with government systems, or anything else for that matter -

[Teams connection lost 10:32:43 to 10:33]

Ms THOMAS - Oh dear, frozen.

CHAIR - All going well, until it's not.

Ms DAVIS - in some cases age through the process and allow those people who are legacy attitudinal situations to do so with a bit of dignity. And that's what it comes down to.

Ms THOMAS - Thank you, Jan. It's been interesting to consider your submission and to hear from you today. I have two questions on different topics. Firstly, in terms of COTA's engagement, if any, with the department or the hospitals about care for elderly patients with

cognitive decline in hospitals, has COTA had any engagement with what that model of care looks like and what some of the requirements might be for staff across the staffing spectrum in the hospital? So, not just for nurses, but other people who assist patients with cognitive decline or experiencing cognitive impairment at the time they're in hospital?

Ms DAVIS - There's two answers to that question. At an individual level, we have a team of care finders that are funded through the federal government, and they work with individuals on their specific circumstances and needs. So, our care finder team does have that sort of conversation, but it's at an individual level, not a population level. The engagement with COTA at a community-wide level on these conversations is almost non-existent. There seems to be no willingness to have conversations with not just us, but other groups with specific interests. We're treated as outsiders and left out of those conversations.

Ms THOMAS - I'm sorry to hear that. Do you hear stories of where, despite the absolute best intentions of the staff who are on wards, perhaps lack of sufficient resourcing leads to adverse patient care outcomes, particularly for older patients or patients with cognitive decline?

Ms DAVIS - All the time. And I want to make it really clear: most of the staff that work within the system have the best of intentions and do an extraordinary job under very, very challenging circumstances. It's not generally something that - the adverse outcomes are not generally things that are down to ill will or malice; they're down to an absolute lack of resourcing. And the frustration and distress that that causes to the care providers is as palpable as it is to the people we talk to who are on the receiving end of these outcomes. So, it's not about individuals; it's about systemic change.

We had an email yesterday from a chap in a nursing home. He's 84, and there simply aren't enough care providers to look after the people there. He was left in a shower the other day - Tuesday, I think it was, with nobody to attend him because an emergency bell had gone off and their instructions are they have to respond to the emergency, and leaving him sitting in a shower wasn't classed as an emergency. So, it's often the cumulative effect of the things that, by themselves, you might be able to cope with. But when you layer them in, particularly with somebody who's in a stressed, emotional state, in an environment that's not familiar to them, facing all sorts of frightening processes and procedures, that it becomes overwhelming.

Ms THOMAS - Is there any particular thing in the hospital setting that could change to improve those outcomes in terms of resourcing? Is there any specific resource that there could be more of?

Ms DAVIS - Look, I mean, that's a 'how long is a piece of string?' question, isn't it, because whichever bit you pick - I mean, the same comments apply to me picking solutions as they do to people making other decisions. You might say, well, you need more frontline staff to look after people in waiting rooms; you need to make sure that we don't have people waiting in beds when they could be out doing stuff somewhere else. Ultimately you come back to the raw, hard fact that there are limited resources and often, as much as I've just said this is an issue for the system, these are almost unfixable problems. Where you take money from one thing, you create a problem somewhere else.

I think, to me, it's a bit of the case of if you keep doing the same stuff, you'll keep getting the same outcomes. We need to have, you know, whilst we deal with the everyday, we need to get some of the best brains together in a problem-solving manner to look at, okay, well, what

could we do that would give us better outcomes outside the guardrails of what we do now? So, you know that brainstorming, blank sheet of paper thing. It won't solve problems now, but what we have to do is recognise the increasing ageing of our population and the extraordinary demands that that's going to put on a system that's already struggling. We've got to do things different. We can't keep doing the same stuff.

Ms THOMAS - The other question I have is, obviously, there's been change for COTA in terms of how its funding agreement with the government is managed. I wondered if there's any insights you have to share with the committee about that transition now from the Department of Premier and Cabinet to having your funding agreement managed through the Department of Health, and if there's anything you'd like the committee to be aware of in relation to that change?

Ms DAVIS - This one's a bit like the curate's egg. It's an interesting question, and thank you for asking it. There are good things to the change and there are not-so-good things. The good things are: it was quite easy for something, someone, some group like COTA to be lost in DPAC because there was such a plethora of groups and things happening there. So, we did sometimes feel that we weren't quite where we needed to be to get the airspace that we needed. But the challenge in going into the Department of Health. And, again, this is not a personal criticism of any of the people. To date, everybody we've dealt with has been fantastic.

However, what our longer-term concern is that, by moving COTA, and some other groups, into the Department of Health, you're reinforcing the assumption, the perception, that the only issue for older people is health and the healthcare system. Whereas, I can't remember the exact figure, but it's something like less than 10 per cent of older Tasmanians are involved significantly in the healthcare system or in the aged care system, and the vast majority are out there in Seniors Month playing mahjong and learning how to ice-skate, and doing a whole bunch of other things that are everyday activities. Health, where it's an issue, is one of a mix of things that we have to deal with. So, the concern longer term is that we don't become invisible outside the Health portfolio.

CHAIR - It's so much, isn't it? We now have, for a few years now, have had a minister for the ageing. There's no line item in the budget for that; it's tacked on currently to the Minister for Health. Do you think that sends a mixed message? And how should we do it, because we know that aged care and those matters are a federal government responsibility? I'm not denying that at all, because it absolutely is. But I'm just thinking: are we misleading by even having that position with no funding and then no clear remit?

Ms DAVIS - That's a really interesting conversation. The Minister for Ageing, minister Archer, will be convening later this month the first meeting of the Older Tasmanians Ministerial Advisory Council. This is the first visible deliverable that we've seen from that portfolio. Again, there's a very well hidden and quite small budget allocation to service that committee - nowhere near enough but it's a start, and it will enable the older persons community to have a bit more of a voice. But, without some specific - we're back to measures and accountabilities, without some specific data and some specific requirement for other agencies to reflect outcomes for older people in their activities, then we're not going to see any great progress, I don't believe. One of the most useful things that the Ageing portfolio and the minister, in particular, could do is to work to dispel the pigeonholing of older people into a stereotypical, you know, older cranky person who can't do computers and won't do a whole bunch of other stuff; to recognise that there is a large majority cohort of older people who are

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just getting on with stuff and recognising that - this is a bit a bit of a trite saying, but 70 is the new 50. Now that we're all expected to work into older and older age, how are we going to deal with that? What are the provisions that are going to be made to recognise the fact that when I was young, my parents' generation retired at 55. They went off and played tennis or golf.

CHAIR - And they seemed old, didn't they? But maybe it was just because we were young.

Ms DAVIS - They absolutely seemed very old, Ruth, they really did. Whereas many people are working well into their 70s, and that's not something that's unusual in a workplace these days. So, how do we recognise that ageing is a changing perception and age is not the measure of a person? It's one factor in how you assess what people need and how they engage with communities more broadly

CHAIR - Thanks, Jan, for your time today. Are there any closing comments you wish to make, something you wanted to say and haven't?

Ms DAVIS - No, Chair. The only closing comment I'd make is to once again thank you for the opportunity to submit, to speak to you, and to make a very, very clear statement that COTA's interests are not just in the Health portfolio area, but we are there at any stage if we can provide any input or assistance. It's what we're here for. Please make sure that you're not shy in reaching out to us, and I know none of you will be.

We, as a community, have an opportunity to change the way we deal with ageing, from young age to older age, it's not just about older people, and to develop a more resilient approach to communities, both in terms of the age descriptors, but also how we empower regional communities to be more resilient as well. We want to play a part in doing that, and this inquiry will be an integral part of assessing how we can do things differently moving forward.

CHAIR - Thanks very much for your time, Jan, we appreciate it.

Ms DAVIS - Always a pleasure, lovely to see you all.

The witness withdrew

The committee suspended from 10.47 a.m. to 10.59 a.m.

Dr John Lambert

CHAIR - Dr Lambert, thank for your appearance before the Government Administration Committee A Inquiry into the Financial and Operational Performance of the Department of Health. We know you have a specific area of expertise here that we'll be keen to hear from you in.

This is a public hearing. Everything you say, though, will be covered by parliamentary privilege. It is a formal proceeding of our committee that may not extend beyond the committee hearing. If there are matters of a confidential nature you wish to share with the committee, you can make that request and we will consider that. If that was relevant, we would - not that there's

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anyone else in the room at the moment - but we would clear anyone else in the room and ensure the confidentiality of that session. I will invite you to take the statutory declaration if you're happy to do so.

Dr LAMBERT - Yes. Do I have to read it out? I got sent an email, but I can't find it.

CHAIR - Well, I can read it for you if you like and if you can just confirm. Do you, Dr John Lambert solemnly and sincerely declare that the evidence you're about to give the committee is the truth, the whole truth and nothing but the truth?

Dr JOHN LAMBERT, FORMER CHIEF CLINICAL INFORMATION OFFICER, DEPARTMENT OF HEALTH, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED via TEAMS.

CHAIR - Thank you. Over to you in terms of we were interested to hear about your experience with Bluegum project. This is a matter that we raised a number of questions around, particularly Bec Thomas at the table here, in relation to the expenditure on it, the procurement processes et cetera. There's also the history of the HRIS project that's now the HRTM TP - whatever it is -

Dr LAMBERT - H RTP.

Ms THOMAS - H RTP, yep.

CHAIR - Yeah, TP project, in DPAC now. We're looking at the operational financial performance of Health here, which is having pretty significant impacts with the digital transformation piece they're doing. So, we're happy to hear from you with whatever information you're able to assist the committee, because this is a large expenditure.

Dr LAMBERT - Yep. Apologies, I've actually only six weeks ago finished treatment for head and neck cancer, so, my saliva is still not normal and I may need to stop and clear my throat and drink water a bit more frequently than I might otherwise.

I was brought down to Tasmania fairly late in the process of the Digital Health Transformation Program, as it was then called. So, I started - I hope I got my years right - early in 2025 and I finished up earlier this year. When I was offered the position, I was assured that the full funding for the project was already obtained to the tune of, I think, the number was about \$430 million. I'm sorry, it's been a while, so I haven't got all the numbers in my head, but I'm sure you can find them if you need them. I then found out that in fact Treasury had only approved a much smaller number to the tune of \$30 million a year for 10 years, I believe, and the rest was to be made up with Department of Health contributions.

At the point that I had arrived, there had been a very extensive tender process with multiple respondents and they were at the preferred applicant phase. There were two vendors that were deemed appropriate and the preferred applicant had been chosen, and I was part of the process that publicly announced that to be Epic, and we were in the negotiation phase for the contract.

The project had already - sorry, the Digital Health Transformation Program consists of many, many projects. The EMR is only one of them. I have to be honest, in the year that I was

in the role of CCIO and I took over - so, I arrived in January or February, but I took over responsibility for the projects from Brent Feike, the CIO, the chief information officer, only in about the end of May, from memory.

When I inherited those projects, they were in a lot of trouble. There was, in some cases, absent governance or infrequent and ineffective governance, the projects were invariably over schedule, over budget and not delivering their initial scope of effort. So, I and Brent - and look, I'll be honest with you, Brent Feike, the CIO, I have a lot of regard for. He was very much my partner in crime and we worked very well together. He was responsible for the HRIS project, or at least for a period of its time. Then, I think at the request from the then-secretary of Health - hyphenated name, I've forgotten her name - in charge of DPAC - I've forgotten her name now, but I think you'll know.

CHAIR - Kathrine Morgan-Wicks.

Dr LAMBERT - That's it. Kathrine Morgan-Wicks, thank you. At the request of Kathrine Morgan-Wicks, moved over to Health and I think at that point the HRIS was handed over to a different department and became the H RTP. I have nothing to do with H RTP so I can't comment on that project. I know that Brent was very concerned about the project and felt he did his best and you'd have to talk to Brent more about that.

But in terms of Health, he and I had to work hand-in-glove because his team was responsible for the more technical projects: putting in networks, putting in computing hardware, server backend, the technology side of an installation. I was more responsible for the overall program delivery and the change management and the adoption.

At the phase I turned up, most of the projects were in fact technical, apart from the EMR. The projects were definitely being run very much as, as I said, IT projects. The understanding of the impact of change and the humans and the clinicians - I'm a clinician by background primarily, I've spent 25 years working as a doctor - so, I get the viewpoint of the clinicians. So, a lot of my work was to improve the awareness of the impact on the business and the delivery of health care as opposed to the technical nuts and bolts of machines that go ping.

That was the initial work, and then as part of that work I was aware that there really wasn't a lot of awareness of what the digital health transformation program was going to do; it was a bit of a mouthful anyway. That's when we changed the name of it to Bluegum. That actually happened I think about the same time as I took over the project. I think it was about May.

It was then, actually, that I realised that the government support for this project wasn't as strong as I thought, because if this was really and truly a high-priority project for government, they would want to sing the song and dance about the project. There were repeated delays in announcing Bluegum, and in fact, in the end we never did announce it. We only announced it internally. The minister's office, it was about the time of the second election. There were other priorities and I have to be honest over the remainder of my year-and-a-bit with Tasmania it became very clear to me - and I don't mean this as an insult or in a negative way - it is simply a matter of, in my opinion, fact, and it's totally okay for governments to do this, but it was clear to me that the government was more interested in building a stadium than building a transformed Health system.

That then impacted everything, because as you probably noticed, the funding contribution to Bluegum keeps on getting reduced. Currently, they have very little funds to get through to the end of the year. The signing of the contract, which was so urgent I left a job in Darwin for a one-year contract, which was a mistake, has still not happened. It probably won't happen until June next year. The funding of the entire project for the EMR component of the project is inadequate currently, and the overall envelope of funds to do all of the necessary prerequisite projects is absent as well.

I'm very concerned because, without the prerequisite projects, they will never be successful at rolling out something as big and complex as Epic.

Overall, I felt I was attracted to Tasmania because it looked like you had a decent budget for a whole-of-system transformation that included an EMR, but the reality when I turned up was very much not the case and it just kept getting worse. The amount we were allocated kept getting cut. Originally, I think, for this financial year it was \$30 million, it was cut to \$20 million or \$18 million or something, and then Dale had to make up the difference.

Reading between the lines, it became very obvious to me that the government was not really interested in delivering the Bluegum Health Transformation, and that's about when I left and, subsequently, the things that I expected were going to happen, happened.

In terms of the financial performance inside the organisation of the projects that we were running, as I mentioned, they were all over budget, over schedule, not delivering on the original scope - which is a very bad look, and the governance of the projects was not really up to scratch. I actually managed to convert all the projects back to a green status. We had a wall of red that had been that way for over six months. Brent had delegated the management of the projects in question to Lisa Hagstrom and when I went under the bonnet and discovered all these projects were in this state, he was actually as horrified as I was. He hadn't realised that they were in that state. And I took until basically the end of the year to get them all back online with proper governance, with well constituted steering committees.

I couldn't fix the overruns, or the budget overruns, but I could at least get a better idea of the ongoing expected duration and budget. That, of course, wasn't received very well by the people who were responsible for the projects before I arrived. I did my very, very best to not make it personal. These things happen, I get it, there's priorities, people have different skill sets, et cetera, but I couldn't deny that this is what happened and I was employed to fix it, so that's what I attempted to do.

I know that there's been a lot of commentary in the public forum of the use of contractors. Tasmania is actually in a really, really difficult position. You're an island across a ditch. It's hard to attract. You don't have a big population; you don't have the skills required to deliver these sorts of digital health projects. These sorts of digital health projects are best managed by a group of people that are very small in number. Even in New South Wales, we had trouble getting the highest-quality people to deliver these projects. It was really interesting, and I've done this job in New South Wales, Northern Territory and Tasmania. Obviously, Northern Territory's the worst of the worst cases in attracting people up there, but in Tasmania it was worse because unfortunately Treasury imposed some rules on Health that were very disadvantageous to sensible digital health projects. We could not offer any decent person - and there are many reasons why people only work as contractors and will not take an employed position. I know everybody wants people to be employed, and Tasmania is a highly unionised

state, which is great, I'm a union member myself. But the reality is that there are certain people we need for these projects, if they're going to be successful, that you cannot employ other than by contract, and to expect a person to move from the mainland or overseas to Tasmania for a \$100,000 rollover contract, which is the only mechanism that Brent was able to employ contractors short-term for this sort of work, was just ludicrous. And the work is too dynamic and changeable to go to tender every time you need a team to deliver a certain piece of work. You need to what we call 'body shop'. You need to find a person that does a certain job for a period of time, but you need to offer them usually a contract that lasts the duration of the project, so that might be two, three years. And these \$100k rollover projects were just for the birds.

That caused massive problems in trying to recruit appropriate people and largely led to a lot of the projects not running as well as they could because we couldn't get the right people in Tasmania to do the job. And that's a Treasury imposition, not a Department of Health imposition.

I know Brent and Dale tried very, very hard to get that changed for this area, but Treasury really just didn't want to hear about it. And eventually they reversed the initial approval that they gave to Brent to use this \$100k rollover contract approach to employ people.

We had people who were employed - well at least the year I was there, but often many years beforehand - who were just every \$100,000 we had to renew the contract and offer a new contract and go to market technically to get them employed. And it was very unsettling for the contractors who really didn't know whether they were going to be employed in the next three months. And as of, I think, about two months ago, all of them were abruptly terminated when Treasury took away the permission they had given Brent in the past, so that was a real mess and even fixed-term employment has now been terminated because of the budget situation with the project.

There's a lot of different factors involved, but inherently using contractors - and generally they run on about 50 to 60 per cent of the project team for this sort of project - is very expected and reasonable for these types of highly specialised digital health projects, and I can back that up from three jurisdictions I've worked in, plus working in the private sector, servicing all the states and territories of Australia. I'm very confident that doing anything to impair that is not actually very sensible. And if you manage the contracts well, and if you can offer a decent length of time on a contract, often the total price of employing somebody under a contract is not that different to employing them, when you add in leave and super and all the other things you have to pay for an employee which you don't have to pay for a contractor - labour-hire contract I'm talking about.

I think those are the main things that I'd start with and very happy to answer any specific questions, or if you have any questions about what I've said or concerns. Sorry, I may have spoken too long without stopping.

CHAIR - No, it's helpful to get the history. I'd just like to start, and I'm sure there'll be other questions, but you talked about - there were lots of things you talked about, but the questions about the lack of governance, I'd just like you to expand that out a bit more in a moment, about what that actually looked like and what that meant and the impact it had.

The other point you made was about the procurement process with these just under \$100,000 contracts. You made the comment that ideally a contract to deliver a project would last the expected duration of the project. Why was that never done?

Dr LAMBERT - There was literally no mechanism allowed by Treasury to do so. It was specifically barred by Treasury. I believe the intent was to increase use of local resources, but the only possible way to employ people in the ICT space - and it's specific to ICT, information communication and technology - was by going to tender, which is simply impractical for these roles. I tried everything I could. Brent was actually responsible for all contracting of staff, so he'd been trying for years before that. He'd been trying when he used to work for finance or legal branch, one of the other departments. It has been an ongoing bugbear forever and the sooner Treasury realise that that policy is counter to effective delivery of ICT projects in Tasmania, the better Tasmania will be.

Ms THOMAS - Can you just expand on that a bit further? What when you say it's simply not practical for IT roles -

Dr LAMBERT - No, not 'not practical' - not possible. Not allowed to, we're not allowed to employ -

Ms THOMAS - Sorry, I'll be a bit more specific. You said going to tender simply isn't practical.

Dr LAMBERT - Correct.

Ms THOMAS - But what we've seen is that the same contractors have been given multiple contracts rolled over.

CHAIR - Some concurrent as well.

Ms THOMAS - Some concurrent, that's right. Why couldn't it -

Dr LAMBERT - I'm not aware of anybody given a concurrent, that would be insane, but anyway. Unless it was 50 per cent, 20 hours a week for one project and 20 hours a week for another project, that could be considered concurrent, but it's actually two half-utilisations of a consultant, but that's very rare.

CHAIR - It could have been that. When you look at it you can't tell from the data that we have access to on the tender site.

Ms THOMAS - It is difficult to analyse it. Can you explain a bit further to someone who doesn't work in the space why organisations wouldn't tender? If clearly they're getting paid a lot of money over a long period of time for multiple contracts, why not do it through a tender process?

Dr LAMBERT - It's also about the nature of the tender. Generally speaking, labour hire, as in employing an individual with certain skills to do a certain job over a period of time, is not something that fits into the tender model, because there's no deliverable that you can measure against. The problem with these projects is we often don't have enough detail on exactly what is deliverable to actually give enough parameters to attend the applicant to effectively price

against the tender. What happens is the risk of delivery is so high, they have to overprice, sometimes in the order of 30 to 50 per cent.

A tender would have to say, 'We need this person' - there are lots of different types of people. There's business analysts, there's architects, there's back-end developers, system configurators, project managers, program managers or directors. There's a whole lot of different individuals you need on a project and they vary at different times and some will come on early and some will come on late and some will come on for the whole project, some will come on for part of it. If you tried to define that as a deliverable that you'd go to tender, 'I want you to deliver this particular piece of software or this particular architecture document or this particular project', it takes an inordinate amount of our time to actually write the specifications for that, sufficient that you could actually hold a company accountable. But the uncertainty of delivery because of all the external factors that the person responding to the tender has no control over - availability of doctors and nurses, availability of executives to make decisions, timing of decision-making there is so much risk involved that they literally have to blow out the prices. So, in the end, going to tender is impractical because it's almost impossible to define these end points until you've run the project, because projects are absolutely sort of defined by uncertainty, in many respects. The workload is huge, the cost is higher, and so nobody would ever do it. But to make matters worse, the Treasury stipulation doesn't allow a tender for labour hire. You have to actually say, 'I'm going to go to tender for somebody to deliver this project scope,' and again, that then becomes a tender management process of a very, for many of these projects - so that was another problem. The vast majority of projects I inherited had very poor scope documentation, so there was no actual clarity over what was actually going to be delivered in many of these projects, and so that then becomes a very challenging process. Hope I'm explaining myself reasonably well.

CHAIR - Yes. So, if the scoping of the projects - and I accept there's multiple - was such a mess -

Dr LAMBERT - Especially for the more clinical ones, yeah. Less so for the technical ones.

CHAIR - The rostering system, things like that? Or what are we talking about?

Dr LAMBERT - My focus is very much clinical, so there was a meals management system, the EMR itself - I have to remind myself, but there wasn't just one EMR project, like, there was a billing system. These are all projects that require a huge amount of change management; people and process change. Those projects were less well scoped, where it was about, 'We're rolling out a network to this location, which is going to require this much length of cabling, and this many switches, and this much working rooms.' They were better scoped, because that's sort of a more well-trodden path and less human change involved in rolling out networks. So, there were projects of that nature as well.

CHAIR - Right, so, I'm just trying to understand what the challenges were here. Those projects weren't scoped well enough or had enough detail in them to enable - some could argue, even enable a short-term contract being awarded, if that's what was relied on, to deliver or to start delivery of the project. I'm just trying to understand this, because it doesn't make a lot of sense.

Dr LAMBERT - No, I understand, and the challenge is that the tender process for deliverables is very mature for delivering buildings and infrastructure. And the sorts of errors we expect in building - and you know how many times buildings go from \$300 million to \$500 million to however many billions the stadium's up to - but even in that industry, it's hard to predict exactly the full scope of the project, right? Well, digital projects are like an order of magnitude worse, and so it's very typical, when you start a digital project, to be out by 50 to 100 per cent of the total cost of delivering the project. So, what we tend to do is we tend to do progressive, so we set a scope that's reasonable and accurate - and the more work you do in setting the scope, the better digital projects do tend to go - and then you will start the process, and that's where you need the bodies. So, that's where this body shopping or labour hire contracts can come in helpful, because you need very specific skills of people with experience who understand how long things take, who understand how much things cost. And they then start developing the elements of the program which then iterates, and you keep getting higher and higher levels of confidence and lower and lower levels of risk as the project continues.

I know it sounds a little bit 'how long is a piece of string', but having worked in this space for over a decade-and-a-half, I can assure you that this process is the process in every jurisdiction I've worked in, because with digital projects where there's a large degree of people and process change, the one thing you can't guarantee is how long and how hard it is going to be to change the people. You can work out how many computers you need, you can work out the software licences, you can work out the integration and everything, but there is too much variability on the human side. Even with the integration thing, like when you're connecting two pieces of software together, you can think you know how much work it'll take to connect the piece of software, but until you actually get down in the weeds and do it, you realise that there's complexity and nuance that wasn't appreciated at the scoping stage, and sometimes the cost to fully scope a project, to get down to that level of detail, can almost be half the cost of the project itself. So, it's rare for that to be done to high levels of detail when you start a project. That's where we tend to just say, well, this is a fairly robust estimate of what we are doing and how much it's going to cost. We will commence, we'll build the team, the team's job will be to finesse that, fine-tune it, get down to a more accurate level, and then if there's an adjustment needed to the budget or scope, then we go to governance. So, the other question you asked about was the governance, and I'm happy to answer that, but I've been talking for a while already.

CHAIR - No, go to that one, and I'll come back.

Dr LAMBERT - Okay, so governance - there's a whole lot of different areas of governance. There's the internal project governance that's normally the responsibility of the project manager or the program director for a larger program of work, and I was effectively a portfolio director. So, at each level you get sort of a broader scope but less detail. But generally speaking, that is also then governed by an executive-level governance where the business owns the project and is expected to ensure the project will deliver against the benefits expected by the investment of money in that project. That's an executive steering committee that's normally chaired by somebody as senior as appropriate for the scope of the project. So, for instance, a project that affects the whole state of Tasmania Health system needs at least a deputy secretary chairing the project. For some of our projects, we were able to use the regional CEs, but there weren't many projects that I was involved in that needed less than that top, you know - if it wasn't Dale, Dale wouldn't generally be a chair of a committee; although you could argue he should be the chair of the Bluegum Transformation because it's going to transform the whole of the Health system. Secretaries are not normally chairs of committees, but for Bluegum, that

would be justified. But if it wasn't Dale, it would be the next tier down or the tier below that. That's just for the chair.

The membership of the committees has to be carefully chosen to make sure the qualities of the people and their knowledge base on the committees. It's a bit like a skills-based board decision; if you're building a board, you'll know that you look at the different skills to make sure they're complementary and appropriate. The membership of many of these steering committees was not particularly well thought out. It was more a case of who was available and interested, rather than who was the right person to make these decisions.

The next problem was attendance. They would have meetings that literally weren't attended by - well, there were many meetings where the only people who turned up were the project team and the technical people, and the business barely turned up at all.

Then the final problem was that the meetings were simply not being held; there were stretches of months between steering committees of projects that were still running, and that's just unacceptable. So, just basic project discipline: get the right people on the group, get the right level of authority in the chair and the members of the decision-making group, make sure people turn up and make sure that the meetings are held.

Then, finally, the agenda items - it was very interesting looking at the papers that were being presented to these committees, because they were often written in IT gobbledygook and weren't sufficiently described in language that the business owners could understand to actually make informed decisions. So, that was the final quality issue.

Those four issues were present in almost every project, except for the pure technical projects where the correct sphere of authority was the CIO or their team. So, for technical projects delivered by technical people, they did okay, but for projects that needed business and health delivery system governance, there were lots and lots of problems which had to be fixed.

Ms GLADE-WRIGHT - Were you able to complain about that along the way to anybody?

Dr LAMBERT - I'd like to think I was a bit more constructive than just complaining. No, it was my job - I just fixed it. I mean, we just literally reviewed every terms of reference - oh, and the terms of reference were ridiculous. I don't know where they got the terms of references from, but they didn't really understand how programs fitted under portfolios, and they didn't understand that broader governance.

Tasmania - I loved living in Tasmania; I'm very disappointed it didn't work out. I think Tasmania is fantastic, but the maturity of a lot of its project, at least in the Department of Health, I can't speak to other departments, but the maturity of its project program and portfolio governance structures was very, very low, and acknowledged to be. This is not a criticism that anybody will push back on - they knew that they didn't know how to run portfolios and programs. At the same time, they didn't really like learning how it should be done at times, and so it was a bit of a delicate conversation and politics. And I was under time pressure, so, a lot of the time I really didn't have time to sort of cajole and wait for six months for people to get comfortable with something. I just had to say, 'Well, look, this is what I have to do. This is what I've been asked to do by Dale. Dale has fully supported what I'm trying to do. We have to change this because this is not sustainable for a portfolio as big and complex as Bluegum.'

So, that ruffled feathers, I'm free to admit that, but that was the job. So, I didn't complain. I just got into the weeds of every different project and said we've got to get people attending. I rang executives and emailed people to get onto committees. I set up reporting structures where if committees weren't meeting that would be notified to the next level up in the governance - so, the governance goes project, program, portfolio. And we exposed all of the statuses of the projects to the highest-level governance committee. And that's when the senior executives, who actually were turning up and now seeing material they could understand were saying, 'Well, why are these projects not delivering what we asked? Why are these projects taking two, two and a half times as long as they were supposed to? Why is this budget two to three times as much as the original budget we approved? How do we know we're getting the value out of this project?' So, they started asking all the right questions, but that of course didn't -

CHAIR - So, how did you answer those questions?

Dr LAMBERT - As honestly as possible. But it certainly didn't make the teams who'd been responsible for those projects for the two years before I turned up happy, of course. And, even though it wasn't personal, it's hard to not be sort of - you know, you tend to have your babies and love them. So, it was very difficult. It was a really hard part of the job, because I was totally not responsible for anything that happened before I took over the projects, but I was responsible for fixing them and, unfortunately, it would have been a dereliction of my job and responsibility to the public.

Ms THOMAS - Are you aware if any of the concerns you were raising were escalated to the minister at the time, Dr Lambert?

Dr LAMBERT - I'm very confident these would not have been on the minister's radar.

Ms THOMAS - Did you suggest that they ought to be? I mean, you've mentioned that clearly there was frustration about the government's priorities.

Dr LAMBERT - That I wanted to talk to the minister about. I think, Dale read the tea leaves and realised that there wasn't that much interest in Bluegum and, so, it never seemed to get on the topic. I was supposed to meet with the minister every month from May until I left in March this year. And I never got to see her - or was it him, originally? Might have been him and then her. At my level, I would normally sit with Dale and brief the minister on a project worth half a billion dollars, and I never got that opportunity. And I did wonder, is it me? Am I too brash and hard to deal with?

CHAIR - You don't know why that was though, Dr Lambert?

Dr LAMBERT - No. I mean, Dale would say to me, 'The minister's office doesn't want to meet with you.'

CHAIR - So, it was resistance at the minister's office then, not -

Ms THOMAS - That's what you were told?

Dr LAMBERT - At least at the adviser level, I don't know if the minister themselves knew.

Ms THOMAS - It's one thing to say it's not a priority of government but also, if the government isn't being informed by the department or by the secretary that there are significant issues with this project -

Dr LAMBERT - I can assure you that Dale was aware of everything that was going on. I would meet Dale every fortnight and he was well aware of all these issues: the recruiting issues, the contracting issues, the Treasury issue impact, the governance issues. And he said to me - I mean, I don't know what he said about me when I wasn't there - but to my face he was very happy with what I was doing, very supportive of what I was trying to do and thought the things that I was doing were obvious things that should have been done. He couldn't understand why they hadn't been done before.

Ms THOMAS - But, in terms of reporting up to the government, are you aware as to whether he was conveying these concerns to the minister?

Dr LAMBERT - No. It's interesting, I never thought to ask him that. I just thought it was his responsibility and he would decide what he talks to the minister about. It's sort of one of the few times I say it's a bit above my pay grade. But I really wanted to look into the eyes of the minister and say, 'Are you serious about Bluegum or not? Because I'm not going to put this much effort into this if you're not serious, and it needs some serious funding injection if it's going to be successful.' I got the feeling, very much, that the rest of the health system wasn't prepared for the sacrifice they were going to have to make to make this happen, whether it be a financial sacrifice, because you don't get \$100 million gap in funding out of nowhere, or whether it was time you have to stop doing things you're currently doing to invest in this project if you want it to be successful. Everybody sort of wanted the magical solution but didn't want to put the hard yards in to make it happen. That was everything from the coalface up. But it was really about the leadership because, if the leadership of the Department of Health wasn't going to push for this to be a priority, then it was never going to happen. I felt that Dale was waiting to see the support from the minister's office before he pushed, maybe, I don't know. I'm not Dale, you'd have to ask Dale.

Ms THOMAS - That's right, and we will. I guess that's questions that for us then to ask further of the minister and of the secretary around awareness of these issues and how they were raised and escalated, because you can only respond to what you know.

Dr LAMBERT - Absolutely. I know the issue of labour-hire contracting was raised with the minister, and the minister apparently was having a fight with the Department of Finance, or it might have been at secretary to Treasurer level. Anyway, there was definitely an interdepartmental challenge there that they couldn't fix this ridiculous situation. That I definitely know the minister would have been aware of. Obviously, the minister would have been aware of the overall budget situation, but down to the level of governance of individual projects and - we wrote very detailed, we call them RAG statuses, and project monthly reports. The RAG is the red-amber-green rating. All the projects that were red then became green. All of that was available, probably, to the minister, but whether they ever saw it? Probably not.

Ms THOMAS - Dr Lambert, following your departure from the department as the chief clinical information officer, you made a post on LinkedIn that made reference to the organisation's values no longer sort of aligning with your own - I don't want to verbal you, but something along those lines - I sort of have a sense of what that means by listening to you today. But is there anything more specific you could explain in terms of what you meant by

that? Was it around the governance, the transparency, accountability, organisational culture, or is it more the government priority? What did you mean?

Dr LAMBERT - There were two elements to it. One was the number of broken promises. I was made a lot of promises when I was heading down to Tasmania, by Dale mainly. He really didn't deliver on a lot of them and that was disappointing. But the real issue was more the organisational culture, and this is really more of a people and culture team. It had nothing to do with the project team or Health ICT or all the other things I've been talking about. It's more about people and culture.

By and large, I loved the people I worked with in Tasmania. I was able to build a great team reporting to me. I have a humanistic, empowering leadership style. But at times you find individuals that are clearly not doing the right thing. There were less than a handful of them, and there was clear evidence that they were not doing the right thing, and, in fact, some of them were literally exhibiting toxic behaviours. They were toxic. I don't like using the term 'toxic people'. They're not toxic people; they're just normal people. But they were behaving in a way that was toxic to the culture of the organisation.

The problem is: that if those people happen to be favourites of somebody above them, nothing would get done. In fact, the opposite would get done. One of the people proven to not be delivering and be quite toxic - and a whole lot of evidence was collected about the behaviours that were highly inappropriate, like promising somebody something in a private meeting then going to a public meeting and throwing them under the bus for the thing that they promised to do - it's just unacceptable behaviour.

They would get promoted. I'm talking very senior levels, like tier 3, tier 4, tier 3. That was a repeated behaviour, and, so, I came to learn the hard way that, if you were somebody's favourite, then you had a protective bubble around you and you would get promoted regardless of how effective you were in the role. That is poison to effective delivery of projects. You want to make projects take twice as long, blow their budget and not deliver? Have people like that in leadership positions.

I tried to fix that following all of the due processes, but, because they were favoured people, it got turned around by some very worrying behaviour in People and Culture to be my problem, not theirs. I've been in this job so many times. I know what I am and what I'm not. Yes, when I started in executive roles 13 years ago, yeah, I was a pretty arrogant intensive care specialist doctor, you know, God complex -

CHAIR - They all are, to be fair.

Dr LAMBERT - Exactly, exactly, totally. I've been through a 14-year process of coaching, charm school, if you wish, learning leadership skills - no, seriously, it's been a hard developmental work in me. I know what I am now and I know what I know to be true. To not be supported in trying to follow the values of the organisation and treat people according to those values and then get, in a sense, punished for it is appalling. That's what that post was about.

Ms THOMAS - Thank you for sharing that.

CHAIR - Are those people still involved in the project?

Dr LAMBERT - Oh, yeah. I've mentioned one of them.

CHAIR - Okay. I don't know how you fix this problem. This is a culture problem. We hear - we've had a number of -

Dr LAMBERT - There's only one place you can fix it from, and that is the very top. The fish rots from the head. Yes, this is something - and look, I actually think Dale is the most lovely person and really is very well-intentioned. He is, I think, a social worker by background. He wants a great culture. But to be honest, he doesn't actually do anything to create that culture. I was there for a year. There was no executive team building, there was no 360s, there was no effort to improve. I got absolutely zero professional development despite asking for it on multiple occasions. It was just expected to happen by magic and I feel that Dale isn't aware of what you have to do to create an optimal culture in an organisation, especially in an organisation as large and as complex and messy as Health.

CHAIR - This is not the only area of Health we've heard about cultural issues. The Auditor-General has had to look at various other areas and it seems when you've got an embedded cultural problem here, unless there's the appropriate actions taken - one presumes, and this is making a presumption, you can say what you like with it, that you left because you didn't believe the culture could be changed from within and so you left. That's pretty right? Yes.

Dr LAMBERT - Yes. It was just incompatible. I'm old enough now where culture of an organisation really matters to me. If I sense dissonance between stated culture and enacted culture, it's just too much mental stress to deal with. Others may have different views about what I've told you, which is of course understandable and I'm happy in any forum to talk in detail and show you the evidence and show you everything that I did there. I'm very very proud of what I did in that role. I feel I gave everything to the public of Tasmania. I really loved the role and I was really disappointed to leave. I'd go back if the culture issues were fixed.

Ms THOMAS - You were working in the chief information office, I guess -

Dr LAMBERT - Chief Clinical Information Officer. Brent is CIO, he's different.

Ms THOMAS - The only reason I - is the actual area or the unit called the chief information office or something like that? What's the unit actually called?

Dr LAMBERT - My office was called the office of the CCIO, the office of the Chief Clinical Information Officer - which doesn't exist anymore, in the new org structure, I don't think.

Ms THOMAS - These sort of issues that you were seeing about people being protected in these bubbles and the behaviour that didn't match with the values of the organisation and those sort of issues you talked about, were you seeing those across other teams in the organisation? There are different units that all have very senior level leaders; were you seeing it across those different areas?

Dr LAMBERT - Obviously in my team I had the ability to manage that. Most people respond well to guidance and assistance. I had one person in my team that - well, they were a contractor and we just let their contract end and we didn't reappoint them. In my team I had

some control over that, and, you know, we hadn't finished. It takes a long time to change culture. But people were very clear that I expected transparency, honesty, I expected people to say the same thing in any forum - basic behavioural stuff that you'd expect.

In adjacent teams, so in Brent's team, there were some issues which I felt Brent felt hamstrung in being able to address, due to past history, loyalties, whatever, orders from above. There were people at my peer level that obviously only Dale could address behaviours at that level, and there were some people - that sort of tier below - in other teams. Obviously, I totally respect my bounds of control and I can only do what I can to help and as you're probably aware, the behaviour you walk by is the behaviour that exists, and so there were times when I would simply take people aside and said, 'Look, this is what I just saw happen. I don't think that's in keeping with our values, so maybe have a think about that.' Sometimes a bit longer meetings for people who had big issues. But if it was in another team, I would always have those meetings with the awareness of the line manager up to the level of my peer.

It was in - and in fact, I actually think some of the issues are in the People and Culture team, which NAM acknowledged some of those and she was working on them herself as well - but I think the issue with NAM is perhaps more inexperience at managing culture in such a large organisation; her previous roles have not been quite as big and complex or Health-specific, but yeah, she had some people in her team that had some worrying behaviours as well.

Ms THOMAS - Just going back to the procurement issues we talked about earlier: not having worked in the IT space, this is very hard to sort of wrap your head around, and I appreciate your analogy to a building and how it's different in developing a whole new IT program or framework or whatever you call it. But in terms of the contracts, you mentioned that these were labour-hire contracts for individuals - it's very hard to attract people to work within the organisation in this sort of IT role. But what we can see from the contracts that were awarded were that they weren't going to individuals, they were going to organisations who then, as I would imagine, were then recruiting individuals -

Dr LAMBERT - Oh, the labour-hire firms?

Ms THOMAS - Yes, the labour-hire firms. So that's what I struggle with. Why not make it the labour-hire firm's thing to be managing the individual contracts?

Dr LAMBERT - We wanted to. We wanted to have a panel of labour-hire firms; Treasury wouldn't allow it.

Ms THOMAS - But why couldn't they be - so it goes back to -

Dr LAMBERT - Treasury policies.

Ms THOMAS - If we're seeing the same firms being given big contracts on a time-limited basis over and over again, why couldn't they have gone to tender for those labour-hire reasons?

Dr LAMBERT - Yeah so, although the contract mechanism is with those firms, the arrangement is with the individual contractors. So, when we go to market for a labour-hire person, we go to market for an individual or a set of individuals with a particular set of skills, and what we get back are a whole lot of CVs and individual skill responses. Even though they

might be on a letterhead from a labour-hire company, it's the individuals that we pick, and then they often - for just super and tax and other reasons - they allow a company to do the billing and all the rest for them. And yes, that company takes a cut. When we go through one of those firms the fee is generally 10 per cent higher than people who we contract directly. There's some issues there now, too, because there's another policy about not employing people who have their own ABN or something. There's some funny rulings.

But look, can I just make it clear: I am a secondary respondent; this is not my area of expertise. All of the detail of this was managed by Brent, and if you want somebody who knows the absolute answers to your questions, it is Brent Feike and Brent Feike alone. He knows this stuff backwards and he would try to explain it to me. I'm sorry. It's just not one of my areas of expertise and I hope I haven't bastardised anything that he said.

But honestly, if you want the deep detailed answer Brent Feike will tell you, and he knows this stuff like the back of his hand, and I love that, and I couldn't have done anything without him managing the contracting process. I mean, we did what we could. We advertised 70 jobs using - and like the awards available in Tasmania are just ludicrously inappropriate for digital health experts. Nobody would, I mean - not nobody, we had a bunch of people who took jobs with these rates - the rates are very low, and the only sorts of people you'll attract are people who already live in Tasmania, who really want a job in this space, are generally a bit altruistic. That just was never going to work for the highly specialised digital health experts we'd need. We advertised I think 71 jobs and we got three successful people in positions - and that was a massive effort. You could talk to Liz Waters, the current manager of the project support team in Bluegum, and she can tell you all about that effort. That was actually triggered before I turned up, and it happened about the time I arrived. It was just devastating.

We really did try to employ people on, like, three-year fixed-term contracts. That's what - fixed-term employment - that's what we'd prefer. But the market decides what the market decides. That's why you have to use other mechanisms which are not award-based contracts and that's where the labour-hire contract comes in. It's effectively a way of paying people what they expect to do a job for a period of time.

CHAIR - Can I just pick up a couple of points, if I could. Just a quick one: when you talked about you just can't do that procurement for digital projects like you can for building, say, are there states where they have Treasurer's Instructions or their equivalent or framework work in this space, because clearly it seems to be different?

Dr LAMBERT - Oh god yes.

CHAIR - And what are they?

Dr LAMBERT - New South Wales would be the best example. I mean, yeah, like 'I need a project manager for three years for this project'. 'I'm just going to go to market and contract a person for three years to do that job' - it was just expected like it was normal.

CHAIR - And we can't do that?

Dr LAMBERT - No, your Treasury has this very different view on this. It is unique; I have not seen this in any other jurisdiction in Australia or heard of it.

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CHAIR - I would have thought you could do that.

Dr LAMBERT - No, not in ICT; there is a specific ban on it. I don't know where it comes from. I don't understand it. It is the worst thing for your ICT projects in Tasmania. You will never be as successful as you could be until you fix this problem.

CHAIR - Right. That's really helpful information. You also said that the office of the CCIO has disappeared in the new arrangement, so who is now responsible for the work of delivering this project that you were doing?

Dr LAMBERT - Brent Feike.

CHAIR - Okay. So, it's all bits of [inaudible 11.51.52] the CIO office then?

Dr LAMBERT - Yeah, which is impossible. There's no possible way that he can give it the time it needs and be an effective CIO. But he knows that, I know that, but that's the current decision. It might be not a decision that Dale wants to make, but just the only option he's got at the moment. To make matters worse -

CHAIR - Because you left or because of cost cuts?

Dr LAMBERT - Actually, both because there's so little budget in Bluegum they probably couldn't afford a CCO. But no, there was also change of structure. Like, I don't understand this; I've never seen an organisation as complex as Health where the CIO doesn't report to the chief executive equivalent or the secretary. But Brent now reports to Andrew Hargrave, the dep sec for infrastructure, which is unheard of in Health. I don't know why Brent was demoted in that way by Dale. So, you've got the head of the most significant transformation of Health in multiple decades, like 50 years, who is a third-tier operator. It doesn't make sense to me. I'm sorry, I don't - everything I can see says that Bluegum is just being put in the backroom until somebody decides it's important.

CHAIR - But the systems it replaces are at end of life?

Dr LAMBERT - Yep. It's a mess. The fact that it's been deferred - we are keeping systems alive that have no rights to still be running and all this has done is delayed - this was all written up in reports - but all this has done is increasing the risk to Tasmania, increasing the cost to Tasmania. It is an atrocious situation to be in. I'm really sorry, but some things you just have to bite the bullet and invest to fix. The cynic in me says until the stadium is built, the investment will never turn up.

CHAIR - Okay. But that sort of leaves us with the question I wanted to sort of perhaps close off with, unless others have got questions. Can the digital transformation be delivered in a way that deals with legacy issues? If it can, what has to happen now and what the priorities need to be for that?

Dr LAMBERT - Well, under the current construct - as I see them externally, not knowing all the inner details - the answer is no, the original scope of the transformation cannot be delivered. The most important thing is it needs to be considered a priority for Health and appropriately funded as such from the minister down. It's not just about the money, it's about the entire organisation, all - I've forgotten how many people are in Health down there, what is

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it, 40,000? Anyway, everybody, let's say it's 40,000 - all 40,000 people working for Health have to be committed to want to change the way health care is delivered in Tasmania to bring it in to the 21st century. That requires leadership, hard decisions, ongoing injection of energy and motivation, and I don't see any of that happening currently.

CHAIR - And a cultural change.

Dr LAMBERT - Cultural change and adequate funding to pay for the necessary - which is in the order, realistically, of \$500 to \$700 million, not even \$410 million. But currently they're getting dribs and drabs of leftovers from budgets. That's over three to four years.

CHAIR - Does anybody else have any questions?

Ms THOMAS - Is there anything specific that you think we should be asking when we do have the minister and the Secretary and perhaps the chief information officer before us?

Dr LAMBERT - Well, Brent, obviously, you should talk to about all the contracting stuff. I don't know how you phrase it though, because I'd be saying, 'Are you serious about Bluegum or not? Because all the evidence says you're not. You've demoted the boss, you've carved the budget out to ridiculously low levels, you keep on deferring it; it seems like all the evidence says on the actions that we're seeing, on the behaviours we're seeing, is that this is not a priority. Convince us that this is a priority. Where's the money coming from? Where's the motivation to your teams? When are they going to see that this is more important than anything else that Health is doing.' And that's a really hard thing to say. When your hospital is code yellow and everybody's going spare, nobody wants to invest in this, but if you don't do it, you cannot be successful. This is a massive change involving every human being inside Health.

By the way, not just Health - if you're going to do this successfully, this involves all the healthcare practitioners outside Health. The GPs, the specialists, the allied health, the community practitioners, aged care facilities, right? It's much bigger than just Health. You can't do that without - I mean, the minister's barely even spoken about this project. It's going to take ministerial leadership to say to people, 'This is important, this is a priority, this is government's priority, this is going to happen.' I just don't see that happening.

Ms THOMAS - Thank you. It's been very helpful.

CHAIR - It affects all the patients as well, ultimately.

Ms THOMAS - Absolutely.

Dr LAMBERT - Honestly, I've never been in a job where my job has been so easy when I'm talking to patients, clinicians - this might be inappropriate, but everybody was gagging for it - everybody wanted the spirit and intent of the Bluegum Health Transformation. They all loved it. There were like, 'Oh, my God, John, this is going to be amazing. We want more.' Every time I communicated the vision and the intent of the project, it was just phenomenal. I've never seen a project so well received with so little resistance from the people that mattered. All issues were up in the leadership, funding, and executive level. Sorry, I've made one of you laugh.

CHAIR - How disappointing for them. It lets the people down.

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Dr LAMBERT - It does. Yes.

CHAIR - Thank you very much, John. We appreciate your willingness to appear before the committee and to help us understand some of this, because it's your bread and butter, it's not ours.

Dr LAMBERT - I'm happy it's been useful. I wasn't sure if I'd have anything useful to tell you, but I hope it's -

Ms THOMAS - It's been very, very useful. Thank you.

CHAIR - I have a former health background, and I have some friends who are intensivists.

Dr LAMBERT - So you know how we talk.

CHAIR - That's right. We thank you for your time. It's really been beneficial.

Dr LAMBERT - Reach out if there's anything else you need or if anything gets confusing when you read your notes later. Thank you for having me.

The witness withdrew.

The committee suspended from 11.58 a.m. to 1.00 p.m.

Health and Community Services Union (HACSU)

CHAIR - Thanks, Robbie, and your team from HACSU, for your submission that you provided to the committee -that's really helpful and we do appreciate that, and for appearing before the committee. We, the Government Administration Committee A, are looking into the financial and operational management of the Department of Health. We've had some hearings already, previously talking to the department, et cetera, but we really wanted to hear from stakeholders as well. So, thank you for your input in that.

This is a public hearing. Everything you say is covered by parliamentary privilege while you are before the committee. That may not extend beyond the committee process. If there was anything of a confidential nature you wish to share with the committee, you can make that request, otherwise it is all public and will form part of our parliamentary records. It is being broadcast, and transcribed by Hansard. So, if you have any questions on any of that. Most of you have probably done this before, not all of you. Some of them are new faces. Robbie, you've found a few new friends, so that's good.

Mr MOORE - We have, yes.

CHAIR - I will ask all of you who are going to speak to take the statutory declaration. Then if I may ask you, Robbie, to introduce yourself. - you just say who you are as you take statutory declaration, and then speak to your submission, that would be great.

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Mr ROBBIE MOORE, SECRETARY, **Ms SIMONE HAIGH**, PRESIDENT, AMBULANCE EMPLOYEE SUB-BRANCH AND JUNIOR VICE PRESIDENT, **Ms SOPHIE MUMMERY**, PRESIDENT, ALLIED HEALTH PROFESSIONALS SUB-BRANCH, **Ms LARA WILD**, HACSU DELEGATE, **Mr SHANE HAMEL**, INDUSTRIAL ORGANISER, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - I just need to let you know that Sarah Lovell is appearing online. She's not 100 per cent so she's keeping her germs to herself. Bec Thomas is here and Clare Glade-Wright. Cassy is not well either, so she's an apology. Over to you.

Mr MOORE - Thank you very much. Thanks for the opportunity to make a submission and also for the opportunity to do this. Just quickly on HACSU, it's obviously in the submission, but we're Tasmania's largest union. We have over 13,000 members and we cover a wide range of health and community services workers, both public and private sector. You'll be hearing from some of them today to hear specifically, and they're happy to take questions, obviously. We think we have a lot of information to give to the committee that will be helpful in this inquiry.

I just wanted to outline a few of the key parts of our submission and talk about, I guess, some of the frustrations that we have in this area. Some of them, I guess there's two elements to what we would say in terms of expenditure. We think there's both waste that is occurring, and I'll speak to some examples of that, but we are also concerned with the lack of revenue which is available, often through Medicare and other sources, and through the Commonwealth in other ways, that we also don't bring into the health system. We actually choose to outsource things that bring in money and things like that. We're keen to talk about that.

In terms of the waste, we're obviously, and I'm sure the committee's aware from other submissions, really concerned with the amount of money that gets spent, for instance, on locums, agency nurses and also the amount of overtime that's paid, which is quite significant when it comes to Health's overall expenditure. Yet at the same time - and some of this is associated with the budget cuts. You're never quite sure. But you see cuts that are actually adding to those costs every day. A clear example of that is, at the moment, we're seeing a cut to the outpatients area at the Wellington Clinics across the road from the Royal. That's an area where there's currently a waiting list of over 42,000 people waiting for outpatient appointments. Outpatient appointments are vital appointments that people go to around health conditions. The reality is that if you don't get to one of those appointments, you're likely to end up in the emergency department or in an ambulance because your condition that should be being seen to will deteriorate and then it will become a lot more costly than it would be to provide those appointments by you having to be attended to by the ambulance, potentially coming the emergency department and then be part of the bed-block situation and finally get a bed. And that costs the health system a fortune when you consider the amount we're paying in locums, agencies and overtime. And we see that in the ambulance service, we see that in the emergency department and throughout the health system.

Ms GLADE-WRIGHT - Where was that 42,000 from?

Mr MOORE - The waiting lists?

Ms GLADE-WRIGHT - Yeah.

Mr MOORE - Well, it's publicly available. That's a very good question. I think where that's recorded must be on the dashboard. I know Sarah was speaking about it publicly last week.

Ms THOMAS - You said it's the outpatient clinics at the Wellington Clinics?

Mr MOORE - The Wellington Clinics.

Ms THOMAS - Is that what you meant, Clare? Like what's the waiting list for?

Mr MOORE - Oh, sorry. I misunderstood where I was getting it from. It was a very good question. It caught me out. But, yes, it's for the outpatient clinics. They're a primary health service that are providing lots of things - diabetes and all of those sorts of medical conditions that often have several health issues. If you can support people in those times, they don't need hospitalisation. That's part of our submission, are key parties: that allied health as well provide a central part to our health system, your physios - and we'll hear from Soph, but also occupational therapists, speech pathologists, dietitians. All of these roles are key in preventing people from needing to come into our hospital system.

Even if we don't care about the patient outcome, which of course is everyone's number one priority, if you look at it just from a cost perspective, it costs a fortune. The US health system is the most expensive in the western world because they don't have primary health services that are freely available, and we are seeing that here in our system where, because we're not providing - you can't get into a GP who bulk bills, you don't do something about your condition, it deteriorates. If you can't get into dental, that often ends up in our health system. All of these things where we're not giving people the primary health that we should be then adds a huge burden because it's so much more expensive to treat someone once their position is complex and they end up in a hospital system.

CHAIR - The current dashboard says that it's between 77,000 and 78,000 people across all hospitals.

Mr MOORE - Oh, okay, I'm short. Yeah, sorry, that's the Royal specifically, but yeah, across the state.

CHAIR - Yeah, that's all hospitals.

Mr MOORE - So, there's obviously a huge amount that we can do in that area. Unfortunately, at the moment, the government's choosing to go down the different path, and that is cutting services. That's having an effect. Taking nurses out of those appointments, that means that, if you're in there for another appointment, you can see a nurse and they'll often look at other conditions and things like that, which helps because often people have more than one medical issue. And a lot of that's to do with the complexities of our health system. We're dealing with an older and sicker population. Our socioeconomic circumstances within Tasmania often mean that your health is in a worse position, and it means that we're dealing with that.

CHAIR - Just on that, Rob, before we go off the outpatients matter, we hear public comment from the government that if only the feds would lift their game and fund aged care and NDIS and primary health properly. But this is entirely within the government's remit, the outpatients clinic?

Mr MOORE - The outpatient clinics are solely the responsibility of the state government. They do get some federal government money. There is a few areas where they can bulk bill and things like that, but they run it.

CHAIR - Well, there'd be DVA patients and things like that.

Mr MOORE - That's exactly right. And that is the frustration. I was going to comment on that blame game. Look, there are clear areas that affect our health system that do come under Commonwealth responsibility, and aged care is a really good example of that. Also the NDIS, which is funded federally, or nationally. These issues are real, and I'll talk about them. But what I would say is that, really, the government didn't mention this until four years ago, and I don't think that's a coincidence. When we had Liberal federal government, it was never mentioned. It was only when that we got a federal Labor government that suddenly aged care - it was literally never mentioned by the ministers before that. I only say that, to me, that demonstrates that a lot of this is political. The federal government does need to step it up, and I think Tasmania is in a unique position to be a trial site for a lot of the issues that are there. We should absolutely be going to the federal government and saying, 'We've got 42,000 people on a waiting list. How can the federal government trial things in Tasmania that will reduce our lists?', et cetera, and look at some real opportunities there and working with them on that.

The disability space: again, the state government, when the NDIS came in, made a decision to totally get out of the disability game, which we didn't support. The NDIS provides support for certain people, but it doesn't deal with urgent matters, it doesn't deal with emergency care. It's a bureaucracy. It takes six to 12 months, if you're lucky, to get onto the NDIS and to get the supports you need. Those supports are often reviewed and cut back. They didn't keep things such as respite care.

Respite care, what that has meant, they chose to outsource all of that, and what that means is we do have people in our hospital system, often if they're under the age and they're in there, really, because of their disability. But if they're in hospital, they'll usually be in the ICU part of a mental health ward. That means the entire rest of the ICU part has to be shut down because young people can't be amongst adults for obvious reasons, which we support. What it shows is it's actually cost the system a lot more because we've left the NDIS space entirely and we should never have done that. Emergency care, some of the stuff that happens on the north-west, at Curraghmore for instance, that's run by Anglicare and all of that. I think there's real opportunities for those sort of step-down areas that would cost a lot less than having people in our health system, that costs a fortune. There are other alternatives, because we had them, which were more a respite model.

Aged care: I'd say Victoria have a lot better model where they have kept state-run aged-care facilities. We saw during COVID the success of those ones. They didn't have COVID outbreaks, and that was at a time where 90 per cent of deaths were happening for people that lived in aged care. The state-run systems had staffing models. It actually worked in that area. What it also means is it actually helps majorly with bed block. What it means is if we've got state-run aged care, the secretary of Health can actually make determinations and say, 'No, you need to take these people', where a private operator has the right to refuse. Often the people that you want to transfer are more complex. Aged care are reluctant to take them on because they get the same funding no matter what your needs are, to a certain degree, under that model. A lot of the private industry don't want to take on people who perhaps need more intense services.

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CHAIR - In Victoria, are the state-managed aged-care facilities funded by the Commonwealth?

Mr MOORE - They still are, but you actually unfortunately do get a bit less. You get about 50 per cent of the funding.

CHAIR - So the state have to top them up?

Mr MOORE - The state do top them up, but the money that they would save in their health system could probably pay for that. We're not saying you need all of it. I don't think you could unwind that. If you had one large nursing home that was state-run in each of the regions, I think that would be a real step forward, because we know that it is so much cheaper to run an aged-care bed than it is to run a hospital bed proportionately. We could save a lot of money and actually be delivering a better service. Being an emergency department or even a hospital ward, but especially an emergency department, when you're an older person and you really don't need to be in that environment, it isn't a very nice environment. We see that in mental health as well where, again, you've got a complex mental health issue or you're detoxing, or whatever you're doing, it's not a very good setting. We could easily have step-down facilities for all of those things out in the community that would be cheaper and offer a better service and help with people's rehabilitation.

There'd be a lot of cost saving that could be done. But we get caught up in that game that, 'No, federal government does aged care', even though the state could actually effectively save money because the state is spending a fortune on providing health services to older Tasmanians.

CHAIR - Who don't need that level of acute care.

Mr MOORE - That's right. So, we think there's some real opportunities there.

The revenue, and we'll talk a bit more and I'll give other people an opportunity now, but I guess just a real key frustration we had in the radiography area at the Royal: they have replaced it in the last six months, but they weren't getting Medicare funding because one of the MRI machines was more than 10 years of age. That means you don't get Medicare funding because they do that to make sure you've got up-to-date equipment, and this is an evolving area. And we missed out on millions of dollars through things like that.

CHAIR - They still used it but didn't get any funding?

Mr MOORE - That's right.

Ms THOMAS - I asked this question in Estimates and they denied it, that there was any out-of-date equipment. They've upgraded that one in particular, but they lost about two years' worth of Medicare rebate. They're outsourcing it. The diagnostic services are one area where they do get good Medicare rebates, and they get the same money as a private organisation and they're running profitable businesses. Yet, we're downgrading our pathology services. We're outsourcing a lot of the radiography and other services at the moment because they do have some issues with staff retention.

CHAIR - Are you aware of any other equipment in our other hospitals that is getting to that point or is at that point?

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Mr MOORE - No, but I will check that, if I could take that on notice.

CHAIR - If you can, yes. Bec did ask at that time. Maybe it's been turned over since, but still, if you're not getting this revenue. That's one of the things I'm pretty sure they would have told Estimates or when they were in front of this committee - that they're looking at all the ways they can increase their revenue from an available source. They didn't mention this one.

Mr MOORE - No. It was tied up in the previous budget savings that they couldn't get the tick-off because the protocol they put in didn't factor in how much money they were going to lose. Then three months after, they started the work to then order it and it's now here. But they literally lost about, my understanding is, about two years of revenue from Medicare on that particular MRI machine.

CHAIR - Just on one machine.

Ms MUMMERY - I think then there were delays in getting it commissioned because we didn't have the staff to commission it, or the staff to run it. So then we're missing out on billings for a whole machine because we can't staff that machine, and the waitlists are blowing out.

CHAIR - Was it so different that you needed different staff? Or did you need to train up your staff?

Ms MUMMERY - No, we just needed the staff boots on the ground. We just couldn't retain and attract enough MRI - Sorry, they are specialised staff.

CHAIR - They are specialised staff, but there were already specialised staff there using the old machine, is that right?

Ms MUMMERY - Yes. I just think there was also a shortage of specialised staff, as well, at the time that we couldn't, they were something like 30-50 per cent down in their staffing. There was a huge vacancy rate across allied health, and imaging was one of the areas that was really down.

CHAIR - Because they were unable to recruit into them, or because they weren't trying?

Ms MUMMERY - Both. Sometimes they give up because they don't think they're going to get anyone, and sometimes it's because they can't get anyone. And part of that is the lack of competitive wages with the private sector. A specialised ultrasonographer or MRI radiographer can get much more money, competitive rates, and be treated well in the private system compared to our system.

Mr MOORE - Another part - and I think you were going to touch on this, Soph, is the recruitment process itself and how long it takes to put someone on.

CHAIR - We'll get to that.

Mr MOORE - That's definitely an area of concern. The other quick couple of areas, if I may, just in terms of waste as well that we see, or wasted opportunities, is what goes on around investigations into staff and also workers comp. I'll deal with investigations. We have seen this default thing of standing people down for any sort of investigation. We understood changes

were going to happen after the inquiry into children. That was obviously very important. But they've changed it wholeheartedly. Matters not involving children, they're still - and they weren't great before this, but they're getting worse. We had a paramedic who was stood down. We had to take it to the commission to get them to come back to work. They were stood down, basically, in short, the allegation was that they hadn't resuscitated somebody who they should have. When it came out - it took about eight weeks of them being stood down, we put them back on. The person had died at 2 a.m., the ambulance arrived at 9 a.m. They had arrived, the person was being resuscitated on a bed, which Simone could tell you more about, but it's not resuscitation. They had made a clear, good decision, but there was targeting -

CHAIR - Their family or someone had been trying to resuscitate the patient on the bed?

Mr MOORE - On the bed, yeah, seven hours after the person had deceased because they had died in their sleep. This happened and the person was stood down while this investigation, a person with no other -

CHAIR - Because they didn't take over active resuscitation?

Mr MOORE - Yep, with no other thing. And it's just this default that, 'We're going to stand you down because there's, we've got to check out, somebody had whatever ideas we have'. That's one example. These sorts of things are happening all the time. It was not that, because you could be healthy, but the person was in their 80s, and it had obviously come out that they had a heart attack and passed away. It was just one of those sorts of situations where there is no common sense there. They take a default position, standing down paramedics when we've got a shortage. We've seen doctors and others that I'm sure other organisations have talked about, but we see this all the time. And even -

Ms LOVELL - I just have a question about that - sorry to interrupt, Robbie. They were meant to have reformed the ED5 process as a result of commission of inquiry, and the idea was that these things would be improved, but that's obviously not what you're seeing?

Mr MOORE - No, not at all. It's gone backwards, and I link it directly to the inquiry into children that took place and those recommendations that, for whatever reason, they've decided to implement some of those recommendations, and beyond, wholeheartedly. I think everyone accepted that allegations around children would be dealt with differently given what had happened and what came out of that inquiry. But they did it for everywhere else and there was never -

Ms LOVELL - That doesn't make any sense, because part of the recommendations from the commission of inquiry were around the processing time for those investigations and that they were taking far too long. So, if they've made these changes but they're still, or it sounds like things are taking longer than ever, then something's not matching up there.

Mr MOORE - Absolutely. And they cost a fortune. They're all outsourced, and people are making a lot of money out of them, when you want to -

CHAIR - People are on full pay usually, too, aren't they?

Mr MOORE - Yes, on full pay.

Ms MUMMERY - We're wasting paramedic resources, or health worker resources, but we're also paying external consultants to do the investigations, and that is a lot of money.

Mr MOORE - Lawyers, at lawyer rates, are investigating these matters with what are - the reports come through on a template. It is just such a waste that we could be doing the investigations ourselves. Some, I would have thought, I don't even understand why they're being investigated. They're pretty straightforward and should be dismissed. But if you're going to do it, don't stand people down. Or if you are, alternative duties, get them into it.

We also use KPMG and organisations like this to do a mental health review, yet you've got all these people that are stood down, paramedics, et cetera, who are experts in this area. They could be doing any reviews and things that should be happening. We don't need outside consultants getting lots of money when we've got the skills and the people there, and workers comp's the same.

Ms LOVELL - Is the outsourcing of it a new thing?

Mr MOORE - No.

Ms LOVELL - I know there's always been some outsourcing, but have they always outsourced all of that?

Mr MOORE - It has increased, but it's always happened. Then there were resources before put into the State Service management office through the Department of Premier and Cabinet, but they are not doing any investigations in Health at all. That was always a concept of starting to get that happening, but nothing in that area has happened. Clearly, we could be directly employing people to do these investigations. We do employ HR people who are meant to be able to do these things, as well, but they're not utilised in that way.

The other really frustrating part of their investigation process, that costs a fortune and why it takes so long, is they investigate things where facts aren't even disputed. You'll usually find in any complaint process that 90 per cent of it is agreed. The intent might be disagreed or whatever, you know what I mean. But if I swore or something, I often don't deny that I did, but this was the context. It doesn't matter; they investigate all these things that don't need to be investigated if they could start with agreed facts, which is what most court processes do. But, you know -

CHAIR - And deal with these sort of contested -

Mr MOORE - Yeah, exactly, which come down to three or four matters, and then really the decision is about whether that was reasonable and things like that. So, there's a lot -

Ms GLADE-WRIGHT - When you say it's happening all the time, what does that mean? Is this like weekly or monthly?

Mr MOORE - We would have - ED5s are what we're dealing with, Employment Direction 5, which is the investigation process into an employee when there's been a complaint. I would estimate we'd have over 50 on our books at the moment in the health system. It might be slightly less, but it would be somewhere between 40 and 60. And -

Ms GLADE-WRIGHT - Over the last?

Mr MOORE - Well, some of them have been going on for a long, long time, but I would say you would have three a week of members that we represent coming in. Then there's nearly always preliminary investigations before that that Health do before they decide whether they're doing an investigation. And the amount of resources that go into that, again, are that - now, a preliminary assessment should really only be judging, 'Okay, here's the complaint.' They don't even need to seek, 'Is there validity? Does it stack up?' and things like that.

Ms GLADE-WRIGHT - Three a week. Did I hear that right?

Mr MOORE - Yep, that would be my guesstimate.

Ms MUMMERY - That's just members, so there'd be people who are not members that go through that on their own or with private lawyers.

CHAIR - Or members of ANMF?

Ms MUMMERY - Or ANMF or -

Mr MOORE - AMA, CPSU.

Ms MUMMERY - Also the non-member population, so that's a very small sample of the health service.

Mr HAMEL - And, anecdotally, we see them six to 18 months is the standard. So, we warn members when they go through that process to expect that it's going to take that long.

Ms HAIGH - And they're out of the workforce during that time?

Ms MUMMERY - Yes.

Mr HAMEL - On pay.

CHAIR - In the ambulance service, then, how many people would be out of the workforce at the moment because this process is on foot?

Ms HAIGH - I honestly wouldn't have a clue. Robbie would probably know more than I would.

Mr MOORE - Again, I'm sort of guesstimating. I suspect - at the moment, I reckon there's four or five. But we saw an example of an investigation into, I think it was 17, but there was definitely 14 that we were representing people into one particular matter where they decided to do an investigation. Basically, it was associated with whether people had accessed notes correctly when a serious incident happened on the north-west coast. It wasn't when the incident happened, where the police officer was killed. At the time, obviously, the safety of paramedics was a big issue because they attended the scene before it was safe, is my understanding. And they decided to investigate all these people who had good reasons to be checking it, like supervisors and things who are really checking for the welfare. But instead, they treated everyone in this way, went through a thing.

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They ended up backing down about six months later, but the amount of resources, stress on staff that went through in what was a witch hunt of targeting people that they disliked for other reasons, when absolutely - I mean, I say, look, if something happens and one person, okay, maybe you investigate. But when it's happening to that many people of using the same thing, it's clear you've got a process problem wholeheartedly. It's not an individual's fault. Yet that's how Tas Ambulance specifically operate, and this is why they've got such a bad culture.

But that happens in other areas, too, and the amount of resources that go into unnecessary investigations, instead of looking at their systems and things like that, costs the health system a fortune. Then staff end up on workers' comp and then staff end up on sick leave, which costs a fortune because that can really only be filled by overtime because we don't have enough in the establishment.

Ms HAIGH - There's also the knock-on that many of those staff were issued a lawful and reasonable direction to not access those systems, even though those systems were part of their roles. So, for that six-month period, a lot of people could not actually fulfil their role because they couldn't access the systems to do their job.

CHAIR - So, they were still working?

Ms HAIGH - Yes.

CHAIR - But they couldn't access the system to look up the notes of a patient they were going to pick up?

Ms HAIGH - Yes.

Ms GLADE-WRIGHT - That's crazy. And it's called ED5?

Mr MOORE - ED5 is the -

CHAIR - Employment Direction 5.

Mr MOORE - Employment Direction 5, which outlines the -

Ms GLADE-WRIGHT - Thank you. I'm a newbie here.

CHAIR - Health has not quite as many acronyms as the energy sector, but close.

Ms THOMAS - But employment directions apply across the State Service.

CHAIR - Yes.

Ms HAIGH - And ED4 is where they stood down with or without pay.

CHAIR - There even 6, I think.

Mr MOORE - I'm keen to give everyone else a go as well, but just maybe one other thing, and it's probably using that last dot point in your terms of reference of 'Other matters'. Can I just say one of the other frustrations we do have is with the budget cuts and what's going

on, that the potential income for the government doesn't seem to ever be there and they take this position of no new taxes. Well, we see a clear area that's in disability and that, where you've basically got all of what's called the gig economy that don't pay payroll tax at all. That would bring in a significant amount of revenue to the government that could go to our health service. We see it also that they are able to undercut other providers, so in disability, not paying payroll tax means that you can provide your services and make more profit, and outbid other organisations. We see that as well. We think fairness in our tax system, just focusing on cuts to government services, and especially our health service, isn't the solution. There are lots of ways this government could be bringing in revenue within our health system, but also outside of our health system, that they're choosing not to. I'd really like to -

CHAIR - Payroll tax is always intended to be a very low rate and a very broad base, so that would pick up some of these people, notionally.

Mr MOORE - Absolutely. I think we all use an Uber or whatever. Well, why would you not be paying - if a taxi driver's driving you, you have to pay some, and you don't for an Uber driver. Things like that, where it's a fairness system across that, and we think - I know there's lots of other things I could go into, but that is a clear example where you want a level playing field and would bring in significant revenue to the government. I know Martyn Goddard's done some, I'm not sure, analysis that we bring in less revenue than any other state through other taxation measures. So, we've got to, if we want to talk about a budget issue, it's a -

CHAIR - On a per capita basis?

Mr MOORE - Yes, per capita.

CHAIR - Of course, we will because we're a small state, but on a per capita basis.

Mr MOORE - Yeah, sorry, per capita we bring in a lot less. There are so many other areas they still haven't done - Airbnb, all these sorts of things that we could be bringing in revenue that could be going towards our health system and make it sustainable. If we put that towards health prevention, which I haven't really touched on, but primary health and health prevention, then it's about breaking the problem we have in the health system. That is, everything is about a budget cycle and everything is about a political term, in my view, and we never see the long-term investment. If you invested in our schools and healthy eating programs, school sports and all these things that would make the community healthier, then it would save money. It mightn't save a lot of that money within a four-year political term, but it certainly would over time, and that's why we'd like to see that become part of it. We'd actually like to see a mandated amount of health spending going to primary health, going to health prevention, which allied health play a key role -

CHAIR - Illness prevention, perhaps?

Mr MOORE - Illness prevention. Yeah, sorry. That's a good point. All right, so do you want to get them to introduce - Do you want to go next, Simone?

Ms HAIGH - I'm Simone, I'm the president of the Ambulance Employee sub-branch, and work in Ambulance Tasmania as a clinical support officer and intensive care paramedic. I think the government's missing a lot when it comes to Ambulance. Obviously, as Robbie mentioned, when people aren't being seen in time, their chronic illnesses become emergency

illnesses, and that's when we're called. As we know, because it has been already in the media - and I'll quote the service: 'We are currently having unprecedented customer demand; our caseload is incredibly high.' That has a knock-on effect not only for ramping and everything else that occurs, but our integrated care team that have been implemented, it affects them. So, our community paramedics who should be out there diverting people away from emergency departments are now attending emergency cases because there's no other crews available. It's not uncommon for a priority 1 case to go unresourced, and that's statewide. That used to just be south regularly, but now it's statewide.

There is a lot of research now nationally about the savings that integrated care provides. So, we have secondary triage, which is in our communication centre; we have clinicians, nurses and paramedics who will do callbacks, and advice and referrals, and stuff like that over the phone. We have our community paramedics who all the research shows save \$3200 per patient by diverting them away from emergency departments and into GP clinics, urgent care centres, all those other areas. Then on top of that, we have PACER, which is a police, ambulance, clinician emergency response for our mental health patients.

The implementation of PACER in both southern region and northern region has diverted 70 per cent of mental health patients away from emergency departments. As Robbie mentioned, that is not the place for them. They're already heightened, they're already struggling, and then they're put into this chaotic environment, and it has poorer outcomes when they attend that when, in fact, these systems are not only saving significant money for the Health department; they are providing better outcomes for patients. We really need to see more investment into those to divert people away from those emergency departments and save that money. It costs money to save money, and they need to be smarter in what they're doing, because we know that ambulance ramping, increased demand and lack of staff is causing our delays in response times and availability, and things like that. We really need to think smarter about ambulance services.

CHAIR - The PACER that we started up in the north-west and has been - wasn't it?

Ms HAIGH - No, there's only a mental health emergency nurse that goes in a car. I believe it will be starting.

CHAIR - That's right. It's been proven successful, I understand. It's going to be rolled out right across the state. Is that your understanding?

Ms HAIGH - Yes, it is. But I think it's a little bit undercooked in that there's not enough. We have enough -

CHAIR - Not enough what?

Ms HAIGH - PACER units. There's two in Hobart, one in Launceston, obviously the emergency response in the north-west. But mental health is one of our highest case types that are coming in. It's increasing, and we know that nationally -

CHAIR - Across the state?

Ms HAIGH - Yes, across the state. We know nationally that with prescription medications, that it's now mental health medications that are number one. There really needs

to be more investment into that. At least two crews in the Launceston area would make a difference and expand their scope, and where they can go, because it makes an enormous difference. I had the opportunity to do an observer shift on PACER and I was blown away with just how well they manage these patients and how they can divert them and involve their caseworkers. It's this whole holistic caring approach. You've got the police side, so you find out all the information beforehand and any risks. You've got the paramedic side for that emergency care.

CHAIR - So, it's safer for them because the police have got the intel on them.

Ms HAIGH - Everyone, yes, exactly. Then you've got the mental health clinician who is an expert nurse in that area, who can then access all of this stuff and refer them on. It just works brilliantly. And patients are now ringing, saying 'Can I see PACER?' because they know that that's better for them than attending an emergency department.

Ms GLADE-WRIGHT - So, they're mostly being treated at their home or are they being taken somewhere else?

Ms HAIGH - They're generally treated at home or referred, or they'll get other people in, like their caseworker in to do their stuff for them.

CHAIR - They may not be at home when the incident happens sometimes. They're often out and about.

Ms HAIGH - Absolutely. It's very similar for our community paramedics. Community paramedics have an increased scope of - it's a little bit different. Intensive care has the acute critical care interventions, whereas community paramedics have the more holistic approach. They also have better networks and they're integrated more into the general health system, and can make those appointments for people and get them into GPs, and really divert them away from having to be exposed to an emergency department.

CHAIR - Have you had numbers on the community paramedics, particularly what percentage of their patients they do divert away from the acute system?

Ms HAIGH - No, I've only ever seen the PACER data, which is 70 per cent.

CHAIR - Health might have it. We can ask them.

Ms HAIGH - Health might have it, yes. I think what the government's forgetting, because we're also in the efficiencies, is that we're already doing that with all of these diversions away from the emergency department. They're just not looking at it that way. They're going, 'Oh, you need to save money on this and you have all this overtime', but it's like, 'Yeah, but what about all the money we've saved from not taking people to emergency departments?'.

CHAIR - It doesn't show up on their financial statements.

Ms HAIGH - Exactly, and it's really disappointing because it's -

CHAIR - It's not recognised in any way.

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Ms HAIGH - When all the data nationally is saying it's \$3200 per patient, that's incredibly significant. We are struggling at the moment because of the increased demand and lack of staffing, and dropped shifts and overtime because everyone's burnt out and exhausted. We are now unable to get to those low-acuity cases because the community paramedics are doing emergency cases, and that is not their role. They're available to do that, but they should be focused on their low-acuity diversion role.

Ms GLADE-WRIGHT - Is it the same for the nurse-led care?

Ms HAIGH - ComRRS?

CHAIR - ComRRS is not right across the state?

Ms HAIGH - No, it's not, and it's not integrated with Ambulance, so we're doubling up on some services there. They'll send Ambulance, which is more expensive than ComRRS, when ComRRS could have gone. There's no link, there's no conversation between the two. They're just two separate entities. Really, if we were a bit more integrated with our integrated care, we could be sharing all of that information. For example, I think it's Queensland Ambulance have now employed a physio, and they're going along to falls so that they can do falls assessments and physical assessments on patients that we don't have the skills for that a physio is an expert in, and then they can make referrals and help in that way. That's another diversion process. There are so many opportunities. On top of that, there are so many opportunities for paramedics in the health system. Governments get stuck in - 'Oh, it's only the ambulance service', where there's an opportunity throughout the whole of Health. The paramedics could be integrated like in the NHS, where they are integrated in all areas. But that would require the government to invest in a chief paramedic because just relying on the ambulance service and feedback is not appropriate. We need somebody that's out of that for policy and an overall view of paramedics and what they can do and where they can be integrated. That's very evident now in the Northern Territory, where their chief paramedic has done a lot about where paramedics can be integrated within Health.

CHAIR - So, you would know Ray Bange?

Ms HAIGH - I do.

CHAIR - Of course, you know him. He's been around longer than I have, probably. He's speaking to us later. He will talk to some of these things. I don't know if you've had a chance to read his submission. Do you share those views from a Tasmanian perspective?

Ms HAIGH - Absolutely we do. If we go back and look at the ramping inquiry, I represented twice and I was with the Australasian College of Paramedicine, and we discussed a chief paramedic officer there as well. We are a separate entity. We straddle not only Health but Emergency Services, and I think the government needs that nuanced understanding in leadership to provide that.

CHAIR - Then you have more collaboration between the sectors. You don't double up and you don't leave gaps.

Ms HAIGH - That's right. We're a bit of a different type of profession and I don't think many of the other professions understand what we have to offer. They just see us as ambulance

drivers, which we are not. We are registered health professionals who can provide all sorts of care everywhere. In other states, we have paramedics working in urgent care centres and private providers, schools, everywhere. But here it seems to be a bit more difficult. Chief paramedics have been able to help create policy and procedure to integrate paramedics.

Mr MOORE - We do have a chief nurse, Francine Douce.

CHAIR - She's just retired.

Mr MOORE - She's just retiring this week. We even have it with allied health, with Kendra, but we don't have it for paramedics. It's a major gap.

Ms MUMMERY - Is it okay if I lead on for the healthy stuff?

CHAIR - Yes, how to keep us better.

Ms MUMMERY - Yeah. I'm Sophie. I'm a physiotherapist and have been the president of HACSU's Allied Health sub-branch for a little while now, a few years. I want to present today with a focus on opportunities lost and health savings that allied health could be offering if we were resourced appropriately. Hopefully, we're all aware that Tasmania's population has increased as a whole and we have particular challenges of ageing, more chronic disease and disability, low health literacy, and we're socioeconomically worse off than our mainland counterparts. These factors create additional complexity when we're treating patients, and our current cost-of-living challenges mean more people are coming to our services than ever before.

Tasmania is very undercooked in terms of its allied health services per capita. I think it's something like 53 per cent. We have a lot less when, in fact, we need a lot more to meet our needs. Tasmania actually receives more money from the federal government in terms of how the GST revenue is distributed from the Commonwealth Grants Commission to account for these exact demographics. However, our state Liberal government has chosen not to spend this money on essential health services that keep our population well and fully able to participate in work and society. Our allied health services across THS are in a dire state, with demand significantly outstripping our supply.

We know that investing in allied health services saves the health system money: in the order of \$8 to \$15 for every dollar we spend. If I could get 700 per cent to 1400 per cent return on my investment, I'd be pretty happy. If I just put that another way: health economist Martyn Goddard calculated that we had a \$195 million shortfall in investment in Tasmania's community allied health services over the decade 2011 to 2021. That's \$1.365 billion worth of unrealised savings or waste that should never have occurred. That's not accounting for at least half that again for the last five years, which totals \$2.475 billion over the last 15 years. And we haven't even taken into account the societal, economic and productivity waste in that time from Tasmanians not receiving the care they needed when they needed it.

By this government choosing to leave jobs vacant and delay recruitment, and not staff services to actual demand, we're just writing a more expensive bill for the future when patients are sicker and present to more acute and more expensive levels of care. This cost is seen in outpatients via long waitlists. By the time the patient is seen, they now have a chronic issue instead of an acute one, it's more complex, it has secondary complications and a negative effect on the person's life and work. It now takes more sessions and more clinicians to treat, not to

mention the extra specialist appointments, presentations to ED, potential surgery and admissions in that time, which were never on the cards had they been seen when they needed us.

Allied health services, particularly in outpatient and community settings, have been cut over many years while demand for the essential services they provide increases. Managers have, or are considering, taking drastic action of cutting the services we offer. This is often done covertly so the public are not aware of what they have lost. Community and outpatient physio services in the south have been cut by over half, and five rural sites in hydrotherapy have been stopped completely. And this has been done silently.

Another example is that dietetic services have stopped accepting GP referrals a few years ago. Now, the patient has to wait till they get sick enough to have contact with the THS, then we're allowed to see them, which might be in the form of an admission or take five appointments, instead of two.

CHAIR - Do you understand the rationale for that decision?

Ms MUMMERY - Yeah, because waitlists are too long. It looks bad. And we don't have enough people to see the demand. So, what do you do? You either -

CHAIR - Stop the demand and shut the door.

Ms MUMMERY - You shut the door. But we just write the bill for more expensive down the track. It's really counter-intuitive.

CHAIR - The other side of the door - the door that's shut, on the other side.

Ms MUMMERY - It's so short-sighted.

Ms THOMAS - It's the department of ill health, not the Department of Health.

Ms MUMMERY - Yeah, correct. That example - that we cut our criteria, stands for so many other areas, and the consequences can be more severe and the costs greater. That happens in alcohol and drug services or in our mental health system, where we say, 'We can't see you because you don't meet our acute criteria. But then we'll wait until you're really, really sick. We'll spend more money on you for a much poorer outcome.' Meanwhile, everyone involved has suffered much more by that point, including the patient, the clinician, the family and greater societal costs.

Waitlists for most allied health services are well outside their clinically recommended timeframes. As an example, imagine waiting three months to see a physio after your knee replacement when you should have been seen in two weeks. The replaced knee is now likely to be stiff and non-functional, costing even more in an attempt to remedy it with more surgery and intensive therapy. Not only is the negative effect on the patient far too great, but what a waste of a \$30,000 surgery. What would be even better is if the Tasmanian government funded programs like GLA:D, a six-week evidence-based program of supervised exercise and education for osteoarthritis, which has been shown to avoid or delay hip and knee surgeries, as well as have fantastic patient outcomes.

CHAIR - What does that stand for?

Ms MUMMERY - Good living with arthritis: Denmark. It's a patented program, but it's, I guess, an example of conservative management programs that exist for many chronic diseases. The estimated savings to the Australian healthcare system from implementing first-line conservative management such as GLA:D just for knee osteoarthritis is up to \$690 million per year.

There are many other allied health services that exist and are underfunded or should exist, like they do in the rest of Australia, in the vein of chronic disease management and prevention that have great evidence for health system savings. For example, pulmonary rehab provides savings of up to \$18,000 per patient over the following 12 months of being seen. That's due to reductions in ED presentations, admissions, readmissions and length of stay. Currently, this service is severely under-resourced in the south and the north, and has stopped in the north-west due to lack of resources. Cardiac rehab reduced -

CHAIR - There's no allergens up there, don't worry. It's all fine.

Ms MUMMERY - Yeah, no-one smokes and there's no COPD.

CHAIR - No, no-one smokes up there, no.

Ms HAIGH - Yeah, we don't report that.

Ms MUMMERY - Cardiac rehab reduces readmission by 56 per cent; participants are 40 per cent likely to suffer a subsequent heart attack; and there's a 26 per cent reduction in mortality. The health system saves \$7000 to \$13,000 per patient per life year saved. Currently, this service is under-resourced across the state and is not funded for an exercise professional in the south, where patients are missing out on effective exercise intervention, which is an essential component of this program. Oncology rehab saves approximately \$1500 per participant, it reduces length of stay and has a 28 per cent relative risk reduction in cancer reoccurrence, new primary cancers or death. Routine preventative oral health services have been shown to save between \$8 and \$50 for every dollar spent, noting that currently we are unable to provide sufficient prevention because resourcing is so poor and demand is so great. Our services are seeing patients once they already have a problem. The unrealised savings in this space in both health expenditure and local economics and productivity are huge. Dental conditions remain the leading cause of preventable hospitalisations in Tasmania. Poor oral hygiene and untreated gum disease are heavily linked to chronic illnesses, including cardiovascular disease, diabetes complications and adverse pregnancy outcomes. Along with preventing admissions for dental conditions, managing gum health directly reduces hospital expenditure required to treat the associated chronic diseases -

CHAIR - And reduce premature birth rates.

Ms MUMMERY - Yes, and low birth weights. Falls prevention saves \$1300 per patient episode, and we know many people who have a fall will break a bone and end up in the acute system. Back pain treatment saves \$6000 per patient. Emergency department diversion services save up to \$24,000 per patient, and these are heavily reliant on a multidisciplinary team inclusive of allied health.

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In terms of musculoskeletal care, where physios have their bread-and-butter space, so even when we think the department is on the right track, they managed to waste a huge amount of money. The Department of Health conducted a project to install advanced-scope physiotherapists in all musculoskeletal care pathways, which is a fantastic idea and has lots of evidence, and has been happening in the UK since the 1990s. The successful pilot of this in the south for low back pain has reduced duplicate referrals to multiple services for the same condition; reduced imaging costs compared to standard care; actively managed waitlists; reduced duplication and provided timely assessment; reduced pressure on other services, allowing them to concentrate on more appropriate complex care; identified patients who don't require surgery or are too risky, and have diverted them to non-operative care options, saving surgical and inpatient costs, and provided faster access to care, preventing ED presentations. The estimated cost savings are about \$900 per patient.

This model of care was to be rolled out to all musculoskeletal conditions across the state, which would have provided large savings, increased efficiencies and, importantly, improved patient outcomes. So, not only have we not addressed the current system waste and inefficiencies, but the department spent time and money on the projects themselves and then continue to scrap them.

CHAIR - Was that a particular project that's got a name?

Ms MUMMERY - I thought it did, but I've since found out that it's had multiple iterations over many years and it never quite gets across the finish line and gets implemented fully.

CHAIR - Spend lots of money on looking at this thing -

Ms MUMMERY - Yep, and lots of effort -

CHAIR - Checking the evidence -

Ms MUMMERY - Lots of data -

CHAIR - So, someone's been paid to do that work?

Ms MUMMERY - Yep, and then we just scrapped it.

Ms THOMAS - Are they in the health service or are they in the department?

Ms MUMMERY - I have a feeling they're in the Department of Health, but they will have consulted our existing advanced physios.

CHAIR - You wouldn't have been paid for your advice?

Ms MUMMERY - No.

CHAIR - The person being paid is the person in the department.

Ms MUMMERY - The department is, yeah, doing the work -

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Ms THOMAS - Doing that project planning and feasibility and all of that, and then nothing happens?

Ms MUMMERY - Yeah. Health system service, model-of-care planning. Yeah.

On a different note, there are, of course, huge amounts of waste in our digital systems - and I might let Lara talk to that in a minute, which are inefficient and not fit-for-purpose. As a clinician, they're very frustrating. There is waste in the clinicians and allied health assistants doing administration and bookings, instead of seeing patients, when we don't employ enough administration and customer support to do this work for us. We also waste valuable appointment slots due to not having the support to fill last-minute cancellations, as well as integration problems in central administration not telling us that the patient's cancelled, so then we can't fill the appointment because the systems are not integrated.

CHAIR - Is that a shortage of admin staff predominantly?

Ms MUMMERY - Predominantly a shortage of admin staff.

CHAIR - Because they're not frontline, are they?

Ms HAIGH - No, that's right. They see them as backroom when, really, they're not. They're just as important. Everyone in Health is important.

Ms WILD - Non-essential workers, so that the essential workers are diverted to do the admin desk instead.

Ms MUMMERY - Yeah, and if I'm busy seeing a full list of patients, I don't have time to fill my 4 o'clock appointment during the day.

Just a quick note on recruitment in terms of burnout: given that allied health services are under so much pressure and the workers are under so much stress, and we have trouble attracting and retaining our workers, we under-resource the services, we burn out our staff and we see them resign. This creates long vacancies, and skills and experience shortages in the Tasmanian Health Service. This leads to bed block and waitlist blowouts, with increased patient complexity and chronicity, and poor outcomes, requiring even more resources to manage them by the time we do get to see them. This perpetuates our longer waitlists and more vacancies, and the cycle continues.

Then we have the ongoing costs of trying to recruit to these positions that we're continually losing people to, and each recruitment round costs - I don't know how much, but it's not cheap. So, we need to be considering these challenges and looking after our workforce when we're talking about workforce strategies and investment, including wages, conditions, retention, recruitment and staffing services to demand. We have a health professional shortage across the country, and we can't continue to afford to burn through our workers as we have been doing, let alone the sick leave and workers comp bills that ensue from burning people out.

By now you probably get the point. The inefficiencies and the waste in the system is pretty clear. There are countless examples where allied health services could have seen people when they needed us, preventing more and longer occasions of service, preventing admissions, preventing specialist appointments, surgeries, ongoing costs to other parts of the health and

social care system, and preventing economic and productivity losses in the Tasmanian community. If only these allied health services had been resourced to the evidence base and the actual demand of the Tasmanian community.

In the scheme of health, we're not asking for very much. In terms of allied health, we're often forgotten. We're often asking for two clinicians instead of one. We're asking for one instead of none. We're asking for equity across regions and to reinstate FT that's been silently cut over the last 15 years. We want the government to resource to our actual demand, to reinstate those rural and regional services, and commit to not cutting further, because at the moment, cutting further is what's on the table. Not only can the community not afford to do that, and the staff not afford to do that; the budget can't afford to do that.

CHAIR - Thanks. That's a really, really helpful snapshot of it. Have you added the numbers all up to just give a bit of an idea, just all those costs? I mean, we can do it, we can go back through *Hansard* and get the calculator out.

Ms MUMMERY - The costs of what?

CHAIR - The cost savings that could be made that you've listed one after the other, which should just be one patient for this, one patient for that. Just what you've read out. Did you do a total?

Ms MUMMERY - No, it's too complicated, I apologise, because each of those services are individual, and these are just like -

CHAIR - Examples?

Ms MUMMERY - A small number of examples. They're examples that I know of and many of them are physio-adjacent or physio-based. The examples would stretch into the psychologist and social work services. There's just a huge amount out there. And the evidence is very clear that if we spend money on allied health interventions - we're evidence-based clinicians, we're not doing this without data behind us and without the economics behind us. It's just huge.

Ms THOMAS - What's your view, then, on - the government comes up with this Healthy Tasmania strategy and allocates money. They decide a figure and say they're going to allocate \$5 million to the Healthy Tasmania implementation and then give out ad hoc grants to well-intentioned, but not necessarily expert-based in those areas, organisations to deliver preventative health programs when, instead, that money could be going into the foundational preventive health services that already exist, rather than create something new that might be sexy or politically attractive -

Ms MUMMERY - Announceable.

Ms THOMAS - And announceable, exactly. Is there some level of frustration that you feel that your services aren't announceable, therefore they're not funded to the level that they ought to be, and that that ought to be the priority of the government over some big, thick Healthy Tasmania, or whatever it's called now.

Ms MUMMERY - The preventative -

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Ms THOMAS - Health Revolution, they've called it The Health Revolution, haven't they?

Ms MUMMERY - Or the 20-year preventive strategy?

Ms THOMAS - We were going to be the healthiest state in Australia by 2025, weren't we? Now we've got that plan failed, and we've got a new one that says lots of words and has very limited tangible actions that mean anything on the ground to the community. Sorry, I'm on the wrong side of the table here.

Ms MUMMERY - I agree. One thing that I find super-duper frustrating is that I got told by someone very high up in the Department of Health that if the services on the ground need more funding, we need to go via HACSU, or as a member of the public, and put a submission into Treasury at budget time.

CHAIR - Great.

Ms MUMMERY - That was the methodology of me as a clinician on the ground having a service that's falling down around me, with a waitlist of three years when it should have been six weeks with a preventive focus. And that was my method.

CHAIR - You're just not heard.

Ms MUMMERY - There's no linkage.

Ms THOMAS - Not even working in through the Public Health team in the department?

Ms MUMMERY - No. They don't know we exist because we're siloed, we're separate. I find it absolutely ludicrous that not once, as the funder and the commissioner of health services - so the government or DoH has not once talked to workers who run allied health services on the ground.

Ms THOMAS - About the preventive health strategy?

Ms MUMMERY - Well, we could attend the consultation if we looked at it and our diaries were free. We're not invited. They don't know we exist. If you're a clinician with, say, head down, bum up, just on that treadmill, you don't have anyone advocating for you to actually fix it. There's no remedy coming, which is completely disheartening for the people trying to do the job on the ground. It's not their job to advocate for these existing services. These are government services that are pretty staple in a First World health system, or they should be.

What's frustrating is even when we have the motivated clinicians who put up a business case to say, 'My existing service are collapsing around me', they just get completely ignored. There's mass risk to the patients, to the staff, to the community and the health system by not having those processes. One thing we tried to get going in our last bargain was to have robust processes where workers can, from the floor, talk directly to bureaucrats and the government, or at least have a periodic review process where the department says, 'How's your service going? Is our funding meeting the actual demand and the actual need?'.

CHAIR - If only they could spend a day with you.

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Ms MUMMERY - Yeah, it would be nice.

Ms HAIGH - Can I just also add to that, as an area that is seen as sexy by government and there's lots of announcements about paramedics. There are announcements that aren't necessarily they understand, for example, paramedic practitioner, which ARPA is still working on. That doesn't even exist as a role yet. They'll make all these promises about that but don't understand the context around it and what is required to train these people.

CHAIR - Ask the King Islanders about that.

Ms HAIGH - Yeah, exactly. And community paramedics, that was like, 'In 100 days we'll have all these community paramedics'. We can't even do a recruitment process in that time to even -

CHAIR - Or build a station or anything.

Ms HAIGH - Exactly. They say a lot without the understanding of what the actual impact is and the work that needs to go in behind that. That is throughout the whole of Health, not just us.

CHAIR - Did you want to hear from these two before we run out of time, perhaps?

Ms WILD - Is it all right if I follow on, because I can speak to some of the resourcing stuff that Sophie has touched on? I suppose the overarching message is that it really feels like we're not investing in the preventive stuff and the things we can do ahead of time; preventing some initial costs and initial expenditure to make initial savings that look really good on a report and on a budget, but they actually cost the service and the government more. That occurs in the workforce as well. We see delays in recruitment processes. We see lost candidates due to the poor experience that candidates have when they apply. It's a very lengthy process. You do have a lot of hoops to jump through to apply. And, even then, at the end of that time, if you want to speak about clinicians, but any areas, you need to tools-down and commit the resourcing and the time to recruit and to try and attract people. That does take a significant amount of effort from the people on the ground. And a lot of the time, it's clinical managers and stuff that have to do that because they're pushing that through. But then what I have seen, in my experience as a recruitment officer, is that occasionally you either get no applications, like no suitable people, which wastes that - for every external job that we advertise, the Employment Direction No.1 dictates that we need to have that advertised for a minimum of nine days and that, functionally, is two weeks. So, even having that out there for two weeks before we can even look at the candidates, and then the x amount of time in the bureaucracy at the end of things, the red tape going back and forth -

CHAIR - Where's the back-and-forth happening?

Ms WILD - In terms of administration and -

Ms MUMMERY - I was going to say, in terms of getting a job card up in the first place is a battle.

Ms WILD - Correct, yes.

Ms MUMMERY - That's step number one, and then approvals -

CHAIR - So, the department have to actually issue the job card?

Ms WILD - We do, yes. Sorry, I'll step back just a little bit to paint the picture of the timeframe and where the delays, I think, occur. Prior to advertising a job or a vacancy, which includes a contract extension or a transfer internally, we raise a request and that goes through - like, we put in what we need, what the job is, and then it goes through an approvals process. So, it goes through the internal HR area. They make sure that it's compliant with the employment directions so we're not breaching any requirements there. Then there's a few different steps in the chain, for example, the area's delegate or chief exec, there's finance and budget management to make sure that the funding is available to pay for those resources. Then we have -

CHAIR - Even if it's an establishment position, you still -

Ms WILD - Yes, correct. Also the vacancy committee is in that step as well. We do see lengthy delays in even just the request for the job card. So, before we even get to the point of this minimum two-weeks job advertisement and the subsequent effort and time in interviewing and recruiting candidates, and then additional pre-employment checks prior to onboarding, there's already an extensive delay. In my experience - I ran just a couple of numbers in the things that I have seen and I think, on average, it was about 11 weeks from the raising of the job card - so from the initial request to having a contract issued at the very end.

CHAIR - How could we expedite - I mean, I understand them being a bit finicky about newly created positions, but an establishment position that's been vacated because someone's resigned, retired, whatever, how could you speed that up? What would you do to make that efficient? Because we do hear anecdotally and in other ways that people get tired of waiting, they get offered another job, so they're off. So, what would you do? There needs to be checks and balances, but what could you do to streamline that process?

Ms WILD - Certainly. In my view, the biggest source of delays is getting stuck in back-and-forth, as I'll call it, and that does occur at the beginning of the process, so frequently with either, I would say most commonly with the vacancy committee. So, sometimes you submit your request into the job card, which states exactly what you need, position filling: 'This person's resigned, we would like to fill this job for this amount of time, there you go.' Then sometimes we'll get questions returned from the vacancy committee, and I know that they meet approximately once a week, so even if you provide a response, you won't get any action until they review your response at the following meeting. And if there is -

CHAIR - But why would they even be questioning an establishment position?

Mr MOORE - Well, that is what it's set up for, the vacancy control committee: it is literally looking at established. You don't get new positions really through. They are looking at the thing. I actually think the fundamental issue, because this happens on every decision, is that they don't let managers manage, they don't delegate responsibility. But it shouldn't have -

Ms MUMMERY - Well, they recently removed delegation.

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Mr MOORE - That's right, it should just be about delegating that. I've always said a bad decision's better than no decision. That's what the health system is held back on most of the time. Bad decisions can be corrected. It's this no decision and idle sort of thing that's -

Ms WILD - Yeah, and occasionally we do see - even the questions come back to us, it's questions about information that's already been provided, like, 'Why do you need this position?' and I was, like, 'Oh, okay, because this person has resigned.' So, there's a disconnect there somewhere with -

CHAIR - They don't read what they get?

Ms WILD - I'm unsure. I don't know what the exact content is that they received, but for some reason some of the questions we get, it seems quite frustrating because you try and provide as much info as you can so it's a justification, tick-and-flick, this is replacing somebody that's left. It's not an increasing expenditure, it's not over-resourcing. It's filling a gap.

Ms MUMMERY - Or this person is currently in the job and the contract needs rolling over, and these people then don't have four weeks without pay, or five weeks, while they wait and we either lose them or we're unfairly not remunerating them for the actual duties they're doing.

Ms WILD - Precisely.

CHAIR - The government have said they're not cutting frontline staff, however defined. But clearly a nurse in ED, or a nurse on -

Ms MUMMERY - But delaying frontline staff is not cutting them, is it?

CHAIR - But you're paying more in overtime and double shifts and agency.

Ms WILD - That's that was going to be my next point. Due to the amount of time it takes, sometimes we do see, even if we find a suitable candidate at the end, which is hard in our Tassie market, occasionally they do leave because in the eight weeks or however long it's taken, they've found something that's more attractive elsewhere. Or they feel like they're not valued as workers because they've been kind of just left and strung along due to this lengthy process.

And while not having an employee is an immediate saving in terms of on a salary report, you do see those costs reflected elsewhere and often in a greater amount, so things like: agency, locum nursing, you see overtime, you see staff burnout, turnover, lack of retention and the associated impacts on patients. It means that we've got people running double shifts that you probably shouldn't have. It means that people in crisis situations, maybe they don't feel that they can take the leave that that they need to support their own wellbeing and our workforce retention. And then sometimes you do see people that leave the service because they can't handle, because they need to now take care of themselves because we haven't been able to properly support them as workers.

CHAIR - We're almost out of time. Particularly, we haven't heard from Shane yet. Sorry to cut you off. You can always provide further information to the committee, but I just wondered whether -

Ms WILD - There's really not very much more that I had to add. It was more just that while some of these immediate savings, they look like immediate savings, that the actual true cost is greater and reflected elsewhere that might not be immediate. Like, every dollar that we spend in preventive health and doing things correctly in the first instance saves us multitudes down the track. And just a really quick note on the digital systems: it's the exact same thing. So, there's wasted effort, wasted resources. We haven't invested in our digital systems, which means that we've got doctors and nurses and clinicians who could be seeing patients, they're spending more time doing paperwork, chasing records. They don't have what they need in front of them, which means that our health service, in terms of infrastructure and workforce, is just not conducive. There's wasted time and effort, and that's all I have to say. It's all costly.

Ms MUMMERY - Poorer patient outcomes in terms of patients get lost in the system and we miss referrals.

Ms WILD - Without knowing some things, you do see, for example, repeated blood tests from someone coming from LGH to the Royal because that data hasn't transferred with them. So, they've already got a diagnosis from LGH, but they haven't received that info in Hobart.

Ms THOMAS - I'm not sure if you have you been watching any of the early hearings, but we heard from Dr John Lambert in our hearing just before lunch, who provided his insights into his experience in working on the Bluegum project. It was very interesting.

CHAIR - Transcript or the feed will be available.

Ms THOMAS - You'll be able to watch it back. But one of the things he talked about was the lack of prioritisation by the government of investment in digital health systems -

CHAIR - Digital transformation.

Ms THOMAS - Digital transformation, sorry, in the Health department. From the people who work around you and your perspective, what would you say in relation to that? I'm interested to know because, clearly, quite a significant amount of money has been spent on HRIS and Bluegum to date. In terms of the future for these digital health programs, is there a sense among people working in this area that a lot of that effort's been wasted and dismay about what will be done in the future about that?

Ms WILD - There is a general feeling that we all agree that we do need to improve the digital health systems because, again, it's like the preventative health argument. If we invest some now, that will save us later. That does apply to the digital stuff as well, even though that's more of a shadow operation, but it is a supporting thing. We all see the value, we are committed to that and it does still need to occur in our view. I suppose there is a general feeling, like maybe the amount spent to date could have been better prioritised, maybe with some better planning or - I'm unsure. There is a bit of disagreement.

Ms THOMAS - It's a difficult question.

Ms WILD - I don't want to say anything that's not correct because I haven't been in the room for any of those conversations. I don't want to provide anything that's not true.

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CHAIR - You could always provide something back to us after you've had a chance to have a look at it, if you wish.

Ms HAIGH - There is a lot of scepticism around the digital transformation because I know when I started in the ambulance service 20 years ago, that was promised and nothing's happened. We're still using spreadsheets and paper, and all of that sort of stuff. I think there's a lot of scepticism about it because nothing's happened.

CHAIR - If I could go to Shane perhaps, because we have the next person on.

Mr HAMEL - Over the last few months, in July-August, we ran quite a lot of surveys with members and, especially out on the ground with members, we had a lot of conversations with them around what's going on in Health and very much from a waste point. And across the state there's a lot of discrepancies. One such example that I can give is that at the Launceston General Hospital, for instance, they have quite a robust facilities and maintenance team, probably the best out of any of the hospitals in the state in terms of the number of staff. There are still things that they outsource and don't use internal staff to do, such as refrigeration. They effectively pay external contractors quite a lot to do that. There is talk of them stopping their electricians from doing testing and tagging, for instance, and outsourcing it. That is a practice that at the moment is done externally at the Royal Hobart Hospital and other hospitals. We pay contractors to do stuff that someone can actually do that is already on the staff.

Also, with that, they spent a lot of time and effort training their electricians to do fire door testing and smoke alarm testing. Shortly after they started doing that testing, it was taken off them and it's been outsourced. Again, it's an investment in something that reasonably should be done in-house and we are instead paying contractors to do those tasks when, reasonably, we actually have people on staff who could be doing them. Even with the LGH having the pool of workers that they have, if they had more, they would actually be able to service places like St Marys and Beaconsfield, and all these other things which we pay contractors. Did you know those contractors are actually travelling from Launceston as well and we pay for their travel time because they don't have the trades in their regions.

Another example that I can give you is that the two major hospitals, being the Royal Hobart Hospital and Launceston General Hospital, both used to hire their air mattresses for the beds. Obviously, that comes at quite an exorbitant cost. Some years ago, it was put forward by the equipment team down at the Royal Hobart Hospital to actually purchase them for the equipment team to manage them and to look after them. That paid for itself within 12 months. We still hire them at the Launceston General Hospital.

CHAIR - And the North West Regional?

Mr HAMEL - They don't really have that many. I think at the North West Regional and the Mersey, they actually own theirs because there's only a handful of them at both of those hospitals. But things like that, the equipment teams have spoken between the Royal Hobart Hospital and the Launceston General Hospital. Even though the teams agree that clearly it's an easy way to save money, it's just something that cannot be pushed through up the chain.

Another example I can give you from our members within the pharmacy space is that back in 2021, there was \$1.1 million spent in what's called the Partnered Pharmacist Medication Charting Scheme. We developed a program to have people credentialed to do a

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trial, et cetera. It ended in \$2.9 million being allocated for pharmacy to put the initiative across all hospitals. This scheme effectively has an accredited pharmacist in ED doing charting. When someone is brought in, it leads to a - well, it's shown at the Alfred Hospital to lead to a 97 per cent reduction in medication errors. It reduces length of stay by, on average, 10 per cent. To date, it is not in place because we cannot actually staff Pharmacy to a level to actually put it in place.

CHAIR - So, Pharmacy itself is not staffed enough to have another pharmacist that could be in the ED?

Mr HAMEL - Yes.

Mr MOORE - At this stage.

Mr HAMEL - It showed that it's really on the paper, it's a 10 per cent length of stay reduction. That's an easy saving right there, if we could just attract and retain pharmacists to put that in place.

CHAIR - You'd want more than one pharmacist in the ED at the Alfred, I imagine.

Mr HAMEL - I think it's about 14 positions across the state.

Mr MOORE - We had people being discharged last night at 8.30 p.m. just because there weren't enough pharmacists. You know what I mean, if we had more pharmacists, you would literally get people and you wouldn't be paying overtime. It's that simple.

Mr HAMEL - Probably the only other one that I'll touch on that has been brought up with us on numerous occasions within the mental health space is the lack of appropriate facilities. The example I'll give is that there is something called SILU, which is, I believe, secluded independent living units, out at Wilfred Lopes. There are three of them. They were purpose-built as a sort of step-down for people transitioning out of Wilfred Lopes as they go into the community. They are used for storage of equipment because they are not fit for purpose and do not get utilised, and have never basically been utilised or operationalised after we spent money on putting them in place.

CHAIR - Where are they?

Mr HAMEL - At Wilfred Lopes. The idea is to transition someone back out to being back in the community.

CHAIR - Yeah, it would be very hard to straight from Wilfred Lopes into the community.

Mr HAMEL - Exactly. Even for them to go out to Millbrook Rise is not appropriate in that first step, for instance. Not having those appropriate facilities leads to patients basically bouncing in the system. Quite often they'll go from places like Wilfred Lopes directly out to places like Millbrook Rise, where they don't adjust. They will have reoccurrences occur and then they go straight back into HDU in the hospital.

CHAIR - And then they cycle back to Wilfred Lopes.

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Mr HAMEL - Exactly. There's a patient in there at the moment who's on more than a 12-month stay in HDU, which costs an astronomical amount. If there were appropriate treating facilities, they would actually potentially have been able to be reintegrated into society and back out.

CHAIR - Is Wilfred Lopes funded by Health or Prisons?

Mr HAMEL - It's funded by Health.

CHAIR - Even for the criminal patients in there? That's probably not quite the right term for them.

Mr MOORE - Wilfred Lopes is Prisons, is it, but the hospital is Health, isn't it? Or the other way round.

Mr HAMEL - No, I think effectively what happens is that Health charges out the services to the Department of Justice, is what I understand.

Ms THOMAS - Because it's a mental health facility.

CHAIR - It's a secure mental health unit.

Mr MOORE - This is an area that's significant. The amount of people that are in our prison system simply because they have a mental health condition is astronomical. You talk about the costs: if we had better mental health services, they would not be in our justice system.

CHAIR - Prison's not the best place for a lot of those people either.

Mr HAMEL - Even the HDU at the Royal Hobart Hospital, which is brand-new, effectively, in K-Block, it's somewhere where you don't have access to daylight. The conditions work for short term. Anyone that's in there long-term, it becomes a contributor to their length of stay.

CHAIR - To their mental illness?

Mr HAMEL - Yeah. It's not appropriate. We quite often see a number of people go through the system repeatedly who have to spend extended time there because there is nowhere else for them to go.

CHAIR - I'm really sorry to wrap up. Thank you all for appearing before the committee. It's really helpful. If there is other information you wish to share with the committee, feel free to send it on through Robbie. If there's anything that comes up, particularly after you view some of the hearings that we have, then we're really happy to hear from you.

Mr MOORE - Thank you very much.

The witnesses withdrew.

The committee suspended from 2.25 p.m. to 2.28 p.m.

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Ray Bange OAM

CHAIR - Thank you, Ray and Matt, for appearing before the Government Administration Committee inquiry into the financial and operational performance of the Department of Health. I know you're particularly focused in the paramedic ambulance service space, so, we welcome your contribution on that. Thank you for your submission. That's really helpful and comprehensive. This is a public hearing. Everything you say will be covered by parliamentary privilege and form part of our official parliamentary records. It is being transcribed and broadcast, and will form part of that record. If there was something of a confidential nature you wish to share with the committee, you could make that request. Otherwise, it is all public. Do you have any questions before we commence?

Mr BANGE - No.

CHAIR - Apologies for being a little bit late starting.

Mr MATT WILKINSON-STOKES WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED. (via Teams)

Mr RAY BANGE OAM WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED. (via Teams)

CHAIR - Thank you very much. I'll invite you, Ray, if you want to lead off, to provide some opening comments in support of your submission and to bring up anything of particular focus for us. Then you could hand to Matt or manage it however you two see fit.

Mr BANGE - Thank you, Chair, and members of the committee. I acknowledge the Tasmanian Aboriginal people, the traditional custodians of the land, and I pay my respects to elders past and present. I appear in a personal capacity, and I disclose that I'm a listed co-author of the Tasmanian cost-benefit study by Westpac scholar Matt Wilkinson-Stokes which is cited in my submission. My central recommendation is that Tasmania improve the efficiency of the Department of Health by making better use of the paramedicine workforce, starting with a chief paramedic officer, or CPO. I'm accompanied by Matt, who has studied for a number of years in his PhD work and has a particular knowledge of the Tasmanian ambulance situation. My recommendation (a) in my submission is clear: establish a CPO role, resource it and measure what happens - namely, avoided ED presentations, re-presentations after non-transport, transfer of care times and cost savings. Tasmania already has the workforce. What it lacks is the leadership to use it well. A chief paramedic officer would fill that gap. I have prepared a slightly expanded opening statement and, with your permission, I would like to table that to be part of the record.

CHAIR - Thanks, Ray. If you haven't already emailed that, if you could email that to the committee secretary, that will be included as part of your evidence. Thank you.

Mr BANGE - I would also ask if Matt would have any comments he might like to make at this time.

Mr WILKINSON-STOKES - Thanks Ray. Nothing at this stage. I agree with everything that Ray said. Happy to answer any questions as they come up.

CHAIR - Did you want to add anything, Ray, at this point or do you want to go straight to questions now?

Mr BANGE - Straight to questions.

CHAIR - Could you just flesh out for the committee how the role of the chief paramedic officer would be structured and what the benefits of it would be?

Mr BANGE - Well, the benefits are manifold. Essentially, I would see the role as being complementary to the operations of the ambulance service, which really only looks after the paramedics who work for the ambulance service. The paramedic profession is a registered health profession and has expanded considerably in recent years. In Tasmania, the numbers are now 807 registrants, whereas the last time that I appeared before this committee, at which I think you were present, there were far fewer. Those paramedics work right across the health sector, in aged care, in palliative care, in event circumstances, in industrial sites. The idea of having an independent CPO is to ensure that the capabilities of those professionals working outside the ambulance sector are utilised effectively.

Matt has actually spent quite a long time in his doctoral research looking at what community empowerment could be, and he is also aware of the role of a CPO. I'm prepared to give you a more extensive outline of what those duties and functions can be and make this available to the committee in a written submission.

CHAIR - That would be helpful. I think for people who look from the outside, we've got a head of Ambulance Tasmania and there's a general view, because of lack of understanding of the system, that that person is like a chief paramedic officer. I guess it's helpful for us to see how that would bring together a range of health-related services. Would it also cover management of the volunteers? We have a very heavy reliance in our regions for volunteer ambulance. In fact, still on King Island it's entirely run by volunteers. Would all of that fall to this person?

Mr BANGE - Not necessarily. I think you've heard from other respondents that there was a lack of integration in the system. The chief paramedic would work in the peak management and leadership role, and would have a focus on paramedics in particular. The volunteers in Tasmania are normally organised with the ambulance service. I'm now referring to the health volunteers, although there are volunteers across all allied health areas. I wouldn't see the CPO as having a direct functional role associated with ambulance volunteers. Certainly, it would be important that the CPO liaise closely with Ambulance Tasmania, and with the health sector and with the private sector.

CHAIR - From a governance and structural point of view, should the CPO report directly to the secretary of the Department of Health?

Mr BANGE - Yes. It would be a hybrid role, actually; not only to the secretary of the department but as part of the peak leadership team. That would mean that the CPO could also provide advice to Ambulance Tasmania and to the minister's office.

CHAIR - So, it would sit up there with departmental secretaries, or is it a step down from departmental secretaries? I'm just trying to understand the governance model you're suggesting here.

Mr BANGE - The role is hybrid, the role is complex, the role really needs to be seen in the same light as a chief medical officer and the chief nurse and midwife -

CHAIR - Okay, so it's at about that level?

Mr BANGE - Yes, definitely.

CHAIR - I'm looking at the role of community paramedics and their scope of practice, and even the varying sets of qualifications for ambulance officers as well. Like, some are intensive care, they're called different things to different jurisdictions, but some have critical care qualifications, some don't. So, what would the role of CPO be in responding to workforce planning and delivery in all of that?

Mr BANGE - Well, the CPO should be part of the system and at the present moment we have evidence, or we have lack of evidence, that the paramedic profession as a whole is being considered. Perhaps I might refer to Matt at the moment because he's also done a considerable amount of study into the role of community paramedics. Matt?

Mr WILKINSON-STOKES - Thanks, Ray. Thank you all very much for having me here and having me have a little chat about this. I've just got a handful of notes that I've jotted down which I thought might be helpful. Right now, in Tasmania, between 10 and 20 per cent of your workforce for paramedics work outside Ambulance Tasmania. That covers dozens of different employers in a range of environments. Right now, essentially no-one has oversight of them; no-one's making sure that these people are being utilised in the most effective way possible throughout the healthcare system.

Well, what does that look like when they're really used effectively? Well, we'd probably want to look at Victoria if you want to look close or the United Kingdom if you want to look further afield. The UK, for example, has about 1200 paramedics working in GP clinics relieving the pressure off primary care, which is where we're really seeing those flow-on effects into increased ambulance presentations, increased ED crowding, increased bed block and reduced aged care placements - all beginning. They're looking at relieving the beginning of that rather than going right to the end of that cycle.

Paramedics are working in EDs in trials in New South Wales, they're working in urgent-care centres in Western Australia and in Queensland, where I am. All of those roles come with regulatory challenges.

If you're looking at doing something like Victoria, where paramedics are about to have prescribing rights - New Zealand are bringing in prescribing rights, UK already have prescribing rights for hundreds of medications - that is very regulatory complex. We're not saying - you don't need a full team to tackle this; one full-time person is really a very modest investment and the rewards on that are many fold. You can see that if you look at the outcomes of the chief paramedic officers in Victoria - they're now up to their third one.

You could certainly consult with Professor Eade, Professor Reynolds or Associate Professor Baranowski about their roles and how effective they have been over the last few years. Or you could look to the Northern Territory and Associate Professor Michelle Piercy for her role. These are roles which those of us who work within this space, at the risk of kind of

forecasting the future, we all think that they're somewhat inevitable. It's largely inevitable that paramedics will eventually get some kind of prescribing rights in all the states. The evidence for this is overwhelmingly supportive, and it helps relieve the pressures that we're seeing universally across the system. Having one person to help provide you with the really up-to-date evidence and policy guidance that you need to make an informed decision is really pretty logical - pretty much a commonsense suggestion.

That's all that I'll say at this time unless you have any more specific questions. Happy to chat about community paramedics if you want.

CHAIR - Well, this is my ignorance on the community paramedics themselves: are they recognised by AHPRA as a separate entity or are they considered paramedics?

Mr WILKINSON-STOKES - That is a phenomenal question because it's happening right now. So, up until - sorry, as of this exact moment, they're covered by general paramedic registration. In 2024 the - you'll have to forgive me if I get the terminology slightly wrong - Health Ministers' Meeting, I think, all the Australian state and federal Health ministers got together and they put a recommendation to AHPRA to have what they're calling endorsements for specialisation for paramedicine, and that's going to include what we variously called community paramedics, extended-care paramedics, Paramedic practitioners is what they've passed in legislation in Victoria - the terminology is a mess, don't let that distract you, it's paramedics essentially who have a master's degree - also for the critical care, intensive care, which you're already aware of, that is about to become regulated at the national level, which will help mean that when they work outside of these large employers, like an ambulance service, there's an appropriate safety and governance structure in place and will also help in opening up things like the prescribing and regular challenges.

What it won't do is provide the kind of state-specific advice which you really need to utilise these roles effectively on a state-by-state basis; this will just be the big picture national stuff. That is being approved. It's coming in right now. Professor Stephen Gough from Queensland is in charge of the project. I'm sure he'd be happy to chat to you about where it's up to, but it's a work in progress. But shortly, yes, they will have specialist endorsement under AHPRA.

Mr BANGE - If I may add something to that: the terminology in the profession is a mess, and it has developed over many, many years before the advent of registration - national registration, which recognised paramedicine as a health profession, helped to clarify that. So, you have different employers using different terms for different roles and it's only under registration that that has become far more rational.

The other thing is that with the advent of the Chief Paramedic Officer in the Northern Territory, within less than 18 months after her appointment, the Northern Territory has promulgated a capability statement which applies to all paramedics within the territory. That has clarified the role and the activities of those working both within the public and the private sector. That's one of the big advantages, and that's one of the issues related to governance, which Matt referred to previously.

CHAIR - So, what you're talking about here is the scope of practice for them to be clarified and hopefully be consistent - that would be really helpful - but also, the prescribing rights. Clearly, the prescribing rights are state-based because the states have their own poisons acts. That means it is a state-based thing, but are the prescribing rights provided to community

paramedics in the jurisdictions they've got them consistent, or are they different? If I'm a community paramedic, can I prescribe different medications in one jurisdiction than I can in another?

Mr WILKINSON-STOKES - Do you want me to answer that, Ray?

Mr BANGE - You may as well.

Mr WILKINSON-STOKES - The short version is right now, outside of ambulance services, the only independent autonomous prescribing rights are in Victoria. So, there's no-one to compare it against at the moment. Within the ambulance services, paramedics don't prescribe, but they can, in some instances, be providing what are effectively prescriptions, but that's under the authority of an employer. So, it's a different regulatory system.

CHAIR - It's under a standing order.

Mr WILKINSON-STOKES - Yes. That is slightly different from state to state, enormous amount of overlap, because the fundamental medications that the kind of people that paramedics are seeing are - really these are basically similar to what you would find a nurse practitioner handing out. It's a different version - a nurse practitioner is a really good intuitive way to think about it - with some minor state-to-state changes. For example, the Northern Territory has a lot of rheumatic heart disease, so they have specialist medications for that. That would be less of an issue where I'm working in Queensland. By and large, they're similar.

Mr BANGE - If we want to take an example from New Zealand, the New Zealand Ministry of Health has just approved a list of 232 medications which appropriately qualified paramedics will be allowed to prescribe. That has come into effect just within the last month.

CHAIR - Gosh, that's an extensive list, that many.

Mr BANGE - Yes.

CHAIR - Can you send the list? Just out of interest, more than anything. Not right now. When you got a moment.

Mr BANGE - Yes.

CHAIR - I mean, I think consistency across jurisdictions is important, and if we want to attract paramedics from other jurisdictions to Tasmania, it's helpful where there is consistency of terminology, prescribing rights, scope of practice, all those things. Will the new regulatory framework under AHPRA for these professions make that more likely, do you think? It would be helpful if it would do that.

Mr BANGE - That would be my fond hope. I do have some reservations about the process. My own personal reservations are that the group of endorsements, or the endorsements which were proposed by the health ministers' meeting, don't actually align with the occupational classifications under the Australian Bureau of Statistics' OSCA classifications. But they really have to get their act together. They really have to talk together. They really have to decide how to align these descriptors, how to align these definitions, how to align the scopes of practice. I'm relying on the Paramedicine Board of Australia and the studies that have been

done under the AHPRA framework to clarify that. In the meantime, I cannot be definitive in saying that it will actually align exactly.

Mr WILKINSON-STOKES - And as you would know, AHPRA's role is really the public safety perspective. They provide this specialist endorsement with the idea that it will then provide a legal precedent, which means that if anyone practises outside of what is safe, they're able to be appropriately monitored and regulated: What AHPRA are not going to do is go to any of the states and say hey, here's a list of medications these people should be giving. That's just not their role. They're certainly not going to ever do that. That's where you would need someone within government at your level to do that, and that's where we see something like a chief paramedic officer filling that need.

CHAIR - Providing advice on that, yes. So, in terms of the cost saving, I mean our previous witnesses talked about a whole range of interventions in the primary and preventive health space. There's obviously a cost to employing a chief paramedic officer, but how could you balance up the costs with the benefits it would bring, and one would hope, at least break even, if not return a positive outcome?

Mr BANGE - I really must pass that over to Matt, because he sat in on an extensive study which was Tasmanian-based, and I do have estimates which I've prepared. I think the secret is what you've heard in the previous discussion, which is sometimes you have to spend money to really save big money, and that's what the CPO would do. Matt?

Mr WILKINSON-STOKES - You are right, this is right within my wheelhouse of where I've spent the last few years of my PhD at the University of Melbourne investigating the economic impact of these community paramedics. And I can rattle off a whole bunch of figures for you, if that will be helpful, but to give you just a rough idea - and I'm going to mention the ambulance service first, but we'll transition out of that in a second - something like 50 per cent of ambulance calls, and this is more or less globally consistent, are not what we within the medical world would classify as an emergency. In fact, the rates of an emergency, those of us who work in this space, normally put it somewhere between 3, 4, 5 per cent, depending on what definition you use.

So, something like 95 per cent of calls - and this is the case for Ambulance Tasmania as well. There's some 2017 data which put it at about 2 per cent true emergencies. Ninety-eight per cent of calls are not what we consider a medical emergency. They are suitable for something like a GP, going to the ED but taking themselves there rather than having these two paramedics take them there, or going to an urgent care centre, and those are all options, certainly within the Hobart area.

The reason why it's problematic that people continually use ambulance services - and we're in no way, shape or form blaming people for calling ambulance services - they're making a good, reasonable decision based on the evidence that they have available to them as people who aren't experts in this - we, as the system, need to be the ones who help guide them down the right care pathway however they choose to access care. Where we see the problem from an economic side of point is, an ambulance is, if someone was to instead go directly to an emergency department, the ambulance costs 125 per cent more.

If they go to an urgent care centre, it's 642 per cent more, and if they go to a general practitioner, assuming that's suitable - and at least 20 to 30 per cent of ambulance calls, we

know from the data, are suitable - just to take themselves to a GP, that costs 1608 per cent more. Now, admittedly, the GP gap fees are borne by the patient, the GP cost is borne by the Commonwealth, but from a systems level, those are all extraordinarily expensive options relative to calling an ambulance.

So, what we're really seeing is this huge inefficiency in how people are, I guess, having these services delivered. Then there's numerous flow-on effects. You would have seen in the news yesterday or the day before someone died waiting for an ambulance after one wasn't available for 25 minutes. Look, I do not know the data. I think it's extremely likely that a large number of those ambulances that were ramped at the hospital were ramped with people who probably didn't actually need to go to an ED at all, and they're there because of systems and regulations and these complexities which kind of coerce paramedics into taking people to the ED when they often don't require it. I have data on that which I can talk to, if you want it. But the important point is: something like community paramedics would provide them with the extra education - we provide regulatory oversight to make sure that they're monitored, we provide them with the access to things like prescriptions, access to things like imaging to do the appropriate investigations, and that really trains up and empowers that individual to provide safe care, which doesn't default to taking someone to the ED, which is an extraordinarily expensive option.

Bringing those roles in is simply too much for someone like a CEO or commissioner, an executive of an ambulance service to handle. They're already doing a massive more-than-full-time job just to kind of - well, essentially, we talk about it as putting out fires on a day-to-day basis, managing these multimillion-dollar organisations. They don't also have time to go over the regulatory frameworks and the prescribing and the individual medications necessary to introduce a complex role like this. This is something where a chief paramedic officer can help introduce those community paramedics roles, can help make sure that they're safely positioned within the system and that then, even if you only reduce the number of calls and transports by margins of a per cent, it more than pays for that person's salary many, many times over. You can see some of the evidence of that in our cost-benefit analysis.

Mr BANGE - If we look at the evidence, I recommend that the CPO sit at the same level as Tasmania's other chiefs like the CMO, chief medical officer, chief nurse and midwife, and the chief allied health adviser. So, a reasonable working assumption is that the level should be about SES 3. So, the office cost, if you start to look into the individual support, the office ranges between \$500,000 to \$650,000 a year. They're ballpark figures. I absolutely suggest that this is ballpark and it really has to be examined in the light of discussions with the Health department and with the ambulance service and with the profession at large. So, if we look at, I think, say \$550,000 or thereabouts, we only need to have something like less than 200 additional community paramedic responses a year to have covered that cost. And, I think, the figures last year were something like 4100, 4093 that were quoted. When you're looking at 200 to 4000 that's like 20-to-one ratio of cost effectiveness. So, from a purely economic point of view, the CPO would very quickly pay for themselves and hopefully improve the level of care. After all, what we're really looking for ultimately is access and equity and effective, satisfactory high level of care.

CHAIR - It seems to me, if you listen to a whole range of different perspectives on this, there's not one thing we should be doing in health to try and address the financial pressures, it's a whole range of things. This is just one of them, but there's lots of ways you can save money. And as you said, sometimes you have to spend it to save it. Spend it at the outset to save it at

the end. That's sometimes difficult when you've said you're freezing all new positions, puts the government at odds with their own statement to consider this. But that's a matter for them.

Mr BANGE - Yes, but I think common sense should always prevail.

CHAIR - Thoroughly.

Mr BANGE - And what I've suggested in my written opening statement is that five years or so ago we heard from then-health minister Rockcliff that he was actively looking into appointing a CPO. The former chief medical officer also mentioned how a briefing document had been prepared. We then saw in the 2040 strategy that consideration would be given to a CPO, and, as we get closer and closer to 25-26, suddenly the CPO has disappeared. Where's it gone?

CHAIR - We can make a lot of commitments, Ray. Delivery is another thing.

Mr BANGE - Correct, absolutely. And I'm now saying it's time. It's time to start delivering.

CHAIR - Well, particularly as there are others who have already moved on it and seen the benefits. The evidence is there. You can't say there is not the evidence now. So, that hopefully puts a bit more focus on it. But we'll be hearing from the minister a little later, well not until early next year. But it's something, certainly, we can pursue, along with the other suggestions that have been made by people. I really do appreciate your insights. I know you have been talking about this for a long time, and have had numerous and frequent announcements, I won't call them commitments, because there are very few commitments that are actually followed through at the moment on this, but certainly announcements. We'll certainly pursue this matter with them.

Mr BANGE - Thank you. Victoria has been operating since 2017, Northern Territory for the last two years, and South Australia is in the process of looking into the implementation. In all of these positions, I once again stress it should be looked at as a seat at the table and not simply a nameplate that is tokenistic. It has to be resourced properly and it has to be evaluated properly. That is where I will rely upon the committee to hopefully help me in this exercise.

CHAIR - Is there anything else either of you wanted to add before we wrap up? Unless there's no questions from you, Clare or Sarah? No.

Mr BANGE - There's one other thing in that I did recommend something like eight separate recommendations, A to H. They are still all relevant in my view, but the primary one or the principal one, which will help to make it all happen, would be the appointment of a chief paramedic.

CHAIR - Yeah, when I read through those, I thought that's the first point. It's after that, because so many of these things would be responded to and delivered by the CPO.

Mr BANGE - Yes. At the moment there are very few, if any, paramedics actually employed within the Health hierarchy other than through the ambulance service. That is a little strange when you think about it, when you think about the role that paramedics do play and

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could play, when you think about what the private sector paramedics can do, 200 or more in Tasmania now and potentially available to be working within the Health sector.

CHAIR - Some of them in our regional communities can work across - you know, they work in a mine, in mine safety, in mine rescue teams, that sort of thing. They can also work at the local health facility, whether it's a small regional hospital or whether it's the doctor's surgery or whatever. Hopefully they're not doing a mine rescue every day, they're not responding to car crashes every day because the mine rescue team do the car crashes as well sometimes down there, for example. But you can utilise them across a range of areas, surely?

Mr BANGE - Absolutely. I think one of my definitions that I've used in the past is that the paramedic is the ultimate generalist allied health practitioner. They're not nurses. Some of them are dual qualified. They're not doctors. Again, some are dual qualified. I know at least four who are both medical practitioners and paramedics. My term I think of it as the ultimate generalist allied health officer who can work in multidisciplinary and interdisciplinary roles, I think is one of the key things about a paramedic.

CHAIR - Yes. Thank you. Unless you have anything else you wish to add, we might wrap it up there. I thank you for your time, I really appreciate it.

Mr BANGE - Thank you.

The witnesses withdrew.

The committee adjourned at 3.02 p.m.