PUBLIC

THE LEGISLATIVE COUNCIL SESSIONAL COMMITTEE GOVERNMENT ADMINISTRATION A MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE, HOBART ON FRIDAY 17 APRIL 2026.

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

The committee met at 2.05 p.m.

CHAIR (Ms Forrest) - Welcome minister, to the Government Administration Committee Inquiry into the Governance and Financial Management of the Department of Health. Some of this inquiry has flown out of some recent Auditor-General reports, but in more broad terms the budgetary matters sit around the budget - the whole state budget focusing on Health. I am not sure if you have appeared before a committee like this before.

Mrs ARCHER - I don't think I have appeared before a committee at all.

CHAIR - Estimates committees?

Mrs ARCHER - Only Estimates committees.

CHAIR - This is a little bit different, obviously. By way of explanation, everything that everyone says is covered by parliamentary privilege. That may not extend beyond the hearing. If there is anything of a confidential nature you wish to share with the committee, you can make that request. We would need to deliberate on that and let you know that was acceptable to the committee. Generally, we respect that request should that occur. Otherwise, it is all public. It is being transcribed and broadcast and will form part of our report at a later time. I think all of you have probably been at tables before, but do you have any questions before we start?

Mrs ARCHER - No.

CHAIR - Okay. I will ask the members of your team to take the statutory declaration in front of them and then I will invite you to introduce your team and to make an opening comment should you wish.

Mr **DALE WEBSTER**, SECRETARY, Ms **SALLY ELISE BADCOCK**, ASSOCIATE SECRETARY, Mr **KYLE FRANCIS LOWE**, ACTING DEPUTY SECRETARY, SYSTEM MANAGEMENT AND REFORM, and Mr **CRAIG ROBERT JEFFERY**, CHIEF FINANCIAL OFFICER, DEPARTMENT OF HEALTH, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Thank you. Over to you, minister.

Mrs ARCHER - The Department of Health representatives have introduced themselves by name. Today I have with me, Dale Webster, Secretary of the Department; Sally Badcock, Associate Secretary; Kyle Lowe, Associate Deputy Secretary, System Management and Reform; and Craig Jeffery, Chief Financial Officer.

I have some opening remarks. Thank you for the opportunity to speak to the committee today about the financial and operational performance of the Department of Health. The

government provides record funding of nearly $10 million every day into our health system, and Health makes up more than one-third, or 34 per cent, of the entire state budget. This is ensuring that we can continue to deliver better care to Tasmanians when and where they need it most, while responding to rising demand, especially in our hospitals.

I would like to take the opportunity to acknowledge and thank our health workforce: the nurses, doctors, paramedics, allied health professionals and countless support staff who care for their fellow Tasmanians every day. We want to ensure that they have the facilities, tools and resources they need to help provide the high-quality health care that Tasmanians deserve.

However, at the same time, as a government, we are taking clear and meaningful action to ensure that the state can provide these essential public services and infrastructure on a sustainable basis. We're taking a prudent and measured approach to restoring our fiscal buffers and we should always be looking for ways to be more efficient, which is why the government continues to work with agencies to determine the most appropriate approach, with a strong focus on improving efficiency and productivity while ensuring that key essential services are delivered.

As the Minister for Health, Mental Health and Wellbeing, I am very committed to ensuring the highest possible standards, and I believe that it is very important to pursue any opportunities for change and improvement across the Health system.

I do not know if Dale wanted to make some remarks as well?

Mr WEBSTER - As Secretary of the department and also the accountable authority under the *Financial Management Act*, I take my assistance, performance and accountability for public funds very seriously. Our workforce delivers a broad range of essential services to Tasmanians, often in a highly pressured operating environment, and continues to achieve important outcomes for the community.

The department has clear strategic priorities with key performance indicators (KPIs) and targets for these priorities published annually in the Tasmanian Health Service Service Plan. These indicators are actively monitored through executive committees and monthly accountability meetings, and performance is published each year in our annual report. There has been commentary about the overall number of KPIs, including a reference to figures of 400 or more. To be clear, the 2025-2026 Service Plan contains 126 KPIs. This number reflects a deliberate choice in recent years to report across the full Health system, not just the acute hospitals. We have included Public Health Ambulance Tasmania in more recent annual service plans. Tasmania's 126 KPIs is fewer than some other jurisdictions; Victoria, for instance, has 176 in their 2024-25 report. However, if you do count the fact that we do look at each of our hospitals separately, you do get to the 400 mark. But, if you correlate it at the state level, or the system level, there are still 126.

CHAIR - That's not in addition to the 400?

Mr WEBSTER - No. You split the 126. For instance, your ED performance for the state, if you split that down to the four EDs, you start adding up to the 400.The keys are the statewide system ones.

I also acknowledge that we continue to improve how that information is presented. We'll provide greater clarity on whether or not a target is met and an explanation of any variances as part of the next annual report. Performance outcomes must be understood in context. Demand for health services has increased significantly, driven by both population ageing, chronic disease and increasing complexity of that care that we're providing.

Delayed discharge relating to aged care and National Disability Insurance Scheme clients remains a significant pressure, with an average of around 100 patients medically ready to leave hospital but awaiting external support. This contributes to pressures on patient flow, emergency departments and ambulance transfer of care.

Under the National Health Reform Agreement, Commonwealth funding growth is capped and has not kept pace with activity growth or the real cost of service delivery. While the 26–31 NHRA addendum improves the funding trajectory, these structural pressures remain throughout the addendum period.

A few other areas that I'll touch on that have been brought to the inquiry's attention already: in relation to community sector organisation funding, work was underway over several years to improve our administration of these agreements prior to the Auditor-General's report, including the establishment of a consolidated team. We accepted the recommendations of the Auditor-General's report, which aligned with the work we already had underway.

CHAIR - This is the annual?

Mr WEBSTER - The Auditor-General's report into CSOs. He did an audit.

CHAIR - Into the CSOs? Yep.

Mr WEBSTER - Since the release of the report, we've made further improvements, including better grant approval processes, interim updates to the grant management guidelines, reinstatement of the quality and safety reviews, and the development of a contract management framework. The work is ongoing.

On fraud control, the issues referenced by the Auditor-General were identified by the department's own internal controls and internal audit processes, escalating in line with the established governance arrangements of the department. While we do not accept these matters indicate a systemic failure, we have used them to strengthen oversight and documentation. Hence with the CSO report, whilst we didn't quite agree with the findings, we accepted the recommendations and got on with implementing them.

In relation to commentary on the Emergency Air Service tender, this procurement was conducted within the state's state procurement framework, and focused on safety, capability, continuity of service, and value for money. I'm happy to provide further evidence on these topics if desired by the committee, but it may be that further detail will need to be in camera, because of commercial-in-confidence and other reasons. Thank you for having me here today.

CHAIR - Well, thanks. We'll come to some of those matters as we work through some of the questions, if that's alright.

I'd just like to start with the financial performance of the department to date. The first question I have for you, and if these can't be answered here, we're happy to take them on notice, minister. It's not a problem.

Mrs ARCHER - It goes without saying that the nature of many of the questions that you ask will be, probably, at a not very operational level.

CHAIR - Yes, that's right. But if there's something that you can't provide now, if you indicate that you're happy to take it on notice, we'll write to you with those, so you don't have to remember them, in other words.

Minister, what is the department's performance against appropriated budget in the last four years?

Mr WEBSTER - Last four years; I can tell you the last two, but -

CHAIR - Well, start with that, and if we need to write to you for the previous - the other two.

Mrs ARCHER - We might need to take the other two on notice.

Mr WEBSTER - In 2024-25 we required a supplementary appropriation of 345 million, which reflected demand over the previous period. I have to say that prior to 2024-25 the financial performances of the department is mixed up with COVID funding and arrangements that were made with COVID. When we come back with those figures, they're a bit skewed by the fact that COVID funding, COVID funding from the Commonwealth, is included in our statements through that period.

CHAIR - Is it possible to separate those out? So to clear the Commonwealth funding that was still washing through?

Mr WEBSTER - Yes, it is, I am told by the chief financial officer.

CHAIR - Yes, I am sure he has all the numbers there somewhere.

Mr WEBSTER - Yes.

CHAIR - So with regard to the COVID funding, how long did that continue to wash through, into what financial year? The actual COVID-related funding.

Mr WEBSTER - The last year that we have it in COVID-related funding in our books would be 2023-24, CFO?

Mr JEFFERY - Yes.

CHAIR - Okay, so when we get those figures from you, that would be helpful to see what was specifically related to COVID.

Mr WEBSTER - I've just been handed the four-year figures.

CHAIR - So that is why you bring Mr Jeffery with you.

Mr WEBSTER - He is very good.

Mr JEFFERY - I haven't got them all, sorry.

CHAIR - Haven't you? Oh.

Mr JEFFERY - A few key ones.

CHAIR - Right.

Mr WEBSTER - Okay, so he has split them into employee and supplies and consumables. So I will do it that way as well.

CHAIR - It looks like a lot of detail and numbers. Is it something you could table for the committee?

Mr WEBSTER - Yes.

CHAIR - There's nothing sensitive?

Mr JEFFERY - As per the annual report and financial statements?

CHAIR - Yes.

Mr WEBSTER - We only have one copy.

CHAIR - You can send it to us at a later time, perhaps.

Mrs ARCHER - We can table it and take some copies.

CHAIR - Yes, all right. We can get our secretary to do one copy and keep that for us, and hand the original back to you if that's helpful? Yes.

Mr WEBSTER - I can't read it out because I've just handed it over. We will take that as tabled.

Mrs ARCHER - Unless you want to speak to it first?

CHAIR - Sorry, if you give it back to the Secretary, he can refer to it first.

Mrs ARCHER - When you've finished referring you can have it.

Mr WEBSTER - Look, I think it's really important: in my opening statement I talked about the Commonwealth contributions and the NHRA. I'm not sure whether any members of the committee, or members of the Treasurer's budget matters bipartisan - or multipartisan group - but in that, you know, the Department of Health, and Treasury and Finance, gave an overview of the demand trends in health. If I refer back to that, the Commonwealth does two caps under the NHRA. The first is: they cap the amount of growth through, and over the previous

addendum it was 6.5. So any growth above 6.5 therefore fell to the state to pick up; the second thing they do is actually cap the total amount of money that's available.

Even though the objective of the NHRA is espoused over a period of time and, repeated in national cabinet in 2023, was that the Commonwealth contribution would grow back to 45 per cent and in its first five years would get to 42.5 per cent, in fact, at the moment it sits at just over 36 per cent. Our projection is that over the period of this five years it will get to less than 38 per cent. That is quite significant, and that's because demand has grown more than the 6.5 per cent over the previous period, but in addition to that, the Commonwealth cap kicks in on total funds, and therefore pushes down the amount that can be spent. It's really important to say that when demand goes over 6.5, and demand is made up of both cost growth and actual-patients-through-the-front-door growth, so it's a combination of both those things. For instance, in the 2024-25 financial year, IHACPA calculated that the cost growth in fact exceeded 6.5 per cent, so there was no room for demand growth in that particular year. So they're important things that put pressure on the Health budget, and the $345 million supplementary appropriation was effectively a catch-up of demand over the previous period to say demand has now outstretched both the Commonwealth contribution and the state appropriation, and needed to be adjusted.

Ms LOVELL - Question for just bit more detail around that: so the 6.5 per cent growth you said is made up of a combination of cost - growth in costs and growth in numbers of patients?

Mr WEBSTER - That's right.

Ms LOVELL - Is there a breakdown of that? What proportion of that would be cost growth and what proportion is patient growth? Is it the two together?

Mr WEBSTER - Sorry, through you minister: it's the two together. So, if cost growth is above 6.5, then there is no room for patient growth.

Ms LOVELL - And you said that you were already on track, correct me if I'm wrong, because I was trying to take notes as you were speaking, but the cost growth was already on track to be higher than 6.4; was it the previous year you were talking about there?

Mr WEBSTER - In the previous year; so IHACPA calculates it, unfortunately, in arrears. So you know, the cost growth for that year as calculated by the independent authority was in fact in - greater than the 6.5 per cent.

Ms LOVELL - And when you talk about cost growth, that's specifically the amount that Tasmania is spending in that year? It's not set around a national average, and inflation of the general average of providing health services, or is it specifically to what Tasmania is spending?

Mr WEBSTER - The cost growth calculated by IHACPA is a whole-of-Australia figure, and as we've argued throughout the NHRA negotiations, the cost growth in the smaller regions, and in fact all states argue this - and we see Tasmania as a smaller region - outstrips that of Sydney, Melbourne, Brisbane, Adelaide and Perth; but Sydney, Adelaide, Brisbane and Perth actually weigh against - if you like, bring that average down, but it's still averaged above 6.5.

CHAIR - So does that mean then that the model's not suitable for the whole country because of the specific challenge that South Australia and Tasmania, and notionally the ACT and Northern Territory, face?

Mr WEBSTER - Yes, through you Minister. You want to go?

Mrs ARCHER - I will have a crack; yes, I think that's why there has been, for the first time I think, that recognition with the small-state adjustment, which is really positive and goes to - which I think Dale might talk in more detail about - the IHACPA review there as well.

Mr WEBSTER - Yeah. So under the NHRA addendum and process, in the first two years we do have a small-state supplement that comes to us to compensate the state government for additional money it needs to put in, but through that two years IHACPA will be doing - sorry, I should actually spell that out: Independent Health and Aged Care Pricing Authority is what IHACPA stands for - will do a review, and the review is of both the regional cost, regional weighting that should go into the NHRA going forward, a rural weighting, but also a small-states weighting. So once that work is done, then it will be factored into the formula and hopefully address some of these issues, but you still have a situation where it is possible that cost growth can mean that you get no money for demand growth because of the cap. I've said 6.5 because that's what we're working on in this financial year, but under the new addendum the new growth cap from the Commonwealth is 8 per cent; so it does go up under the new addendum.

CHAIR - Just to then perhaps look at the department's current and forecast full-year level of expenditure against budget for this year; where's that tracking?

Mr WEBSTER - So, we are, at the moment, forecasting a $43.2 million overspend on budget.

CHAIR - So I know that the cash reserves are significantly reduced over the last period, so where is that money going to come from?

Mr WEBSTER - At this stage, we are confident of cash reserves being able to cope. We have not put in for a supplementary appropriation as such. We are confident that we will balance the books at the end of the financial year given that forecast of $43.2 million.

CHAIR - I know it is just a bit over 1 per cent of the budget, that is not a huge amount as it has been, but are you saying that cash reserves will cover it, you will not need a request for additional funding (RAF)?

Mr WEBSTER - We have indicated there is some of it that we may request a RAF for relating to unforeseen expenditure. But we are still confident, even if we do not get the RAF, that cash reserves are available.

CHAIR - To go back to the over-budget of $345 million in 2024-25, which is a lot more obviously than what you are projecting for this year, acknowledging that some of that was cost growth as well as demand, what specific actions were taken to remedy the situation so that - well, if you can contain it to the $43 million, it is a bit of a turnaround?

Mr WEBSTER - The first of those is that the 2025-26 Budget included an amount for demand. There was a total of $202 million for demand, as well as another, I think, $5 million for mental health demand, so a total of $207 million. There was a step in the state Budget to pay for demand.

In addition to that, we put in a number of measures to hospital avoidance measures over the previous years that started to bite. We also looked very carefully at locum costs and trying to drive those down. We have also put in a number of financial sustainability measures looking at our contracting and de-risking some of the contracts and those sorts of things. It was a combination of a whole lot of factors that have contributed to the $345 million coming down. The $345 million was not a one-year figure, as you have alluded to; the previous year we actually used our cash reserves to cover off demand for that year and that was on the public record back then that we did that.

Again, coming out of COVID, with COVID money coming out of our budget, you could then see that all of this additional demand had not been paid for. Therefore, we took measures over that two-to-three-year period to make sure that we were covering off on demand, but also looking at how we were making ourselves more efficient.

CHAIR - How and when did the department advise Treasury and the minister of potential natural overruns in the past four years? I know this minister has not been the minister for that long, but what actions were taken to notify Treasury during that period?

Mr WEBSTER - Through the budget information management system, we provide regular updates, in fact monthly updates, through that system. I am going to have to throw to the Chief Financial Officer (CFO) given I was not secretary prior to 2024. Craig, do you have memories of when?

Mr JEFFERY - Yes, Secretary, as you have said, the budget information system is open to agencies periodically through the year and we update the forecasts through that. For the past two years, Treasury has established a monthly reporting template which all agencies complete and provide to Treasury for review both by Treasury and by budget committee. That forecasts the position year-to-date for each agency as at the end of that current month and forecasts as at the end of June. Obviously, during the year, depending on the timing of when the budget - last year there was a delayed budget process and so there was not budget certainty until later in the year, which meant that the reporting for the first six months last year was based on the supply, and only in December when the budget was being considered by parliament, updated for the full financial year. But, in general terms, once the budget is passed usually in June-July each year, you've got full-year certainty, and you can forecast where you're at each year, or each month, and towards the end of the year. Prior to that -

CHAIR - When was it implemented, sorry?

Mr JEFFERY - About - I'm getting old, Chair, and my memory is not as good as I would like it to be. I'm thinking almost two years. So probably 20, 22 months, something like that.

CHAIR - So, before that there wasn't this monthly reporting to Treasury?

Mr JEFFERY - Not through the template that is now being used, but it was being reported through to Treasury by lodging budget risks in BIMS. So -

CHAIR - How long was that done?

Mr JEFFERY - BIMS. The Chair would know, BIMS is the Budget Information Management System. That's been in place for eight to 10 years, the new system. Lodging updated budget information and budget risks has always been part of that system. So the budget risks are lodged in BIMS, but the monthly reporting is about two years old.

CHAIR - So during that period, has there been feedback? Has Treasury provided feedback, or does Treasury provide feedback? Where things are perhaps tracking, particularly in the 2024-25 year, where there was a significant overspend, what feedback did Treasury provide during that period?

Mr WEBSTER - If I go back to - you asked about the four years. So 2023-24, which there was $200 million demand pressure there, which we funded internally, we formally wrote to the Secretary of Treasury on 17 April that year.

CHAIR - 2024?

Mr WEBSTER - 2024. The previous secretary wrote on 17 April, and then I met with the Treasury, as the incoming acting secretary, on 22 April to outline how much it was, and what our strategy was in terms of managing it to the end of the financial year, including the strategy to use accumulated funds. And then in 2024-25, we started to indicate that to Treasury, and have discussions with Treasury from, I think it was September 24 - yes, getting my years right - and the supplementary appropriation was indicated in Treasury reports. And then the supplementary appropriation was brought to the parliament, in relation to Health and a few other things, in February or March, when parliament returned after the summer break. It was indicated publicly as soon as that bill was tabled.

CHAIR - Okay. Have you had much feedback from Treasury as a result of the monthly reporting?

Mr WEBSTER - Through the minister again, I have regular discussions with the Secretary of Treasury, but in addition to that, the Deputy Secretary for Budget Management Branch, and his 2IC, who I don't know the title of, but we're in contact with the Chief Financial Officer as we go. I can say there's probably six to seven occasions where the two secretaries have spoken about where our projection is going, and those sorts of things.

CHAIR - You're confident that your overrun won't be any more than $43.2 million for this year?

Mr WEBSTER - Through minister, as confident as we can be. There can be budget shocks that occur, but we're projecting - we have to project forward for, for instance, Commonwealth payments that are coming in over this last two-and-a-half to three months, and those sorts of things. So there are still projections that the Commonwealth payment will be a certain amount on a certain date. We're as confident as we can be that it will be that.

CHAIR - What dates are those Commonwealth payments? Are they expected?

Mr WEBSTER - There are expected dates that we put in our sheet, but they don't just arrive exactly on date. We factor them in to arrive. The Commonwealth payments are quarterly, Craig?

Mr JEFFERY -Yep.

Mr WEBSTER - And there's one due in late May, I think it is.

CHAIR - So that should hit before the end of the financial year?

Mr WEBSTER - That's right. But the exact amount of it is calculated on activity. We can estimate it, but we can't precisely say we'll get exactly this amount of millions of dollars from -

Mr WEBSTER - (cont) millions of dollars from that payment; but we are as confident as we can be, you know, it might be less because the Commonwealth payment per activity is higher. It might be slightly higher because the Commonwealth is lower. But we try to project that, and we do it with a reasonable level of certainty.

CHAIR - So, barring any other shocks, you're confident in that figure?

Mr WEBSTER - As confident as we can be on 17 April.

CHAIR - You talked about reducing some of the cost or trying to contain some of your costs to keep it at that level. You talked about reducing locum costs. Do you have any figures of the locum costs over the last two years? That may be the document you were going to table, I'm not sure, and if you have a breakdown by region, that would be really helpful as well.

Mr WEBSTER - So, locums, if I do the total, then I will go back through the regions, if you like. So - and you wanted over the four years, so 2022-23 was $85,264,232; 2023-24, $105,739,782; 2024-25, $104,731,249; and for the first three quarters of 2025-26, it's sitting at $66,884,120. So if I go by region: the southern region, or RHH, $17,510,353 -

Ms LOVELL - Sorry, can you repeat that?

Mr WEBSTER - $17 million.

Ms LOVELL - Which year was that?

Mr WEBSTER - Sorry, that's the 2022-23, so I'm starting back again. In 2023-24, $24,186,058; then 2024-25, $16,319,808; and then to the first three quarters of this year, $6,640,240. Launceston General: so 2022-23, starting from that year, $27,167,370; 2023-24 was $33,988,266, and then in 2024-25, $38,240,808; and for the first three quarters of this year, $22,740,871.

CHAIR - How much was that?

Mr WEBSTER - 22. North-west: 2022-23, $14,377,437; 2023-24, $20,473,723; in 2024-25, $17,876,512; in the first three quarters of this year, $13,029,122. Mersey: 2022-23, $9,218,315; 2023-24, $9,264,607; 2024-25, $13,743,761; and the first three quarters of this year, $12,053,753.

CHAIR - So, just looking at that, without doing all the maths in my head, because that's an impossibility for me, it looks like, whilst the south and the north may see reductions, it seems like the north-west and Mersey are still going to be pretty much the same -

Mr WEBSTER - Yes.

CHAIR - as previous years. So, what are the efforts there to try to contain locum costs? What's going on there?

Mr WEBSTER - So, if I finish, because -

CHAIR - You haven't finished yet? Sorry.

Mr WEBSTER - I haven't done mental health, by the way. Mental health, which is actually done on a statewide basis only, in 2022-23, was $14,754,258; in 2023-24 was $15,724,331; in 2024-25, was $17,054,742; in the first three quarters of this year, it was $11,828,143. Then there's another category, which is those that aren't attributed directly to any of those cost centres: in 2022-23 it was $2,236,599; in 2023-24, it was $2,102,797; in 2024-25, it was $1,495,618; in the first three quarters of this year, it was $587,991.

So then to answer your question, we have the same efforts attempted in the north-west as in the south and the north. The issue we have with the north-west is that the market for doctors in Australia is such that the farther you're away from a major tertiary centre, the harder it is to recruit. We've got that effect in the north-west. We have market allowances in place for the north-west. So a doctor in the north-west gets a 20 per cent market allowance on top of their salary, compared to the rest of the state; but it just -

CHAIR - How long has that been in place, and has it made any difference?

Mr WEBSTER - It's been in place now for a number of years, and it certainly makes a difference when we can get people, but again, we're really competing against, you know, every other region in the country for these jobs, as well as the major centres. It's no coincidence that the major centres are more successful in doing that. A number of strategies that we have in place is, again, working with UTAS, trying to attract doctors that might want to do clinical research alongside an appointment in the THS; as I said, the allowance; in addition to that, looking at shared models. Someone who's appointed to the LGH, say 0.5, but does 0.5 in the north-west, which we are doing more and more with oncology, for instance; again, trying to get models in place that attract people to the north-west, but it's a market that's tighter and tighter.

In addition to that, we have what I call the locumisation of the medical workforce, where we have a phenomenon at both ends of the age spectrum, where younger doctors are choosing to actually become locums and follow the sun, in one sense, but also to make sufficient money in eight months so they can have four months off. We're also seeing that in the over-55s doctor market, where people are, almost as a transition to retirement, they're moving out of the paid

workforce into a locum workforce, and can work part time or work in blocks, and then have time off. So that's increasing the issues that we have. In the north-west, it's about the same as you said, but in previous years it's been growing. So, the fact that we've kept it to about the same says that our strategies are starting to work in the north-west; not at the rate they are in the south or the north, but we will continue to pursue those particular things.

CHAIR - So, minister, with those: I mean the North West Regional and the Mersey don't provide a full range of services, so you're not trying to recruit to every challenging position. There's a lot of things we don't have up there. So, where are the key areas that are difficult to fill, or is it everything?

Mrs ARCHER - I think it's reasonable to say that everything is more difficult to fill the farther out of Hobart that you get. You can see from the numbers, there has been some success in driving down the locum numbers in the south, but some of those issues are - and they are, as the Secretary said - not just related to pay; there are market allowances available and that sort of thing. I think it is about recognising what other attractants are there for people to live. I think the work that has been done with UTAS will be important over time in terms of growing that local workforce as well and recognising that people -

CHAIR - They are doing the full medical degree there now.

Mrs ARCHER - That's right. I think UTAS had very good uptake as well. That is, I guess, in the future. I think then it is also about other opportunities perhaps, for example, rural generalists. Looking at other approaches to attract people that we need to deliver those services.

Mr WEBSTER - As the minister said, looking at those rural generalists is a really good model that we are pursuing in the north-west.

CHAIR - Are they actually growing? They seem to have stalled.

Mr WEBSTER - It is now, and we have actually appointed a director for rural generalists to the north-west to make sure that we have got a focus, to make sure that we are growing it.

CHAIR - Across both North West Regional and Mersey.

Mr WEBSTER - For the North West. There are statewide, but particularly we are focused in those areas because rural generalists can be a model that is pursued at the Launceston General Hospital (LGH) and Royal Hobart Hospital (RHH) as well. I think importantly, the minister said, the farther away from Hobart, it is really the farther away you are from a tertiary hospital because the tertiary hospital gives you the chance to do the full range of scope of practice versus a level-three hospital at the Mersey, where you don't get the full range of surgeries and things occurring. So it is that as well.

Of course the phenomena is that even though we refer to the RHH as a tertiary hospital, there are some subspecialties where we either have to rotate our doctors to Victoria so they can actually do a number of activities to keep their full range, or indeed we send patients to Victoria because we do not have the full scope at our tertiary hospital.

All of those add to the fact that, and this is why, through the IHACPA process, the National Health Reform Agreement (NHRA) process, we are saying there have to be

adjustments for rural, regional and small states in the formula because your costs - it is almost you have to accept that we will never get to a point where we can staff our hospitals without locums. I think that's a reality -

CHAIR - I do not think that is a reasonable expectation because of annual leave et cetera.

Mr WEBSTER - Yeah, exactly.

CHAIR - Can I just ask again about the agency nursing - is this a similar situation?

Mrs ARCHER - Yes.

CHAIR - Have you got data you could table around agency nursing with the same sort of breakdown rather just read them all out now? We have a few other areas we want to get to.

Mr WEBSTER - We can. Probably we can go back further than the current period, the four-year period. If we can table those.

Mrs ARCHER - Probably the numbers are a similar kind of story to locum doctors in terms of distribution of that -.

CHAIR - Are we seeing since the Cradle Coast Campus has been offering full nursing degrees any change in that in the north-west?

Mr WEBSTER - Yes and no. When we table it you will see that we have had a reduction in the last nine months we're on track to reducing agency nursing, but there is still the situation where people finish their degree and there is a 'locum-isation' of nursing as well as doctors, and also completing the numbers going through there are not keeping up with what we need in the north-west as well. For the last four years, we have offered every nurse graduating from UTAS a place in our transition to practice. Not all of them take it up, and we then look to other universities. We have maintained the number we invite to do transition to practice is 350 over the last four years, which happens to be the number graduating from UTAS. But not all of them come from UTAS because some of them move -

CHAIR - How many would take up from UTAS?

Mr WEBSTER - This year was just under 300, but we still took 350 because we then went and filled those extra spots. So, we've tried to bring in the new workforce over the last four years into the transition to practice, and importantly for the last two years, we make them permanent on day one. We had a process where they do the transition to practice and they would have to apply for a job with us, so we make them permanent and we find them placements during their 12 months. We think that means we're keeping more than we did in the past, so growing our internal workforce.

Ms LOVELL - I wanted to move on to another topic, but just before I do, I wanted to ask you a question. I'm not even sure if you can answer this question, but I'm going to ask it anyway and you can tell me if it's not the kind of thing you answer. You talked before about the forecast overspend for 2025-26 being at around $43.2 million, but that you're confident that cash reserves would cover that. How much do you have in cash reserves this year for the Department of Health?

Mr WEBSTER - If I explain how we get cash reserves, is that?

CHAIR - If you have the number, don't worry.

Mr JEFFERY - Got it there now, Secretary.

Mr WEBSTER - Alright, and then I'll explain it.

Mr JEFFERY - Ms Lovell, the cash balance at 30 June 2024 was $13.2 million, end of June 2025, $21 million.

Mr WEBSTER - And now?

Ms LOVELL - Do you have a year-to-date figure now?

Mr JEFFERY - It's around about $20 million to $25 million.

Ms LOVELL - Maybe you need to explain more about that.

Mr WEBSTER - The cash balance changes almost daily because the cash balance is made up of our revenue streams. For instance, the money we get from private insurers goes into a SPA rather than to Treasury, money we get from -

CHAIR - Special purpose account.

Mr WEBSTER - Special purpose account (SPA), sorry, which contributes to our cash balance. Unlike other federal funding agreements the NHRA operates that - in fact, the revenue from the Commonwealth comes direct to the Department of Health; it doesn't go through Treasury and end up in appropriations. Again, that's a source: motor accident insurance claims (MAIB), workers compensation, veterans affairs, sale of goods and services, like sales of pharmaceuticals, contribute to our cash. It's made up of all of these elements and goes up and down on a daily basis, which is why we can say we'll cover it at the end of the financial year, so the balance is a net figure on a given day, sort of thing, and we've got one big payment coming from the Commonwealth.

Ms LOVELL - Yeah, well, that was going to be my question, because if you look at 30 June 2024, $13.2 million, up to $21 million, at the end of last financial year - and then now, sorry I didn't jot down that figure, but about the same. What's going to change between now and the end of the financial year that makes you confident that you'll cover that $43 million? I guess you don't want to leave yourself with nothing, either, like you weren't going to say, 'We'll have $43.2 million in cash reserves', and then leave nothing at the end of the year.

Mr WEBSTER - The $13 million at the end of the financial year would be after we've balanced off things. We've probably spent some of our cash reserves on 29 June, and then on 30 June it ends up at $13 million. There's that effect because it's an accounting figure after you've balanced off your other figures. That's how it works, so it's possible, and thinking back to the $13 million figure in 2024, is, in our balancing on 30 June, we would have paid off certain things, leaving $13 million, and that's what we do.

The other important thing is that in our special purpose accounts (SPAs) there is money there that we have to leave there; for instance, unspent research grants, and things like that. There is always a balance that has to be there.

CHAIR - Can I just ask you then, minister, what you would see as a reasonable cash reserve at the beginning of the financial year - like 1 July 2026, how much do you relatively need there to give you the buffer you need to pay your bills as and when they're due?

Mrs ARCHER - Yes, I think, as the Secretary has said, there's a lot of variability in terms of what you're managing on the way through, so -

CHAIR - It used to be a lot higher. I'm just interested, this is quite a low amount of money when you look at the total budget. Some might say that that's a very low cash reserve to have in such a large department when all manner of things can happen. I do [inaudible] at the end of the financial year, but then you're starting a new one.

Mr WEBSTER - Through you, minister: of course, different to a business where the cashflow continues is, of course, on 1 July we get an appropriation through the state budget. So in terms of the cashflow, it automatically goes up the day after we balance it on 30 June, because of the appropriation. Of course we know we are getting certain payments from the Commonwealth on certain dates. It's difficult to put a figure in it; it was incredibly high coming out of COVID. That probably reflects the fact that we did less of balancing off at the end of the financial year, because of the flow of COVID dollars into programs and things like that; but I think it's recognised that us holding at that stage just over $200 million in our cash reserves was too high in terms of what you would normally have in an organisation of our size. So I will throw to the CFO, but I think sitting somewhere in between $20 million and 40 million is the right figure, given the way that a state government budget works.

Mr JEFFERY - Thank you, Secretary. Just in relation to the Australian Government revenue that you talked about, we're expecting to get $58 million on 7 May, and another $58 million on 8 June, and a cash balance we're currently forecasting to be around $35 million in June this year.

Ms LOVELL - Can I just ask another question to that then, because I am not a money person: the Commonwealth payments, and some of those other payments, are they not - I mean we talked about the appropriation, and then overspending the appropriation amount that comes in at the start of the financial year, all of those things, I think I understand that; but are those Commonwealth payments and other payments not already taken into account in that budget appropriation?

Mr WEBSTER - Through you, minister: no.

Ms LOVELL - They're not?

Mr WEBSTER - No, they are not. So if you have a look at the budget chapter for health, we have the appropriation, then we have other revenue, and our other revenue amounts to just over a billion dollars. So if -

CHAIR - I've got a budget here if you want?

Mr WEBSTER - You have got a budget paper there? If you go to Table 6.5 -

CHAIR - Okay, 6.5.

Mr WEBSTER - which is our comprehensive income table. Craig's going to supply me with the version, so I can read it.

Ms LOVELL - So, in that instance, then, when you talk about overspending the appropriation -

Mr WEBSTER - Yes.

Ms LOVELL - I'm struggling on how to articulate this.

Mrs ARCHER - It is activity.

Mr WEBSTER - Yes, it is linked to activity. This goes to the - if you like, in the past, 6.5 per cent. So if our activity, the cost growth, according to IHACPA for 2024-25 was 12 per cent, but the Commonwealth only gave us 6.5 per cent of that. The balance has to be paid for by the state government, which comes out of appropriation. That is how we overspend on appropriation. That is the issue with the funding model - is that we don't control supply and demand in the traditional sense. So demand comes through the door: as a public health system, we have to match that demand. That means that if we then exceed the cap within the NHRA, the state government appropriation can end up being overspent.

Ms LOVELL - I understand that. Can I ask the question in a kind of simplified way, just to try to consolidate my understanding of it?

Mr WEBSTER - Yes.

Ms LOVELL - So in previous years where you've had to have an additional appropriation through a RAF (request for additional funds), or a supplementary appropriation, for example; is it fair to say then that that is where the Health department has overspent the budget by more than you were getting from the Commonwealth and other sources of revenue?

Mr WEBSTER - Mm.

Ms LOVELL - So what you might - and forgive the expression - you might term that as blowing the budget entirely -

Mr WEBSTER - Yes.

Ms LOVELL - whereas, for example, this year you're expecting that that overspend on the appropriation will be covered by those cash reserves, so that's technically what you would, in simple terms, say is within budget essentially -

Mr WEBSTER - Yes.

Ms LOVELL - because of those other sources of revenue.

Mr WEBSTER - Yes, that is right. In years where we're asking for RAFs, or supplementary appropriations, you probably find that it's a catch-up on demand over a period of time, and it hits the bottom line, so, in your terms, blows the budget; but it's probably indicative, if you look back over the figures - the outcome figures - we've been balancing off expenditure for a few years, and then demand gets to the point where we can't balance it off any longer. That's why in this current financial year, in the budget chapter there is a figure for health demand, which is a balancing off of the demand growth over the previous period.

Ms LOVELL - Okay, thank you. That explains it.

Mrs ARCHER - I think also speaks to why trying to take additional measures to meet demand or drive down demand outside of hospital settings - yes.

Ms LOVELL - Are you happy to move on?

CHAIR - Yes.

Ms LOVELL - Thank you. So, I had some questions about performance information. You touched on KPIs in your opening statement as well. It's difficult sometimes to look at the performance information and the KPIs that are reported, in any kind of meaningful way, or for people to get meaningful information from that. I'm going to speak to the Productivity Commission data, the RoGS data, because that seems to be the best publicly available information that we can use meaningfully. From the RoGS data, it appears that Tasmania is spending more but getting worse outcomes than other parts of the country. So we spend more on care, but we're not delivering better outcomes. In fact we're delivering worse outcomes in a lot of those measures. Does the department analyse the RoGS data, and what outcomes, or conclusions, do you draw from that? Then further to that, what actions do you take around that analysis of the data?

Mr WEBSTER - Through you: yes, we do analyse that RoGS data, and data from a whole lot of sources there, Australian Institute of Health and Welfare data that's published regularly, as well as our internal data. All of that's taken into account. What I would say is that it does indicate what I've already said around the growth in costs, in a smaller state, in a regional area are higher than are being calculated on the national-average basis that IHACPA calculates. That's the first thing: our costs are being driven at a higher rate; because RoGS is reported as a statewide figure, every other state, bar the NT and the ACT, has a major, urban area with multiple tertiary hospitals that drive down prices that we don't have the advantage of in the three small states. The Chair indicated South Australia is a small state; we don't actually treat them as a small state anymore.

CHAIR - Don't we?

Mr WEBSTER - No.

CHAIR - They've grown.

Mr WEBSTER - Because of the growth they've had. So it's just the territories and Tasmania in the small-states calculation.

CHAIR - It used to be that South Australia went into bat with Tasmania, but not anymore; is that what you're saying? Not anymore? Every man for himself.

Mr WEBSTER - We're aligned with the territories. There are still three of us fighting the good fight, but it does indicate that; but the second thing is it also indicates the dispersal of our population. Again, if you calculate it as population within a catchment of a tertiary hospital, which is almost the same as a capital city, we've got more population outside of the tertiary hospital catchment than any other state or territory. So again, that dispersal of population counts against us. Again, this is indicative of, if you break it down into regional costs per service, the north-west will be higher; but that's - again, dispersal of population in the north-west. It's a ribbon in the north-west, you know, whereas Launceston and Hobart have got catchments. There is no - you can't treat the north-west as one catchment because of the way it's actually spread across the whole coast.

CHAIR - And down the west.

Mr WEBSTER - And down west, exactly. So you've got this dispersal population. So that contributes to it. I think that the third area is that it actually highlights to us the areas that we also know that we need to work on. There are effects such as, when we switch - a third area that we really focus on in data is benchmarking against similar hospitals across the country. We're never going to compare, say, the Royal Hobart Hospital to Royal Melbourne. So we would pick a tertiary hospital in a regional centre to compare them to, and making sure that we're matching to those regional centres. Can we do - are our hospitals performing to the level of those? We get that benchmark data on a regular basis to make sure we've got those comparisons happening. So the short answer is: we are focused on performance on, dare I say, that in fact I get four reports a day on flow in hospitals starting at 6 a.m. We're very heavily data-focused to try to work out where our hotspots are and what we're doing. But what RoGS shows us there are some inherent issues in comparing our one health district to the multiple health districts of the larger states. In that I use the example of Frankston or Mornington Peninsula as a similar size health district to Tasmania, but the advantage they have is that if they need help from a tertiary centre, it's an ambulance ride in 30 minutes

CHAIR - And the really complex cases, it's just up the road.

Mr WEBSTER - Exactly. Whereas ours is a two-hour flight to Essendon plus an ambulance at either end, type of issue. So we've got inherent disadvantages and RoGS really highlights that for us.

Ms LOVELL - Does the department set its own targets and measure against those targets that are consistent with the RoGS data, for those measures?

Mr WEBSTER - Yes, we do.

Ms LOVELL - Are they part of the publicly available information?

Mr WEBSTER - Yes, through the service plan. Within the KPIs in the service plan, they're made-up of a number of factors. RoGS certainly drives some of them. Australian Institute of Health and Welfare performance indicators drive some of them. But also, when we look at some of the colleges, so for instance, the Australian College of Emergency Management (ACEM) has certain targets around emergency. We try to match with them as well. The KPIs

are made up of a number of sources of performance indicators that are external to the department, but we pick them up as internal indicators.

Ms LOVELL - The KPIs that you're talking about there in the service plan, that's the - we've talked about it earlier - the 100-and-something that extrapolates out to 403. I understand they're not consistent with the same measures that the RoGS data -

Mr WEBSTER - Some of them would be consistent. For instance, time of ambulance et cetera. We split it into urban and regional as well, and those sorts of things. We try to be consistent with the RoGS, but we actually bring in lots of other things like ACEM, AIHW -

Ms LOVELL - I don't have the service plan in front of me. Do you report to all of the same measures as the RoGS data in the same way?

Mr. LOWE - We report some measures from RoGS as part of the KPIs. Some of them are generated internally through our targets, through our hospital sites as well, and as Dale said, the Australian Institute of Health and Welfare, we also reflect some of their measures, but some of them will be different as the Secretary outlined. We report median emergency response time on a similar basis, on the same basis as RoGS, but if you go through RoGS, there are, I would say, hundreds if not thousands of measures in there, so you can't include them all. Some of those are reflected in how we set our targets in the service plan. Some of them we monitor and provide advice on throughout the year, but they're not in the service plan. The service plan is, if you like, our best suite of measures to monitor our performance, trying to keep it broad coverage, but not too large.

Ms LOVELL - You mentioned earlier that you're reviewing those KPIs and how they're reported. Can you speak a bit more about that? The difficulty with the current measures is that it's really difficult to take anything meaningful from that. Can you speak about what action you're taking to make that better?

Mr WEBSTER - In the service plan, we put in the targets that are at the statewide level, but in the annual report we then break it down by region, and that creates that - you can't compare one to the other sort of thing. In the future, we'll report the statewide data in the annual report and have the regional data available internally.

But the second thing - and again it's to the size of the annual report, which I decided not to bring because it's hard to carry.

Ms LOVELL - Yes it's here, I can show how big it is - you can imagine people sitting down and flicking through this.

Mr WEBSTER - Yes exactly, so by bringing it down from the 403, so the regional breakdown back to the statewide, we can then include the commentary without increasing the size of the annual report.

What I would say in defence of those that put together our annual report: it is actually not one annual report; it is several annual reports because we are required to give several annual reports by legislation, so we collate it into one, but as a result it is a big read.

Ms LOVELL - I am pleased to hear there is some work being done on that because it is kind of meaningless. I guess we will report back later this year as to whether or not we think that is better or not. I think the point to make is that it would be good to have some more meaningful data that people can interpret and use.

I had one other question just around -

CHAIR - [Inaudible] One of my criticisms has been - and I know auditors-general current and past have raised it too - these targets do not actually reflect on the outcomes of the patients. We can spend all the money - we could spend a whole budget on Health, and we may or may not make a difference if we do not understand what the outcomes are. It would be really helpful to have some outcomes-focused data that tells us whether, for example, is a re-admission to mental health a good thing or a bad thing? It could be both.

Mr WEBSTER - That is why this year we will have narrative so that it is not just a - and again why we won't report on 403, we will report on the key that are in the service plan, which is 126, but with a narrative that actually does comment on that. Return within 14 days is seen as a bad indicator, by the way - we need to say that and why.

CHAIR - That is right, because it could be because people are going back and getting the care they need, but if it is because they did not get the care they needed when they were there, that is a bad thing.

Mr WEBSTER - That is right.

Mrs ARCHER - I think it is also why we report things now, for example, the long-stay patients on the dashboard because we talk about access and flow. If we are trying to meaningfully get to some of the reasons for that, we are having to measure and report on those things. That is another example where if you can see now that that is a direct issue that is affecting that data.

Ms LOVELL - That is actually the point I wanted to go back to from the opening statement - was around the patients that are ready to leave, waiting for external care outside of the hospital. You said that at any given time there is around 100 of those patients. Has the department done an audit of those patients and what care they are requiring? What is that audit showing you in terms of where the needs are?

Mr WEBSTER - We have a process - and someone is going to have to remind me of the acronym, but MCAP, which stands for:

Mr LOWE - Making Care Appropriate for Patients.

Mr WEBSTER - Which is a process by which the journey of the patient is tracked. If they are acute, we know they should be in an acute ward. If they become subacute and they are still in the acute ward, then we need to be taking steps to move them. Then they eventually get to the point where they are ready for discharge, and that is the indicator that says they should be out of our system. That is where this data is drawn from, this long-stay older patient.

The big issue is, what we are reporting are those who are ready for residential aged care - and NDIS - so ready to move into a supported -

CHAIR - Assisted.

Mr WEBSTER - Yeah. One of the piece of works that we are doing, and we are working with other states and territories for, is there is another cohort that gets stuck, which are those waiting for a home-and-community package. Being eligible for a home-and-community package and then on the waitlist; so they go home and then return to us because the package has not been delivered. So there are two other cohorts that we have started to work on in terms of trying to quantify who they are and what the numbers are.

In these particular ones, the ones we are reporting, we look at these very closely. Medically, there is no reason for them to be in hospital, but they cannot be supported in anything other than residential aged care or a supported position if it is NDIS; they are the ones we are reporting on in this data.

Ms LOVELL - That is ready for discharge?

Mr WEBSTER - Yes.

Ms LOVELL - Okay. What about patients who might be - not have a home to go to, might be homeless, are they included in that data? And what about patients who might be - I guess maybe a step before this - maybe they're not categorised as ready for discharge but, for example, need some kind of rehabilitation or step-down care, and there just isn't a facility in Tasmania for that; are you analysing those patients who might not need to be in a tertiary hospital, but because of a lack of facilities in Tasmania that could provide the care they need, there is no other option for them at the moment?

Mr WEBSTER - Through the minister: yes, we are.

Ms LOVELL - What's that showing you?

Mr WEBSTER - That data is a lot less than what we've just spoken about because, generally speaking, we do have the facilities. For instance, if they still need rehabilitation, we have rehabilitation units across the THS. We, in fact, have a contract in Hobart where we deliver some of that through Calvary St John's. So, those people are not included in this cohort. This is a cohort that is ready. We also have a jointly funded program with the Commonwealth called the transition care packages. What they are, are people who are not yet ready for a residential aged care facility, because they still need allied health support or some high level of medical support and things like that. So, they go into that transition care package cohort. So, they're all tracked, and across the state as well, but they're separate to this long-stay, older person and NDIS group. That's the number that there is no reason for them to be in a public hospital program, versus those who are still in rehab or a transitional care circumstance. They still have a reason to be part of the THS cohort. So, we are talking about those who are completely cleared to go to another setting.

Mrs ARCHER - And that's named up on the dashboard, like the wording of the dashboard specifically refers to those residential aged care and NDIS-appropriate patients.

Ms THOMAS - I just want to talk a bit more about the workforce. We touched on locums earlier, but in terms of the workforce within the Department of Health, are there currently any

positions in the department that are not funded within the budget, like unfunded positions? If so, how many and what's the cost of those positions?

Mr JEFFERY - Thank you, Secretary. I think I would say, Ms Thomas, yes. There are a number of unfunded positions in the budget. We're asking - we're currently seeking information through the expenditure review committee from the responsible groups to update those numbers with the latest information, and the reason for that is a number of areas - and, as the Secretary referred to earlier, the north-west region is carrying a significant number of vacancies which have been filled with locums and so while, in theory, they've got unfunded positions, they've got more vacancies than those unfunded positions. So, we need them to update their numbers, so we're getting that information together. The last time we did that numbering of the unfunded was just after COVID, when we were transitioning from COVID positions, and we had a significant amount of health demand which the Secretary has talked about. The unfunded positions were in the region of 750 but we, as the Secretary mentioned -

CHAIR - FTEs, is that?

Mr JEFFERY - We've got $200 million of demand funding in the 2025-26 budget, so that has been targeted to address those unfunded positions, and the Secretary asked the groups to fund unfunded positions and to make them funded, and for any remaining unfunded positions to be transitioned out through either reprioritisation or natural attrition, and that's the information we're currently waiting to be updated.

Ms THOMAS - Okay. Do you -

Mr JEFFERY - So, that's a long story, sorry, but that's where we're at.

CHAIR - Can I just say: in the budget papers, it says here that there was $872 million - sorry, that's meeting health demand, sorry, not the - that is, isn't it, meeting health demand? That's what we're talking about, the meeting demand, 872 -

Mr WEBSTER - That's over the forward Estimates.

Mr JEFFERY - Over the four-year budget forward Estimates.

CHAIR - Of course. Always looks better, doesn't it?

Mr WEBSTER - The work we're doing on this is in - and I know the Chair is going to say I've been talking about this since I joined Health, but I will go there: updating our human resources system.

CHAIR - Dangerous territory.

Mr WEBSTER - I know. One of the exercises we're doing in preparation for that being switched on later this year, one of the modules is an establishment module which is - will allow us to monitor a number of things, but the establishment versus what we're filling in real time. One of the exercises - and the CFO has just indicated that we're going through this exercise across the state - is actually verifying the establishment versus what we are filling, so that when we move to that system we've got the right data in there. That will allow us to literally run a report to get the answer to what you've just said, whereas at the moment, it's almost manual

counts across each of the wards to work it out. So we just need to - we are working towards that coming on board later this year, that first module, which is establishment management.

Ms LOVELL - And that is -

CHAIR - How many times have we heard that?

Ms LOVELL - I know.

CHAIR - For many years?

Ms LOVELL - It will definitely be coming online this year? Because we ask this question every year, and it's pretty extraordinary. I mean I've been in Parliament for nine years; it's extraordinary that in nine years we haven't been able to get these figures, really. You've been here longer.

CHAIR - And every time we're told [inaudible].

Mr WEBSTER - Which is why I was reluctant to say it.

Ms LOVELL - It's not the first time you've heard us say it.

Mr WEBSTER - However, the module is being tested in Premier and Cabinet as we speak; Health is the second agency to be switched on, later this year. So we might not have it by Estimates, Chair, but we will have it later this year.

CHAIR - How much has it cost us so far?

Mrs ARCHER - You hopefully don't ask this question again next year.

Ms LOVELL - We will ask it.

CHAIR - Yes, we will ask; hopefully he will have an answer.

Ms LOVELL - Hopefully you will be able to answer it.

Mr WEBSTER - We will have an answer, yes.

CHAIR - How much have you spent on it so far?

Mr WEBSTER - Look, I don't have that figure in my head, but it's across two systems. I know the Auditor-General's just doing a report.

CHAIR - Maybe we will wait for him; he will have all the data. He would have gone across both DPAC and Health, I'm sure.

Mr WEBSTER - That's right.

Ms THOMAS - So when do you expect to have that updated information from the different areas on those unfunded positions? Is that something you can take on notice, and bring that updated information back to the committee?

Mr JEFFERY - It's been, as the Secretary said, Ms Thomas, it's being done for the implementation of the People Central system as part of the establishment. We should have some, at least, pretty good preliminary information. The aim will be, when we create the establishment, to know exactly which positions are funded, which are unfunded, and then to manage from there. But we will have the information from that, which we should be able to provide out of session.

Ms THOMAS - Okay.

CHAIR - So we'll write to you.

Mr JEFFERY -That may take a period of time.

CHAIR - No, this committee is not wrapping up any time soon - just so you can look forward to another appearance.

Mr WEBSTER - Jan, you might have noticed that Human Resources has now got a new name called People Central.

CHAIR - That is just to try to deflect from the reality.

Ms THOMAS - So, given the significant number of underfunded positions, was it ever realistic to expect that Health could operate within the 2025-26 budget? Was there always an expectation that there'd be a need for additional funding?

Mr WEBSTER - Through you, minister, we had an expectation we would. But we do projections of demand and costs, and things like that. There was significant extra demand money in the 2025-26 budget, which we have attempted to manage within. Some of these, you know if you call them unfunded roles, come from if you have a nurse, or a doctor, that unfortunately is on workers compensation, or even maternity leave, we need to backfill them. That then becomes an unfunded role, so all of those complications on a daily basis.

We will be able to have a system that monitors this. I have to say that the Commonwealth had one in '94, so it's taken a while to catch up. Once we're monitoring that, we can get that figure. But there's always going to be an element of unfunded, because if you have unplanned leaves or those sorts of things, you have to backfill them in a health system generally.

CHAIR - So, on that, the $200 million for each financial year roughly for the additional demand, not meeting health demand, that surely is not just for the 750 unfunded FTEs that have been identified? So, what else is that to fund, because it doesn't seem like a lot of money when you're talking about 700 FTEs there?

Mr WEBSTER - Firstly, as I said, that number will go up and down almost regularly but the second part of it is it also funds things like - as demand goes up, things like pathology tests and I'll start with pathology and then come back to this list, but the number of pathology tests goes up as well as the number of patients coming in, so you actually have to fund

additional pathologists and things like that. So, the demand money was to recalibrate all of those things, and I think we've spoken in Estimates in November around the demand in medical imaging and pathology.

So, the demand money was actually about we need more radiologists, we need more pathologists to keep up with the demand. It's just not a number of beds that are being funded.

CHAIR - We also tried to mitigate against the unnecessary use of radiology and pathology and when someone rocks up at the emergency department, they had a blood test yesterday in the GP, and they may need another one. Clinically, it may be indicated, but not always.

Mr WEBSTER - Yes, so I take that one as a really good example, is our electronic medical record, our Bluegum transformation is around making sure that we are sharing information between the GP and the hospital in real time. Efforts we're doing with the Australian Digital Health Agency, with My Health care record, which is now called 1800 Medicare Record, which actually has the pathology tests and scans, et cetera, uploaded into that record so that can be shared against multiple settings. All those things have to happen as well because you're right, there is this waste of this cost to the whole system of you get a blood test at the GP today, but you repeat them in the ED tomorrow because the ED can't see the test that was done by the GP.

So, EMR or electronic medical record and My Health care record are designed to actually overcome those problems as well but areas that we spent the $200 million or it was allocated to spend is infection prevention and control. So, the learnings that come out of COVID and the additional education staff, cleaning staff that we needed across the state to match with our review of what was available at the start of COVID.

PPA usage, as you'd appreciate, has gone through the roof since COVID, so demand money was put into that space. We put that under infection prevention control, in quality and safety, again. An outcome of the Commission of Inquiry and the governance review was the split of the regions, the North West having its own separate organisation to the LGH. So, there was some additional roles that we funded in quality and patient safety in the north-west. Access and flow, so discharge planners, again, so we can try to reach a benchmark of how we're getting people out of our hospitals or additional roles.

CHAIR - Is that something you can table for us as well, that document?

Mr WEBSTER - It's probably not because: (a), it's not in a form that it's easily readable but we can summarise it - only because it's got terms like 'med c is funded,' those sorts of things. So, I'm reading, sort of interpreting, as I go.

Mrs ARCHER - Do you want us to take that on notice?

CHAIR - Yes, if you can take it on notice to provide, because that'd be a helpful summary.

Mr WEBSTER - We can take that on notice, but how we spread that across the system - but they're just examples that I've given. What we're calling 'winter wards' concept, which is actually how we manage the flu season, is funded because that's demand.

CHAIR - So, for each of these different components or whether it's pathology, radiology, 'winter ward' situation or whatever, and the unfunded positions, are there numbers against all of those that are up to the $200 million?

Mr WEBSTER - Yes.

CHAIR - That would be really helpful if you could give us that sort of breakdown, in a readable form, for members of the committee.

Mr WEBSTER - Yes, you'd have to interpret that.

CHAIR - That would be really helpful.

Ms THOMAS - Did you say before, with that $43.2 million forecast as predicted overspend, that that would come from cash reserves? Is that what you said?

Mr WEBSTER - Yes. We balance from within internal reserves. Cash reserves and things like that.

Ms THOMAS - You weren't seeking additional -

Mr WEBSTER - I did say we would seek a small amount, through the RAF process. Usually you don't find out what's happening with the RAF process until 30 June. We're planning to balance it off internally.

CHAIR - We can expect some RAF when that's tabled in parliament from Health?

Mr WEBSTER - I don't believe we will need that. We are projecting that we can do it. We flag that we may need it, but by 30 June, if we don't need it, we won't get it. And we wouldn't expect to get it. That's what I'm saying. Trying to -

Ms THOMAS - Back on workforce, do you know what the ratio of administrative staff to clinicians is within the Department of Health?

Mr WEBSTER - Not off the top of my head, but it's incredibly small. If I look at those who are employed in the administrative stream versus the nursing, allied health and doctors streams -

Ms THOMAS - Would that be something you could take on notice and provide to the committee? I'm interested in understanding whether, and if it has, how it's changed over time - over a period of, say, five years.

Mr WEBSTER - We can take that on notice, but incredibly important is that, in the health context, a lot of our administrative staff employed under the administrative award are people like ward clerks or medical orderlies. We're not like a traditional public service where every public servant or administrative person fits into the the public sector award. Our version of the public sector award covers our frontline service delivery in our hospitals. Orderlies, ward clerks and cleaners come under that. It's not as clear cut. We can provide an award split, but that doesn't tell you that the administrative staff have increased. That increase might impact

our number of cleaners, and they're in that administrative stream or that general stream. It's actually called -

Mrs ARCHER - We can provide the data, but you might then -

Ms THOMAS - Yes

Mrs ARCHER - want to interrogate it further once you have it.

Ms THOMAS - Yes, well have you, minister, or has the department analysed anything in that regard - in terms of frontline staff or - for want of a better word - staff in the office?

Mr WEBSTER - We can provide a split, which is Department of Health versus the Tasmanian Health Service.

Ms THOMAS - Okay.

Mr WEBSTER - We've got it with us. There you go.

CHAIR - Cleaners are considered essential staff, ward clerks are essential staff, aren't they?

Mr WEBSTER - That's right. We can split THS versus the department. Within the department we've also got a chief medical officer, a chief nurse and those sorts of things - essential to running a health system, you have to have those roles. It's not as clear cut as you may think.

CHAIR - Your CNCs and your nurse educators, and those positions; clinical nurse consultants and nursing educators, et cetera, where do they sit?

Mr WEBSTER - They sit in the THS, as part of the front line.

CHAIR - I did notice in some data that was tabled in the lower House yesterday that there's been a saving of $3.713 million, and there are a number of positions that were listed here. You've got a clinical nurse consultant. You've got a clinical nurse specialist. You've got an allied health assistant. You've got a clinical lead and education support and the clinical nurse educator transition to practice. These positions have been not filled to support that $33.3 million So aren't these clinical positions?

Mr WEBSTER - Yes. Not necessarily to support the $33 million. The process would be that these, over the period that's covered by that, we would have seen 1000-odd vacancies, but for instance, the clinical nurse consultant, it was a non-facing role that was going to be part of an infrastructure program. So we've said we want to do it a different way. We're not going to fill that role. The nurse practitioner candidate that's on that list, they asked for a .63 FTE. You can't have a .63 nurse candidate because they need to be full time to actually achieve getting to be a nurse practitioner. So that's why it was knocked back. And so the .6 is knocked back, saying you can't fill it on that basis. You have to find enough money to do a full-time role.

CHAIR - But if you filled it as 1 FTE then that's not a saving, is it?

Mr WEBSTER - No. So they're not, it's a list of what vacancy management has said no to, rather than a list of these are the savings per se, and there are reasons why each one we've said no to.

Ms LOVELL - So they're not necessarily linked to the year-to-date savings.

Mr WEBSTER - No.

Ms LOVELL - That's separate.

Mr WEBSTER - Yeah, it's a separate answer.

Ms THOMAS - So given budget efficiency dividend measures, and the freeze on public service that was announced by the government last year, what's the process within the department for approval of any new positions that are created?

Mr WEBSTER - Through you, minister. So, if it's due to the nursing hours per patient day, it goes through a process where the calculation - the benchmarking exercise, I think it's called - happens as a joint ward and ANMF process, which then goes through the chief nurse's office for verification, and it's then advertised. So the process is the chief nurse verifies the benchmarking exercise. They are treated through that process.

Every other role within the Department of Health and THS goes through what's called vacancy management process, which is a committee chaired by me, currently, and made up of senior members of the department who look at the roles and make sure that they actually fit in the definition of frontline and unneeded. Of that process, and we average probably 100 to 150 vacancies a week in the Department of Health, you can see we've actually refused six or eight or something like that. It's a very small number that get refused. The process is you apply vacancy management, which meets every week, has a look to verify that it's a needed role, and we've said no a handful of times in 12 months or nine months or whatever it is. We try to match what we're doing to the needs of the service, and you only have to look at the *Gazette*. We dominate it with the number of job vacancies we've advertised.

Ms THOMAS - So not in the frontline space, but in the administrative space, how many new positions have been created in the last 12 months in the department?

Mr WEBSTER - I honestly cannot say that, but some of those roles would be tied to projects like new buildings and we have to put on contract project managers and things like that. So we're going to say they're essential. Some of them would be tied to the Bluegum transformation, which again is a project that we're doing. I can't tell you exactly how many we've agreed new roles, but the vast majority are tied to a source of funding that is new as well, because it's in the department, you have the infrastructure team, the ICT team, et cetera. It's really hard for me to say how many new roles, but in terms of the department as at June 2025 we had 13,733.12 FTE and as at the 30th, I don't know why this is only three months, but anyway, by 30 September 2025 that had grown to 13,749.88.

Now the other thing I would say is that there's always a jump in January to February in our data because that's when we put on our new interns, new residents, new registrars, our transition to practice nurses coming at that time, which as I've said is 350. Our FTE goes up and down throughout the year.

CHAIR - Some of those leave, though.

Mr WEBSTER - Exactly, and then it balances out over time, so you have these ins and outs that happen at different times of the year, and we do secondary intakes in August, for instance, TTP, interns, residents and registrars as well. We are also trying to recruit to replace agency nurses and locums throughout the period. Again, I am not trying to be obtuse and not answering; it is just that it is really complex to actually say 'this is the number on a given day in Health'.

Ms THOMAS - Okay, could you take on notice how many new positions have been established in the past 12 months and provide a list of what those positions are and the funding source?

CHAIR - In the department?

Ms THOMAS - In the department.

Mr WEBSTER - We will take it on notice and attempt to do it. Again, it will be quite a manual process to do that because we will have to interrogate the records.

Ms THOMAS - So you do not need to provide that information to the State Service Management Office or the Treasury? Given there is a public service job freeze, one might expect that that information would have to be provided when new positions are created.

Mr WEBSTER - Again, in terms of the public service job freeze, it was a freeze on non-frontline roles, which is the majority of our department. As I say, you could call them departmental roles, but if a role is in the Chief Medical Officer's office, it is in the department, but it could be interpreted as, for instance, if it is the accreditation team or credentialing team, no doctor can actually work in the THS unless they have been credentialed so you can not just say if you work in the Department of Health and not in the THS, you are not frontline or essential.

It has been suggested by a number of the union representatives that my role is not essential. I am not trying to say to you - we'll get it the best that we can, but you cannot interpret that as because they are in the department, they are not essential because they might have a departmental role that if it didn't exist, we couldn't employ the doctor to do their role.

Ms THOMAS - That is what I'm interested in, the list of -

CHAIR - Can I clarify what I think you are asking for, Bec, if I might. The secretary role has been there forever, the CFO has been there forever. There are a whole heap of roles that have been there forever and they are always there. I think what Ms Thomas is asking for is since the hiring freeze has been in place, what new roles have been created in that time and what are they for. If you need someone to roll out your new-beaut system, then tell us that and that is what it is for, and we can make our own determination on whether it is essential or not based on what you tell us.

Mrs ARCHER - I think that what the Secretary is saying is that he would prefer to provide you with that data rather than just a number.

CHAIR - It is not about the positions that already exist. It is about the new positions that are being created.

Ms THOMAS - Exactly right.

CHAIR - While we are on that, can I just ask, in the document that was tabled in the House of Assembly yesterday where you have a list of Health for the $33,713,000 year to date savings at 31 March 2026. There is a list of things there. Are you able to provide that list with a number beside each of them - such as, you have improvements to procurement and consumables, contract management improvements. Some of these things you mentioned in the opening comments, but it would be really good to understand what savings you have made in those areas in dollar terms?

Mrs ARCHER - We might take that on notice.

Mr WEBSTER - So you want it broken down more than was tabled yesterday?

CHAIR - It didn't seem to -

Ms LOVELL - There is a little bit more.

CHAIR - Oh, there is another table, is there? If you can provide a breakdown, even if it was tabled downstairs, it would be helpful for us to get it.

Mrs ARCHER - We will take it on notice.

CHAIR - That's alright.

No, House of Assembly, not our House.

Ms THOMAS - No, you're talking about something different.

CHAIR - Oh, sorry. That's right. We'll write to you with that as well.

Ms THOMAS - The other question I have is in relation to workers compensation outcomes and patterns within the department. Has there been any analysis done or is it something that you look at regularly, the workers compensation data for the department across different departments and whether there are any trends that exist across particular departments in relation to workers comp?

Mr WEBSTER - Yes, we do look at workers comp quite closely and, in fact, the whole area of workplace health and safety is actually a subcommittee of the health board so that we can actually directly look at it.

Our numbers of workers comp have been increasing and the complexity of them, particularly with amendments to the act around PTSD, presumption and things like that, have meant that there is a growth in the workers comp bill for the department.

There's two pieces of work that are really important: one is WorkCover Board did a piece of work on injury management in the State Service and Secretary's board has endorsed that

piece of work for implementation, which is about focusing on the rehabilitation side of the workers comp act, which is, in fact, the Workers Rehabilitation and Compensation Act, so we're focusing on that rehabilitation and bringing costs down.

But the second piece of work for us is, in fact, looking at areas where we are getting claims and putting in - if you like, call them wellbeing programs - but really preventative programs and programs that allow for psychological harm to be diminished or reduced, and the prime example at the moment is the program that we have jointly with Police Fire and Emergency Management, which Ambulance Tasmania has access to, and the learnings we have from that program is we should be rolling that out to all of our areas that are in that emergency suite, so the emergency department, et cetera across the state. Importantly, I know the Royal Hobart Hospital has been running a wellbeing program within its ED. It, in fact, achieved a national award for what it is doing. So those sorts of things we need to learn from and roll out in all of the areas that we're experiencing this problem.

Ms THOMAS - Are there any particular areas of the department or the THS where you're seeing higher rates of claim?

Mr WEBSTER - The first of those is Ambulance Tasmania - as a proportion of claims is higher and you'd expect that, given that it's in that emergency services space, but the other areas are areas that are involved in that emergency. Why highlight it that that's where we need to be putting our effort into in terms of diminishing or reducing the harm that is occurring from those types of roles.

Ms THOMAS - So given that claims have been increasing across the department, has there been any thought given to doing some sort of audit or micro-audit of workers compensation claims?

Mr WEBSTER - Yes, and that's what I'm really talking about - is drawing the inferences from them. It's not just workers comp claims, but reports of safety events and things like that and learning from them.

If I use a really simple example of the detail that we need to get into is that the ramp that our laundry trolleys come down: we had a number of back injuries from people pushing those trolleys down that ramp. We got to a micro-level and realised there's actually a hump in the middle of the ramp. It was when they were hitting that that hump that was causing the injury, so we had to get rid of it. We're looking at the data at that sort of level, and I just use that as an example. It's an old example, and I think the Chair has probably heard me use it before, but that's the level you look at your workers comp claims at.

CHAIR - There was and appropriation in this year's Budget. It went into Finance General, but it was $183 million into the Tas Risk Management Fund, which funds workers comp and that sort of thing, so did Health put in some sort of request, or was that just actuarial advice that Health obviously would have fed into? Because not only have you got your workers comp, you got your medical liability claims that are also increasing as I understand it.

Mr WEBSTER - So through your minister, it's my understanding that that was actually an actuarial assessment of additional - can't call it equity, can we? - underwriting.

CHAIR - Yes, but the need to top up the fund.

Mr WEBSTER - Yes, the need to further the underwrite the whole fund, obviously Health is one major user, but there's Police, every other agency, and a number of the GBEs -

CHAIR - Is Health engaged in that to give some sort of indication of the growing demand in medical liability and workers compensation claims?

Mr WEBSTER - Yes, so the actuarial takes all of that into account and we get regular reports on that, and we actually have a - I don't know what you'd call it - a reference group that we're represented on that sits around the TRMF.

CHAIR - We haven't got a lot of time left, so we did anticipate we'd probably need another hearing in the future anyway. I've got more witnesses to hear from. If we can touch on the matters of fraud reported in the Auditor-General's annual reporting on the department's performance, and I know that from the opening comments, I think from the Secretary, that you said that these were identified in internal processes, and the Auditor-General does state that in his report, but can you tell us what the status of the department's investigation of the frauds is? Where it's at? You did say that you were writing to the regulator and the Auditor-General because you printed the full response from the department in his report.

Mr WEBSTER - Yes, there's probably some detail around that probably should go into in-camera form and I'm happy then to go into more detail. But on one of those, the regulator is not us and so the impropriety is against an external organisation and we've reported that to that regulator to follow up.

CHAIR - So you have done that?

Mr WEBSTER - Yes, but we don't know what the status of their process is.

CHAIR - So, you haven't heard anything back from them? And do you expect to?

Mr WEBSTER - We don't expect to.

CHAIR - We might go into camera to discuss that more fully.

Mr WEBSTER - It wouldn't take very long.

CHAIR - Could you take an extra 10 minutes? I'm not sure about our members? An extra 10 minutes to do that? Yes? We might do that just to try to cover this area off. It saves trying to deal with that at a later time.

Alright, so if you could just please leave the room for a moment and we'll deliberate on that request. So, we'll stop the broadcast.

The committee suspended from 3.53 p.m. to 4.07 p.m.

CHAIR - Thank you, minister, for your appearance and your team today. There may be a need to have a further hearing at a later time to cover other matters. Obviously, there'll be budget scrutiny and that sort of thing as well, which is another opportunity to ask some of these questions. We will write to you with the questions we've got on notice. Thank you for appearing.

The witnesses withdrew.

The committee adjourned at 4.07 p.m.