PARLIAMENT OF TASMANIA

TRANSCRIPT

LEGISLATIVE COUNCIL

ESTIMATES COMMITTEE A

Hon. Bridget Archer MP

Wednesday 3 June 2026

MEMBERS

Hon Ruth Forrest MLC (Chair)
Hon Clare Gade-Wright MLC
Hon Sarah Lovell
Hon Cassy O'Connor MLC
Hon Bec Thomas MLC

OTHER PARTICIPATING MEMBERS

IN ATTENDANCE

HON. BRIDGET ARCHER MP
Minister for Health, Mental Health, and Wellbeing, Minister for Ageing, Minister for Aboriginal Affairs.

Ministerial Office Representatives

Chris Medhurst
Chief of Staff

Megan O'Brien
Senior Adviser, Health

Jill Maxwell
Senior Adviser, Aboriginal Affairs

Ben Davidson
Senior Advisor Health

Georgia Virgona
Clinical Adviser, Health

Melissa Snadden
Senior Adviser, Health

Melita Griffin
Senior Adviser, Mental Health and Wellbeing

Health, Mental Health and Wellbeing Portfolio

Dale Webster
Secretary, Department of Health

Sally Badcock
Associate Secretary, Department of Health

Prof Dinesh Arya
Deputy Secretary CQRA, Chief Medical Officer and Chief Psychiatrist

Anita Planchon
Executive Director, Office of the Secretary

Jen Duncan
Deputy Secretary Community Mental Healtrh and Wellbeing

Craig Jeffrey
Chief Financial Officer

Kyle Lowe
A/Deputy Secretary Systems Management and Reform

Namidja McKenzie
Chief People Officer

Nicole Ashworth
Chief Executive Ambulance Tasmania

Andrew Hargrave
Deputy Secretary Infrastructure Services (from 6pm)

Mark Veitch
Director of Public Health (6 pm)

Ageing Portfolio

Dale Webster
Secretary, Department of Health

Sally Badcock
Associate Secretary, Department of Health

Jen Duncan
Deputy Secretary Community Mental Health and Wellbeing DoH

Anita Planchon
Executive Director, Office of the secretary, DoH

Kim Ford
Nursing Director - Aged Care Reform Unit DoH

Craig Jeffrey
Chief Financial Officer, DoH

Courtney Hurworth
Chief Reform Lead, DPAC

Noelene Kelly
Deputy Secretary, Community and Government Services

Corinna Smith
Director, Community Services, DPAC

Aboriginal Affairs Portfolio

Mellissa (Mel) Gray
Deputy Secretary, Policy, and Reform, DPAC

Caroline Spotswood
Director, Aboriginal Partnerships, DPAC

Jason Jacobi
Secretary, NRE

Louise Wilson
Deputy Secretary, Environment, Heritage and Land, NRE

Will Jocelyne
General Manager (Heritage) NRE

Alice Johnson
Actor Director, AHT

Anita Yan
Deputy Chief Operations Officer, NRE

Josh Brown
Manager Budget Services, NRE Tas

Adrian Pearce
Manager (Finance), NRE

Health, Mental Health and Wellbeing

The committee met at 9 a.m.

CHAIR (Ms Forrest) - Welcome, minister Archer, to the Estimates hearing for Health and we will get to the other ones later. I invite you to introduce the members of your team at the table. We do have a new member here, Clare Glade-Wright, the new member for Huon, who some of you may not have met. I expect you want to make an opening comment or statement. We will go to questions after that.

Mrs ARCHER - At the table I have Dale Webster, secretary, Department of Health; Sally Badcock, associate secretary, Department of Health; and Prof Dinesh Arya, deputy secretary, Clinical Quality, Regulation and Accreditation (CQRA), Chief Medical Officer and Chief Psychiatrist. Welcome to Ms Glade-Wright as well, and thank you, Chair, for the opportunity to speak to the committee today about our strong investments into the vitally important areas of Health, Mental Health and Wellbeing in the 2026-27 Budget.

The Budget continues the Tasmanian government's plan to deliver better health care for Tasmanians with record investment of more than $15 billion into our Health system across the forward Estimates; that's more than $10 million each day invested into our Health system, with Health now making up 35 per cent of the state budget. When compared to the year-on-year spend in the 2025-26 Interim Budget, total expenditure on Health will increase by $583.6 million across the forward Estimates. This includes $1.2 billion for emergency departments, supporting timely, high-quality emergency care for Tasmanians, and strengthening the frontline of the hospital system. We're also backing Ambulance Tasmania through increased funding and resourcing to recruit more paramedics and build more ambulance stations, and the Budget invests $776.6 million for ambulance services.

We're delivering important infrastructure upgrades with more than $844 million to deliver new and existing projects across the state, including a significant program of works including major hospitals and community-based facilities. We're investing $6 million in the TassieDoc initiative, which will improve access to primary care, ease pressure on hospitals and provide tens of thousands of free GP services in areas of community need in each region.

There's a new meningococcal B vaccine program, new CT scanners on the east and west coasts, and a significant $20 million investment to commence delivery of our 20-Year Preventive Health Strategy, which I will have more to say on in the coming days. The Budget also increases access to lifesaving breast screening across Tasmania, with a major $30.8 million funding boost, including the delivery and operation of the new Tasmanian Breast Care Centre and four new permanent breast screening clinics.

The Budget also invests in mental health and wellbeing services, including new mental health beds at St John's Park, boosting the capacity of the Youth Mental Health Hospital in the Home and support for community organisations. Our government is investing in the services and infrastructure needed to meet growing demand and continue delivering the essential services that Tasmanians expect and deserve.

Ms LOVELL - Minister, I'm sure you would agree that it's important to keep patients' medical records secure and confidential.

Mrs ARCHER - Yes.

Ms LOVELL - Do you agree also that it's important to keep staff medical information confidential and secure?

Mrs ARCHER - Yes.

Ms LOVELL - Do you believe that health and wellbeing matters related to your staff should not be shared with the media?

Mrs ARCHER - Yes.

Ms LOVELL - And if you were aware that that had occurred, would you investigate it?

Mrs ARCHER - Probably.

Ms LOVELL - Okay. Did your chief of staff receive the email from our committee secretary regarding the use of strong fragrances during these hearings?

Mrs ARCHER - My office received the email, yes.

Ms LOVELL - Okay. Did they forward that email to anywhere?

Mrs ARCHER - No.

Ms LOVELL - Okay. Have you checked whether they forwarded it to any media outlets or showed it to any media outlets?

Mrs ARCHER - No. My office has not forwarded any email to any media outlets.

Ms LOVELL - And you've investigated that?

Mrs ARCHER - My office has not forwarded any emails to any media outlets.

Ms LOVELL - But how do you know? Have you asked them?

Mrs ARCHER - Yes.

Ms LOVELL - Have you investigated it? So, you've asked them and they've told you that they haven't?

Mrs ARCHER - Yes.

Ms LOVELL - Okay. Thank you. We're dealing with 1.1 first and I think we normally do 1.1 and 1.2 quite at the same time because they're one after the other, because there's quite a bit of crossover. If I can just go to the health funding generally, you've said record investment in the Health system and $15 billion across the forward Estimates and that funding is increasing; can you point exactly in the Budget to where the funding is increasing? Are you looking at Table 5.3?

Mrs ARCHER - The funding is increasing across the Health budget and I will ask the secretary to make some more detailed comments, but as I said in my opening statement, the funding is increasing across the Budget. Total expenditure on Health will increase by $583.6 million across the forward Estimates when compared to the year-on-year spend in the interim Budget - $10 million every day, $15 billion across the health system.

Ms LOVELL - Yes, so you've said that in your opening statement. Can you point in the Budget to the table that you're referencing there?

Mrs ARCHER - I'll ask the secretary to make some detailed remarks.

Mr WEBSTER - Thanks, minister, and through you, so, the Health budget is made up of a number of sources, including the appropriation; our NHRA funding, which is shown in the Budget as a grant; but also federal funding agreements; income from a number of sources, including private health, workers comp, MIB, those sorts of things; and a number of things that are listed on the sales within the Budget. So, if you look at table 5.5, it shows our income over the forward Estimates.

Ms LOVELL - That's in budget paper 2?

Mr WEBSTER - Budget paper 2, table -

CHAIR - Page 107.

Ms LOVELL - Thank you.

Mr WEBSTER - Page 107.

Ms LOVELL - Minister, you referenced in a media release, table 5.3, and the total figures in that, can you explain how that demonstrates increasing Health funding.

CHAIR - That's expenses by portfolio in the output.

Mr WEBSTER - And it's 5.3?

Ms LOVELL - Yes, well that was the table that was referenced in this media release from the minister.

Mr WEBSTER - That's the expenses table, not the revenue table, so that's what we're planning to spend across the forward Estimates.

Ms LOVELL - So that's what you're planning to spend, not what's being appropriated from the Budget. So, 5.3, the table that you referenced in your media release on 22 May, showing record funding in Health, doesn't show what the state government is investing in Health, but what you're planning to spend in Health, taking into account all of those other revenue sources, is that correct?

Mrs ARCHER - Yes, that's correct.

Ms LOVELL - Okay, thank you.

So, if we can go to table 5.2, which is the revenue from appropriation by portfolio and output, so this is the money that's being appropriated from the state Budget for Health. In that top line we have system management. We had a budget in 2025-26 $146,887,000, estimated outcome 148,839, and then the budget for 2026-27 is $133,281,000, that then decreases further over the forward Estimates. Can you explain that decrease in funding?

Mr WEBSTER - Through you, minister, firstly, the systems management health line includes things like grants to the community sector, organisations, et cetera. So, there are a number of fixed-term grants that end, there are a number of grants that come into the next financial year. But, again, a number of sources that flow through systems management include things like the Commonwealth Home Support packages, so, again, the true figure has to add in the revenue side of it as well. But, the main difference in that move there, is a movement in things like fixed-term grants and things like that.

Ms LOVELL - Are you able to provide a breakdown for the committee, and I'm happy for you to take this on notice, but a breakdown of that line item, specifically including any of those grants that are ending next year on the forward Estimates?

Mrs ARCHER - I suspect we might have to take that on notice?

Ms LOVELL - Have you got something you can table, if it's -

Mr WEBSTER - Not in a form that can be tabled, but I can, if you like -

Ms LOVELL - I'm probably happier, if you're happy to take that on notice, to provide something in writing that would be great, because I know we've got a lot to get through, and Health funding, as we all know, is very complicated. So, it does sometimes feel like we're going over and over things, but it's important, I think, for people to understand it all.

Mrs ARCHER - I think it's important, yeah, to acknowledge that it is complex, which is why I think it is also important to acknowledge that we are calculating that in the way that we always have, and that that funding does increase over the forwards, that expenditure in Health increases over the forwards.

Ms LOVELL - I think there's a difference between expenditure and Health increasing over the forwards, and investment from the state increasing over the forwards, but we will get into that with a bit more detail.

Minister, the Budget in budget paper 4, which is the new budget paper has the operational efficiencies table on page 103 and there's $702 million, roughly, over the forward Estimates allocated to the Health department. I just want to unpack that a little more. So, $1.5 billion, I think it works out to about 40 per cent of the cuts have been allocated to the Health budget. As you said in your opening statement, the Health budget is around 35 per cent of the state Budget. Have you had conversations with the Treasurer, or your department with Treasury, about why that kind of bigger proportion of those cuts has been allocated to Health than is the proportion that Health makes up of the state Budget? So, if 35 per cent of the Budget is Health, why have you been allocated 40 per cent of the cuts?

Mrs ARCHER - The Budget, as I said, I would not characterise the investment in Health in the Budget as cuts. That would be the way that you would characterise that. We are seeing health expenditure increase over -

Ms LOVELL - We've gone into that in the last answer but -

Mrs ARCHER - Well, we have but I think it is -

Ms LOVELL - But this is specifically about this particular table and fine, we can use the terminology of the Treasury, 'operational efficiencies.' So, 700 - we've explored this with the Treasurer, the expectation is that the Health department will spend $702 million less over the forward Estimates. So, have you had a conversation with the Treasury at all, or with the Treasurer, about why you've been allocated 40 per cent of the operational efficiencies when the Health budget makes up 35 per cent of the state Budget?

Mrs ARCHER - Well, the conversations that we've had, and I'll ask the secretary to add further to this around the conversations that have been had more broadly, are around what sort of efficiencies would be achievable. Those are the conversations that make up the discussion in going into forming any budget, I would say. I'll ask the secretary to make some comments about the process by which those efficiencies were determined to be possible.

Ms LOVELL - Great, thank you.

Mr WEBSTER - Through you, minister, I think the technical issue would come from the secretary of Treasury for a technical answer, but within the state Budget, there are a number of things excluded from the calculation of where the efficiency should go, for instance, capital and things like that. So, the 35 per cent as a headline for Health doesn't include those things that need adjustment before you actually calculate the operational efficiency. In addition to that, the Health budget, is the largest budget. We have the largest number of staff and, therefore, that factors into the calculations that Treasury do. But, it really is around what are the inefficiencies within the Health budget and, therefore, what do we need to do to actually overcome that. As I said, there's a technical answer that the secretary of Treasury could give better than I can, but it's really around what gets excluded from the calculation before you actually look at operational efficiencies, because the Budget does include grants, capital - all those sorts of things.

Ms O'CONNOR - Thanks, secretary. Minister, you put out a media release that said there were no cuts to Health, but if you look at Table 5.2, there's quite savage cuts in ambulance services, public health and community health. Taking on board what the secretary just said then, what enabled the Department of Health to believe that those areas could absorb such unarguably savage cuts?

Mrs ARCHER - Like, as I said, I wouldn't characterise the Budget in the way that you have. I acknowledge that you will and that's the politics.

Ms O'CONNOR - It's just the numbers don't lie.

Mrs ARCHER - But the numbers also don't lie that we're continuing to expend in Health across the forwards and that that has substantially increased as a proportion of the state Budget in the time that we have been in government. Those don't lie either. Budgets are, though, of

course, about allocating those funds across the system and when we are designing a budget, as we have quite openly said, that needs to be sustainable into the future, that needs to make sure that we're able to continue to invest in health care that Tasmanians need. There does need to be those efficiencies found. But, I'll ask the secretary to speak to the detail of -

Ms O'CONNOR - The actual question. And it really goes to, how did the department - and ultimately the decision's approved by the minister - zero in so specifically as an opportunity for cuts - and you can call them operational efficiencies if you like - in ambulance services, public health and community health, particularly if you just look at ambulance services - the enormous pressures on that system?

Mr WEBSTER - Through you, minister, so if I go to Public Health and, again, the later tables are more explanatory because public health appropriation is not the full revenue for public health, but if you look at the difference between 2026-27 and 2027-28, there are things like the setup of the meningococcal B program for children is funded in 2026-27, but that then reduces over the forward Estimates because we've set up the program, we've expended the original money, which is just over $2 million, and then the ongoing program becomes 600, so there are factors like that that are factored into table 5.2 but, as I said, if you look at, later, the revenue tables and things like that, the Public Health Services gets funding through things like the National Immunisation Program and a few other programs like that, so there are a number of factors there. Ambulance -

Ms O'CONNOR - Let's talk about ambulances.

Mr WEBSTER - Yes, Ambulance Tasmania, estimated outcome for this year is $154 million, rising to $160 million in 5.2 from appropriation.

Ms LOVELL - And then dropping in -

Mr WEBSTER - Then there are adjustments, and then it comes back up again. It's again -

Ms LOVELL - Can you explain? We will come to that later. We will come to ambulance services later.

CHAIR - I think we should leave that, yes, until we get to that line number; otherwise we will get a bit lost.

Ms LOVELL - Yes, we can explore that a bit more later.

Ms O'CONNOR - Yes, no, that's fine. I didn't really get a satisfactory explanation for why it was possible to zero in, for example, on ambulance services and think that that was an opportunity for operational efficiencies, but we will be back.

Ms LOVELL - Just back to the operational efficiencies: $702 million in savings, or less money spent in Health, can you explain how you're going to achieve that? From your answer before, secretary, through you, minister, I heard that that had been a conversation with Treasury, that Health, I guess, had had some input into that measure and felt that that was achievable; so can you talk us through how you will achieve those savings?

Mr WEBSTER - Firstly, focusing on a number of areas, including revenue areas, and the first of those revenue areas is, in fact, the named referrals implementation. We've identified and, in fact, Deloitte did a deep dive into our revenue - we've identified that we're actually missing out on Medicare revenue, so separate to the NHRA, so we're targeting an increase in Medicare revenue across our system. We're also -

Ms LOVELL - Can I just ask a further question on that: that's been identified as something you've been missing out on. Why? If we've had revenue opportunities that haven't been -

CHAIR - Exploited.

Ms LOVELL - Well, yes, for want of a better word - haven't been, I guess, maximised. Why is that?

Mr WEBSTER - A range of reasons: the first of those is just the handwriting of some of our doctors and trying to convert that into clinical coding, so trying to pick up on that side of it. The second of those is how we've actually -

CHAIR - So inaccurate coding?

Mr WEBSTER - Inaccurate coding.

Ms LOVELL - Is it inaccurate coding, though, or just not being able to code -

CHAIR - Misreading.

Mr WEBSTER - because handwriting is too messy? That seems -

Mr WEBSTER - Yes, exactly, so that back and forth; that happens around clinical coding, and trying to interpret what it is that the doctor has put into the notes in terms of a code for MBS. The second is that, and I've referred to this 'named referrals', where a referral comes through a GP and they want it to go to Dr Webster, for example, we didn't allow for that, we just had the referral come in, because Dr Webster's name wasn't on it, under the Medical Benefits Schedule (MBS) rules, we couldn't actually claim that as a Medicare benefit, so we've changed our eReferral system to allow doctors now to actually choose which of the senior salaried medical practitioners they're referring to. Again, that means that we're meeting the rules under MBS, we can claim that revenue, so there's a number of things -

Ms LOVELL - It seems a shame that these things weren't picked up sooner, I guess.

Mr WEBSTER - Look, picked up, but needed system changes to make sure that we could actually maximise it, and that's why we've picked it up, and so we've targeted that and the changes to our eReferral system, which is only - we put in place and we've rolled out across the state in stages over the last couple of years. The change for named referrals comes in on 1 July.

Ms LOVELL - Okay.

Mr WEBSTER - The costs recovery, so again -

CHAIR - Do you have a figure you think that might attribute?

Mr WEBSTER - Yes: so around $5 million.

Ms LOVELL - In the revenue, increased revenue?

Mr WEBSTER - In revenue for that one. There's a cost estimate for how we charge for what we call 'external patients'. This is a mix of MAIB, DVA, workers comp, and private health insurance. There's a clunky way where we set fees for that, and it's actually not the cost of the fee. So, we've revisited all those fees, saying we need to actually recover the cost, they're external patients, and in fact we're seeing a gap of that 9.3 million that we need to recover there.

Ms LOVELL - So, 9.3 million through that.

Mr WEBSTER - That's right. We need to do a review of our clinical workforce. So again, what is the mix of international medical graduates versus registrars versus senior medical practitioners that can supervise, et cetera. We've become out of sync there. We believe there's around $10 million worth of staffing that can actually be either saved there or repurposed in different ways to make savings in other areas.

Ms LOVELL - And are these savings you expect to see in the first year, or is it over -

Mr WEBSTER - These are savings for the first year that I'm quoting, because that's the budget year. Enhancing our vacancy control, and no doubt we will come back to a question on what we're spending on locums and agency nurses, but we're already seeing drops in our locums and agency nurses by focusing on getting salaried employees in quicker -

Ms LOVELL - That's good.

Mr WEBSTER - and more of them, so that we don't - we're not paying as much for locums and agency nurses; but also, looking at from 1 July, the department's executive will be restructured, and we are losing a deputy secretary from the structure, and the office that supports that deputy secretary. So that saving alone is 2.5 million in the first year.

CHAIR - What area was that in - what area was that deputy secretary in charge of?

Mr WEBSTER - So, the deputy secretary was hospitals and primary care, and we also have one deputy secretary of community mental health and wellbeing; both of them are operational areas, so we're bringing that together as one set of operations. As members would be aware, the Tasmania Health Service has gone through a number of iterations, and the most recent was spot-on when we went into COVID, and we restructured and tried to combine our corporate services. We believe that revisiting that, what we see is that duplication of roles across the state, that we can also combine through a corporate consolidation. Then finally, you know, again, because 5.5 is critical for us: generating revenue, including revenue from the NHRA is important, because our total expenditure is against our total revenue, not just against the appropriation in 5.2.

Ms LOVELL - So, you didn't give, sort of, estimated savings for all of those, but I appreciate -

Mr WEBSTER - So they add up to, in the first year, 131 million.

Ms LOVELL - Have you got something you can table for us that outlines those savings?

CHAIR - 130 or 103?

Mr WEBSTER - 131.

CHAIR - Thank you.

Mr WEBSTER - Yes, look, I don't have that in tabulated form, but -

Mrs ARCHER - Take it on notice.

Mr WEBSTER - Take it on notice.

Ms LOVELL - Yes, thank you.

Mr WEBSTER - Sorry, I hadn't actually finished.

Ms LOVELL - Well, keep going, if you'd like. I thought you'd -

Mr WEBSTER - There is more. In addition to those, to contribute to this, we have looked at our communications expenses, and we've targeted some of the campaigns that we've run, revisiting is it valuable for us to run television versus social media, and things like that, and managed half-a-million dollars worth of savings there. Contract management we've targeted, particularly things like whole-of-state contracts, contracts where we carry a lot of risk, but we can actually transfer through the contract; an example there is pharmaceuticals. So, traditionally we order enough pharmaceuticals so that we've got a buffer, and quite often because of that, we actually have wastage in that area; they're past their use-by date. By actually entering into contracts that are actually just-in-time delivery and things like that, we've actually been able to find $3 million worth of savings across that portfolio. Just to put that in context: the pharmaceutical bill is a couple of hundred million dollars, so it is a large budget.

CHAIR - Is that only the pharmaceutical area, or are you talking about contracts broadly?

Mr WEBSTER - And then broadly, we've gone into - that's just one example, but broadly in total we've actually made savings of around $8 million from, in fact, combining contracts instead of, you know, the LGH having a contract, we actually have a statewide contract.

CHAIR - I think Bec's got a question on that haven't you?

Ms THOMAS - Thank you, Chair. Minister, I want to ask some questions about - while we're on contracts and procurement - procurement of contracts for the Bluegum Health Transformation project. A search of the Treasury contracts website returns over 130 results for contracts that have been awarded in relation to that project at a value of under $100,000, totalling around $12.4 million. How do you explain that number of contracts being awarded for that project without a tender process, given that multiple of these contracts are to the same

contractors and even some to the same contractors for the same contracted period? How are you assured that there's no breach of the Treasurer's Instructions here?

Mr WEBSTER - Through you, minister, so, in this process I want to assure people that all officers are required to comply with the TIs. The department's ICT resource management approvals process is applied and the detailed resource management approvals are in accordance with the delegations. In addition, we acknowledge there are a large number of small contracts and there is a -

Ms O'CONNOR - To the same provider.

Mr WEBSTER - To multiple providers, but they are in the nature of labour hire in that sense, in that, the TI and PF-3, which requires accountable authorities to ensure external consultants are done through panel arrangements, but, consultants are not under the direct instruction of the department, whereas labour hire and contractors are. And, in relation to Bluegum and getting us ready for Bluegum - or for the EMR but Bluegum includes - we've rolled out Wi-Fi across all our hospitals so that we can actually be ready for the electronic medical record, we've rolled out a number of base systems to allow us to get ready for when we bring in our electronic medical record. All of that has required us to have people on the ground doing things and those contracts fit into that category. We have, on a number of occasions, highlighted to Treasury that the panel arrangement for consultants doesn't fit into the broader ICT context, where you want to be able to direct people on what they're doing, whereas the consultant panel is for people to come in and tell you about things and what you're doing.

So, we've had to use labour hire and we've declared those. We've been really clear that we are using multiple small contracts to bring people in to do this work, but the difference is that if they came in as consultants, we wouldn't be able to direct them because that's the nature of that panel - we bring them in to do work, but they do that independently of us. For this particular work or this series of work, we needed to direct them. There isn't a way of doing a panel for that under the TIs, so we were forced into a labour-hire arrangement, which is what we've done, and we've put those contracts up to make sure that we're transparent. That's what we're doing.

Ms O'CONNOR - They're coming in just under - just under - the threshold for it to go to a competitive tender, and - sorry, Bec -

Ms THOMAS - No, you're right.

Ms O'CONNOR - but it looks really bad. You know, you've got the one provider who's got consecutive contracts coming in under the Treasurer's Instruction threshold for competitive tender.

CHAIR - One after the other.

Ms O'CONNOR - One after the other, often on the same day or for the same contract period, as Ms Thomas said, and I just don't think your answer satisfies Ms Thomas's question.

Mr WEBSTER - Through you, minister, I accept that, and I accept we put them up to make sure that there is a declaration of what we're doing. But, we see it, and we've highlighted

to Treasury, that it's a problem with the TI in that, if we need this labour hire, there isn't a process for us to go out and do it because they don't fit the panel arrangement for consultants. So, if we're to move this project forward, we're forced into a situation. Now, can you go out for a competitive tender for an individual contractor to do a particular piece of work? Yes. However, the amount of work and the number of things, where they're in the middle of things and those sorts of things, mean that it becomes almost - you bring the whole program to a freeze. So, we've written to Treasury, saying we believe this is a fault in it, this is how we are doing it, we believe that meets the TIs. We've been open with that - putting it on the website.

In addition to that, there is a current order from the Auditor-General of this space, and we've supplied all of the documentation around the contracts, all of the copies of the letters we've sent to Treasury around this. We are open to transparency, that's why we've put them up in that way to show what we are doing, we are complying with the TIs as they currently exist, but we have advocated for changes to the TI, which would allow for a panel-type of arrangement for this type of contracting.

CHAIR - So, when we've seen the pretty disastrous efforts under the Human Resource Information System now being transferred to DPAC - and I know that you may have a different view and I know that the government has provided different views to the Auditor-General's report, but they've not disputed the findings or recommendations, just put a different meaning on some of it. Do you understand why we might be a little bit concerned about another digital program that seems to be having, so far I think Bec said $12.4 million, spent by way of small, below the required level for competitive tendering, to deliver a project that's critically important. So, it's really concerning that all this work is being done in what appears to be small pieces of work, which you could argue perhaps led to some of the problems we've seen in the past.

Mrs ARCHER - I think the secretary will speak more to it, but what he has previously said, and what he said now is around the work that's undertaken to get ready for some of these wider pieces of work as well. I'll ask him -

CHAIR - Was there a budget to get ready to start the actual work?

Mrs ARCHER - I'll ask him to speak more on that.

Mr WEBSTER - Through you, minister, we've been reporting for a number of years the activities in our digital health strategy, which we now refer to as our Bluegum health strategy. So, we've been in horizon one, which is the foundation horizon, which is actually rolling out across our system all of the base level things that get us ready for horizon two, which is the electronic medical record. We couldn't introduce electronic medical record with bedside recording of the patient's record, and things like that, by running tables and plugging them in. So, we had to actually implement wi-fi, as one example. We've had to look at keeping our Digital Medical Record going, and fit for purpose going forward. We've had to roll out e-referrals, so we've got connection between GPs and us. All of these are - so there's not one project; these are a series of different projects under banner of the transformation.

CHAIR - So, how many more areas need to be fixed, if you like, before you can roll out the Bluegum system properly? Because this is the problem with the HRIS as well. There was the whole rostering thing, there was the concurrent employment, there was all those things that were never resolved during that process.

Mr WEBSTER - Through you, minister, we're at the end of horizon one, if you like, in fact, we're in the negotiation -

CHAIR - What does that mean?

Mr WEBSTER - So, what it means is we are now at the point where we're in negotiation with a preferred tenderer for our electronic medical record, and -

CHAIR - So all the problems, all the things like the wi-fi, the e-referrals -

Mr WEBSTER - All of the bases are either -

CHAIR - all of those things have been done?

Mr WEBSTER - Yes.

CHAIR - All of them?

Mr WEBSTER - All of the base, I wouldn't say that we 100 per cent done, because underneath the electronic medical record, we will also need a billing and payment system, but that project runs in horizon two, underneath the Epic rollout, which is the preferred tenderer that we're negotiating with. It also needs to intersect with things like - and I don't know what this stands for, in terms of spelling out the acronym - our RIS-PACS, which is, in fact, our imaging database, if you like, or the images sit on these data sets. So, how does that, and things like that intersect. So, there are a number of plug-in bits that will be done as Epic is rolled out as well, but we are ready for the next step, which is to sign the contract and roll out the EMR.

Ms THOMAS - Thank you for the explanation, secretary. Minister, it sounds to me like what the secretary has just described there is that, it's not a problem with the process Health is going through, rather it's a problem with the Treasurer's Instructions, therefore, potentially, they have not been followed because they don't fit the bill for this project. Are you satisfied, minister, that the Treasurer's Instructions haven't been breached here?

Mrs ARCHER - Yes, I think that's the explanation that the secretary has just provided around complying with the Treasurer's Instructions and being accountable and transparent in that way, acknowledging that it is not the same process as for our consultants and has had to be done in that way. I think he's identified that's not a preferred process and has written to Treasury in relation to that, but I am satisfied he has worked with the system in a transparent and accountable way.

Ms THOMAS - Are you aware at what point this problem with the Treasurer's Instructions was identified and that it would be encountered in this project?

Mr WEBSTER - I'm doing this from memory but the first letter I signed was almost as soon as I became secretary so, to my knowledge, at least two years I've known about this problem and have written to Treasury about it.

Ms THOMAS - What have you specifically asked for them to do?

Mr WEBSTER - A change to the Treasurer's Instructions to cover this type of circumstance.

Ms THOMAS - Okay, and what has their response been?

Mr WEBSTER - That the Treasurer's Instructions, as they currently stand, can be used in the way that we've done it and there's no need to change them.

Ms THOMAS - So, Treasury doesn't see any concern, as far as you're aware, with the process that you're going through here. I mean, the Treasurer's Instructions exist for a reason.

Mr WEBSTER - Through you, minister, I don't want to verbal Treasury, but it's my understanding that they are aware of what we're doing. I've made that very clear to them - they don't believe there's a need for change to the TIs.

CHAIR - So, we'll keep doing it this way?

Mr WEBSTER - Well, through you, minister, as I said, my preference is not to do it this way, but to do it a different way, but I have to comply with the TIs.

Ms THOMAS - What is the budget for labour hire, as you've described it, to be engaged through this process?

Mr WEBSTER - As I said, we have finished horizon one. In terms of some of these roles that have been used, we've used labour hire, so we move into the next horizon where there is a fixed period of three years to do with the rollout and the hyper -

CHAIR - Of the EMR?

Mr WEBSTER - of the EMR, sorry Electronic Medical Record and the hyper-support - I think that's what they call it - that follows that. It allows us to look critically at some of these roles and say can we actually employ people to do this, so the next phase, and put them on three-year contracts and things like that, so the team within our Health ICT and our Bluegum Health Transformation are working on that side of it as well, but the capital budget is in the budget papers this year and $160 million, I'm going to say, but the calculation in my head might be wrong, for the EMR and associated systems. Then, of course, there's a number of staff, et cetera across our Health ICT that come into that as business as usual as well.

Ms THOMAS - An amount of $160 million for horizon two?

Mr WEBSTER - Sorry, it is $140 million, it has just been pointed out to me, so my maths was wrong.

Ms THOMAS - Okay.

Mr WEBSTER - For the capital side of this system.

CHAIR - What about the people side?

Mr WEBSTER - As I've just said, that draws up on our Health ICT staff, our existing staff to support that. As we're currently in contract negotiation, which includes how we do the rollout, what's the schedule, et cetera, my team is still working on the exact figures for each category of budget because we need to actually make sure that we've got things like the design workshops, which will draw on clinicians, but then we support those design workshops, so some of that capital money is staffing that's capitalised, which is how you do a build, but some of it will be the BAU staff or 'business as usual' staff that are donated to this particular program.

Ms THOMAS - So, how much of that $140 million is allocated to procuring labour hire through this short-term under $100,000 contract model?

Mr WEBSTER - Through you, minister, through the negotiations with Epic that will become clearer and as at today, I couldn't tell you exactly how much we're going to spend on labour hire, but our preference is, given that we've got a three-year rollout is, in fact - and you'll see this through the Tasmanian government job site - to bring in staff for a three-year period because once we've got the plan tied-in with Epic, we can then work out our exact staffing to match that.

Ms THOMAS - Okay. And how much has been spent through horizon one on this project?

Mr WEBSTER - Through horizon one, which started in 2022, $118 million has been spent.

Ms THOMAS - And how much of that was on labour hire?

Mrs ARCHER - We'll have to take that one on notice, Ms Thomas.

Ms THOMAS - Okay.

Ms O'CONNOR - Just a quick follow up on Bec's question. Is it the department's contention that, because of the Treasurer's Instructions, they couldn't put that provider - who was awarded multiple contracts under the tender threshold - onto a single contract for labour hire? Was the department prevented from doing that?

Mr WEBSTER - Through you, minister, it is my understanding from how it works that we were prevented from doing that.

Ms O'CONNOR - Interesting. Okay, can we go to the Auditor-General's report on the Human Resource Information System, noting of course that it has been transferred to DPAC because there were no outcomes after four years. A project that was initially slated to cost $22 million, now will cost an estimated $120 million. Nothing has been delivered. The Auditor-General's report is scathing. I'm interested in understanding how that could happen; that a funded program that's designed to modernise an agency's system has produced nothing after three or four years and has to be taken away from the agency. What kind of accountability is there in the system for that kind of inefficiency, waste of resources and time?

Mrs ARCHER - I'll say a little bit and then I'm sure that the secretary will add to that, Ms O'Connor. The HR transformation program is critical to deliver public sector infrastructure to replace more than, and the committee has heard this in previous years, 40 ageing HR payroll

and rostering systems for over 36,000 Tasmanian State Servants. The systems are out or beyond the end of life and Health alone runs over 1200 different rosters and enters its payroll information manually twice for over 16,000 employees, including into a system which requires restarting during the pay run to allow it to complete.

So, the need for system-wide reform is both evident and pressing and this program will deliver PeopleCentral, a single modern HR platform to make it easier to pay people, roster people, reduce paperwork and free up time, improve workforce visibility, including volunteers, supports and delivery of commission of inquiry recommendations, and strengthen a more consistent, capable public service. Work on - a staged delivery approach has been adopted and this -

Ms O'CONNOR - A staged non-delivery approach, it sounds like.

Mrs ARCHER - Well, the Auditor-General's report on planning and early implementation of HRIS recognises both the strategic importance of the work and the scale and complexity of delivering a whole-of-government HR payroll system. I think it is necessary to state that I don't agree with all of the observations or conclusions that the performance audit contains and it doesn't adequately or accurately characterise the program, the basis for key decisions or the extent of work undertaken today. Nor does it sufficiently reflect the complexity, sequencing and risk profile inherent in a program of this nature.

The system that was built in the Department of Health is the foundation of what has been rolled out to government now. It's delivered the critical foundations required for success, including design development, market engagement, governance structures and a more mature understanding of delivery risk, and that goes to some of the points that I think have just been made around Bluegum as well, in terms of the foundational work that is undertaken to enable the switching on of Bluegum down the track. I will ask the secretary to -

Ms O'CONNOR - Before we go to the secretary, because I asked you the question: how can it be that a publicly funded program that's to be implemented by the Department of Health can spend $47 million over four years and, according to the Auditor-General, produce none of the intended modules; and if the government does disagree with the Auditor-General's report and findings, could you be specific about which of his findings the government disputes and why?

Mrs ARCHER - As I said, it's delivered critical foundations for success including design development, market engagement, governance structures and a more mature understanding of delivery risk. During the early phase of the program, Health procured whole-of-government SAP SuccessFactors licences, securing a 10-year deal for government. The program built core system components including employee central, recruitment, onboarding and payroll. The program cleaned and prepared tens of thousands of workforce data records, resolving legacy complexities and enabling future migration.

The program undertook system integration and data migration testing, validating the build and confirming readiness. From this Health build, the first functionality, establishment management, was deployed to the Department of Premier and Cabinet in 2025. The system that was built in Health is the foundation of what is being rolled out to government now. Of course, there are lessons to learn in major ICT programs, and we note the guidance provided by the

Auditor-General's report and his acknowledgement of the improvements that we've made. Both Health and DPAC have noted and accepted the recommendations of the Auditor-General.

Ms O'CONNOR - Hang on a minute. Sorry, can I just pull you up there, minister, with respect: 'noted and accepted the recommendations of the Auditor-General', but the government disputes his findings?

CHAIR - Your question was around the findings.

Ms O'CONNOR - Yes.

CHAIR - Just restate the question about what findings, Cassy.

Ms O'CONNOR - Yes. We're trying to understand what exactly, within the Auditor-General's findings about how this program was administered, does the government dispute?

Mrs ARCHER - Well, clearly from the information that I just provided, we dispute the assertion that nothing was delivered.

Ms O'CONNOR - Okay.

Mrs ARCHER - There has been a substantial amount of work delivered, which now forms the foundation of the program that has rolled across to DPAC, but I will ask the secretary to give you some more detail across the frontline -

Ms O'CONNOR - I don't understand how nearly $50 million over four years was spent, according to the Auditor-General, to deliver very little. I'm taking on board what you said, minister, that you believe some modules have been delivered.

Mrs ARCHER - I think there's been substantial delivery that has informed the foundations of the program as it now moves into a whole-of-government phase, but I'm happy for the secretary to provide some more information.

CHAIR - Before we go to the secretary, because he can address this as well, minister, but for you: what was pretty clear in the Auditor-General's report, there were matters raised - the Auditor-General did a review into rostering of specialists, et cetera. I can't remember what year that was, and the Public Accounts Committee followed that one up and found that, indeed, things still hadn't been changed. For example, there was an industrial matter that prevented doctors from having electronic rostering. These are the things that need to be fixed before this had even a snowflake's chance of working. Why weren't those matters addressed before continuing to spend money, when it clearly couldn't be implemented, like the concurrent employment; the rostering; there was another matter I can't recall; but there were key critical things that needed to be addressed to enable it to work that weren't. So what do you say about that?

Mrs ARCHER - Well, as I said, I would reiterate what I said about acknowledging the Auditor-General's findings, but what I don't acknowledge is that there was no work undertaken.

CHAIR - No, no, I'm not asking that. I've moved on from that. I'm asking about the things that were identified like the rostering matter, the concurrent employment: why weren't they addressed to give this half a chance of success?

Mrs ARCHER - I will ask the secretary to make some more comments about that.

CHAIR - This was years ago.

Mr WEBSTER - Through you, minister, and if I start with the latter question. There's a series of things you identified there that were industrial in nature, as well as a number of things that had to actually work through outside of the Department of Health; but if I take the industrial provision around electronic rostering for doctors, that was identified in 2022. We did a new agreement with doctors and we actually negotiated to have that clause inserted in the 2022 agreement. We were working through -

CHAIR - That has been fixed?

Mr WEBSTER - That's right. We were working through the list of things that blocked it.

CHAIR - But you still have to enter the payroll twice and then restart the system, in rostering?

Ms O'CONNOR - Still today?

Mr WEBSTER - Through you, minister, we are, in fact, for our nursing cohort in the north-west, we now have what's called roster to payroll, which means it is all electronic there. The north will be fully implemented by 30 June this year and we're working through the south. Now, again -

CHAIR - So, they're still on paper rosters down south?

Mr WEBSTER - Well, some of them are and some of them are not. But your question was about roster to payroll, which is different to electronic rosters, because you've got to actually take the electronic roster and have an ability to put it into your payroll. That will become easier with People Central, in that the support modules, et cetera, are built to do that, whereas we've had to actually go through a process of building that to put it into our current legacy system called Empower. If I go back to the earlier questions -

CHAIR - And the concurrent employment, why wasn't that addressed?

Mr WEBSTER - Well, because it wasn't within the remit of the department to fix that ourselves. We actually had to actually - because concurrent employment affects most agencies and it was the central government or central administration of the State Service that actually had to work its way through and find a solution that fitted, not just our employees, but Education -

CHAIR - But Health's a big one with concurrent employment - Education to a degree, but Health definitely.

Mr WEBSTER - Exactly: but there were impacts on a number of agencies from concurrent employment.

CHAIR - This was being done in Health -

Mr WEBSTER - Yes.

CHAIR - and whilst this work was being done in Health, the issue of concurrent employment wasn't addressed, according to the Auditor-General's report.

Mr WEBSTER - Through you, minister, I would agree with that, but that didn't mean that we weren't working on it and trying to work with the rest of the State Service on how do we get a solution to this.

CHAIR - Has it been fixed yet?

Mr WEBSTER - To my understanding, as a member of the steering committee, that's fixed and ready to go as the new system is rolled out, but the others - answering the earlier questions about some of the findings - is firstly, it is really important to understand that you cannot characterise that HRIS was taken off Health and given to DPAC because, you know, you naughty people, you didn't do anything. What occurred was, through our governance structure, the Department of Health made a decision in late 2023 to pause the program and bring in an independent reviewer -

CHAIR - Yes, and the reviewer suggested that -

Mr WEBSTER - to have a look at that. The reviewer suggested that Health was too big, and the issues we were facing were too big, and it was too big bang, if you like, and we were likely to fail if we did it that way, and we should start with a smaller chunk, which is a smaller agency, and build the system up, and so -

CHAIR - That was outlined in the Auditor-General's report.

Mr WEBSTER - Yes, exactly. So, it's not a characterisation of we were so bad that suddenly it was taken - the Department of Health steering committee took the decision to pause and have a review done -

CHAIR - Who undertook that review, that independent review?

Mr WEBSTER - I can't remember the name of the company, I think it's K&L Gates, but don't quote me on that.

CHAIR - Are you able to provide a copy of the report they provided?

Mr WEBSTER - Cameron Morrison was the person and that report has been provided to the Auditor-General as part of his -

CHAIR - Are you able to provide it to the committee, a copy of that report?

Mr WEBSTER - Through the minister, because I can't -

CHAIR - Take that on notice.

Mr WEBSTER - Yes.

Ms O'CONNOR - Chair, I've been trying to establish what was that $48 million spent on over those years? Do we have a sort of an accounting of it, because it's a large sum of money; that's sort of $12 million a year for the period of time that Health had the project.

Mr WEBSTER - Through you, minister, the first major thing is that we built the modules for the system. So again, the Auditor-General's report is really clear that we didn't get to the point of implementing the modules, but the modules were built. The reason we didn't get to the point of implementing them were the other issues that impacted upon the program, such as concurrent employment, negotiating industrial agreements and those sorts of things. Then the complexity of the Health payroll is also an impact there. That's why we paused and said if we keep going the way we are going, we are - and the report said this - we are likely to fail. As the steering committee, and I was present there, we actually looked at the issues and risks and thought, this is signalling to us that all these other issues are impacting, so we could continue to build, but if it fails -

Ms O'CONNOR - Secretary, thank you, you sort of explained this before. I think the committee should be able to understand what that $48 million was spent on.

Mr WEBSTER - The first of those was the build of the modules, so the actual system is built -

Ms O'CONNOR - Okay, what was the next bit?

Mr WEBSTER - The next bit is that -

Ms O'CONNOR - Is there something you can -

Mr WEBSTER - Is the, if you like, business readiness. So, we're sat at this table for a number of years saying we can't work out -

CHAIR - We know.

Ms LOVELL - We know.

Mr WEBSTER - On a daily basis we can't work out vacancies, all of those establishment, underlying things that we needed to do. So, if you like, the cleanup of our establishment, we had a situation where one FTE, or one position number, was allocated to multiple employees -

CHAIR - So the concurrent employment issue, yes.

Mr WEBSTER - Not, no that’s -

CHAIR - Well then in addition to.

Mr WEBSTER -This is multi-employment rather than concurrent employment.

CHAIR - Right.

Mr WEBSTER - One example is that, through COVID, when we were setting up our clinics and working out exactly what staffing we have, what we did was create one position, then the number of nurses we needed for that clinic became the number of people that were allocated to that one position.

Ms O'CONNOR - Okay, thank you.

Mr WEBSTER - So multiple employment. So we had to tidy that up as well.

Ms O'CONNOR - Okay, thank you for that. How many State Servants within Health, were dedicated to work on this project? So, we can have a picture of the salary component of that $48 million over four years. Was it a whole team, was it one person, two, three?

Mr WEBSTER - Through, the minister, there were two teams. There was the team working with the vendor on the build and there was a second team working within our human resources as it started, but people and culture as it became, on the cleanup of data and the business-readiness side of this.

Ms O'CONNOR - So, what was the vendor cost?

Ms LOVELL - How many in the teams, too? You didn't get a number.

Mrs ARCHER - Take it on notice?

CHAIR - Happy to take that on notice?

Mrs ARCHER - Yes, take that on notice.

CHAIR - I might move on back to Sarah, if that's alright?

Ms O'CONNOR - Yes.

Ms LOVELL - Thank you. Just one last question on HRIS. Minister, the secretary told the Inquiry into the Financial and Operational Performance of the Department of Health that you're expecting the first module to be switched on in Health later this year. Is that still the case?

Mr WEBSTER - Yes

Ms LOVELL - Do you know when later this year?

Mr WEBSTER - Through you, minister, DPAC's hyper-support period is just completed. So, we're now going through the - first part of our rollout starts in July.

Ms LOVELL - Okay, thank you.

If I can just go back to the operational efficiency measures that you were outlining before, and I appreciate we'll write to you on notice with that and you'll provide something in writing,

but you mentioned in the vacancy control, you talked about locums, agency nurses. Then, in the department executive restructure, you talked about a reduction of two deputy secretaries. Are you expecting any other reduction in jobs?

Mr WEBSTER - Through you, minister, one deputy secretary, a saving of $2 million is our -

Ms LOVELL - Oh, I thought you said there were two deputy secretaries.

Mr WEBSTER - No, one.

CHAIR - The combining of one.

Mr WEBSTER - Two combining into one.

Ms LOVELL - Right.

Mr WEBSTER - Is what that was.

Ms LOVELL - Thank you, so one deputy secretary. Any other jobs you're expecting?

Mr WEBSTER - Look at the other side of this is I've said we would look at, through you, minister, corporate consolidation, as in going back and saying: have we still got duplication of roles and things like that. That's a process that we will work through. So, we haven't identified particular jobs, but within that deputy secretary's office and the support staff, et cetera, we've identified 18.5 FTE reduction.

Ms LOVELL - Sorry, where was that in the -

Mr WEBSTER - The executive restructure and the support for the executive.

Ms LOVELL - So far, that's all that's been identified?

Mr WEBSTER - Through you, minister, yes.

Ms LOVELL - Okay, thank you.

If I can just go back to the funding, broadly speaking, so the health system funding or Health department funding. Do you, minister, have a figure for where Tasmania and Australia is sitting at the moment for health inflation?

Mrs ARCHER - Look, what I would say, and when I responded to this question the other day, I would just reiterate the comments that I have made previously around continuing to invest in the health system -

Ms LOVELL - That's not -

CHAIR - It was a pretty direct question.

Ms LOVELL - We've had those comments already, minister and with respect, we've got a lot to get through in limited time. So, the question is really just: where is health inflation sitting at the moment?

Mr WEBSTER - Through you, minister, in the 2025-26 national efficient price, the Independent Health and Aged Care Pricing Authority calculated that jump by 12.2 per cent, in 2026-27 they showed 2.2. We've done some work and nationally there's been work done, about where is the long-term figure in this and, over the long term, we're expecting it to sit around 3 per cent.

Ms LOVELL - Do you have projections for increases in demand in Tasmania over the forwards?

Mr WEBSTER - Through you, minister, again, we're expecting demand to sit somewhere around the 3 per cent as well.

Ms LOVELL - I know in the budget in, I think it must have been in the interim Budget, there was an increase, like a funding amount, specifically for demand. Was it $200 million, I think, is that right? Is that money in the Budget again this year? Is there an allocation for demand?

Mr WEBSTER - Through you, minister, that was permanent funding that started at $230 million in last year's state Budget and went across the forward Estimates and becomes permanent funding and index funding from there.

Ms LOVELL - Okay, so that's just been rolled into the -

Mr WEBSTER - Into the base.

Ms LOVELL - I had a question also about another matter - before I move on from funding, has anyone else got one?

CHAIR - Yes, if I could do that. Minister, as Sarah alluded to earlier, there's a pretty significant task for Health in terms of the operational efficiency. It's a big department, a lot of people there, but when we go to the policy and parameter statement, Health has an administrative parameter adjustment for 2026-27 of $209.4 million. These are the unavoidable costs, things you just can't avoid. Can you give us a breakdown of what's included in those unavoidable costs that you just can't save? That's what this tells me.

Mr WEBSTER - Through you, minister, this is medications, those sorts of things. Underlying costs that - it's a range of things. I'm just I'm trying, I've got about 50 things in my head going through, but we may bring the CFO who is going to give a more exact answer than I can give.

CHAIR - If you could introduce Craig, minister?

Mrs ARCHER - This is Craig Jeffery, CFO.

Mr JEFFERY - Yes, Ms Forrest, I've done a reconciliation of the changes in the policy and parameter statement. Do you want me to go through that at an output level or at a total level?

CHAIR - Is it something that you could perhaps table for the outputs? Just give me the headline and then table the detail? Otherwise, it could take quite a while.

Mr JEFFERY - I'll give you the headlines, the table is something that I've done. It's probably not in a fit state for this committee.

CHAIR - I doubt that.

Mr JEFFERY - I'd have to tidy it up and we'd probably have to provide it later if the minister would have to tidy it up. I do have that. We'd probably have to provide it later if the minister-

CHAIR - Well, you can do that. Let's start with the headline then.

Mr JEFFERY - The Output 1.1 System Management Health, the main changes in that across from the 2026-27 Budget as per the 2025-26 budget papers to the 2026-27 Budget, key initiatives. They're the key deliverables outlined. I'll just give you the totals. The 2026-27 Budget in the 2025-26 budget papers was $3.541 billion; the changes in that to the 2026-27 Budget key initiatives: $43.9 million. So, they're the key deliverables that are in the budget chapter on page - sorry, I've been shuffling papers as we've been talking - they're on -

CHAIR - On page 87.

Mr JEFFERY - pages 87 and 88. Prior-year initiatives - so, just some adjustments in the cashflows for prior-year initiatives is negative 1.4 million. Australian Government funding updates: 167 million. That's changes in Australian government ABF funding.

CHAIR - Less money rather than more?

Mr JEFFERY - That's - no. That's additional money, yes. So, 43.9 positive, 1.4 negative for prior-year initiatives; 166.9 million positive Australian Government funding update; changes in NPAs, COPES: 25.3 million positive; output reallocations, there were some changes in outputs which zero out, so nil, but I've got the detail if required.

CHAIR - You can provide that later, the full detail of that, yes.

Mr JEFFERY - Yes. Revenue updates: 9.2 million positive; interagency transfers I've got - that's 318,000, I've got more detail if you want to know what that is. I think that's just some money that came across from Premier and Cabinet. Indexation updates: $3.4 million, and operational efficiencies we've already talked about: $120 million.

CHAIR - You will provide - through you, minister, Mr Jeffery will provide a breakdown of the $209.4 million for 2026-27, the parameter adjustments and what sits behind that number; are we clear on that?

Mr JEFFERY - Yes, we are.

CHAIR - Good, and can you do it for the out-years or is that not known yet?

Mr JEFFERY - Yes, it can be done for the out-years.

CHAIR - That would be great.

Mr JEFFERY - That's in the budget papers.

CHAIR - The numbers are, but not the detail.

Mr JEFFERY - Yes. So, we would reconcile with the number that's in the Treasurer's budget chapter.

CHAIR - That's correct. Thank you.

Mr JEFFERY - Some of the parameter changes are made at the Treasury end, so we may or may not know the detail on those, but we will adjust if required and explain that.

CHAIR - Sure. Thanks.

Mrs ARCHER - Hopefully in a larger font than what he's got there.

CHAIR - Yes, so that we could actually read without a magnifying glass would be helpful.

Mr JEFFERY - Yes, I did say to you that it wasn't fit for tabling.

CHAIR - An A3 sheet would be fine.

Mr JEFFERY - Okay.

CHAIR - Anyway, we will get that, no doubt. I will go back to you, Sarah.

Ms LOVELL - I just wanted to go back a step if I can, just to the Health inflation and demand projections we were talking about. So you've got there, on average you're expecting an increase, when you combine the two, of around 6 per cent. Can you confirm that the money in the Budget, including all of the revenue and all of the appropriation from the state, and all of the partnership agreements, is that increasing by 6 per cent at least every year?

Mr WEBSTER - Through you, minister, I don't think it's as simple as that, in that we've just talked about parameter adjustments and things like that within it. The indexation from the appropriation that's been applied over the last few years, and I think the CFO will correct -

Ms LOVELL - Well, I appreciate that -

Mr JEFFERY - Hang on, just - it's 2.5 which is applied to both non-salary and salary, but the NHRA is a different calculation in that there is money that's block funding and ABF funding, so if you're looking for a 6 per cent increase across the forward Estimates, we can't do that.

Ms LOVELL - Well, I appreciate that health funding is complex, but the bottom line is that you're expecting increases in costs of at least 6 per cent, probably more, once you take into account wages and all of the other things that we haven't even really touched on yet; can you demonstrate to Tasmanians - and sorry, secretary, because I should be addressing this to the minister - can you explain to Tasmanians and assure Tasmanians that Health funding in Tasmania, regardless of where it's coming from, is increasing by enough every year that you will meet those increases in demand and inflation?

Mrs ARCHER - Well, I think I've repeated this many times -

Ms LOVELL - Well, I haven't asked you the question yet, so you haven't repeated the answer to this one.

Mrs ARCHER - that of course, from time to time, it's a Health budget and so there may be some unexpected demand as well that happens from time to time, and if that is the case, we would respond accordingly, so I think it's important to note that.

Ms LOVELL - But that's not - we're talking about expected demand, that the secretary has said you've got a projection for expected demand of, on average, 3 per cent a year. So, the question is quite - and I know it's a complex matter - but the question is quite simple: can you assure Tasmanians that funding for Health, from all of its sources, is increasing by enough to cover those expected known increases in inflation and demand, 6 per cent?

Mrs ARCHER - I'm confident that the Budget will meet demand and if it didn't we adjust it accordingly.

Ms LOVELL - That's not the question. The question is: is the money in the Budget budgeted to account for those expected increases that you know are coming, 6 per cent at least?

Mrs ARCHER - I'm confident that the Budget will meet demand.

Ms LOVELL - Well, that's not really the question, minister.

Mrs ARCHER - It is the question.

Ms LOVELL - Well, the question is: is the Budget increasing -

Mrs ARCHER - That's why we put forward the Budget as we have, because we're confident that it will meet the demand. It is complex, as you've identified; it isn't as simple as yes or no, and I think it doesn't recognise all of those things that form part of the Health budget that also seek to drive down demand as well.

Ms LOVELL - Well, I disagree with that, but anyway, I did have one last question on funding, and then Cassy I know has some more questions on efficiencies. You were expecting, again, when we had the financial and operational performance of Health inquiry hearing, an overspend on the budget for 2025-26 of $43.2 million; is that still the case?

Mr WEBSTER - Through you, minister, yes, at this point.

Ms LOVELL - Is that reflected in the Budget, that amount?

CHAIR - The estimated outcome, isn't it?

Ms LOVELL - You've got an estimated outcome, but I haven't done the maths myself. Is that what's reflected here?

Mr WEBSTER - Through you, minister, I believe it would be, because we put that information into BIMS for Treasury and that's what they base this on.

Ms LOVELL - And that hasn't changed since then? You're still expecting that?

Mr WEBSTER - Through you, minister, the Chief Financial Officer has just alerted me to the fact that one of the changes since that hearing was, in fact, that there's been a longstanding superannuation issue with our private practice scheme that has added an amount, I think - the chair just calculated it for me - of around $16.5 million related to the back pay of superannuation back to 2002, I want to say, where we hadn't paid superannuation for certain periods based on advice, and then we've got legal advice that says, in fact, we did have to pay it. We've had to actually back pay that to that period. Some of that is through the ATO, which is the Australian Tax Office, which administers the superannuation guarantee; but some of that is actually through the retirement benefits fund legislation, the state superannuation legislation.

CHAIR - How much was that worth?

Mr WEBSTER - Around 16.5, 16.6.

Ms LOVELL - So, that's on top of the -

Mr WEBSTER - 18.6, I'm hearing:18.6. We've identified that on top of the amount -

Ms LOVELL - So that's on top of the 43.2?

Mr WEBSTER - that we identified in the hearings.

CHAIR - Can I just point out that on your expenses table 5.3, that's across the whole Budget. Sorry, I just have to recalculate. It was just across systems management. You keep going.

Ms LOVELL - Is that projected overspend or expected overspend reflected in the Budget, or that 16-point-something has happened since?

Mr WEBSTER - In the budget papers?

Ms LOVELL - Yes.

Mr WEBSTER - It was since the hearings that we had.

Ms LOVELL - Yes. So, is it since the numbers were provided to Treasury?

Mr WEBSTER - I'm just advised that, in the budget papers, the estimated outcome just includes the PPS. It doesn't include the 43 that we identified at the hearings.

CHAIR - Let's not calculate this wrong.

Mr WEBSTER - I don't - I can't - I don't know is basically the reason I'm given. I'm just looking at getting an explanation of the papers.

CHAIR - Can I just - unless I put the numbers here wrong, perhaps I should put my glasses on - but it seems to me that the estimated outcome from the expense table to the bottom of the whole lot is 384 million, let's say, and the budget was 3.315 billion, which is a 68 million gap.

Mr WEBSTER - Which is the 18 plus the 40, so -

CHAIR - So it is in there?

Mrs ARCHER - So it is in there.

Mr WEBSTER - So it is in there. Sorry, I just -

CHAIR - So it is there. So, it's a 68 -

Ms O'CONNOR - It's a big week.

Mr WEBSTER - It is a big week.

CHAIR - The estimated outcome is expected to be around $70 million now, of overspend; are we correct on that?

Mr WEBSTER - That's right.

CHAIR - 68 plus.

Mr WEBSTER - Yes.

CHAIR - Because it's an estimated outcome; it could be more, could be less.

Mr WEBSTER - Yes.

CHAIR - Quite unlikely to be less, sorry. Are you happy to -

Ms O'CONNOR - Just on the efficiencies: so unions are saying that of the 130 million in cuts for this budget year, there's around 2 million in leadership role restructures, which Sarah asked about earlier, and 80 million related to small state grants. Perhaps you could detail that, noting the Auditor-General's findings on the way the Department of Health administers community grants, which leaves about $50 million in efficiencies or cuts to be found. Page 93 of budget paper 2 lists some strategies for achieving these cuts that include: reducing operational costs and supplies; consumables; communications; postage; and freight. Is it the department's contention that you could save $50 million on postage stamps? Where do you plan to find these savings and what will be, if you like, shaved off the agency's output in order to reach those savings, which services and what's the projected FTE cut this year?

Mrs ARCHER - Thank you. As I've said, we are committed to having a sustainable Health system for the future and we want the Health department to focus on the delivery of those frontline services, ensuring that our taxpayers' money is used wisely. We have also been upfront about wanting the department to be more efficient, and we've heard some of those today, and I note your comments about unions, who I meet with regularly and who often do have very good ideas themselves about where efficiencies can be gained and we will, of course, always listen to everyone, including, I think, the comments in the recent weeks from the AMA, for example, who have been very clear where they think that there are efficiencies that can be made, and that hard questions have to be asked and I agree with that. I think that it is necessary for us to have those conversations.

We've talked about some of the ways that the department believes that they can do this and some of those things that are already underway, such as the introduction of technology and removing duplication, and we've heard a little about those digital processes across the Health system, and again, an increased focus on decreasing locum and agency costs. So, looking at boosting cost recovery, as we've heard, in regard to what we can claim in Medicare rebates and those structural changes with the revised executive.

Again, we have noted that we are still spending too much in relation to primary care initiatives, for example, which remain the responsibility of the Commonwealth. Those are some of the areas that we do have to continue to have a focus on and that's not, as I've said, about blaming; it's about how can we work together on those issues that can be more integrated, for example, and not keep having to step in and pick up those costs as well, but I will ask the secretary to make some more specific comments around -

Ms LOVELL - Just before you do, minister -

Mrs ARCHER - Yes.

Ms LOVELL - if I can be clear too: the AMA has also said that the Budget can't cope with a dollar less. So, while they're saying money can be spent more efficiently, they're not talking about not spending that money, saving that money and not spending it in Health; they're talking about reinvesting that into better Health service delivery. So, I think we need to be really clear about what the AMA has been saying around efficiencies and tough decisions.

Mrs ARCHER - Well, I think we also have to be really clear about the necessity to have efficiency so that we have a sustainable budget, and I think everybody has been very clear about the need to not continue to grow debt, to not continue to borrow.

Ms LOVELL - Yes, but I think it's important that you're not saying that AMA is saying that it is comfortable with cutting $700 million, or spending $700 million less in the Health system, because that's certainly not what the AMA has been saying.

Mrs ARCHER - They have identified very clearly that they believe, and I agree, that there are efficiencies that can be gained.

Ms LOVELL - As have I, minister, and I was also misrepresented in parliament.

Mrs ARCHER - And that's why we will continue to -

Ms LOVELL - We would all agree on that, but -

Mrs ARCHER - Yes, of course.

Ms LOVELL - It's not about saying: let's spend less money, let's spend money more efficiently and take that money out of the Health budget; that's not what anyone's been saying.

Mrs ARCHER - We're not spending less money; we're continuing to spend more money, but we need to spend money that we are not borrowing. We need to spend money that we're not borrowing.

Ms LOVELL - You will be spending $702 million less, is what this Budget says.

Mrs ARCHER - Well, the Budget says we will be spending more than what we were spending at the interim Budget last year.

Ms LOVELL - Once you take into account the $702 million?

Mrs ARCHER - But we also - but what we need to make sure -

Ms LOVELL - Is that reflected in the increased funding?

Mrs ARCHER - What we need to make sure is that, you know, in three or five or 10 years' time, we're still able to invest in those essential services that Tasmanians need.

Ms LOVELL - Yes, but it's important that we're honest about it too, and if that's the case -

Mrs ARCHER - And it's important that we're honest that we must find efficiencies so that we can have a sustainable budget into the future, so that we can continue to invest in those Health services and can continue to have that budget. As I said, when we came to government, you know, as a proportion of the total state budget, the total state proportion on Health spending was not 35 per cent.

Ms LOVELL - No.

Mrs ARCHER - It is now at 35 per cent -

Ms O'CONNOR - It was close: pretty close to it.

Ms LOVELL - It's always been pretty close, but -

Mrs ARCHER - It needs to continue to be sustainable into the future.

Ms LOVELL - But you can't say that you're going to be spending more on Health if you're also spending $702 million less.

Mrs ARCHER - Yes, you can say that you are continuing to spend more money on Health, but you are also identifying that you must make efficiencies -

Ms LOVELL - But you're also spending less at the same time. Yes.

Mrs ARCHER - You must have efficiencies so that you can continue to have sustainable funding into the future.

Ms LOVELL - But let's just be really clear, minister: that $702 million in efficiencies is not being reinvested back into the Health budget. That's money that you're expected to essentially save, spend less, put back into Treasury. That's not money that you're saying we're going to spend it more efficiently and reinvest it into Health.

Mrs ARCHER - $10.2 million every day investing in Health -

Ms LOVELL - That's not the question.

Mrs ARCHER - growing over the Budget -

Ms LOVELL - Yeah, at minus 702 million.

Mrs ARCHER - It must be sustainable and efficient for future generations.

Ms LOVELL - Yes, you've said that, but that's not taking into account -

Mrs ARCHER - I've said that because that's the facts. The facts are that you have to have a sustainable budget into the future. The only way to do that is to be more efficient.

Ms LOVELL - By spending $702 million less? That's what you're doing.

Mrs ARCHER - By being more efficient.

Ms LOVELL - But that's what you're doing. That's what the intention of this Budget is, is to spend $702 million less in Health: correct? That's what -

Mrs ARCHER - The intention of the Budget, and as the budget papers say, that we will continue to invest in health $15 billion dollars, 35 per cent of the state Budget -

Ms LOVELL - In here, yes, but then in here -

Mrs ARCHER - but we will do that in a way that is efficient so that we can continue to invest in those services that Tasmanians rely on.

Ms LOVELL - Yes, so you do that, but then you've got to take out this.

Mrs ARCHER - We've been very open about the fact that there needs to be efficiencies to continue to have a sustainable budget.

Ms LOVELL - We're going around in circles. Sorry, Cassy.

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

Mrs ARCHER - Of course we're going to go around in circles.

CHAIR - Can I just go to one more question before we go on that?

Ms O'CONNOR - Thank you, minister. Can I just get see if we can get an answer on that projected FTEs -

CHAIR - Yes. That was the original question.

Ms O'CONNOR - in this year that will be cut, or made more efficient, by removing them; what's the - sort of the job number?

CHAIR - Can I just add to that question, perhaps: are any of those that you're looking at currently vacant, so they're not really savings, if they're not filled and being salaried?

Mr WEBSTER - Through you, minister, the only targeted FTEs are the ones that I've already outlined, which is the 18.5, the streams from their operational efficiencies at the executive level. All of the other things that we're doing -

CHAIR - Are they all full positions at the moment?

Mr WEBSTER - Yes, They are, sorry, through the minister, that's FTE that is actually occupied.

Ms O'CONNOR - So in an agency with thousands of employees -

Mr WEBSTER - Can I - sorry -

Ms O'CONNOR - Yes, sure. Okay.

Mr WEBSTER - Sorry, but as I've also said, we will be going through our corporate structure across the state and if there is areas of duplication, we will look at those areas of duplication; but as the minister said earlier, and I said in the other place, is that we've given an undertaking to work with our unions on this. So as we identify these areas, one of our first steps, as we did with straight after the Budget with the executive change, is to brief the unions, but at this particular point there's no target, there's no, you know - we've identified that we have to, there's duplication of you know, X number. What we're saying is we will work through that. I think the other side of it is that, you know, we're also confident when we do that - is that given the rate of turnover across each of the categories of our employment, there is, you know, the necessity for forcing people to take redundancies, or leave the State Service, won't be necessary in Health given our rates of turnover across there, but what I'm saying is that we haven't - we haven't got a strategy that says we must reduce by X number of FTE, other than in that one area where we've already identified it and already identified it to our unions and that's the saving.

Mrs ARCHER - I think it's in part because as we've also said very clearly, we remain committed to delivering those frontline services that people need and we want to continue to employ in those areas because that's what's going to help to drive down some of those locum and agency nurse costs as well.

Ms O'CONNOR - It's not part of the THS's brand to be efficient. We've seen that now through multiple Auditor-General's reports, the damning report on the administration of community grants, the equally damning report on the failure to deal with fraud in the agency,

then the Human Resources Information System. You've got an agency there, which is unwieldy and has not to date, possibly in its entire history, been able to operate efficiently. Why should we believe that everything will change in the way the agency is managed and that efficiency will become part of the culture? Because again, culture is one of the things that's been identified by the Auditor-General.

Mrs ARCHER - I think because it has to, I mean, that's the point that I just made and whilst we're saying we're going around in circles, I think what we actually all agree on and you've just identified is that there needs to be efficiencies and there is a place for efficiencies. That work needs to happen. We've been very clear about that. I've been very clear about that. We need those efficiencies to be found. We need to have difficult conversations about them because we need to find those efficiencies so that we can have a sustainable budget and a sustainable health system into the future.

Ms O'CONNOR - Just a quick final follow-up question, if I might, One of the areas of the Budget that hasn't been cut is the AI Accelerator project, which has received $8.5 million over the next two years and we've heard in various committee hearings this week that there's a conversation across government agencies about the implementation of AI into systems. What is the Health department's plan for how you might integrate artificial intelligence into the health system and has any work been undertaken on how many roles AI might fill?

Mr WEBSTER - Through you, minister, I'll make initial comments, but as no real expert on AI; I will get terminologies wrong. We haven't targeted AI to replace roles. We have a very different setting than the broader State Service in that AI will impact how we deliver patient care into the future and the introduction of things like robots and those sorts of things that will make our delivery of the health service, hopefully, safer. But, won't - you will still need that human interaction that goes with that.

Ms O'CONNOR - We keep hearing that, but it's all very uncertain.

Mr WEBSTER - The endometriosis urology robot, I forget what we call it, the Da Vinci robot at the LGH, for instance, has actually allowed us to increase the number of surgeries done in those categories as we've rolled it out. It really is a better way to deliver that service and, in fact, the length of stay for each patient has been reduced in using that robot.

What I'm saying is, there is the broader, if you like the administrative side of AI, which is the broader program that the State Service is looking at and we'll be looking at as well, but we actually have a specific health sector task around our AI as well.

Ms O'CONNOR - There's also a specific health sector task in protecting personal information and data. What kind of guardrails or systems is the Tasmanian Health Service looking at, in order to make sure that AI - some system that may be administered by some entity on another shore even, how do you protect that really intimate personal data of pretty much every Tasmanian?

Prof ARYA - Through you, minister, I think the discussion that we are having at the moment actually identifies that there is a huge potential, but as you just said there are also safety considerations that we need to make sure we are incorporating in our strategy, in our plan. But AI is not new, I mean AI we have been using for a long time. If you look at machine learning, if you look at predictions, forecasting that we do, we have been using AI. It is the

new, more recent form of AI that is helping you generate new information, or new knowledge, I think that's the bit we need to manage quite carefully. We have had a long discussion in our agency, and across the government, about the fact that information needs to be protected, for example, in the country. So, those are the kind of safeguard, those kind of cybersecurity issues that we need to manage, so that we are containing that information appropriately, do not have breaches, do not have leakage of that information. So I think that is -

Ms O'CONNOR - Thank you for your answer, but do you think that's possible?

Prof ARYA - Oh, yes, of course. I mean, there are now considerable safeguards available in the country that do not allow data to leak. So, I think those kinds of provisions are beginning to occur and that may also be the reason why we have not made as much advancement in the last two, three years, as we could have, because we want to be safe, we want to make sure that there is no leakage. Within our department, within our agency, we are now beginning to experiment with AI in a very limited way. For example, we are looking at ambient listening technology at the moment, where you use AI to be able to summarise and document information. We'll do those pilots in a very contained manner, so that these are safe, there's no leakage, and we can see what the value of that technology is. If that is successful, then we will expand that into other initiatives.

Mrs ARCHER - So cautiously, I think is the answer.

Ms O'CONNOR - I hope so.

CHAIR - Well, we see humans fail in that space, don't we?

Just back to the $68 million overspend. How's that going to be funded? Or, possibly more, or possibly a bit less, we're expecting about that.

Mrs ARCHER - I think the secretary did give you some response to this in your health committee, but perhaps my luck to contribute that here.

CHAIR - Well it's bigger now than what it was then, yeah.

Mr WEBSTER - Again, through you, minister, we still remain confident of cash flowing through this, so making sure that we get to the end financial year.

CHAIR - So you won't pay bills right at the end of the financial year?

Mr WEBSTER - Managing the timing of payments is one of the cash flows, but it's also, again, making sure that revenue comes through the door in June rather than July, all those sorts of things.

CHAIR - So, how many outstanding accounts are there sitting across the department at the moment that are beyond their terms? Unpaid bills I'm talking about.

Mrs ARCHER - You taking on notice?

CHAIR - Don’t know?

Mr JEFFERY - Through you, minister, obviously, it's a large agency, we're heavily decentralised, so paying invoices on time relies on those with delegations approving them, getting back to payment. We've got to the stage where the majority of invoices are being paid with no more than around about a two-week delay, which is a good achievement. When they started reviewing that, it was many more weeks than the two weeks, but they're always invoices that are being reviewed or held back because - maybe the service hasn't been fully delivered, or maybe the charging is incorrect, or various reasons like that. So, there's always going to be late payments in the system, or maybe it was sitting on Craig's desk and he was unwell and didn't process it on a certain day or something like that. So, there's always delays, but in general terms, just say two weeks.

CHAIR - Yes. Minister, going back in history, because I've been here a while now, and so has Mr Jeffery, but not in Health necessarily. This was a bit of a strategy to push out payments at the end of the year, I used to hear from small providers of hospitals for consumables, and, you know, food and all sorts of stuff that the bills weren't being paid. So, can you assure Tasmanians who have outstanding accounts, or have accounts sitting with the Department of Health that they will be paid in a timely manner, in light of this having to cash flow this $68 million thereabouts, overspend.

Mrs ARCHER - Yes, as I think Mr Jeffery's said, I mean there's hundreds or thousands of invoices at a time and, for a range of reasons, they might have varying degrees of complexity. But, yes -

CHAIR - Yes, but those are not contested. I'm talking about the uncontested invoices here.

Mrs ARCHER - I certainly can assure people that invoices will be paid as quickly as possible.

CHAIR - You spoke earlier about one of the efficiency measures was the removal of a deputy secretary position, which would save about $2 million. What would it cost to separate that person?

Mr WEBSTER - Through you, minister, that separation will - and this is an estimate we still haven't signed off on the separation - is $136,000.

CHAIR - Right. And that's the only redundancy we're looking at the moment, is that right?

Mr WEBSTER - Through you, minister, only redundancy related to the operational efficiencies.

CHAIR - There'll be other redundancies for what reason?

Mr WEBSTER - Through you, minister, from time to time, individual workplaces will put up proposals for redesign, et cetera, so, throughout each financial year we may have redundancies or what are called workforce renewal incentive payments (WRIPs). What I'm saying is, I'm not ruling out that they won't continue to occur because they've occurred every year since I've been in the State Service. But, in terms of a targeted redundancy, the only one that we've negotiated related to the operational efficiency is with that deputy secretary.

CHAIR - Is there funding in the Budget to cover the separation costs of this person plus the usual run-of-the-mill redundancies?

Mr WEBSTER - Through you, minister, in relation to this is that the savings we've quoted are net of the cost of implementing it. So we've netted the $2.3 million - to say we've got a payout attached to it in that financial year. So, of course, then it goes up in future years. In relation to the others, it's all done on a business-case basis of: this is the what we want to do in this particular workplace, are there sufficient savings in what you're doing or a strategy for what you're doing. For instance, with a WRIP, it may be that you've got someone on the top of the scale -

CHAIR - Yeah, yeah, yeah, I understand how they work.

Mr WEBSTER - and so there's a payback period for that. We haven't got a specific bucket of money. It's done on a business case-by-business case basis.

CHAIR - Minister, what I think I'm hearing and I'm happy to be corrected if I'm wrong, is that there will need to be other efficiencies found to fund the separation costs?

Mrs ARCHER - I don't want to verbal the secretary. I think what the secretary is saying is its sort of business as usual in as much as, if there is an efficiency to be gained by that redundancy, it's factored in. A business case would be developed - we think there's this much efficiency to be gained, net of whatever the cost of that is. Is that what you're saying?

CHAIR - We're not looking at having to save even more than what the budget papers suggest? That's the question.

Mrs ARCHER - No, it would be included in what you anticipate the saving would be. the efficiency would be from that change.

CHAIR - It's factored into your projection when you do - what did we have - the budget sustainability plan, they've been called in another department. Have you got such a thing?

Mr WEBSTER - Through you, minister, not that we call it that particular document.

CHAIR - What do you call it?

Mr WEBSTER - We've got a series of documents around the strategies et cetera. We have a financial sustainability program that's been ongoing and that's what identified some of the things.

CHAIR - I think the SSMO requires a more direct response to the operational efficiencies. A previous minister yesterday referred to - well, he didn't his staff did - a budget sustainability plan that will outline how these savings are being made. You're not working on one of those?

Mr WEBSTER - Through you, minister, yes.

CHAIR - What's yours called?

Mr WEBSTER - We call that our financial sustainability plan.

CHAIR - Right. Bec, I'll go to you.

Ms THOMAS - That's something you've been asked to prepare now given the operational efficiencies that need to be found for this Budget? You mentioned that it's something that has been done as a piece of ongoing work, but will there be something now we've heard from other agencies that there is an expectation that there'll be something presented to budget Cabinet?

Mrs ARCHER - We have - you might like to add - but we have outlined the strategies that we are intending to use to deliver those operational efficiencies - some of those things already underway that will be progressed or amplified and some of those that may be new strategies Those are things that we've already outlined here today.

Mr WEBSTER - It's not a new program for us. We're not creating a new set of reports for this particular budget document, but we will build on our existing financial sustainability plan as our way of reporting through the minister to Treasury. In addition to that, through the budget system, we're reporting regularly to the Treasury on how we're doing and those sorts of things. But, our financial sustainability plan is the basis for what we do with these operational efficiencies.

Ms THOMAS - Okay. In terms of operational efficiencies and jobs that may need to go, you've mentioned the one SES position, has there been any restructure? Minister, are you aware how executive level team has been restructured to be able to still deliver the functions of the executive while losing one person?

Mrs ARCHER - Yes, so the secretary alluded to that earlier. He might speak more freely about the streamlining of those roles into a single -

Ms THOMAS - Has there been any reclassification of other positions as a result of that loss of one person?

Mr WEBSTER - Through you, minister, the loss of the SES 4, and it's one SES role, but there has been a change to the classification of one other from an SES 2 to an SES 3, so the new structure is a single Deputy Secretary for Health Service Operations, they then have five reports to them - one for the north-western Primary Health; the second is Launceston General Hospital plus statewide diagnostic and treatment services; the third is the Royal Hobart Hospital plus access and flow, or integrated operations; the fourth is an existing role, which is Statewide Mental Health Services; and the last one is a change to the role of the CE public health to become broader and take in population health.

Ms THOMAS - Minister, are you aware of the cost of the senior executive service positions and specialist role positions in the Department of Health, the total cost of those positions?

Mr WEBSTER - As at the end of March, the senior executive service in Health is 29.99 FTE -

CHAIR - At a cost of?

Mr WEBSTER - We don't have that broken down by cost, but we can calculate it.

CHAIR - You can provide that?

Ms THOMAS - Can we take that on notice?

Mr WEBSTER - Yes.

Ms THOMAS - Thank you. When you say, senior executive, does that include the specialist role positions?

Mr WEBSTER - Yes.

Ms THOMAS - It does. That would be very helpful if you could provide the cost.

While we're talking about staffing, information that you provided to another committee, inquiring into the Health finances demonstrated that total staffing in the Department of Health has increased, despite the fact that there's been a jobs freeze over the past 12 months in terms of policy by the government. The increase from March 2025 to March 2026 was a total of 381 employees; 71 of these were in non-clinical health professional roles, professional and administrative support functions, and non-clinical management, so that made up 18 per cent of the increase between 2021 and 2026, and just 2 per cent of the increase between March 2025 and March 2026; and there were 14 operational roles added in that one-year period of the jobs freeze and 296 clinical roles. So, I'm interested in understanding, minister, how do you explain the fact that, at a time when there was a jobs freeze announced and efficiencies to be found, there were 71 new non-clinical health professional roles added to the workforce?

Mrs ARCHER - Thank you. The secretary might be able to detail them. The point I would make is one that I think you would frequently hear: that non-clinical roles support clinical roles as well.

Mr WEBSTER - Through you, minister, as I think I tried to explain in the previous committee, non-clinical roles are not administrative roles or those sorts of things; a non-clinical role can include a cleaner in our hospitals.

Ms THOMAS - No, that's in operational category in this table I've got. Cleaners are in operational. So, in this description, non-clinical health professionals: professional administrative support functions; non-clinical management; ED; payroll; hospital administration; policy and regulatory functions; recruitment; IT; project and infrastructure management; budget management; accounts payable reporting; IT; injury management; workplace relations; communication; and senior executive service.

Mr WEBSTER - If I go back to hospital administration, then that includes ward aides; it includes the admission staff at the front desk; it includes the receptionists, which are called communications officers -

CHAIR - People who try to read a doctor's handwriting.

Mr WEBSTER - The clinical coders that are reading the doctors' handwriting, et cetera.

CHAIR - Trying to.

Mr WEBSTER - So, you're right, the definition is payroll, hospital administration, policy and regulatory functions. That includes that quality and safety supports, recruitment, IT professionals, project to infrastructure, so all that -

Ms THOMAS - I just said all that: so what justifies 71 new positions in that category in the last 12 months?

Mrs ARCHER - I can probably answer that to the point that when you talk about a recruitment freeze, it's not a complete recruitment freeze. If those roles are deemed to be essential, they will be recruited to.

Ms THOMAS - I will reframe my question, then: how are they deemed essential roles? What evidence is presented and to whom to determine that those 71 roles were essential?

Mr WEBSTER - Through the minister, so, because these are point-in-time figures, I would point out that they may actually, in fact, be vacancies that we've filled that were already in existence; but if they're new, they come up to the vacancy management committee, which, at the moment, I chair, where you have a look at: do they satisfy the criteria of 'essential', and then we sign off on filling them. The changes in numbers can be of impact on vacancy rates, but if they are new, they actually do come through vacancy management.

Ms THOMAS - So, vacancies don't go through vacancy management: only new positions?

Mr WEBSTER - A range of roles go through vacancy management, but there are a number of categories, such as nursing hours per patient day, frontline nurses, that don't go to vacancy management. It's funded through a benchmarking exercise which is part of an industrial agreement. So, vacancy control don't actually sign off on that. We see a range of roles, but if there is an increase - as in a new role being put in - that must come to vacancy management, unless it fits within the change to the benchmarks in NHPPD, or it's part of the bulk registrar recruitment that reoccurs every year -

Ms THOMAS - I'm not talking about clinical roles - sorry, to interrupt you - but just to be very specific: I'm talking about non-clinical roles. All those categories that both I've described and you've described, there's been 71, an increase of 71.

CHAIR - Nothing to do with the nursing aspect [inaudible].

Ms THOMAS - Can you tell how many of those -

Mr WEBSTER - Yes, but the question was what comes to vacancy management.

Ms THOMAS - Well, how many of those were new roles and how many were vacant roles that were filled, and is it correct that vacant roles in that non-clinical health professional space don't go through vacancy control, only new roles go through this process that you're talking about to demonstrate the need for them?

Mr WEBSTER - Just to explain my answer, because I was answering the question which is: do new ones go to vacancy management? All roles outside of a defined category - and there's a defined category in lots of areas - come to vacancy management. So, that will include a lot of these roles. Some of them you say are essential. Some of them will be around, as I explained to an earlier question, we're trying to say: if that's labour hire and it's going to be ongoing, can we convert it to a position? So the IT roles there would be positions that we're trying to actually say, let's get rid of the labour hire and bring in the staff member. Traditionally in Health, for instance, and it came in in this period, we actually - our rollout of laptops was done through a series of labour hire. We now employ those staff. It's cheaper for us to do that.

When you say it's a hiring freeze, it is also the budget task. If it's cheaper to actually hire the person than to pay contractors, then we would see that as essential, because the work's got to be done. If we don't get the doctors their laptop, we can't - they're not going to be able to operate. We would - we took a decision, instead of using labour hire to go out and hand out the PCs, we would bring the staff, we would bring on board staff. That's just one example of, you know, that it's not easy to say there's a labour freeze -

CHAIR - A cost was going to be incurred. It was a determination of what's the best way to incur it?

Mr WEBSTER - That's right. Is IT staff or is it labour hire, that's right.

Ms LOVELL - Minister, there was a case before the industrial commission earlier this year around - and this is public sector more broadly, but it was around information to do with family violence contact officers being provided or not provided to the CPSU. I understand that case has been resolved, but something that's become evident through that case is that, at this stage at least, which was, I understand, last year, there were no family violence contact officers in Health, despite a workforce of - the figures I have here at 15,839, but the secretary said over 16,000 employees before; is that still the case? Do you still have no family violence contact officers in the Department of Health?

Mr WEBSTER - No. Through you, minister, no, it's not the case. In fact, there is a list of them on our intranet.

Ms LOVELL - How many do you have?

Ms WEBB - Through you, minister, I think someone's just looking up the intranet.

Ms LOVELL - Thank you, because obviously we can't access the intranet.

CHAIR - We will keep moving.

Ms LOVELL - Cassy, you can keep going if you like. I will come back to this.

Ms O'CONNOR - I just want to go back to the data security, private information protection: the National Health Service in the UK has contracted Palantir to provide a federated data platform and so what's happened - it's a half-billion dollar project - and what's happened is that the private health information of UK citizens is being held offshore, and there are huge concerns about the safety of that data, particularly given Palantir's role in supporting the Israeli Defence Force, ICE in the US through its surveillance tech. Has the Department of Health

contracted any private companies to advise it on the implementation of AI or data protection, and has the Department of Health any contracts with any Palantir-associated companies?

Prof ARYA - I'm not aware of any contract that we have in place to look into AI. We are developing a plan ourselves to make sure that we have got those safety considerations covered appropriately and properly, and I think if, in the future, if we do need some further advice or expert opinion then we will look at how we get that advice, but at this stage, with the research that we have done and with the background work we have done, as Mr Webster was saying before, both in administrative side of things but also in clinical side of things, I think we have good expertise within, and one of our strategy or a couple of our strategies are that we develop that internal capability ourselves, we are not reliant on external providers. Also, as we were discussing before, that we have very good governance over this, and we're investing quite a lot of time and effort to make sure that everything is in place before we go out.

Mr WEBSTER - Through you, minister, just to add to that: is that the Department of Health in Tasmania is subject to the national legislation, security of critical infrastructure legislation, and so we actually have to report to a federal agency, I'm not sure which one it is off the top of my head, on a 12-monthly basis, where we have to attest to what we are doing to protect critical infrastructure, which includes what we're doing in the area of cybersecurity around our information. And the NHS equivalent that you spoke to is, in fact, the My Health Record and sits under the federal government rather than the state government.

Ms O'CONNOR - Okay. Well, noting that the Albanese government is currently in negotiations with the Trump administration about the transfer of private health and biometric data to the Trump administration, is it possible to put the question on notice about whether or not the Department of Health has any contracts with any Palantir-connected companies?

Okay. Can we just go back to Dinesh's statement that we're developing a plan? I mean, if you're storing personal data on an external system or in the cloud, how do you protect it?

Prof ARYA - Through you, minister, I think probably two components to this. One is the cybersecurity, generally, the cybersecurity arrangement that we have in place and we have got a reasonably strong team within our Health ICT division that do cybersecurity checks. When we get into the AI environment, I think the cybersecurity may have to be slightly different and I refer to the fact that we probably will need to make sure that data is contained, that data does not leak, does not leave the country. All those additional measures I think we will have to put in place.

Ms O'CONNOR - Is that hard-drive technology? I mean, how do you do that? How do you protect personal, very private information of Tasmanians in a time when you've got these whole new systems that are coming in that are demonstrably a potential risk to privacy and the protection of personal information? Do we talk about putting things on paper copies in folders? Do we re-establish hard drives or do we just think that we've got solutions that so far, as far as I can understand, no administration's been able to give effect to?

Prof ARYA - Through you, minister, I'm not an IT expert, so I can't -

Ms O'CONNOR - I thought you were, sorry Dinesh.

Prof ARYA - I can't give you a full response to that question, but as a clinician, I can say that is our starting point. We cannot compromise on patient safety, patient information. So, I think whatever provisions, measures we put in place as AI evolves, I think that probably will be our starting point.

Ms O'CONNOR - Okay, thank you.

CHAIR - We're going to move on.

Ms O'CONNOR - But, I just want to make sure we can get the question put on notice about contracts or arrangements with any Palantir-connected company.

CHAIR - You'll send that through.

Ms O'CONNOR - I will do that.

CHAIR - Did you want to pick up on that? Bec's got one and we need to have a break.

Ms LOVELL - I've got one more quick one as well, or one more.

Ms THOMAS - Mine might have to be taken on notice.

CHAIR - If you could put it out then.

Ms THOMAS - Just quickly, do you know how many band 9 roles, minister, are in the Department of Health? Have any been advertised in the last 12 months and, if so, how many were new roles?

CHAIR - While we're looking for that, minister, have you got the number of family violence -

Mrs ARCHER - Yes, two family violence contact officers.

Ms LOVELL - Right. To be clear, family violence contact officers - it's a provision that's standard across public sector awards - and the purpose of them, as it says in the award, 'each agency is to provide support for employees who are experiencing family violence and to notify employees of the name of the nominated contact officers.' So, the contact officers are to be trained in family violence and related issues, they're to be available for employees to seek support for them to, with the person's permission, liaise with the employee's supervisor or manager about what sort of support can be offered. So, you've got two for 16,000 employees. Do you have a plan to appoint more?

Mr WEBSTER - Through you, minister, yes, and we're doing that through an expression of interest because, obviously, this is an area where we don't force employees to take on these contact officer roles. But, in addition to the formal contact officers who have nominated to do the training et cetera, we do advertise supports through our people and culture section, through our People Connect area of that, for contact. We regularly advertise our EAP and those sorts of things. But, you're right, two for 16,000 is not enough but we'll continue to advertise expressions of interest on people who want to join those ranks.

Ms LOVELL - If I can just explore - and I appreciate you're doing those other things - but that's separate, this is an award provision. Department of Treasury and Finance has eight for 354 employees, Department of Premier and Cabinet has six for 604 employees; State Growth has three for 1000 employees; Justice has five for about 1900 employees. Do you have a ratio that you're working towards, or a number that you'd like to see, minister, in those roles?

Mrs ARCHER - Obviously, from my point of view, I want to maximise the opportunity that is available for people to seek that support wherever they are able to.

Ms LOVELL - So do you have like a KPI or a ratio that you've set for the department?

Mr WEBSTER - Through you, minister, there isn't a ratio. I think the ideal ratio would be 16,000, so that everyone is actually aware of the family violence and can provide the support. But, if we've got 16,000 employees, given the rates of family violence et cetera, I would have thought we have to have around 50 to 60 across our agency. But, as I said, we also want to make sure that our awareness of these issues is greater than that.

Ms LOVELL - Thank you. Minister, were you aware that there were only two family violence contact officers across your department?

Mrs ARCHER - No, that's information from today.

CHAIR - I'll just go back to Bec's question. Have you got the answer to Bec's question?

Ms THOMAS - About band 9 roles?

Mrs ARCHER - We'll take that one on notice.

Ms LOVELL - I've got one more, but we could do it after the break, or I could probably fit it into another.

CHAIR - Fit it into another. We'll take a break from now till 11.15 a.m. and we'll move into 2.1, permitted services, when we come back.

The committee suspended from 11.01 a.m. to 11.15 a.m.

Output Group 2 - Health Service
Output 2.1 Admitted Services

CHAIR - Thanks, minister, for returning. It's always a good start for the second bit. We will move into Output 2.1, Admitted Services, and we will go to you, Sarah.

Ms LOVELL - I will ask this question here: it probably fits better in the previous output, but I think it fits here as well because it really crosses over all of the output groups. The Treasurer in his budget speech spoke about workers compensation and escalating workers compensation costs as an impact on the Budget - flow-on effect on agency premiums. He specifically talked about psychological injury claims accounting for a growing share of claims and incurring substantially higher average costs than physical injuries, and said that legislative review is clearly needed. Have you had any conversations with the Treasurer about what he means by that, what his intentions are around workers compensation, and in particular, is it

something that will impact on the provisions for first responders to presumptive post-traumatic stress injury workers compensation cover?

Mrs ARCHER - Look, the Treasurer has spoken broadly, and I think you've identified the issue itself, that is a growing issue, right across, not only government but right across the community as well. In relation to what specific actions the Treasurer might propose around that, I've not had those conversations. In relation to work, health and safety, more broadly, across Health, obviously I would reiterate my commitment to improving workplace culture, workplace health and safety and all of those things to contribute to improved wellbeing for staff. I'd ask the secretary to make some more comments specifically around workers compensation.

Mr WEBSTER - Through you, minister, we are aware of the WorkCover Board doing some work on the workers compensation legislation. Obviously, we look forward to that. They already did a piece of work on injury management, which we think is critical in this space as well, and through that it emphasised that need for early contact. It goes back to - and I've been around long enough - to when I advised on the workers compensation legislation in 1996 where the objective is to get the worker back to work at the earliest possible juncture, so the injury management work of the WorkCover Board has reinforced that we need to redouble our efforts. The period that someone's off work means once they're off for a certain period, it becomes a long-term issue, so we need to get them back earlier. It also emphasised the need to lift the capability of our managers in dealing with workers who are going through return-to-work programs and those sorts of things.

The other thing is not just seeing the injury as the injury: a more holistic approach to the impacts that injury at work can have on whole of life, and family, and those sorts of things, and including that as part of your injury management. The last area is faster, more evidence-based decision-making on the medical and support needs side of this, so those elements of that report from WorkCover, we are revisiting our processes to make sure that we're following through and to make sure we can do that. For us it's looking at the actual workers compensation, the rehabilitation part of it is - that the report tells us we need to revisit to make sure we get that right.

Ms LOVELL - In terms of that revisiting and what you're doing in that space, do you have any kind of tangible, concrete actions that you're taking around any of those, because they're all worthy goals, but what are you doing to achieve those things?

Mr WEBSTER - I think the first thing is changing the focus from when someone puts in a claim, we go through a process of thinking: are we disputing it or not, and that becomes the dominant factor at the start, so put that aside and actually say: okay, regardless of whether we're going to dispute it or not, we still have a worker who's not at work, so let's focus in on getting that person back to the workplace as soon as possible, so divorcing those two processes - because one of the things of not divorcing them is that you're deciding on the dispute and that becomes the predominant thing instead of the focus on the worker, so it's switching that focus.

Ms LOVELL - How are you doing that? Is it about the instructions that you're giving to people who are managing those claims, or what?

Mr WEBSTER - Yes, it's a couple of things. It's about the instruction we're giving to management, but it's the appointment of the right rehabilitation people early on and those sorts

of things. All of these things are sort of - in writing, we say we're doing them, but what the report was saying is that on the ground, we're not doing enough of it, so it's revisiting that with all of those staff and case managers to make sure that we're focused on the return to work, not on the technical side of the workers comp act.

Ms LOVELL - Is this a fairly new change in approach, or when will you start to be able to measure that? Presumably, if you're doing all of these things, you will see an earlier return to work; you might see a reduction in claims or length of time off work.

Mr WEBSTER - We've started, if you like, the set of KPIs to track where we, are we starting to have an impact? This report came out - I want to say - late last year but it may have been early this year, but we've been basically doing this work to think about how we're doing it, and we're restructuring - not restructure, but refocus what we're doing since then, but what I would say is: you've talked to my case manager - say we've been trying to do this the whole time, but I think as an agency, we have to say injury management is important. Sorry, through you, minister, in answering the question, sorry.

Ms LOVELL - Minister, with the work that the WorkCover Board is doing, and the Treasurer has indicated he would like to see that happen, what will you do to protect that entitlement to frontline workers to that presumptive PTSI cover?

Mrs ARCHER - I think as the secretary has said, I think there are two parts to this: one is continuing to invest in that culture work as well -

Ms LOVELL - Well, it's more to the - any legislative or policy change around that presumption; is that a position that you continue to back?

Mrs ARCHER - Look, I would probably have to take the specific question on notice, but broadly we would be looking at, as the secretary has said, improving culture and continuing to ensure that we're able to minimise those workplace injuries as well, and supporting people through that as a general principle and ensuring they're able to return to work. In terms of your specific question, I will have to take that on notice.

Ms LOVELL - You're happy to take that on notice? I will send that through, and just one last question on this, I know Cassy has a question on this as well: we've talked about early return to work, which is great, that all of the things that you've talked about in terms of the WorkCover report are very commendable, but really there should be more of a focus on prevention, because ideally we don't want people to be being injured at work. We don't want people to be suffering from post-traumatic stress injuries at work. What specifically are you doing and, particularly, is there money invested in the Budget specifically towards prevention of workplace injury, including psychosocial injury?

Mrs ARCHER - Yes, I guess building on the existing comments that I've made around the importance of that positive workplace culture and that focus on wellbeing in the workplace, and I will ask the secretary to give you the specifics about –

Ms LOVELL - Okay, because building on the - I mean the comments were very broad and high level, so specifically what actions are there being taken to improve those things?

Mr WEBSTER - Yes, through you, minister. So the first of these is the longstanding program, the MyPulse program, for our first responders, of course, Ambulance Tasmania is included in that even though it's within the DPFEM budget lines; but what we're also showing is, you know, there is a wellbeing program that's been developed at the Royal Hobart Hospital in the ED, as another example, and that, you know, that's received national awards for what it's doing. We want to take the, if you like, the elements of MyPulse that would apply more broadly to people in high-stress roles, you know, areas like EDs and et cetera that are exposed to trauma, and see how we can adapt MyPulse into that.

Now, that's not a specific line item in the Budget; that's part of a strategy we're putting in place to help manage, as you said, preventing the injury in the first place, so, taking that and making it part of the whole agency so areas like ED also have those psychological supports at the point of trauma and those sorts of things. On a broader basis, you know, we have a series of programs that we're tracking through workplace health and safety. About 18 months ago, we started to focus in on making sure our executive were aware of their responsibilities, et cetera, and now make that part of the Health board agenda on a regular basis that we're getting reports directly from our workplace health and safety team to the executive about, here are the things that we need to be working on, and then tracking that back to the workers comp; are we getting a lessening of our workers comp, are we stopping people from getting -

Ms LOVELL - And are you?

Mr WEBSTER - Look at the moment, I don't think we're seeing the results of what we're doing, and so that's why we've got to keep generating more ideas to try to get traction on this. There's no doubt that the changes to the workers comp around presumption, et cetera, saw a lift in psychosocial claims, but you know, the answer for us has to be still preventing the psychosocial claim, not addressing, you know, the other end which is once the claim is made, do you dispute it or not? You've got to get back to how do we stop someone being injured at work so that we don't actually have to question the workers comp side.

Ms O'CONNOR - Can we go into - sorry, minister.

Mrs ARCHER - And I think recognising that, as I think the secretary has alluded to, occurs in different ways at different points as well, and including things like, you know, addressing violence in the workplace and a range of those measures as well.

Ms O'CONNOR - Yes, thank you. I just want to just drill into the sort of workers comp data a little bit more, but also it's a question that I ask each year: what is the sick leave rate in the Department of Health? How many people are on long-term sick leave, and how does that compare with previous years?

Mr WEBSTER - That's the rate for the -

Ms O'CONNOR - Is that a comparative rate, and does it break it down into sick leave type, whether it's long leave or short leave; you'd remember, Dale, that we've had this conversation across the table a few years running now.

Mr WEBSTER - Through you, minister, and yes, we probably should have done that split; sorry, our rate is 5.42 for paid personal leave. Now that does include both sick and carers

leave categories, and that compares to 5.33 in the previous year. There's varying rates depending on profession across the agency.

Ms O'CONNOR - Okay, thanks. It doesn't really answer the question, though, because I said how many?

Mr WEBSTER - How many?

Ms O'CONNOR - Yes. How many staff employed in the THS, but I'm particularly interested in staff who work in hospitals currently on sick leave or long-term leave due to illness. You're happy to take that one on notice? Well, can I ask, are we seeing any trends?

Mr WEBSTER - Through you, minister, I don't think we're seeing trends on long-term sick leave; we are seeing trends, you know, in particular areas, but what I would say -

Ms O'CONNOR - Which areas are they?

Mr WEBSTER - Well - and the trend is basically around - it's stable over the last four to five years. So, for the whole agency: 5.38; 5.24; 5.33; 5.42 over four years. But if you look at ambulance, that sits higher at 7; 6.8; 6.75; 6.92: again, stable but higher.

Ms O'CONNOR - Stable but higher than when?

Mr WEBSTER - Higher than our average for the agency is what I'm getting at. So ambulance is one which sits higher, but allied health professionals sits just on the average for the agency.

Ms O'CONNOR - What's the department's current infection prevention and control policy, as it relates to hospitals? Noting before what the minister said about the importance of improved wellbeing for staff, and obviously infection prevention and control impacts on staff and patients: what's the policy given that we've got, as I understand it, 170 per cent increase in COVID rates in the past two weeks in Tasmania, according to national data that I saw. There's been significant increase in influenza A and B, significant increase in RSV rates; what's the infection prevention and control policy currently within our public hospitals?

Mr WEBSTER - Through you, minister, so, infection prevention control, obviously we have teams in each of the hospitals that determines what the ongoing program is, but also specifically when we address particular issues of that. So, through COVID, we built negative-pressure rooms -

Ms O'CONNOR - We're still in COVID, just to be clear.

Mr WEBSTER - Yes.

Ms O'CONNOR - We're still in the pandemic.

Mr WEBSTER - Sorry, through the COVID emergency -

Ms O'CONNOR - We're just not in the emergency period, thank you.

Mr WEBSTER - We're in the endemic period.

Ms O'CONNOR - Well, it's not an endemic condition, but anyway, we will have that argument another day.

Mr WEBSTER - Yes.

CHAIR - Let the secretary respond, please.

Ms O'CONNOR - I just think he needs to stick to the facts.

Mr WEBSTER - So, we are fortunate that we now have a number of negative-pressure rooms, and those sorts of things. So, in terms of the presentations to our hospital, just to put on record the data in week 2, 31 May, there was in fact a decrease in respiratory presentations at the LGH of 9 per cent; the Mersey was up 9 per cent; North West Regional was down 10 per cent; and the RHH was steady. In terms of figures, the respiratory presentations for the state were 306 for the week, and as I said, it varied across the state, but that's in fact a drop of 3 per cent on the previous week.

Ms O'CONNOR - Okay.

Mr WEBSTER -So, how we're tracking in our hospitals varies to the prevalence from the survey that's done as part of that national data, but this is actual presentations.

Ms O'CONNOR - What's the infection prevention and control policy inside our hospitals?

Mr WEBSTER - Through you, minister, so as I said, it varies from hospital to hospital, but in terms of severe respiratory, as I started to say, we've got the negative-pressure rooms that are available, we've got isolation procedures, we go into PPE, depending on the rates, et cetera, as we move into winter, and I heard Dr Veitch on radio yesterday afternoon saying that we're still a few weeks away from where we might start to see a peak. That's when we start to cohort patients -

Ms O'CONNOR - When it peaks? Not preventatively? When it peaks?

Mr WEBSTER - No. We have all our preventative strategies, but once we get - once we see that there may be spreading across our hospitals, then there is a step-up in what we do. IPC is something we do on a daily basis and then we respond to the risk factors on a case by case, and then, as the data increases and winter respiratory illness, we expand our IPC response.

Mrs ARCHER - Ms O'Connor, if it's helpful, Dr Veitch will be here after lunch if you would like to -

Ms O'CONNOR - Oh, no, I've got plenty of questions for Dr Veitch. But these also relate to -

CHAIR - Let's perhaps move on then.

Ms O'CONNOR - No, I just need to understand -

CHAIR - It's public health.

Ms O'CONNOR - Thanks, Chair. In the emergency department, where a lot of very sick people -

CHAIR - Can we talk about it under emergency department line, just to try to keep us moving through.

Ms O'CONNOR - Okay. When is that? When is the emergency department?

Ms LOVELL - It's a couple - that's two lines down.

CHAIR - Just keep it for emergency department.

Ms O'CONNOR - Okay. Alright, I'm happy to do that then. Just confirming that the minister is happy to take a question on notice in relation to staff sick leave year-on-year and long-term leave due to illness and workers compensation due to illness?

Mr WEBSTER - Through you, minister, clarifying - that's numbers rather than percentages?

Ms O'CONNOR - Numbers rather than rates. Thanks.

Ms LOVELL - Minister, can you provide us with an update on what's happening with the sale of Hobart Private Hospital?

Mrs ARCHER - Yes, I'll ask the secretary to take you through where we're at now, noting that it does seem to have been a somewhat protracted process and it is continuing, but I'll ask secretary to provide an update.

Mr WEBSTER - Through you, minister, the sale of Holmesglen, I think it's called, and Hobart Private, which were the first two announced, has been held up as the negotiations around the rest of the, I'll call it fleet, but the other 35-odd hospitals. The formal step that Calvary has been announced as the proposed purchaser of Hobart Private by the receiver - they can't purchase this until they get - there's a regulatory step with the ACCC. We are now advised that the ACCC has the information they need from the receiver. There's another trigger where Calvary will need to submit the information to the ACCC and that hasn't happened yet. On that basis, at the moment, it's still a proposed sale.

We were in discussions yesterday and we believe that somewhere between September and November the broader fleet issues might be resolved that will then allow for Hobart Private and Holmesglen also to go ahead.

Ms LOVELL - So, between September -

Mr WEBSTER - And November. Again, that might slip, but it's, that - we're really in this hiatus where the receiver is doing their role around the whole 37 hospitals. Even though the first two were announced with a proposed purchaser, they're held up by the broader implications of the entire thing. That's important, I think. The other thing I'd say is that Calvary

will need to come up with a suite of services that they're delivering once they take it over. We're making some assumptions about what may or may not be available at the Hobart Private -

Ms LOVELL - Probably where my next questions were going to go.

Mr WEBSTER - Sorry.

Ms LOVELL - No, that's okay. Go.

Mr WEBSTER - We are working through, in fact, under direction from the minister, that there cannot be a service suite gap in southern Tasmania. We're working on making sure that there is an alternative, so that the day the service suite is announced by Calvary, we can confirm what the alternative is, if any.

Ms LOVELL - Obviously, the procedures that are of concern, IVF procedures, termination of pregnancy, gender-affirming surgeries and other procedures, what plans do you have in place to ensure that there will not be a gap in service, if that sale proceeds and those services are no longer offered by Calvary at that facility?

Mrs ARCHER - Thank you. I'll start from the, I guess, the public statements I've made, and that the Premier has also reiterated, that we want to ensure that those essential services continue to be provided for Tasmanians. As the secretary has said, that's the direction that I've provided to the department to ensure that there is not a service gap, noting that those services are currently continuing as the sale proceeds.

As the secretary said, and he can speak some more to it to the extent that he's able to, that's involving looking at what the suite of those services are, where else they may be provided. I think it is really important to note that mostly these are private services. We do have a view that where people hold private health cover, they ought to be able to use it. We want to strengthen the private sector.

Ms LOVELL - They can only do that if there is a facility offering those services here.

Mrs ARCHER - That's right. We would like to see that as private choices. The department is undertaking that work around what suite of services are currently provided that we would want to see no service gap in? Who else might be able to undertake that or by what method or means that might be able to occur.

Mr WEBSTER - Through you, minister, I think the first of those the IVF, Nexus is already announced, which is great. We're negotiating in a market sense and that's why I really can't go into too much detail, to try to get providers in each. The underlying assumption that should be, and the minister's made clear, is that if we can't get to the point where Calvary is announcing to take over and there is going to be a gap, then it will be the THS that that fills that gap to ensure that there is no service gap.

Ms LOVELL - While the sale is proceeding, Hobart Private is continuing to offer its services at the same level?

Mr WEBSTER - Correct.

Ms LOVELL - Thank you. My next question - I know there are some difficulties with this collection of this data, or there has been in the past. I suspect you might not be able to give me the answer. I will ask them and hope you might be able to even take them on notice and see what you can. It's in relation to the number of surgical terminations of pregnancy that happen in the public health system. Just looking at the last financial year, do you have the data on how many surgical terminations were performed in the public health system at the gestational limit of nine weeks and under?

Mr WEBSTER - Through you, minister, we don't have it split the way that you've just asked, but there were 667 terminations of pregnancy recorded in Tasmania's public hospital in 2024-25 compared to 647 in 2023-24. In 2024-25 there are 1005 prescriptions dispensed for medical termination and that compares to 1004 the previous year in 2023-24.

Ms LOVELL - That was through the public health system as well?

Mr WEBSTER - Both those are public health.

Ms LOVELL - Okay. Is it possible to get the breakdown by gestational limit?

Mr WEBSTER - We don't have it split by weeks in any data.

Ms LOVELL - Okay, thank you. Do you have the total cost of surgical termination procedures in the public health system in 2024-25 financial year?

Mr WEBSTER - Through you, minister, that's not something we would calculate as a separate cost. It's part of our total admitted services surgical area. I don't believe we would split it down to -

Ms LOVELL - Okay, you don't collect cost per procedure?

Mr WEBSTER - Yeah, we don't collect cost per procedure in that way.

Ms LOVELL - Do you know what the cost of a surgical termination would be?

Mrs ARCHER - Can we take that on notice?

Ms O'CONNOR - For private patients? Or public patients?

Ms LOVELL - No, I mean to perform it in the public system.

Mr WEBSTER - With the rider that it be sort of average cost.

Ms LOVELL - That's fine.

Ms O'CONNOR - Minister, as you'd be well aware, doctors, nurses, allied health professionals and other staff who work in the Royal Hobart Hospital have been really clear, and the evidence speaks for itself: the Royal Hobart Hospital is struggling to meet current, let alone future, demand. Current facilities are going to need major upgrades, none of which appear to be costed in the Budget. The site is so constrained, which is why previous governments have

planned for a greenfield hospital, the AMA and the ANMF have both come out and said we need to start planning for a new Royal Hobart Hospital now.

As we know, your government has made a decision to pour more than a billion dollars into a stadium at Macquarie Point instead of into a new hospital, but it's a complex and expensive project, we understand that, but kicking the can down the road is only going to make things worse for Tasmanians. Minister, do you acknowledge that the Royal Hobart Hospital, on its current location, is rapidly approaching its use-by date, and will you meet with stakeholders to start making the plans needed for a new Royal Hobart Hospital?

Mrs ARCHER - First of all, I would always meet with stakeholders and do meet with stakeholders and listen to their concerns, of which I already have, in relation to the matters that you have raised, including Mr O'Byrne recently, who raised an alternative proposal, for example, around this. I note your comments around the expansion being outgrown, and I would say that the design was informed by working with the stakeholders and clinicians and it is part of that 30-year vision to rebuild the Royal Hobart Hospital.

Ms O'CONNOR - On its current site, though.

Mrs ARCHER - On its current site: and as you're well aware, that has a long history and we're committed to continuing to deliver on that master plan. I will ask the secretary if he wants to make some more comments.

Ms O'CONNOR - Well, I'm happy -

Mrs ARCHER - I will go back to the point that I have made that, of course, I will also continue to always engage and listen to stakeholders.

Ms O'CONNOR - Thank you, I actually don't need to hear from the secretary on this question, because it's not a question for the secretary. It's a question for you as minister. It's a question for the government, where the evidence speaks for itself, that that site is so constrained and the hospital - for all the money that's been poured into redevelopment in recent years, the hospital itself, according to the people who work in there, clinicians, nurses, allied health professionals, is not able to meet current demand, and so given what we know about the demand trajectory, surely government recognises - and maybe it's a decision government has made to leave it to another government in another day at the expense of Tasmanians, but government must surely recognise that what the AMA, the ANMF are saying about that location is true, and that this government should take the responsible step and start planning for, working with the Commonwealth, potentially, a new royal.

Mrs ARCHER - I would make two points, probably: that obviously we're committed to delivering the commitments that we have already made around the expansion of the Royal, and that expansion is important. Those expansions are important and I also note that they also include the expansion or relocation, if you like, of some services to St Johns Park as well, which I think will also be an important consideration around this. I don't know that you can say it any more clearly, other than to say that, of course with all of these things, with anything, it is important to continue to listen to stakeholders, to listen to clinicians. We're doing that work all of the time. In fact, we revise projects and revise designs for infrastructure projects on the basis of that information as well. Of course, we will continue to work through the commitments that we have already made, but I'm very open to listening to all stakeholders and all views.

Ms O'CONNOR - That's really good to hear, minister, because you'd have been listening when the AMA, ANMF, other representatives of people who work in the hospital have said over a number of years now that that complex is unable to meet current demand adequately, and that it is not going to be able to meet the demand in the future. I know you haven't been Health minister for all of the period that this has come up as an issue, but I guess, you know, it would be encouraging to hear you acknowledge that this is something that government needs to contemplate, that that site is not going to be able to do the job for that much longer, because you can't keep going up and you can't go down any farther; so it would be encouraging to hear you say you've listened and heard what the people who are working in that system are saying about that complex.

Mrs ARCHER - Well, I've listened and I've heard to the extent that we are upgrading facilities as well. I'm listening and hearing, in relation to what I think is also reasonable to say, a range of views, and there is not agreement necessarily across all of those issues or the solutions to them, necessarily; I think that the other point that I would make, which I do think is important as well, in the context of the conversation that we've been having and around demand, and the importance also of prevention, is: that we also don't want to just keep building bigger and bigger hospitals as well. We also want to do some work on keeping people out of hospitals.

Ms O'CONNOR - I guess you don't want to keep trying to put a shine on a cow pat either, because this is a building which for many, many years has done a terrific job, because of the people who work within it, in trying to meet the health needs of Tasmanians; but it is obvious, patently obvious, that that site is too constrained to adequately meet future demands. So I guess, I mean, I'm hearing what you're saying is that it will continue to be kicked down the road, but have you sought any advice, for example, from your department, about that building's capacity or that complex's capacity to meet demand? Have you sought any advice from the department about how you might begin work towards a new Royal?

Mrs ARCHER - Well, of course, I always seek advice and I'm sure that the secretary will be able to provide you with some of that advice. We're continuing to invest in these infrastructure projects here at the Royal, at the LGH and in the north-west as well, for all the reasons that you've outlined: to modernise those facilities, to increase the footprint of them and the treatment points that are available -

Ms O'CONNOR - How do you increase the footprint of the royal?

Mrs ARCHER - I will ask the secretary to make some more comments.

Ms O'CONNOR - Briefly, thanks.

Mr WEBSTER - Briefly, through you, minister, so we are revisiting constantly the master planning of services across the south, including the Royal. To your question, how do we increase the footprint of the Royal? It is about campuses. St Johns Park, we are definitely seeing that as a new campus of the Royal where we can - and we're identifying services that don't need to be with acute services that could be delivered at St Johns Park as part of that master planning. In addition to that, things like outpatient services that don't need to be near the Royal, but not necessarily in the Royal, we've already moved them across to the Wellington building some years ago now, but we've expanded now into what is called the Liverpool

Clinics, the old Vodafone building, I think, so we we've got two floors of that which are targeted to outpatient-style clinics, so it's actually increasing our footprint that way.

Last week we removed a number of administrative roles that don't need to be on campus all the time to across the road in Argyle Street, so that we actually can free up space on that campus for clinical delivery. So it's a combination of those things, but St Johns Park is, you know, consistent with, in fact, the president of the AMA's view of, you know, the existing campus needs to focus over time increasingly on acute, and other services should be delivered on a second campus. Well, St Johns Park master planning is showing that is the second campus.

Ms O'CONNOR - And the St Johns Park master plan, I mean, how's that going? There are some issues, aren't there, with heritage on the site, and some obstacles there because of the - or the historical elements of that site, the fact that it contains burial grounds; like it's quite a sacred site in its own way, and so there are issues, aren't there, for the Health department in bringing that vision to fruition?

Mrs ARCHER - Yes. We don't believe they're insurmountable, and recognising the significant heritage of that site as well and, in fact, the conversation we were having the other day was around how belief that that adds to the potential for that site and what the intended use for it is, in terms of mental health and wellbeing as well. It has had a long, I think it's reasonable to say, planning process recently, taking four years to progress through some of those issues. I'll ask the secretary to just give you a little bit more detail, but it is very significant heritage at the site but we don't believe that that is going to be problematic in terms of the development of the site and, actually, will probably enhance the site in time.

Ms O'CONNOR - Perhaps in the secretary's answer, we could have a sort of guesstimate of what the timing is on the construction of that facility? Because it relates to my earlier question about the fact that the Royal on its current site is just not - it's outgrowing the site.

Mr WEBSTER - Through you, minister, there's a number of initiatives that are now funded in the Budget and will be delivered. The first of those is in fact moving the residential parenting unit to St Johns Park. That building is almost finished and will be commissioned very shortly. But, that shows how we're going to move forward, which is, in fact, new elements that are then connected to a heritage-listed building. That's an example where, by working very closely with Heritage, we were able to get through the process to planning et cetera, very quickly and get a building up.

The mental health unit that has been in planning for four years, we learned a lot from that. That one was - we were building on an existing site - we thought that was the quickest way to do it - to knock down an old shed and build on that site. We've had to work through a series of planning steps to actually get to where we are. That's taught us not to assume that because there's already a building above it there is nothing in the ground. So, archaeological digs, et cetera will be part of our preparatory process, as I said, and the residential parenting units are a good example of that. The other side of that is that we're moving older persons mental health to St Johns Park in the near future. I'm starting the process of that with the build. We've got the child and youth unit going in there as well, so there's a number of projects in the state Budget that are funded to go onto that site that will take some of the pressure off other assets.

Ms O'CONNOR - What about, and back to the question about the timeframe?

Mr WEBSTER - Through you, minister, the four I've just mentioned are all within the timeframe of the state Budget and forward Estimates. The next four years.

Ms O'CONNOR - In the next four years sometime, while the pressure on the Royal will continue, of course.

Mr WEBSTER - But the opening of things like level 6 to create the Liverpool Clinics which happened last year, moving diagnostic breast imaging into level 7 have occurred. The moving of the administrative staff across to 25 Argyle Street occurred last week, the week before maybe. So, we are doing other things along that journey.

CHAIR - Can I just ask? There's two things I want to ask. One is, we know that the Mersey Community Hospital agreement comes to an end and that will just basically drop off a cliff there and, as I understand it, their services there will then be provided under the National Health Reform Agreement under an activity-based funding model. Minister, are you aware of the submission we've had to the GAA committee into the limitations of an activity-based funding model across Tasmania?

Mrs ARCHER - No, no, I'm not sure that I am.

CHAIR - Maybe you should have a look, with all due respect, because it really outlines some of the challenges of an activity-based funding model in a diverse population like we have. So, maybe we'll talk about that in a subsequent committee perhaps because - are you confident then that we can actually continue to deliver the same level of service at the Mersey, particularly as it moves on to an activity-based funding model?

Mrs ARCHER - Yeah, I'll ask the secretary to make some comments about the specifics of the NHRA funding model.

Mr WEBSTER - Firstly, the new addendum to the NHRA signed in January this year includes two additional areas of examination by the Independent Health and Aged Care Pricing Authority that are pieces of work that have to be done within the first 12 months of the agreement - to look at issues for rural and regional Australia and also areas for small states of which we've pushed that pretty hard.

CHAIR - We fit both don't we, actually?

Mr WEBSTER - Exactly. And that work is around adjustments to the national efficient price that should be factored in because of hospitals that fit those categories, will have a, you know, potentially subject to the independent regulator coming up with a formula, a ratio that's higher than the middle of Sydney, for instance. So, those are factored into the NHRA, and I am familiar with that submission, and they are addressed in the NHRA with those changes.

In particular about Mersey, you are right, across the forward Estimates, the Mersey comes off the existing federal funding agreement arrangement where the federal government transferred control back to the state and moves across into NHRA and that is factored into the Budget. But also, in the agreement with the Commonwealth, there are clauses in there specifically about how we transition the Mersey in without it impacting our growth cap or our overall funding cap from the Commonwealth.

CHAIR - So, what do those provisions look like?

Mr WEBSTER - The specific provisions, so there are clauses in the agreement, which the federal government has published. So, there are specific clauses that say there will be no impact on the state's split. So, it's not a case of, if our, I'll just say, split is 100, we don't have to fit the Mersey into that 100, we will end up with 105 because of the Mersey. So, there's a clause that says the Mersey is in addition and doesn't actually factor into our growth. Normally, any growth in activity factors into a cap from the Commonwealth, but the Mersey sits outside that cap.

CHAIR - How long does this agreement last?

Mr WEBSTER - This agreement, the NHRA agreement, is a five-year agreement starting on 1 July 2026. So effectively, the Mersey will transition within this five-year agreement, and then it just becomes part of the base for any future agreements.

CHAIR - Do you want me to ask about the North West Mental Health Facility here, or in 2.5?

Mr WEBSTER - 2.5, or 92?

CHAIR - Alright, I will go to Sarah.

Ms O'CONNOR - You're the Chair, you're the boss.

CHAIR - No, I'm just saying where they'd rather have it.

Ms LOVELL - Thank you, Chair. I've got some questions I wanted to ask you across each of the output groups, so we can do it one at a time where you can present it, you can table it, however it works easily. I'm interested in admitted services, the amount of money spent on locums, agency nurses, and overtime in the last financial year.

Mr WEBSTER - Through you, minister, so, we don't, even though the outputs are structured this way, that's not the structure of the agency. We were very unique, in terms of the state Budget. So, we don't have our locum costs per se split that way, we split them by hospital, by region -

Ms LOVELL - Okay.

Mr WEBSTER - And we're happy to do that.

Ms LOVELL - Yes, great, however you have it.

CHAIR - It might be easiest to table it, rather than read lots of numbers out.

Ms LOVELL - Yes, if you've got something you can table, it would be -

Mr WEBSTER - There's something else on the top of it; that's the only problem.

CHAIR - Maybe you could provide that to the committee, a sanitised version if you need to.

Mr WEBSTER - We can provide that after lunch.

Ms LOVELL - Yes, great.

Mr WEBSTER - But that splits it by hospitals, as well as mental health services.

Ms LOVELL - Excellent.

Mr WEBSTER - Then also splits it by region, so ignore that hospital, so it brings in the whole region, and also has agency nurses.

Ms LOVELL - Great.

I was also interested in, I know there's a number of, I guess what you'd call hospital avoidance programs. I'm assuming people are admitted into those programs, so is this where we would - in admitted services?

Mr WEBSTER - No, it's comes into non-admitted -

Ms LOVELL - Non-admitted, okay. I'll come to that then when we -

Mr WEBSTER - Oh, sorry, it comes into both actually.

Ms LOVELL - Well, yeah, that's what I was - how about I just ask it now, and then you can -

Mrs ARCHER - It's complicated.

Ms LOVELL - What I wanted to ask is -

CHAIR - Avoiding this one to go into the next one.

Ms LOVELL - do you have, like a map, or a list of all of the hospital avoidance programs you have in place, and what they do? Second to that, how do you measure the impact?

Mrs ARCHER - I've got some information around - so Care@home, for example, which is that 24/7 statewide interdisciplinary service providing virtual clinic assessment, remote monitoring, chronic disease management since 2021. Care@home has provided over 54,000 instances of care to patients. Care@home's acute virtual monitoring program has expanded the range of short-term conditions and illnesses for which patients can receive virtual care, and that complements Care@home's chronic disease management program, which launched in December 2024.

Ms LOVELL - And is that a statewide program?

Mrs ARCHER - Yes, that's a statewide program; with the rollout of the acute virtual monitoring program, Tasmanians with short-term illnesses such as UTIs, cellulitis and

gastroenteritis can now access Care@home support. The chronic disease management program is also supporting Tasmanians with long-term chronic conditions through better self-management.

Ms LOVELL - Do you have all of these in, like a list, or a map or a table or something where people can see all of the programs that are in place and the investment into them?

Mrs ARCHER - I think there will be -

Ms LOVELL - It's hard to find that.

Mrs ARCHER - Yes. I mean I think also we're looking at - so it would also have Hospital@home. I think there are other things - it depends on what you characterise as a hospital avoidance as well at that level -

Ms LOVELL - Well, I guess an alternative to -

Mrs ARCHER - because I think also we can try to provide a list, but I will probably also note that we're investing in things such as primary care initiatives which are intended to be a hospital avoidance program as well.

Ms LOVELL - Well, I guess the question is what the department defines as a hospital avoidance program.

Mr WEBSTER - Through you, minister, these group of programs, which we've started to call intermediary care, because they're actually hospital avoidance, but also we use them at the other end to sort of shorten the stay in hospital. They've sort of grown within portfolios and, as part of the executive restructure, we're trying to bring this intermediary care into one, and actually name it up as that, so that you don't have to find it within the services. Within Ambulance Tasmania, for instance, we have secondary triage, which is a hospital avoidance program.

Mrs ARCHER - Mental health responses as well.

Mr WEBSTER - Yes, we have PACER - mental health emergency response -PACER.

Ms LOVELL - There's some good programs there -

Mr WEBSTER - Yes. So -

Ms LOVELL - but I guess the issue is that they've kind of been introduced at various times and various - and there's no kind of map of all of them together.

Mr WEBSTER - That's right. Through you, minister, the work we're doing in the restructure is actually bringing that together under a portfolio called intermediary care -

Ms LOVELL - Intermediary care, yes.

Mr WEBSTER - so that we can actually name it up and then, importantly for us, it's part of that navigation for the public - is they know that there are these services, but the other part of it is they're connected. So, if you're at secondary triage and we do need a GP to do a script,

for instance, then GP NOW is available. If they start in healthdirect but need an ambulance, it gets quickly put across to us. So, it's actually that work to make sure all of these services connect is a part of it; but the main part, and it's the point you've asked about, is we actually have to get the public to be able to navigate them. So, that's why we're -

Mrs ARCHER - I think we could provide a list.

Ms LOVELL - Yes. Perhaps the question then is what will be included in that intermediary care portfolio - I can put that through on notice, though.

Mrs ARCHER - I think even things like navigators probably do form part of that avoidance as well.

Mr WEBSTER - And our campaign in the public is called 'Know your treatment options'. So, we're sort of trying to get all of these gathered under one heading so people can go -

Mrs ARCHER - Including things that are obviously outside of our remit, like urgent care clinics as well, for example.

Mr WEBSTER - We advertise those.

Ms LOVELL - I just had one more question. It's well known the issues around access and flow through the hospitals and the impact that has on everything: emergency departments, Ambulance Tasmania, the whole system, really. I understand that some of that is attributed to wait times for residential aged care and NDIS supports and other disability supports; but what action are you taking or what funding is going towards addressing those action and flow issues, outside of the things that might not sit as neatly with the state?

Mrs ARCHER - Yes. You identified those issues and I can't get away from those; that is a significant issue.

Ms LOVELL - Yes. I understand that.

CHAIR - It's been a problem for quite some time.

Mrs ARCHER - It's going to be a worsening problem, I think. We need to be aware of that: 100 patients at any given time are a significant impact. There are a range of things, and again, we met recently, the secretary and myself with the ANMF, with the federal assistant minister for example, at a roundtable about what some of the options may be for some of those patients. The secretary has had further conversations with the Commonwealth about that. I think there's an understanding that we need to look at that in a shorter and medium-term way as well, whilst building more residential aged care is part of that. Of course, the state is playing their part in that, in terms of greenfield sites for additional residential aged care, hopefully. We utilise district hospitals as well in relation to some of these issues, but there needs to be some shorter and medium-term solutions to this to start to move some of those patients out of hospital where we just really don't want them to be.

Ms LOVELL - I mean 100 patients at any given time - what sort of assessment of needs do you have? Is it just patients who are just waiting for a general residential aged care bed? Is it somebody who needs more complex care?

Mrs ARCHER - Obviously there's individual variation between those people and their needs. They are medically ready to be discharged. I think that's the key point, in terms of they shouldn't be in a hospital. It's not a good place for them to be, and they will deteriorate if they're kept in hospital, but -

CHAIR - They're also waiting -

Ms LOVELL - But they're also not generally - sorry, I was just going to say generally speaking, most of them are not just patients who are just waiting for a general aged care bed.

CHAIR - Assessment: well, they are waiting for assessment.

Ms LOVELL - There are additional needs.

Mrs ARCHER - There are increased levels of complexity, I think it's reasonable to say, with most of those patients. There's some variation in that around things like guardianship, for example, and some of those issues. I think it's reasonable to say there's a level of complexity as well, which is also why I use the argument that we are kind of making to the Commonwealth as well around do the reforms that have been undertaken in aged care, as welcome as they are, are they meeting the needs of this cohort of people as well; I would say no at the moment. So there's more work to be done there, I think. Do you want to make some further comments?

Mr WEBSTER - I think the other thing in addition to complexity is the style of beds. Through the reforms we now use the terminology of concessional beds and non-concessional beds; the difference is the bond, the aged care bond, and so, are there enough concessional beds that can take the patients, and the answer to that is that's part of the issue, the non-concessional - on the NDIS, it's getting the supports in place in time and those sorts of things.

Output Group 2 - Health Service
Output 2.2 Non-admitted Services

CHAIR - Just going back to the Mersey matter: is that impacted with non-admitted services because there are a lot of outpatient clinics, et cetera, in the Mersey that that fall-off of funding may impact; what's the situation there for non-admitted services delivered through the Mersey?

Mr WEBSTER - Through you, minister, so all of the activities on the Mersey site currently that fit into either the activity-based funding category or the block funding category under NHRA will transition. There are some activities already on the Mersey site that are part of North West activity. So you know, we don't, there is no plan to change any of the services at the Mersey because of the change in funding stream. It's around - that's just a transition of funding stream. Obviously, there are plans in terms of the master plan to change services in the north-west and readjust, but related to the funding stream, there are no changes envisaged.

CHAIR - When we look at the line item for appropriation for this line item, it does drop away over the forward Estimates. This is one of those - so, the question is, can you explain how you're going to deliver the same level of services with less appropriation? Where's the extra money coming from? I'm talking about the appropriation, not the expenses.

Mr WEBSTER - Sorry, which table?

CHAIR - 5.2.

Mr WEBSTER - Through you, minister, again through the operational efficiencies, we're looking at revenue streams, we're looking at those - Table 5 point -

Mrs ARCHER - 5.3, I think.

Mr WEBSTER - which shows the other revenues that come in are relevant here. It is important to read the two in context, but we don't actually see that there will be a drop-off in services and not admitted. What I would say is that there is some reconfiguration over time between activity-based funding and block funding because of changes that are brought in through the NHRA and HIACTAS assessments. But, we would say that the revenue across the stream is actually - well, the operational efficiencies -

CHAIR - A lot of these things are going to be self-funded, is that what you're saying?

Mr WEBSTER - Not necessarily, but you know, for instance, outpatient services that you just mentioned, again, if we're bringing in name referrals, outpatients will see a lift in the revenue stream across the forward Estimates.

CHAIR - That'll be funded through Medicare, not through the patients themselves?

Mr WEBSTER - That's right. Sorry, through you, minister, that billing occurs through Medicare, in addition to any activity-based funding that's there as well. And private health.

CHAIR - Sorry, I think you might have said how much you expected to raise from that?

Mr WEBSTER - I did and in the first year it was $4.8 million.

CHAIR - Okay, so when I look at the, I think it's table 5.5, where you see there's money coming in. That's right. It seems to me, it's a quite a bit larger number. I know that there's many - you talked about other forms of revenue that may be targeted there. So, how are you going to get up to about $42 million? Increased sales of goods and services, and I assume that there's other, is that where that's picked up or is it in another line item?

CHAIR - Through you, minister, yes, that's where that's picked up. So, it's not just the name referrals that I just mentioned. That is also the changes across Health to our fees and charges, but you know, private health recoveries - all those targets that we've set.

CHAIR - Private health recoveries. What's the percentage of private patients you get at the Mersey? Most people can't afford the insurance these days up there.

Mrs ARCHER - What's the percentage of private patients in the ones that you ask if they are?

Mr WEBSTER - Yeah, look, I don't know the percentage, but this isn't specifically about the Mersey. Across the state we need to lift this. So, it is also about 'do you get asked,' as the minister just said -

CHAIR - Hasn't this been a focus for a few years now? I've sat across this table for years now and heard there is a focus on this, and the first thing you got to do is ask, so this shouldn't be news to anyone.

Mr WEBSTER - Through the minister, so there has been a lift in this income over the period. Now we're redoubling our efforts on all of these external clients - it's just not private health. So part of that is in, for instance at the Royal Hobart Hospital, we have the private hospital, or private health, I can't remember what the 'H' stands for, liaison officers whose role is to go out and inquire as to this. -

CHAIR - Patients can still choose not to enliven their private health?

Mr WEBSTER - That's right, it's purely choice. But if they're not asked, then -

CHAIR - Yeah, I mean, you could argue, too, that at the North West Regional Hospital and the Mersey there's not a lot of options for you. So the benefits of being a private patient are very limited there. Why would I say I want to be a private patient when I don't get any benefit? That's a lived reality out there, let me assure you. I used to work there, remember?

Mr WEBSTER - Through the minister, again, I'm not specifically answering for those two hospitals. I'm saying there's a program across the state, we need to do that again. If someone comes in who is a DVA patient, we need to make sure that we're recording their Gold Card status; if they're MAIB, we need to make sure that we're recording that and then costing the right items to that. We're recovering all of the income. And that's what that - you're saying it's a massive increase, but it's targeted across a number of streams, name referrals, MAIB, workers comp, DVA, private health.

CHAIR - How much do you think you're missing out on from MAIB patients?

Mr WEBSTER - The total figure from external patients that we're targeting for 2026-27 is $9.8 million.

CHAIR - The question is, how much do you think MAIB, because ultimately if you start collecting more from MAIB, MAIB are going to say, oh, maybe we need to increase our premium.

Mr WEBSTER - I can't really comment on MAIB.

CHAIR - Well, that's a matter for a later time in the year.

Mr WEBSTER - I don't think we have the split with us on just MAIB, but it's across all external patients that there's this estimate of lost income.

CHAIR - How are you going to report against this? How will you know it's happening again?

Mr WEBSTER - An increase in revenue from these streams from external patients?

CHAIR - Yes.

Mr WEBSTER - It'll show.

CHAIR - Are you going to track it from each of the different sources so you know where the effort is having some desired effect? Otherwise, how will you know?

Mr WEBSTER - Through you, minister, the chief financial officer just told me we'll be able to track against the categories.

CHAIR - Craig will be able to report that to us next year. He's made a note.

Mr WEBSTER - Through the minister, the chief financial officer looks forward to providing that to you next year.

CHAIR - I'm sure he does, yes. He will have it on his list to be asked for. I know he'll have it because he's very reliable like that.

Ms LOVELL - Minister, can we talk about radiology. What are the current wait times for x-rays to be read across the state?

Mrs ARCHER - Prof Kate Burbury, Executive Director of Medical Services and Research, Peter MacCallum Cancer Centre, has joined the committee.

Prof BURBURY - Through you, minister, I think the critical question here is x-rays are done on a regular basis every day. The images are always viewable to the clinicians who have requested the x-rays could be viewed at any time. In terms of the demand framework for reporting x-rays, we have timeframes that we meet for that, but it's more around the triage and categorisation for urgency. We can provide the specific time to target for you in a table but, again, I think the critical issue to mention is that all images are viewable by the clinicians who have requested them and can be read real time.

Ms LOVELL - Okay, so the reporting times?

Prof BURBURY - We can give you the targets. They're based on critical, so within seven days to non-critical for semi-urgent and, obviously, non-urgent longer than that.

Ms LOVELL - So, within seven days for critical?

Prof BURBURY - No, for semi-urgent. Critical is always done in real time.

Ms LOVELL - So, critical is real time.

Prof BURBURY - Yes.

CHAIR - Real time reporting as well as viewing.

Prof BURBURY - Yes. A lot of the time that's done through communication, phone to phone and in-person discussion.

Ms LOVELL - And that's happening, you're meeting that?

Prof BURBURY - Absolutely.

Ms LOVELL - And then semi-urgent was the next category was it?

Prof BURBURY - We try to turn it around inside of seven days.

Ms LOVELL - So, that's the target. Are you meeting that target?

Prof BURBURY - I'd have to come back to you on specific numbers, but we've had a demand framework in place for the last two months and we're reporting on that on a weekly basis and we have no outstanding backlog.

Ms LOVELL - Okay. The next category was?

Prof BURBURY - Non-urgent, routine.

Ms LOVELL - What's the target for that?

Prof BURBURY - Again, our target is inside of 28 days and again we're reporting on that on a regular basis in terms of monitoring it in the last six months, and have no backlog.

CHAIR - Who determines the categorisation; is it a clinician?

Prof BURBURY - No, it's set on a standard, so national standards as well as the college standards as well as our demand framework.

Ms LOVELL - You're meeting those timeframes across the state?

Prof BURBURY - I can probably only comment on the south because we have disparate governance according to the north-west, north and the south, but we could certainly get that data for you.

Ms LOVELL - Okay, yes, I'd like the statewide data.

CHAIR - You will take that on notice?

Prof BURBURY - Yes, and I think the other critical component of there's in-house versus out of - outsourcing, and we obviously can only govern the insourcing.

Ms LOVELL - But you collect the data on the outsourced services as well?

Prof BURBURY - So we have turnaround times for that, yes.

Ms LOVELL - Yes. Okay, because that's in particular - what I'm interested in is for those in-house and outsourced services -

Prof BURBURY - Yes.

Ms LOVELL - are we meeting the timeframes -

Prof BURBURY - Targets. Yes, absolutely.

Ms LOVELL - that we've set, so if I can send that through on -

CHAIR - Because a lot of them are outsourced in the north-west.

Ms LOVELL - Well, that's right, yes, and the north, too, I think.

Prof BURBURY - Yes. Correct.

CHAIR - We don't have anyone from the north, do we?

Ms LOVELL - No. That's right.

CHAIR - You are.

Ms LOVELL - Yes. Thank you. The other question I had, then, was on pathology, and I'm just trying to find it now. If I can't find it, I will just make it up.

CHAIR - I will just go to Bec, because she's got a question in this area, and it is on pathology, so maybe it's going to double up, but - yes.

Ms THOMAS - Minister, last year during Estimates, I asked you about a backlog in the pathology test reporting, which came as a surprise to both you and the secretary, with neither of you appearing to be aware that there was a backlog issue. Through questions taken on notice, it was revealed there were 1787 unreported cases, with the average wait time for pathology report being seven days for category 1, eight weeks for category 2, and two to three weeks for category 3cases; so what has been done to address this backlog, and how many unreported cases are there currently are there currently?

Prof BURBURY - Through you, minister, I'm pleased to tell you that the backlog has been reduced down to less than 300 as of this month, from -

CHAIR - In the south or everywhere?

Prof BURBURY - In the Royal Hobart Hospital, which is the level 6 tertiary centre for anatomical pathology, and that's the only one I can comment on. We've done that and achieved that through insourcing, so looking at operational efficiencies, automation workloads, standardisation of templates, and have reduced that without having to outsource it.

Ms LOVELL - That's in the south only, is it?

CHAIR - That's the Royal Hobart Hospital.

Ms LOVELL - Yes.

Mr WEBSTER - The figure that we gave at last year's Estimates on notice was in fact just the south as well, so that's why the focus is there.

Ms LOVELL - Do we have the figures for the rest of the state? I don't know why we'd only ask about the south.

CHAIR - Maybe it was presumed it would be the stage, maybe.

Mr WEBSTER - Through you, minister, I think that's because that's where we'd identified the backlogs, so we were answering particularly on the backlog.

CHAIR - Is there no backlog in the north and north-west then; is that what you're saying?

Mr WEBSTER - Through you, minister, what I'm saying is we're unaware of any backlog in the north and north-west; we were aware of a backlog in the south following questions last year.

CHAIR - How would you be aware of a backlog in the north and north-west?

Mr WEBSTER - Because we ask them these days, because we got taken by surprise.

CHAIR - So you have asked them?

Mr WEBSTER - Yes. That's right.

Ms LOVELL - So there's no backlog in the north or the north-west either at the moment?

Mr WEBSTER - What I would say is that on a daily basis, I'm not sort of answering based on the data but -

CHAIR - Point in time.

Mr WEBSTER - point in time, is what I would say.

Ms THOMAS - So have governance processes been put in place to make sure you are made aware of critical processes like this, then, minister, and what are those processes?

Mrs ARCHER - I will ask Kate to speak to that.

Prof BURBURY - Through you, minister, we've set up governance processes for that and we have weekly monitoring and auditing of all cases that are coming in. I think it's important - and this is probably something you were aware of when the backlog was reported to you, that the increased incidence of cases has been around 5 per cent per annum since 2010, and in the last two years, probably around 20 per cent growth of anatomical pathology, in particular, and biopsies. That's largely due to the increased incidence of things like cancer and complex conditions, but also with the expansion of our novel therapies and new therapies that we're using, they require more complex and sophisticated pathology testing. The demand on

the anatomical pathology labs is exceeding at a pace far greater than we can optimise capacity. I think the team locally, by putting in these governance processes, in terms of streamlining end-to-end workflow as well as the regular monitoring, as well as further opportunities through digital and automation, will pay dividends.

Ms THOMAS - Okay. Minister, I heard you say that there was a process of being streamlined, but was there any additional funding allocated to address the backlog, or has it simply been through governance and streamlining processes that it has been addressed?

Mrs ARCHER - Yes. So there has been additional funding invested in the 2025-26 Budget, including $4.3 million of the $6.8 million for pathology and imaging at the Royal Hobart Hospital allocated to pathology; 1.2 million for pathology at the LGH, 1.5 million for pathology at the North West Regional Hospital; and $2 million towards THS pathology.

Ms THOMAS - Okay, and how much is allocated in the 2026-27 Budget and across the forward Estimates to address this issue?

Mr WEBSTER - That's ongoing.

Ms THOMAS - Noting what we just heard about the increased demand, if demand has increased by 5 per cent per annum in recent years, have we seen an increase in budget to match that demand?

Mrs ARCHER - That's a permanent increase in funding, I'm advised.

Ms THOMAS - Okay. In response to that increase in demand? Do you know what the current wait time is for each category: category 1, category 2 and non-urgent?

Prof BURBURY - Again, through you, minister, so obviously any urgent biopsies are dealt with real-time in terms of conversations, but there is a lag time with processing when the specimen comes in. Again, the turnaround times can vary between less than 24 hours to 72 to one week, depending on: can we process this immediately, or does it need delayed stains and testing? Then category 2 and category 3 - currently the wait time for category 2 is out to four weeks but, again, with refinements inside of that, depending on time criticalness or the need for more sophisticated testing.

Mrs ARCHER - Just to add further to my answer to you, Ms Thomas: in November 2025, we funded an additional $1.45 million for the recruitment of four new permanent FTE at the royal, including two anatomical pathologists, one medical scientist and one pathology technician, and recruitment's currently underway.

Ms THOMAS - Recruitment's underway? So, there is budget for those new positions. Do you anticipate any issues in securing appropriately-qualified people for those positions? Is it a difficult skill to find?

Mr WEBSTER - Through you, minister, yes, we do, and it's a competitive market and the reason why the minister points out there we're still in recruitment is we will continue to put our efforts into getting them across, but also working at growing our own through University of Tasmania, MOU, et cetera, but unfortunately, this is one of the sub-specialities, if I can use that terminology, where there's a shortage across the country, and we've got a - yes, literally

across the globe. So, we really do have a competitive market and we have to push to get the people in.

Ms THOMAS - I did have someone write to me just last week upset that they had been advised they'd have to wait at least six weeks for their category 1 pathology result to find out if cancer had spread to their lymph nodes; is there cases where that is happening - if someone's category 1 report is waiting?

Mrs ARCHER - I think it would be difficult to comment in relation to individual circumstances, given there would be, I imagine, a wide variation in reasons for that.

Ms THOMAS - Yes, I wouldn't want you to, obviously for privacy reasons either, but I just wonder are there cases where that's happening?

Mrs ARCHER - I don't know if you want to add to that, Kate, but certainly I would seek, with consent, to investigate that particular individual case.

Prof BURBURY - Through you, minister, again, agree we wouldn't comment on an individual case; there will be huge compounding factors in terms of what we're reporting back on, but with these governance - and with our rigour around the monitoring, we can be reassured that critical results and/or related to immediate cancer staging and diagnostic and prognostication are done within appropriate timeframes.

Ms THOMAS - Okay, thank you. Just one more on this, Chair, if I may: minister, do you have any insight as to how the end to laboratory technician courses at TAFE - the government has made a decision to no longer continue those courses, I think from 1 July this year - how will that impact on the capacity, particularly for the Royal Hobart Hospital, to find trained staff to fill these roles?

Mrs ARCHER - I will ask the secretary if he wants to make any particular comments around workforce at the royal or elsewhere, but I think in relation to TAFE matters, that would be a matter for the Skills minister.

Mr WEBSTER - I think that - through you, minister, the first thing I'd say is that the categories that we've just read out, like anatomical pathologist, are not in the same category of education that you've just identified, so -

Mrs ARCHER - University degree.

Mr WEBSTER - it won't impact on our ability to recruit those particular categories. In general terms, we have relationships with providers across Tasmania, but outside of Tasmania, to work on our workforce needs. So, for instance: the midwifery program that is starting at UTAS, but prior to that one we had deals with Charles Sturt for dentistry, and we work with James Cook University in Queensland. We are working through our workforce development with a range of providers and creating relationships with students that we hope then end up with them wanting to work with us. That's how I would answer that. The impact of that specific course, we'd be looking at what other providers can we work with.

The committee suspended from 12.35 to 12.36 p.m.

Ms LOVELL - Did we talk about TML, the contract in the north-west at all? If we could just touch on that perhaps. I know there were some concerns early on around that contract and we touched on that last year as well. Do you have any update on that? I'm assuming that would have been monitored quite closely since then and whether we've got any of those concerns currently.

Mrs ARCHER - It is carefully monitored. I did answer this question the other day. In relation to TML, on 1 July 2025, following a procurement process, pathology services in the north-west were contracted to TML. Under the contract, TML are required to meet specific turnaround times and KPIs for processing samples. As you mentioned, there were some issues identified relating to turnaround times in the first few weeks of the transition period. As a result of these concerns, the THS has been working closely with TML to improve these matters. I'm advised that while the service will continue to be monitored, the majority of identified issues have been successfully remediated and the THS continues to have weekly meetings and daily follow up with TML to ensure that pathology results are delivered promptly.

Ms LOVELL - And are they meeting those KPIs in their contract?

Mrs ARCHER - I believe so.

Mr WEBSTER - On a general level, yes, but obviously we're monitoring to make sure it continues that way.

Ms LOVELL - Thank you. Anyone else?

Deputy CHAIR - I have just a couple of others. Is all the public health radiology equipment currently serviced and eligible for Australian Government rebates?

Prof BURBURY - Through you, minister, short answer, yes. We've had some recent upgrades with ultrasound and MRI. So yes.

Deputy CHAIR - Okay, good. Is there any budget allocation in the 2026-27 year to update radiology agreements?

Mr WEBSTER - Through you, minister, there is funding in the Budget called the Medical Equipment Fund, which is now $6 million over each of the forward Estimates. Part of that would be addressed to critical needs in radiology as well as other equipment around our hospitals. The creation of that fund creates that opportunity.

Mrs ARCHER - New CT scanners for the west coast and St Helens, which were election commitments as well.

Deputy CHAIR - My other question is in relation to chemotherapy chairs. There are concerns that the current number of chairs is not enough to meet demand now, let alone growing demand as we see cancer rates continue to rise. My understanding, minister, is that chemo chairs were meant to have increased from 17 to 25 in 2025, but this has not occurred. Are you aware of this and why hasn't it occurred? Is there any budget in this year to increase the number of chemo chairs?

Prof BURBURY - Through you, minister, I can comment on two aspects of that and I think this lends to the out-of-hospital models that were being referred to by the minister and the secretary, is how do we optimise both in-chair inside the building versus out of hospital. That's really where we grow models of care. We touched on formal services like Care@home and Hospital@home, but really what we're asking all of our craft groups to do through their clinical service plan, is explore opportunities where care can be delivered outside of the hospital environment. That's the first aspect of it. The second is looking at different scheduling and rostering techniques to expand our capacity to deliver care.

Deputy CHAIR - Is there a likelihood of either of those things really making a difference in this coming financial year?

Prof BURBURY - Absolutely. They will increase capacity.

Deputy CHAIR - Okay. Minister, is there any plan still to increase the number of chairs as was originally the plan?

Mrs ARCHER - I'll ask the secretary to make some more comments, but just reflecting that, there's increasing the number of hours of operation of those -

Mr WEBSTER - The minister's right, you don't necessarily need to increase the number of chairs. If you change the way you're operating, including the number of hours you operate and things like that, you actually meet that increase in demand. So, we're trialling those and I think Prof Burbury outlined the other initiatives. So, the combination of all those things mean that - physically, do we need to increase the number of chairs, reduces by, are we delivering the number of 'occasions of service.' It doesn't necessarily match to a number of chairs.

Prof BURBURY - Because we've delivered in a different way.

Mr WEBSTER - So five chairs could deliver 25 chairs worth if you actually use those five chairs five times.

Deputy CHAIR - So long as you've got the staff -

Mr WEBSTER - That's right.

Deputy CHAIR - to service them without making them work 24/7. Minister, are you confident that the staffing capacity is there to operate this chemotherapy service on those extended hours of operation that you're proposing?

Mrs ARCHER - Yes.

Deputy CHAIR - There is budget allocation for that?

Mr WEBSTER - Through you, minister, we're not proposing that. They're already extended hours in these areas.

Deputy CHAIR - So, that's already funded?

Mr WEBSTER - It doesn't operate 9.00 a.m. to 5.00 a.m.

Deputy CHAIR - So, you're satisfied that the current service provision, in relation to chemotherapy chairs, is sufficient to meet demand?

Mrs ARCHER - Yeah, I'm confident.

Prof BURBURY - Yep. Through you, minister. Exactly as you were talking about and as the Secretary mentioned we've already modified our scheduling. So, from a staffing perspective, it's not having all the staff there at the same time, but staggered starts and extending the hours to increase our capacity.

Deputy CHAIR - Okay. We might move on then to 2.3, which is Emergency Department Services.

Output Group 2 - Health Service
Output 2.3 Emergency Department Services

Ms LOVELL - Minister, do you have a breakdown across the four emergency departments - three? - of the number of presentations in the last nine months?

Mr WEBSTER - Through you, minister, we have four emergency departments. Our presentations at the LGH for the nine months to March 2026 were 33,456; the Mersey 22,691; the North West Regional 21,526; and the Royal Hobart Hospital 61,513; for a statewide total of 139,186.

Ms LOVELL - Thank you. And do you have - again, bearing in mind it's a lot of numbers to read out and I think in previous years you may have just provided this on notice or tabled it - the number of patients by category seen on time across the four?

Mr WEBSTER - We have it as a percentage.

Ms LOVELL - Yep, that's fine.

Mr WEBSTER - Just getting to the right table. Recommended times, so category 1, 100 per cent; category 2, 43.2 per cent -

Ms LOVELL - Sorry, is that statewide?

Mr WEBSTER - Yeah, these are statewide - oh, no, that's LGH.

Ms LOVELL - If you've got them by hospital

Mr WEBSTER - I can do it by hospital.

Ms LOVELL - By hospital is good.

Mr WEBSTER - I went back a chart, I can do statewide. I'll start with LGH.

Ms LOVELL - It's 100 per cent category 1

Mr WEBSTER - 43.2 per cent category 2; 24.8 per cent category 3; 38.1 per cent category 4; and 75.1 per cent for category 5.

Ms LOVELL - Thank you.

Mr WEBSTER - Mersey?

Ms LOVELL - Yep.

Mr WEBSTER - 100 per cent for category 1; category 2, 64.7 per cent; category 3, 67.5 per cent; category 4: 68.6 per cent; category 5: North-west: 100 per cent for category 1; category 2: 63.3 per cent; category 3: 52.1 per cent; category 4: 60.2 per cent; category 5: 85.8 per cent; and the royal: category 1: 100 per cent; category 2: 44.8 per cent; category 3: 29.8 per cent; category 4: 35.5 per cent; category 5: 60.5 per cent.

Ms LOVELL - Thank you. Now, obviously I can go back and compare those to last year, I'm not asking you to read out all figures for last year as well, but are there any areas where those numbers have increased or decreased significantly, or are you seeing trends across any of those categories or hospitals?

Mr WEBSTER - Through you, minister, it varies across the hospital. So LGH, that's reasonably steady; the Mersey, that is a decline in performance; the North West Regional, it's a decline; the Royal Hobart Hospital, it's a slight improvement.

Ms LOVELL - Okay. What projections do you have in terms of expected demand over the forwards?

Mr WEBSTER - So demand over in our EDs has been growing at around 3 per cent, but it varies by category. So we have seen category 4 and 5, whilst it remains around 37 per cent, that's down by about, you know, several percentage points, I can't remember now.

Ms LOVELL - Demand is down?

Mr WEBSTER - Demand is down for 4 and 5s; but demand in 1s, 2s and 3s is up by about 8 per cent. So overall it's around 3 per cent. So complexity is up, is what I would say to you.

Ms LOVELL - Which obviously is more resource intensive. So how's that reflected in the Budget, then? Do you have increased resources going into emergency department services, because it doesn't look like it.

Mr WEBSTER - Through the minister, so as part of demand in the last two years, in fact, the ED at the Royal Hobart Hospital, staffing was lifted by $22 million, and that's now ongoing funding to the royal, and the demand, the 230 million, which is ongoing across the forward Estimates from last year, some of that was for demand within the EDs as well. So both of those factors go into that, but in addition to that, the complexity leads itself into pathology and imaging and other parts, and diagnostics. So that's why the demand increases in those areas to support that as well.

Ms LOVELL - So the table 5.2 shows a decrease in funding to emergency or appropriations, or I should say, because we know it's more complex than that; it decreases in appropriation in emergency department services by about 20 million - 18 million, from last year to this year; and then a further decrease 2027-28, to a slight increase the next two years after that. Can you explain that funding profile?

Mr WEBSTER - So a couple of factors in there is that again, EDs are under ABF and other funding so that there is a balancing there; but secondly there is also additional complications at the royal at the moment. We're about to do a build and we've put in some resources to help with that, and there will be complications with decanting. The same is happening in the north-west and the Launceston - so there will be variations across the forward Estimates for these as we work our way through that, in that some of those roles that are essential to when we're doing the build in terms of making sure the decant works and things like that actually end up being funded through the capital program, because they attach to the capital program. So there's a whole - again, I keep saying this, the complications around calculating 5.2 has really no bearing on what we deliver, unfortunately.

Ms LOVELL - It would make it easier for everyone if it was more simple. The expenses by portfolio and output table 5.3 shows that you're expecting to spend less in emergency department services this year than was spent last year by about 5 million; is that right?

Mr WEBSTER - So again, I would say that - yes, but again, it's where the money comes from and those sorts of things, is important there. Importantly, that includes - hopefully our builds will actually make us more efficient, so, those sorts of factors, and those sorts of things, but again, I just - I won't say it. I was about to say it's more complex than that, but -

Ms LOVELL - We can take that as a given -

Mr WEBSTER - Yes.

Ms LOVELL - I think, yes, from here on. Do you have other things, does anyone else -

Ms O'CONNOR - So, just getting back to an earlier line of questioning about infection prevention and control in our emergency departments: I was recently having a conversation with a constituent who went down and presented at the ED with a relatively minor injury, but because of the time of night there was no way to get into a GP. They described an emergency department that was sort of packed to the gunnels, and full of very sick people. Luckily this constituent of mine is a mask wearer. Is there any HEPA filters in our emergency departments? Is there any attempt made within our EDs to prevent the spread of infections within that hospital environment?

Mr WEBSTER - Through you, minister, yes, there are, and there's a number of infrastructure things, like the negative-pressure rooms, there's also -

Ms O'CONNOR - I'm talking about emergency department.

Mr WEBSTER - Yes, these are down in ED, and things like that.

Ms O'CONNOR - I'm talking about - sorry, secretary -

Mr WEBSTER - The waiting room?

Ms O'CONNOR - The waiting room within the ED, where most people initially present.

Mr WEBSTER - So, I may have to pass this to Professor Burbury, but I will start: firstly, the initial contact is a triage-type of arrangement where, those sorts of things are hopefully picked up. I'm - self-disclosure, I guess, is that my experience of going to the ED at the Royal for - with a potential infection, was in fact that immediately I was isolated, immediately staff put on PPE, et cetera, to deal with the fact that I, in fact, may have been in an infectious category. So, I can only talk to that, initially -

Ms O'CONNOR - You can only talk to your personal, one-off experience.

Mr WEBSTER - No. That's what happened when I came into the ED, as someone -

Ms O'CONNOR - That's your personal experience.

Mr WEBSTER - Yes, so you know -

Ms O'CONNOR - I'm talking about the practice within the waiting room in the ED.

Mr WEBSTER - Yes, and I'm talking about what happened through triage, because of that being the case. So, I'm extrapolating that, that that's what would happen for all patients that present that may be infectious, but Kate can probably go into more detail about IPC in those areas.

Ms O'CONNOR - Okay, and perhaps Kate could talk about whether there's any air-cleaning tech inside emergency department waiting rooms, particularly noting that sick people will come in, and prior to them being triaged, will be able to infect other clinically-vulnerable people inside the emergency department. So, what kind of measures are in any of our emergency department waiting rooms to protect staff, and other clinically-vulnerable people, and other people who are just there because they're sick and they need treatment, from a whole range of infectious diseases, including COVID, influenza, RSV, and God help us if it ever happens, but we're currently dealing with an Ebola situation globally. What is the emergency department IPC approach in waiting rooms?

Prof BURBURY - Through you, minister, as the secretary pointed out, it starts at point of entry and moves through. We can work in environments without negative-pressure rooms, and these are the sort of things that we put in place. So, there's vigilance in terms of the questioning of people when they identify themselves. We have to also remember it's not just air droplet, but also tactile; so strict hand hygiene, strict awareness, and mask wearing, and PPE mask wearing where appropriate. Zoning, using single rooms with closed doors, and zoning with closed areas for patients that are identified. There are air-cleaning techniques that can also be undertaken as well. Very hard -

Ms O'CONNOR - Can I just check on that Kate, sorry: you said there are air-cleaning techniques -

Prof BURBURY - Yes.

Ms O'CONNOR - but are any of them in place inside emergency department waiting rooms?

Prof BURBURY - They're very hard to do inside of open areas, but -

Ms O'CONNOR - HEPA filters are hard to have in -

Prof BURBURY - Not HEPA filters per se, and making sure the windows aren't opened and things like that. I would have to take on notice exactly what the infrastructure architecture is, but these are all the techniques that we use not just in the emergency department, but throughout the hospital.

Ms O'CONNOR - Okay, so through you, minister, what I'm hearing is that a lot of it is left to a decision made by the triage team, once a potentially highly infectious person has come into ED, and sometimes you'd have to admit that someone might be triaged into a particular category and there isn't the recognition that they're infectious with an illness that could kill someone else they're sitting beside, or make them very sick. So can you confirm there's no HEPA filters inside emergency department waiting rooms?

Prof BURBURY - There's portable HEPA filters and how they're applied I'd have to take on notice and come back to you, but that would be part of the decision-making.

Ms O'CONNOR - Okay. If a person comes in and presents and says they feel really unwell, they have a fever, they're hacking and coughing, they're lethargic and they could have any one of a number of infectious diseases of varying degrees of severity or lethality, what happens then, and how rigorous is that process with that individual, who may be able to infect an entire waiting room full of people?

Prof BURBURY - Again, through you, minister, the standardised processes are done nationally and having come from a place which was a dedicated cancer centre, so literally everyone that walked in the door was immunosuppressed or compromised, these are the same practices that we implement there: Early identification, strict hand hygiene, application of PPE or appropriate mask and isolation of patients. Portable HEPA filters can be useful but, again, it's following that same standardised process for everybody who attends in the ED and from the staff.

Ms O'CONNOR - I'm not sure that that standardised process is proactively preventative enough because I haven't heard that there's air-filtration technology in all departmental ED waiting rooms, I haven't heard that there's consistent mask wearing on the part of staff in order to protect our staff. What I have heard is that there's some national approach that standardises a reactive response to potential infectious spread, rather than a proactive one.

Mrs ARCHER - I think it's about the clinical judgement of staff who are obviously trained to triage when people present to the hospital. It's the nature of hospital presentations, whether they're walking in through the emergency department or indeed being attended to by an ambulance is that it's the clinical judgement of trained professionals that are undertaking that triage.

I think the other point that I would make goes to the conversation we were having earlier about hospital avoidance strategies and also people understanding their care needs. And, that is part of that education process that I think is also really important about, if you have a

respiratory illness, is there another care pathway that might be more appropriate for you. And, of course, what we encourage people to do is to know their most appropriate care pathways for them and to avoid people who may not need to be sitting in a emergency department with the respiratory illness because they may be eligible to access say, Care@home, or something else. Did you want to speak to that?

Mr WEBSTER - Yeah.

Ms O'CONNOR - No, I'm fine with that, thanks. I mean that's a kind of a utopia view, isn't it of how the - I mean yes, of course we would like fewer people to have to present to emergency departments but there's all sorts of pressures because of what's happened to the GP system. There'll be more pressures because of cuts to the National Disability Insurance Scheme, and what I'm hearing is that it's government policy to leave the judgement about infection prevention and control in emergency department waiting rooms to nurses and clinicians who are in the waiting room, rather than showing leadership by having a proactive preventative policy that cleans the air in waiting rooms, that requires masks for staff at all times. Because I mean, the circumstances within our emergency department waiting rooms would seem to me to be unsafe for clinically vulnerable people. Particularly, the scenario that was painted for me by my constituent a couple of weeks ago.

Deputy CHAIR - Prof Burbury did offer to take the question on notice to provide some additional information. Would you like some additional information to be provided on notice about the actual policy and practice how it's applied consistently?

Ms O'CONNOR - I certainly will put that on notice, but I want to challenge the minister on the notion that it is appropriate and safe to leave it entirely to the clinicians or the nurses who are in the ED on any given day, when what would be required in a health system that was committed to preventing nosocomial infections, so infection within a hospital environment, would show leadership and put in place some preventative measures, particularly around air filtration, which costs nothing in the context of the Health budget.

Mrs ARCHER - I think there are several things to say there, and we will get back to you with a response. First of all, there are infection control measures in place, which Prof Burbury is alluded to and will give you some specific advice about that. I do also think that the points that I made earlier are in fact proactive. We do need to make sure that people understand their care options, understand what is available that is outside the hospital and avoid going to hospital if they do not need to be there and if it isn't an emergency. Also, to reinforce the point that I made earlier that these are highly trained specialists and their entire training is around triage and recognising, in a complex environment as well, that you've got people, as you identified, presenting with a whole range of conditions and that is the work that happens in emergency departments and with 000 call takers and paramedics, is around making those decisions in the context as well of the presentation at the time and the other people that are presenting and all of those things.

Ms O'CONNOR - Thank you. A final question on this line of questioning. There's a large and growing body of research that points to asymptomatic infection of highly contagious and, at times, lethal diseases like COVID. COVID apparently about 50 per cent of transmission is asymptomatic. How is a clinical staff person who's under enormous pressure trying to triage people, going to be able to make a decision then when they don't know that this

person may have something like COVID or RSV or flu, because there is plenty of asymptomatic infection?

Mrs ARCHER - I think this is true more broadly as well, though, because depending on the nature of the illness, that you're talking about, people have periods of incubation where they're not symptomatic, but they may be infectious. And that is true for a whole range of conditions and people are walking around -

Ms O'CONNOR - That's why you might have HEPA filters in your emergency department waiting rooms though.

Mrs ARCHER - It is also why we would seek to empower people to have greater levels of health literacy and be able to make decisions about things, for example, like hand hygiene and masking.

Ms O'CONNOR - If you are poor and you can't afford your GP and you're really sick you'll go to the ED because you're trusting government and the health system to keep you safe. Happy to put that on notice.

Mrs ARCHER - I would trust in those clinicians to do that. I would also highlight the benefit of vaccination as well.

Ms O'CONNOR - It won't stop you from getting COVID.

Deputy CHAIR - Sarah, you have another one on the emergency.

Mrs ARCHER - The secretary has got an answer to a couple of earlier questions.

Mr WEBSTER - First, the surgical termination cost in 2024-25, $5227 based our calculation of the data. A comparison of the locum costs across the nine months in 2025 versus the nine months for 2026. Locums were 66.88 for the state as compared to 82.62 in 2025.

Ms LOVELL - Is that -

Mr WEBSTER - That's the whole state.

Ms LOVELL - But, sorry, what's the measure?

Mr WEBSTER - The nine months to 31 March.

Ms LOVELL - No, sorry - 66.88 what?

Mr WEBSTER - Million, sorry.

Ms LOVELL - Million, right, dollars. Okay, I thought is it percentage, is it people.

Mr WEBSTER - Sorry, it said costs, so -

Ms LOVELL - $66.88 million -

Mr WEBSTER - Yes, on medical locums in the nine months to 31 March 2026 compared to $82.62 million for the same nine month period in 2024-25.

Ms LOVELL - So it's a decrease?

Mrs ARCHER - A reduction of 19 per cent.

Mr WEBSTER - A decrease of 19 per cent or 15.7 million. Agency nurses, so nine months to March 26 was 53.91; but the nine months to March 2025 was 83.4 million. That's a $29.49 million reduction or 35 - just over 35 per cent.

Ms LOVELL - I had a question about the Royal Hobart redevelopment, the emergency room redevelopment. I understand the plans for that extend over three floors; is that right, three storeys? Are there many three-storey EDs around the world?

Mr WEBSTER - Through you, minister, I think the important part is that we work with clinicians about what are the different features of the ED that they wanted, so part of this is -

Ms LOVELL - More stairs, lifts?

Mr WEBSTER - creating spaces that are safe for particular categories. We need to, for instance, make sure that we had a separate waiting room for paediatrics and separate areas for paediatrics. Similarly with the very unwell mental ill people, we wanted to make sure that - in the current configuration of the royal, the rooms for people experiencing episodes are right in the middle of the ED, so we wanted to make sure that they're actually a space that is actually safe but separated from the hubbub of the ED, and I think that's important, because people are trying to actually settle and trying to deal with issues, to then have the hubbub of the whole ED right there as well, so that's why.

DEPUTY CHAIR - I think we understand the nature of it. I just note we're short of time, so I think Sarah's question was directly: are there any others around that you know of?

Mr WEBSTER - The short answer is: we don't know of any that are three storeys, but the reason we've gone with this is (a) to make sure we had sufficient space to do the things that I just described, because if we go back into the ED footprint, we would lose those features.

Ms LOVELL - Accepting that there are obviously some challenges and constraints with the footprint of the hospital itself, obviously that is going to present some challenges around resourcing. You will have staff who will have to travel further, you won't have the same ability for staff to move quickly between those different parts of the hospital or the emergency department. What plans do you have in place to mitigate those challenges? Will it be an increase in staffing, or what does that look like?

Mr WEBSTER - Through you, minister, there will be an increase in staffing because the size will increase. That size was always going to present some of those issues that you just outlined. The second thing is actually dedicated lifts between the facilities, so that we're not competing with the public pressing buttons to get between facilities, but importantly, having the right specialties in each of the spaces.

Ms LOVELL - Is it likely that there will be more staffing, a bigger increase in staffing to address the three-storey issue than it would have been if it was on the same level?

Mr WEBSTER - Through you, minister, I don't believe so, because again, the footprint is enlarged to the point we are moving from a 57-treatment-point ED at the start; when we finish, we will be at 114. We were always going to have a footprint that meant that responding from one end to the other was quite large. In fact, the lifts arrangement will actually probably save people some of that legwork, and I'm just told that the ED at the Austin Hospital is over three storeys.

DEPUTY CHAIR - I heard Ruth ask before about activity-based funding at the Mersey, but I'm not sure if she asked this, so just tell me if she did: did any components of emergency department services funding or activity indirectly adjust due to the transition to activity-based funding?

Mrs ARCHER - That is what she asked earlier, yes.

Ms THOMAS -That is what she asked: okay, good, I just wanted to make sure that the opportunity wasn't lost.

Mrs ARCHER - And 'no' was the answer.

Output Group 2 - Health Service
Output 2.4 Community Health Services

Ms THOMAS - We will move on, then, to 2.4 Community Health Services. We've got a few minutes before lunch.

Mrs ARCHER - Clare has been waiting.

DEPUTY CHAIR - I know. I've got questions I will come back with after lunch, but I will go to you for some of your specifics, if you like.

Ms GLADE-WRIGHT - I just wanted to ask about the Moreton Group and the much-loved Cygnet Family Practice: do you accept that they are reducing pressure on the hospital?

Mrs ARCHER - As with any primary care services, yes, if we can see good primary care in communities where people are able to have that care, then we know that that avoids unnecessary hospital presentations at times.

Ms GLADE-WRIGHT - Then why have they been moved to the transitional funding?

Mrs ARCHER - Yes. So, we have continued to step in and support primary care initiatives over time, despite the fact that they are the responsibility of the federal government. We do that for the reasons that you have identified and we've done that in a range of ways over time; whether that is through capital grants to general practices or, indeed, through the types of support with Moreton or with Cygnet Family Practice. In the case of Cygnet Family Practice, that had been - it's time-limited grant funding, that was extended last year and has now been

given a further extension to enable the Commonwealth to step up and meet their responsibilities.

Ms GLADE-WRIGHT - But they're saying they've given us 700 million towards hospitals, so it's back on us.

Mrs ARCHER - I think what you've heard through this process - well, it is about being honest, because I think what you've heard today, if we're honest, and we've said that it's complex and it is, but it actually just doesn't work like that. The Commonwealth has entered into an agreement with the state, National Health Reform Agreement funding that is for hospital funding: that is for hospital funding. That doesn't mean that the Commonwealth doesn't retain their responsibility for primary care, for aged care, for NDIS.

We have invested $50 million in primary care initiatives since 2022 because we recognise that primary care is important, and delivering that care in place, but we have to be very clear that we are stepping in because the Commonwealth has neglected their responsibilities in this area. Now, they went to the last election talking about strengthening Medicare. We would welcome that. We could think of lots of ways, Cygnet Family Practice is a good example where Medicare - and Moreton is another, in fact - where Medicare could be strengthened that would better meet the needs, for example, of those types of primary care services. We would love to see the Commonwealth to do that. They have also talked about the importance of urgent care clinics and we've talked about -

Ms LOVELL - And delivered them.

Mrs ARCHER - And delivered them, which was the point that I was going to make, is that, subsequent to the funding that we have provided over time to Cygnet Family Practice, for example, there is now a Medicare urgent care clinic in Kingston where there wasn't one that existed before. I acknowledge the value of primary care and I acknowledge the value of these services, and we have stepped in to support them and we have extended a further lifeline to support them. We will work with them and the Commonwealth to advocate for a more sustainable solution that strengthens primary care by the Commonwealth, as it should be.

Ms GLADE-WRIGHT - Minister, are you aware that Queensland's Liberal government has expanded funding for the Gladstone nurse-led walk-in clinic, on the basis that it reduces pressure on hospital services? So, another Liberal state government is taking responsibility for that nurse-led care.

Mrs ARCHER - Yes. We continue to invest in primary care as well. We've got $16 million in this Budget for TassieDoc clinics and $15 million, in fact, for the Huon Valley - was the first of those $15 million commitment to the Huon for a health hub there. We continue to work -

Ms GLADE-WRIGHT - And the community are telling me that they actually just want the services funded; they don't want a new, fancy building.

Mrs ARCHER - Well, we did hear a little bit of commentary in the recent Huon election about what their community wanted or didn't want, and I was very clear at that time that I would be listening to what the community would want. I have been listening to what the community would want, which is why I've met with the council, I've met with stakeholders, including some

of those involved with the Cygnet community practice and other healthcare stakeholders in the area. We will continue to do that. The department will continue to work with the Huon community on the best model for that community, as we are with the others around the state. They have different models around the state where they have been announced, and that is because we're seeking to allow Medicare to do what it does and to respond to primary care, but seeking to respond to that by making more bulk-billed appointments available in communities. Because, we do recognise the value of primary care but, just because we recognise the value of primary care, doesn't mean that we can continue to step in. That has to be sustainable and I think there are also some equity considerations as well.

If, for example, those have previously been funded under competitive processes or competitive grant processes or expressions of interest or whatever, I think that if I just continued to pick a winner if you like and extend funding to that clinic, at what point am I not - Ms Thomas is not going to say, well, actually I have a great urgent after-hours clinic in my community.

Deputy CHAIR - That only happens during elections.

Mrs ARCHER - We need to look at those equity considerations and they're competitive processes.

Ms GLADE-WRIGHT - What does your advocacy look like now on behalf of Cygnet Family Practice?

Mrs ARCHER - We have written a number of letters back and forth between me and Commonwealth representatives. I'm certain that we will meet to discuss those as well, and about primary care more generally. Also, as we've talked about earlier, there's this suite of issues, primary care, aged care, NDIS as well. We'll continue to advocate to the federal government and some of those changes for example, could be just around Medicare rebates. The Medicare rebates that are available more adequately responding to what general practice and some of these more innovative approaches to general practice, being able to respond to that. And I think that would be a great way for the Commonwealth to support these primary care initiatives in a sustainable way. That's what we have to seek to do. It's why we have run the expression of interest the way we have for TassieDoc because we want it to work with the system and be sustainable, not just us continually having to step in to fill a gap.

Ms GLADE-WRIGHT - Okay, thank you. I have a really quick one.

Ms THOMAS - How quick is it? We will continue on with this line after lunch.

Ms GLADE-WRIGHT - It is really quick and I am on a roll. The residents of Bruny Island have expressed their need for a social worker. How do you assess that, or have you assessed that need?

Mrs ARCHER - A social worker for the island, generally?

Ms GLADE-WRIGHT - Yes.

Mr WEBSTER - Through you, minister, Bruny Island is part of the southern part of our network, so allied health services are provided generally across the south. If there is a need for

that particular category of allied health on the Bruny Island, then it would be drawn from that pool. They may not have one resident on the island, but we deliver a number of allied health services to the island on an as-needed basis.

Ms GLADE-WRIGHT - Can I put that your radar then, please, minister?

Mrs ARCHER - I'd be happy to catch up and have a talk further about it.

Ms THOMAS - We will wrap it up because it is 1.18 p.m. We'll return after a short break and continue on community health services at 2.00 p.m.

The committee suspended from 1.18 p.m. to 2 p.m.

Committee resumes at 2.00 p.m.

CHAIR - Thank you, minister. Thank you for coming back again with your team. We're in 2.4, and I thank the Deputy Chair for taking over for a short period there. I'll go to Clare for questions initially, then come to you Bec.

Ms GLADE-WRIGHT - I've done mine.

Ms THOMAS - Minister, I'm just wondering if you can explain the breakdown of funding across the different community health services that are funded through this $198 million appropriation in the line item 2.4. I know the description talks about community health centres, child health centres, parenting centres, dental clinics, district hospitals and multipurpose centres, the descriptor on page 96 says. I'm just wondering if you have a breakdown of funding across those different purposes? This is the line that includes breast-screening services?

Mrs ARCHER - We can take the question on notice, but yes, it is the line that includes breast screening.

Ms THOMAS - Okay, alright. Minister, the expected outcome for 2025-26 is $3 million above the budgeted appropriation. Are you able to explain this overspend?

Mrs ARCHER - The secretary will respond.

Mr WEBSTER - Through you, minister, some of this reflects, for instance, the diagnostic breast imaging which we're rolling out and is fully funded from 1 July. We've put funding into that to get that started to make sure we got employees in place in advance of the 1st. The project team, moving our team from in fact, two premises into Liverpool Clinics, so there's those elements. And then some of it would be just additional demand across the forward Estimates and some of it would be some of the grants that are reflected in here such as the payment from oral health to RFDS - the Rural Flying Doctor Service - for dental clinics and things like that. So, there's a mix of things that contribute to that small overspend.

Ms THOMAS - Okay, so I note that the budgeted amount is around $198 million for 2026-27, but then this drops down to $186.79 million in 2027-28. Minister, with wages and the cost of delivering services increasing over the forward Estimates, which community health services will be cut to achieve the $12 million in savings required here?

Mr WEBSTER - Again, we have a mix of revenue and appropriation in these outputs so it's not a straight - You can look at 5.2, which is the appropriation side. We also need to look at the later 5.3 says, what we're spending in that space, which includes the sources such as, for oral health we have a federal funding agreement with the Commonwealth around adult services - so, a number of the services under community health are also funded under the grant revenue stream, but also in these revenue streams there are some fees and charges that apply that also bring in revenue. Again, I'd direct you to 5.3 and then the combined table at 5.5. So, whilst the appropriation is slightly down. the actual activity, et cetera, is reflected in what we'll expend taking in all sources of revenue.

Ms THOMAS - Okay. Taking in all sources of revenue the forward Estimates project spending about $11 million less in 2027-28 than in 2026-27. So, 2026-27 is a $368.5 million expenses bill and then in 2027-28 it's $357.9 million, so it looks like you're expecting to spend less on community health services in 2027-28. How will this be so?

Mr WEBSTER - So, in 2026-27, we actually go up from our expected outcome and that reflects a number of short fixed-term programs that come in - grant programs, those sorts of things. Then, yes, it goes down in 2027-28, but you'll see it bounces back up in 2028-29 and 2029-30. So, it's really, again, the headings there, they're the estimates of expenditure, but we've got a number of programs that are either growing or across there with different sources, but also got some grants that finish, or expected to finish, at the end of the financial year. So all of those have to come in, but generally speaking, by the end of the forward Estimates, we're actually spending $21 million higher than we are in 2025-26.

CHAIR - Does that keep up with CPI, though? What's the percentage increase? I could work it out, I could get the calculator out again.

Mr WEBSTER - So, through you, minister, sorry, to answer that question, across the general state sector there is an indexation of 2.5 per cent that's applied, in addition to any other changes to our revenue sources.

Ms THOMAS - I guess I understand what you're saying in broad terms. Can we be reassured then, there's nothing specific that is going to stop or reduce in 2026-27, and then in 2027-28, sorry, when that amount goes down, there's not there's no specific program or initiative across community health centres, child health centres, parenting centres, dental clinics, district hospitals, all those things that are bundled into this line item, makes it very hard to scrutinise and ask questions, minister, when we don't see a breakdown. I know that that detail can't be provided in the budget papers, but it'd be helpful if we're able to have it next year tabled at the hearing to be able to actually ask questions meaningfully and actually understand the spread.

Mrs ARCHER - I was going to say some of these things, the secretary can add to my response, but some of these things are, I think he was saying, are time-limited grants and things like that. Although, noting that, as much as we say that they are time-limited grants, then we are then frequently accused of cutting them when they come to their natural conclusion. So, I think the point is that expenditure increases, we're continuing to invest in those things, but things are going to come in and out of that as those processes happen.

Ms THOMAS - Just from a transparency perspective, it would be helpful to know what those things that are coming in and out are, but I understand you've agreed to take that on notice. Or, no, that was no, sorry, that was the actual breakdown of the funding line.

Mr WEBSTER - Through you, minister, yes, we can provide a breakdown in community health services. It won't equal the budget paper and the reason for that is that because of the sources of revenue fluctuate across these, but secondly, the outputs in the Budget are structured not as to our service delivery. So for instance, part of community health service will be at some of the outpatients at the Royal Hobart Hospital. So, you know, it doesn't work that you can say each of these outputs splits into these parts of the department. It's more complex than that. So, I'm kind of warning that we can provide the table that lists what bits of the agency that are funded are under this, but it may not add up to the figure you're seeing under that because there'll be money that's come in from other sources, or there'll be parts of this output that sit with another part of the agency.

Ms THOMAS - I appreciate that point of warning and I understand it's complex. We've heard that a lot today and I generally appreciate that it is complex, I don't envy your job one bit. But, our job here is to try to scrutinise and understand and bring some actual transparency to the specific things that are being funded with taxpayer money, and it's very difficult to do that when things are lumped into categories like this. It's a frustration across different outputs. So, sorry, you're getting me on day three after a late night, and I'm getting quite grumpy about it.

CHAIR - So you might like to ask a question?

Ms THOMAS - Well, I guess that question is, and I think the secretary has said, will they be able to provide some more level of detail so that there is some more transparency around the specific initiatives and programs funded through that?

CHAIR - Will you take it on notice?

Mrs ARCHER - Yes, and we can provide the more specific level of detail with the caveat that it is possibly going to lead to a few more questions because it is complex.

CHAIR - That's fine, yeah.

Ms THOMAS - Okay. On breast screening facilities, which you said is included in here, I was pleased to note one of the key deliverables that is clearly specified and which is helpful, is boosting access to breast screening services, with $7.7 million each year to support the operation of the Tasmanian Breast Care Centre, as well as the delivery of four new permanent BreastScreen clinics. However, I'm concerned that, when it's spread across five sites, the amount sounds fairly small, of $7.7 million each year. Are you able to provide a breakdown of how this funding is split across all five sites, the new breast care centre and four new sites in each year of the forward Estimates?

Mrs ARCHER - Yes. I might need to take that one on notice, but yes, we can provide the detail.

Ms THOMAS - Thank you. Is this $7.7 million - is it all new money or is it money that was already allocated for BreastScreen services or an increase to what was already allocated?

Mrs ARCHER - It's new money to support the establishment of those four new permanent BreastScreen sites.

Ms THOMAS - Okay. So, it's $7.7 million new?

Mrs ARCHER - And the diagnostic breast imaging.

Ms THOMAS - Yes, the five sites.

CHAIR - As opposed to screening?

Mrs ARCHER - Yes. Screening and diagnostic.

Ms THOMAS - It includes it, doesn't it? Diagnostic and screening. So, 7.7 is all new money on top of what was already allocated for BreastScreen. Thank you. Do you know, minister, how does the capacity and resourcing for these breast screening facilities measure up against the demand for services? Do you have any measure of that?

Mr WEBSTER - The location of these sites - we have sites that are currently visited by - or regularly visited by our mobile and obviously we've got some limitations at the moment. We know how many we do in these areas over a 12-month period already, but it's also by postcode data and things like that. The idea of the centres is that (a) they're located in areas where we believe there is a need to locate them and secondly, we then can match the numbers in those areas to the centres. You've made the point about 7.7 doesn't stretch that far, but some of these centres are part-time centres. Locating in Triabunna, we won't be there full time because there isn't the demand, but it does mean that we've got a location on the east coast. It means that people don't need to travel into Hobart or wait for the mobile. In the same way as when we established Rosny, we opened that on a part-time basis and that's taken - the eastern shore people are not needing to travel into Hobart. It is actually a transfer of resources as well as new resources.

Ms THOMAS - Okay. Do you know how much of the total of this line item is allocated to breast screening and diagnostic services, how much the state invests in that specific purpose?

Mrs ARCHER - We would have to take it on notice.

Mr WEBSTER - We will have that split.

Ms THOMAS - Thank you. I note that in the gender impact statement on page 33, there's no data available on breast screening. Are you able to explain why that's the case? It talks about Australia Institute of Health and Welfare data. Is it simply a point in time, another thing we keep hearing over the last few days, a point-in-time issue with data being available, or -

Mr WEBSTER - Through you, minister, I think it may have been a point in time. We have the data and we publish it regularly on our website. We also publish it as part of our annual report. So, it may be that it just didn't make it into that particular document.

Ms THOMAS - Okay. Because it talks about the specific - it talks about Tasmanian three-year trend and then Tasmania's performance compared with national results and for both

it says: data not available. Are you asked to provide data to feed into the gender budget statement?

Mr WEBSTER - From memory, I think, through you, minister, we were. I'm taken aback at the fact that the data's not there, because it is available.

Ms THOMAS - Yes, so it says:

> Data from the Australian Institute of Health and Welfare showed that Tasmanian women had higher rates of participation in breast cancer screening than nationally in 2022-23. While more recent data are not currently available, the Department of Health publishes monthly data on breast cancer screening in Tasmania.

I don't know why we wouldn't use our own numbers.

Mrs ARCHER - Data that is publicly reported.

Mr WEBSTER - Through you, minister, I think it's we can't compare to the rest of Australia for the current period because we don't have that data, but we do have the data for Tasmania for the current period, so I'm not sure why that comment is in there, but we have the comparative data for each of the financial years up to the end of 2024, and then we only have the Tasmanian data for 2024-25.

Ms THOMAS - So, perhaps in future years, could that be looked at, to use Tasmanian data -

CHAIR - Better to raise with the minister for Women, perhaps.

Ms THOMAS - Right, okay.

CHAIR - Who I think is responsible for the gender impact -

Ms THOMAS - Do you want to follow on, sorry?

Ms LOVELL - Yes, is that alright, if you're done on breast screening?

Ms THOMAS - I've got more on breast screening: nearly there. When is the expected date of delivery of the new BreastScreen bus?

Mrs ARCHER - Dale.

CHAIR - Where is it?

Mr WEBSTER - Where is it? It's currently at the Varley assembly plant, getting fitted out, et cetera, or ready for fit-out. We're expecting it to come online in December this year, at this point, but we're doing everything we can to work with Varley to bring that forward as quickly as possible.

Mrs ARCHER - So, we've met with Varley, we've had discussions, I've met with Varley about what the opportunities might be to expedite that, and we've also commenced discussions around, and procurement around, a third mobile unit. Did you want to bring that up?

Mr WEBSTER - Yes, through you, minister, so we're also, as the minister said, looking to a third bus, in fact trailer for a truck, to - but one which actually allows for additional screening categories, such as cervical screening, to occur in the mobile unit, as well as breast screening. We're expediting that, and bringing that, even though that - *Ida*? I get confused at the name of these things.

CHAIR - *Luna* and *Ida*, yes.

Mr WEBSTER - Ida is still operational, the new one will come online, but we want a third one: (a) it allows us to give extended services to some areas that are not meeting targets on other types of scanning, but secondly, it allows us to have a redundancy, so we don't get in the situation we're currently in with *Luna* being offline.

Ms LOVELL - Is that funded, the third unit?

Mrs ARCHER - Yes, so do you want to talk about how that is funded?

Mr WEBSTER - Yes. So, that's funded from a combination of things, we've put the money together to make sure that we can advance that, rather than wait until the replacement period. Some of it will be the medical equipment fund, with the equipment that goes on it, and things like that. So, it's got multiple sources coming together.

Ms THOMAS - And just finally on breast screening for me: I note - I think I've heard you say, I think in Estimates last year, in November, minister, that the Glenorchy BreastScreen service isn't expected to be established until 2028. I just wonder if that is still the case, and why that is the case, when my understanding is it is expected to be located at the Glenorchy Health Centre, which facility is already there; it's a matter of establishing the service rather than building a new facility itself. So, is there any chance that this can be brought forward to be delivered sooner?

Mrs ARCHER - Yes. So the secretary might be able to comment further around this, but much like Devonport, which will be the first permanent site that will come online, which will free Ida up as a priority to move to other areas as well, it will require upgrades to the site, shielding and things like that, for the specialised equipment that needs to go in there. Did you want to speak some more about the timelines?

Mr WEBSTER - Yes. Through you, minister, so we're managing this program, in terms of looking at where our needs are, and we're trying to target this in a way that will increase the levels of screening. Devonport allows us to actually, as the minister said, free up Ida. We're also working on the planning for Kingston as part of the build down there, we're working with the council, but it isn't as simple as rolling in a mammography at Glenorchy. We actually need to make sure that - we've got engineering to do to make sure that the floor will handle the weight of the machine; we then have to build the room to make sure it's got the right shielding in it, because it is radiation in the machine; all of those factors mean that we, you know, we want do this in a logical sequence, and 2028 is what we've targeted.

Mrs ARCHER - And some of that sequence is around also those areas of priority, as identified earlier, and the distance to existing sites as well. So, we've got a new site, obviously in Hobart, we've got sites at Rosny, whereas in Devonport at the moment that one of the reasons why that's been prioritised, is that that will be able to draw in people from that area and allow *Ida* to be redirected elsewhere in the meantime as well. Also, just you know a reminder that there remains opportunity for patients to access transport options if they need to access breast screening.

Ms LOVELL - Leading on from what you said there, minister, around transport options and other options to get women to screening services. *Luna's* been off the road for a while now. Do you have a record of how many breast screens we did in a year where we had both buses on road compared to what we're doing now?

Mrs ARCHER - There would be, whether we'd have it with us is there another question. I might need to take that one on notice.

Mr WEBSTER - The data's to the end of last financial year.

Ms LOVELL - When we had already had?

Mr WEBSTER - We had for a short period, but not. Sorry, through you, minister, for a short period of that financial year we had the *Luna* was off, but mostly it's been this financial year.

Ms LOVELL - What years do you have there, through you, minister?

Mr WEBSTER - We have up to the end of 2024-25.

Ms LOVELL - Do you have the year-to-date figure for 2025-26?

Mr WEBSTER - Through you, minister, no we don't have that, and I think that's because we were trying to do that comparison with the nation and stick to the intervals that they follow.

Ms LOVELL - Okay, I can send that through on notice if that's -

Ms THOMAS - Can I ask just one more one more on breast screening? Minister, are you aware there are community groups that raise money to support BreastScreen Tasmania? There's one in my community that has an annual fundraiser, and recently raised over $30,000 in one day to support some of the services and activities of BreastScreen Tasmania. Are you aware of how much is raised through community groups to support some of the activities of BreastScreen Tasmania?

Mrs ARCHER - I don't have that off the top of my head. I don't know if the we can take that on notice. But yes, certainly recognise the significant volunteer and philanthropic support not only for BreastScreen, but across a range of areas in the health system, which is really valued and welcomed, and the department has processes for dealing with those donations and -

CHAIR - Isn't it counted in the revenues? The money raised by philanthropic and other donations?

Mr WEBSTER - Through the minister, not generally, and in fact, if you look at the north and north-west, we direct most donations through Clifford Craig Foundation through a memorandum of understanding, and we do the same in the south for most of our donations through the Royal Hobart Hospital Foundation.

CHAIR - Some of them are raised specifically for a purpose, though? Like BreastScreen Tasmania.

Mr WEBSTER - When it's raised for a purpose, then there'll be a number of governance arrangements about working with the community group who initially hold the money, to spend the money directly on a particular thing, it may be additional support networks, it may be, changes to the waiting room -

Ms THOMAS - Wigs, blankets, supports -

Mr WEBSTER - Blankets, coffee machines, that sort of thing. So, we don't actually take the money in as revenue, we work with the community.

CHAIR - So where are the sources of revenue that you're referring to?

Mr WEBSTER - So things like, well -

CHAIR - In this area.

Mr WEBSTER - In this particular area, so there's a few community groups that actually raise money for BreastScreen –

CHAIR - No, no, I'm talking about the whole line item, like community health services. You said one of the reasons that the Budget looks like it does is because there's revenue raising in that as well. So what sort of revenue do you raise?

Mr WEBSTER - For instance, through you, minister, oral health is as a copayment arrangement, so that's a revenue source. Oral health, cancer prevention and several others have federal funding agreements that you know we count as revenue in the sources. I'm now getting to the bottom of my memory of what we that, you know, it's either fees and charges such as copayment in oral health, or federal funding agreements that are bringing in revenue as well, and some of the activity here actually sits within the ABF of the NHRA.

CHAIR - Unless there's anything urgent on this we might keep moving, so we get through all our things. We'll go to ambulance services.

Output Group 2 - Health Service
Output 2.6 Ambulance Services

Mrs ARCHER - For Hansard, joining us at the table is Nicole Ashworth, who is CEO of Ambulance Tasmania.

Ms O'CONNOR - Minister, the new Royal Flying Doctors service plane, the King Air 350, as we understand it, can't land at Strahan, St Helens, Smithton or Cape Barren Island.

Communities that the RFDS's old King Air 200 regularly, routinely serviced. How are those rural and remote communities currently being covered for fixed-wing aeromedical services?

Mr WEBSTER - Through you, minister, so Royal Flying Doctor Service branch or unit of that we contract with, under the contract are required to still have access to the older aircraft, the 200 that you mentioned and use that as required by us. The new one is in use, but there is actually a clause in the contract with them that says they still have to service those areas and because of the limitations of the airports they need to actually provide the alternative aircraft.

Ms O'CONNOR - Okay, thanks secretary. That's the contract but what's happening on the ground? Is the old King Air 200 servicing those communities do you know?

Mr WEBSTER - Yes.

Ms O'CONNOR - Okay. The government awarded the contract partially on the basis that the RFDS had the newer model twin-engine fleet, but those planes can't land at four regional airports. How does the government justify that? You've awarded a contract that I note was without tender and there are still significant questions about that contract, but how does the government justify awarding a contract on the basis that the newer model twin-engine fleet would be available, but four regional airports can't be serviced?

Mrs ARCHER - I think that's probably the answer that the secretary just provided, which is that the contract allows provision. It requires provision for those areas to be serviced under the contract.

Ms O'CONNOR - We know now that from the secretary's answer, the RFDS are still using their old planes. Is the government or is part of the service that's delivered in aeromedical services and retrieval, is that being provided by rotary-wing aircraft?

Mrs ARCHER - There are both fixed-wing and rotary-wing contracts for aeromedical retrieval depending obviously on the operational circumstances at the time.

Ms O'CONNOR - What's the status of the RFDS agreement that never went to tender, that was an agreement between former premier, Mr Gutwein and the RFDS in a caretaker period, what's the status of that contract now? How much longer does the contract run?

Mrs ARCHER - It's a 10-year contract.

Ms O'CONNOR - Until when?

Mrs ARCHER - 2035.

Ms O'CONNOR - Not that you can speak for a future government, but is it possible that the government recognises that a contract of that nature should go to an open tender? You've got nine more years of it. What was the value of the contract again?

Mrs ARCHER - The new contract with the RFDS runs for 10 years at the cost of $78.7 million and under, as you said, the new agreement, the RFDS is introduced a Beechcraft King Air B350 aircraft, which provides greater range and endurance than the current aircraft.

Ms O'CONNOR - Thanks, minister, so if we go now to the rotary aeromedical contract, the winning rotary bid was $154 million more than Rotor-Lifts' $200 million bid for the same contract. What justified that premium and the decision to spend substantially more public funds on that contract?

Mrs ARCHER - I think a range of reasons that I've spoken about previously.

Ms O'CONNOR - Is this the three criteria that Mr Webster talked about on ABC Radio maybe late last year? That is criteria for capability, a good social and economic contribution, and cost.

Mrs ARCHER - I will ask Dale to speak some more about it. Obviously, due to the confidentiality requirements of the tender, Toll's aviation tender price can't be disclosed. StarFlight was ranked first in both value for money measures and also qualitative measures, meaning that they can provide the best possible service for the best value for money, which is why they were chosen. Rotor-Lift themselves asked for a competitive tender, I think it's important to note. They have made assertions that they could provide the current service for $150 million less; but that would be, I think, important to note, only to maintain the current service which didn't reflect the state's requirements now and into the future. We need new helicopters, new technology to ensure that we can provide the best service to Tasmanians and comply with the CASA regulations, which is what the tender called for including things like -and Dale and Nicole can speak to this - winching capacity, for example. Did you want to say something about it?

Mr WEBSTER - I think just to reflect on that, is that whilst they met the criteria, Rotor-Lift had every opportunity to put in a tender and meet the specification of the tender. Importantly, we had lost the ability with the existing platforms that Rotor-Lift provided, the BK117, to actually winch a stretcher from the ground up into the helicopter.

Ms O'CONNOR - But they can't do that at the moment, can they, Starflight? Is StarFlight, as it is now - can the helicopters that are flying in Tasmania today do patient-stretcher winching?

Mr WEBSTER - Through you, minister, the Bell 412 has that capability, and in fact, the third helicopter that the state leased from 2020, and Rotor-Lift operated, which we leased from StarFlight, actually had that capability. We only had it on one of our platforms. We said we need that across all platforms. The other features that are in this new configuration are things like night-time searching so that we can actually not just locate people during the day, through infrared and those sorts of things. There were a number of uplifts in capabilities that we asked for in the tender, and that any tenderer could have put in a bid for, and it's on the record that Rotor-Lift didn't put in a bid. They combined with Toll, and Toll put in a bid, and that was then assessed against the criteria, and the criteria the minister has already read out.

Ms O'CONNOR - Okay, but just back to the question: because my understanding is that in September last year you indicated that the current Bell 412 can't do patient-stretcher winching. No?

Ms ASHWORTH - No. You can at the moment [inaudible]

Mr WEBSTER - I spoke to BKs -

Ms O'CONNOR - Okay. So, is the answer to that question yes, that the current fleet of rotary-wing aircraft flying in Tasmania today can do patient-stretcher winching?

Ms ASHWORTH - That's what I've been told, yes.

Mr WEBSTER - That's my understanding.

Mrs ARCHER - Under the new contract arrangements.

Ms O'CONNOR - Yes. This is more sort of a mechanical question, really.

Mr WEBSTER - They can do it.

Ms O'CONNOR - Like, can the helicopters that we have today, which are the old ones, so the Bell 412 is not a brand new -

Mrs ARCHER - Well, they're not all of the old ones. That was one that was leased to Rotor-Lift, but they were running two others as well.

Ms O'CONNOR - But the Bell 412 is a 1980s helicopter, isn't it?

Mr WEBSTER - Again, through the minister, and under the contract they are in place for two years, and that is because we're replacing them with Airbus - and I don't know the number of the Airbus - but an Airbus frame that has already been ordered, so it's still a process. Ordering new platforms is actually a long process, so the 412s have the capability we need, but will be replaced during the term of the contract.

Mrs ARCHER - They are an Airbus H145 D3 helicopter which are versatile twin-engine helicopter platforms -

CHAIR - I know exactly what we're talking about.

Mrs ARCHER - renowned for their multi-role capabilities.

Ms O'CONNOR - The government has stated that it is delivering new aircraft, but it's not yet delivering new aircraft because the H145s aren't here yet.

Mrs ARCHER - But they form part of the contract in the same way as the question you asked about the RFDS and new fixed-wing planes being part of that contract. The Airbus capability forms part of this new contract.

Mr WEBSTER - They've provided an upgrade already.

Ms O'CONNOR - Okay. So when are the new helicopters expected to arrive?

Mrs ARCHER - The new helicopters are anticipated to be operational in 2028.

Ms O'CONNOR - 2028: so two years from now?

Mr WEBSTER - Yes.

Ms O'CONNOR - Right. How long is the StarFlight contract's duration?

Mrs ARCHER - It is 12 years.

Ms O'CONNOR - 12 years: okay. How are those helicopters being funded?

Mr WEBSTER - Through you, minister, the operator, StarFlight and their parent organisations are purchasing all of them. I don't know exactly the relationship, but they own the platforms.

Ms O'CONNOR - Okay. Did the government or Tas Health know when they entered into that agreement with StarFlight that the new capability wouldn't be online for another couple of years?

Mr WEBSTER - I will make it clear that the new capability came online and additional capability came online immediately but, as you pointed out, there are platforms that are old platforms, and they will be replaced by the Airbus.

Ms O'CONNOR - Sorry, what do you mean by platforms? You mean helicopters?

Mr WEBSTER - Helicopters: the Bell is a significant upgrade on the BK, so we now have three helicopters at that level, instead of our base helicopters being the BK, and a separate lease from StarFlight for a third helicopter which we had towards the end of the BK life, to give us extra capability, including distance. The BKs had a wrong distance, but we've got -

Mrs ARCHER - These have a greater range, but they can also carry two patients, for example, than the BKs.

Mr WEBSTER - Yes. So we got an upgrade and we will get a further upgrade.

Ms O'CONNOR - But was it understood by government when it entered into that contract, that was $154 million than Rotor-Lift's, that it would take a couple of years for those modern H145 craft to arrive? Was that understood?

Mr WEBSTER - Through you, minister, understood at all points through the contracting that that would be the case, and it was a similar arrangement with some of the other tenderers as well. It wasn't just this one because this - we wanted this particular significant upgrade. There are a number of factors in that, but we were aware that that would be the case, and in fact, the negotiated price reflects that. Again, there was no tender by Rotor-Lift.

Mrs ARCHER - And important to note as well that the Bell that was being used under the previous contract was used post-2023 because of regulatory changes in 2023 on the ability of the BK117 aircraft to stretcher was compromised, and that's why the Bell was brought on to support that in post-2023. This new contract has that uplift of utilising the Bells before moving to the Airbuses when they come online.

Ms O'CONNOR - Thanks, Chair, that will do me for now.

CHAIR - I have one and then I will go to you, Clare. I expect you might expect me to ask: what the hell's happening on King Island with the ambulance station there and the community paramedics?

Ms ASHWORTH - Through you, minister, thank you, the King Island station is about to go out for tender and it's still on time and on track for completion by the end of 2027. We had some of our educators over there, the weekend just gone, on King Island doing some training and they've started some conversations with volunteers around what kind of permanent ambulance resource that we should put on King Island, including consultation around the hours, our data versus when they feel like they're busiest and when they need support as well. We expect to move to recruitment fairly soon.

CHAIR - Is there still an intention to have at least two community paramedics, you know, you can't [inaudible] and one cop over there.

Ms ASHWORTH - Either community paramedics, or the other alternative is branch station officers, which have a little bit more -

CHAIR - Sorry?

Ms ASHWORTH - Branch Station Officers (BSO) is the other option besides community paramedics. We have the ability with branch station officers for extended coverage, and also the option for BSOs to transport to hospital, which community paramedics do not currently.

CHAIR - How many volunteers do you have over there at the moment?

Ms ASHWORTH - I would have to check for you, but it's under 20, I think.

CHAIR - Are you actively recruiting more? They are a bit burnt out, some of them.

Ms ASHWORTH - So I'm told.

CHAIR - A bit frustrated, I might say.

Ms ASHWORTH - Yes. I think they had - they were quite appreciative of the visit on the weekend from trainers, and I've fed back some feedback that they would appreciate some more support, definitely.

CHAIR - So, 2027 it will be finished?

Ms ASHWORTH - Yes.

CHAIR - End of 2027?

Ms ASHWORTH - End of 2027 is what I have in my notes.

Ms GLADE-WRIGHT - My question is quite similar, it's just regarding Cygnet and Snug, and I could put this on notice, but the community just want to know a breakdown of the

funding because it says that there was additional funding provided in 2024-25. So, they just want to know about that, and what the future commitment is, and the timeframes.

Mrs ARCHER - So, Cygnet, the new station will be built at 48-52 Mary Street, Cygnet, estimated to cost $4.2 million, and the construction tender is expected to be released in late 2028, with construction to commence in 2029, and be completed by early 2030.

In Snug, the department's identified a preferred site for the new station at 45 Snug Tiers Road, and has commenced discussions with the landowners regarding the acquisition, and subdivision, of the required parcel of land. The construction tender is expected to be released towards the end of 2029, with construction to commence early 2030, and be completed by early 2031.

Ms GLADE-WRIGHT - The funding that was already provided, is there already some funding provided for Cygnet and Snug?

Mr WEBSTER - Through you, minister, the funding was provided for upgrade of rural ambulance stations over a number of years. So, for instance, upgrades - a new station at Bicheno -

Mrs ARCHER - Legana.

Mr WEBSTER - Legana is on the list, King Island is about to happen, so it's not funding specifically for Snug or Cygnet, there was funding for -

Ms GLADE-WRIGHT - That line –

Mr WEBSTER - across these rural stations including Cygnet, Snug, Legana, King Island, Bicheno, and I feel like I've missed one.

Ms GLADE-WRIGHT - Okay, that sentence structure's just a bit out, but that’s okay. Thank you very much for that. What was the total cost for Snug, sorry?

Mrs ARCHER - 4.2 million for Cygnet -

Mr WEBSTER - It would be about the same, but we don't have the - it is a fair way out.

Mrs ARCHER - We'd have to come back to you with that one.

Mr WEBSTER - It would only be an estimate because it's so far out.

Ms GLADE-WRIGHT - Thank you.

Ms LOVELL - Minister, how many times in the past year have Ambulance Tasmania resources been used to attend private events on a contract basis?

Mrs ARCHER - We might have to take that on notice.

Ms LOVELL - Do you know how much revenue has been raised through those contracts?

Mrs ARCHER - We'd also have to take that on notice, I suspect.

Ms LOVELL - I'll put the third question on notice as well. On how many occasions have resources been diverted from Ambulance Tasmania to private contracted events, and left resources short in other areas? Thank you.

Can you also provide for the committee a breakdown of ambulance call numbers? If you've got year-to-date figures that would be really helpful. We normally get something along those lines.

Mrs ARCHER - Do we have any year to date numbers, or want to take it on notice?

Ms LOVELL - Or are you able to get anything at all for this financial year?

Ms ASHWORTH - I don't have them yet, no.

Mr WEBSTER - I do. Through you, minister, the number of statewide incidents, year to date, to the end of March in fact, is 90,877. Do you want regional?

Ms LOVELL - Yes, if you've got region, and also category.

Mr WEBSTER - Through you, minister, I don't think I have category, I have regional.

Ms LOVELL - Okay, can you get category on notice or is -

Mr WEBSTER - Yes, we can.

Ms ASHWORTH - Yes, we can.

Mr WEBSTER - Yes, we can break it by category of P0 down to P4.

Ms LOVELL - I'm happy for you to take it all on notice, just in the interest of time, if that's easier?

Mr WEBSTER - I'll give you the three figures on the regions -

Ms LOVELL - Yes.

Mr WEBSTER - And you've already got the total. So, the north is 26,629; north-west is 20,709; and the south is 43,474.

Ms LOVELL - Great, and do you have comparison figures from the previous year?

Mr WEBSTER -I can give you the full year, for the previous year -

Ms LOVELL - That’s, yes.

Mr WEBSTER - So the total is 113,797.

Ms LOVELL - Yes.

Mr WEBSTER - North, 32,205.

Ms LOVELL - Yes.

Mr WEBSTER - North-west, 26,887; and south, 54,632.

Ms LOVELL - Thank you. Do you have response times for the same periods?

Mr WEBSTER - Yes.

CHAIR - Average response times.

Mr WEBSTER - Median?

Mrs ARCHER - Median.

CHAIR - Or median, sorry.

Mr WEBSTER - Median response times for - and sorry, I've only got these for P0 and P1.

Ms LOVELL - Okay.

Mr WEBSTER - So, for the state, 15.5; north, 14.5; north-west, 12.9; and the south, 17.2.

Ms LOVELL - Just for clarity, that's minutes?

Mr WEBSTER - Minutes, yes.

Ms LOVELL - And that was for both P0 and P1 together?

Mr WEBSTER - That's right. That's combined because they're emergency categories.

Ms LOVELL - Again, are you able to provide the other categories on notice?

Mr WEBSTER - Yes, and we can split them rural and urban as well.

Ms O'CONNOR - Just quickly, does the department have information on how many single-response shifts have been worked by paramedics in 2025-26? That is, shifts where you've just got a single paramedic going out to emergency.

Ms ASHWORTH - No. Through you, minister, it's actually quite difficult to tell. We have to go back manually. We can tell how many shifts we might have rostered for single officer types, such as the Community Rehabilitation Units (CRU) that are supposed to be single officer. We can't retrospectively go back and see when another officer might, for example, have gone home sick and that's left a single officer to be redeployed somewhere else. We can't tell the difference so we can't arrive at a total.

Ms O'CONNOR - And obviously, through you, minister, it's something that Ambulance Tasmania would like to avoid in its rostering?

Ms ASHWORTH - Absolutely, yes.

Ms O'CONNOR - A lot of pressure on a single paramedic.

Ms ASHWORTH -We've agreed on a single officer dispatch protocol throughout enterprise bargaining and it's much stronger than the previous policy around it being the decision of the paramedic at the time, on if they feel safe to either respond or treat in a single-officer capacity.

Ms LOVELL - It's a hard decision to make.

Ms ASHWORTH - Yes.

Ms O'CONNOR - Isn't it? Can you imagine how stressful that would be. What is the total number of hours of overtime worked by paramedics in 2025-26?

CHAIR - To date? You'd have to get some date.

Ms O'CONNOR - Yes, to date. Did you want to table some of that? It looks voluminous.

Mr WEBSTER - I won't be reading any of it out, I'm sure. But the overtime -

Mrs ARCHER - We'll take that on notice.

Ms O'CONNOR - Take that on notice? Okay. So, presumably you'd be happy to take on notice, also, the question, how much has been spent on paramedic overtime each month of 2025-26 and how does that compare to 2024-25? I'd be happy to take the first six months of each of those periods.

Mrs ARCHER - Let me take that on notice as well.

Ms O'CONNOR - Yes, so they're comparative. Thank you. Does the department have any line of sight to sort of the percentage of shifts that are worked by paramedics that result in them doing overtime?

Mr WEBSTER - We found it.

Ms O'CONNOR - What did you find, secretary?

Mr WEBSTER - The cost of overtime.

Ms ASHWORTH - It's approximately 12 per cent, but we would have take it on notice as well.

Ms O'CONNOR - So, 12 per cent of shifts result in overtime of some sort?

Ms ASHWORTH - Very approximately, yes.

Ms O'CONNOR - Thank you. How many paramedics - Ambulance Tasmania staff - are on extended sickness or injury leave or workers' compensation plans and not working at this point in time?

Mrs ARCHER - I think that was the question we had earlier that we were going to take on notice to give you a breakdown. I think we had an aggregate number.

Ms O'CONNOR - Okay. I'm happy to put that in the - I mean, if you've got at some level, I'll put that on notice.

CHAIR - Any other questions on ambulance?

Mrs ARCHER - Chair, the secretary said he's got a couple of responses to earlier questions.

CHAIR - Sure, before we move on.

Mr WEBSTER - I think Ms Thomas asked how many band 9s within the Department of Health, in THS we have 36 positions: two are fixed term and 34 are permanent.

Ms THOMAS - Sorry, can you speak up a bit, it's hard to hear over the fan.

Mr WEBSTER - Yes, 36 positions, two are fixed-term and 34 are ongoing or permanent. We've had four of those - have either been created or lower jobs that have been reclassified since June 2025, which is the second part of your question, was how many new ones.

Ms THOMAS - How many, sorry?

Mr WEBSTER -Four.

Ms THOMAS - Four created or reclassified.

Mr WEBSTER - Yes. So there might be a band 8 that's reclassified to a band 9, or indeed it may be, for instance, in our group director roles in Statewide Mental Health Services, because we want to attract a field that's not just either nursing, allied health or administrative, we actually advertise it as a band 9 and take in people from all of those categories. It could be a reclassified AHP6 to band 9 for those sorts of things in those. You also asked how many had we advertised; there are 21 positions at band 9 that have been in advertisements in the last 12 months.

Ms THOMAS - There were 21?

Mr WEBSTER -.Yes, 21: and 34 were subject to an advertisement during that period.

Ms THOMAS - There were 21 out of 34. I'm just - so, 21 out of 34 were advertised in the last 12 months but only four were created or reclassified since June last year?

Mr WEBSTER - That's right.

Ms THOMAS - So how do you explain 21 needing to be advertised in the last 12 months?

Mr WEBSTER - People that may have been promoted - sorry, through you, minister - promoted from the band 9 level to a different level, people that have left and therefore we've replaced them, and those sorts of arrangements. That's why there'd be more advertisements in that category, but that's how many times we've advertised a job classified as band 9 in the last 12 months.

Ms THOMAS - Have there been any reclassifications from SES to a band 9, SES 1 to a band 9?

Mr WEBSTER -Through the minister, not to my knowledge, I don't think we have changed any of our SES to band 9.

Ms THOMAS - Okay. Does that seem like a high proportion? How would that compare to other bands? Like, that's a lot. If there's only 36 positions and 21 of them have been advertised in the last 12 months, that seems like a high proportion.

Mr WEBSTER - Through the minister, it's a raw number, so I'm not sure whether some of them are re-advertising because we didn't get the right person the first time, but we've advertised at band 9 level 21 times in 12 months.

Ms THOMAS - Okay. Minister, are you aware of any government policy direction around not establishing band 9 positions anymore, given that the salary range is generally higher, if not equivalent, to an SES 1?

Mr WEBSTER - Through you, minister, so the process by which you can create a band 9 is that you need to create the statement of duties; that's assessed against the classification standard, and then it must be submitted to the head of state service through the state service management office for approval. In a similar way, before you create a senior executive service office, you need to actually do that same process, and it goes through to the Premier for approval. So for band 9s, there's an approval process for their creation, similar to that of SES.

Ms THOMAS - So, the Premier has to sign off on band 9 positions?

Mr WEBSTER - No. The Premier signs off on SES -

Ms THOMAS - No, sorry. Right.

Mr WEBSTER - and the head of State Service signs off on band 9s.

Ms THOMAS - Right. Thanks.

Mr WEBSTER - And the second answer to, again, I think Ms Thomas' question about how many state servants were dedicated to working on HRIS, in fact, it might have been Ms O'Connor: 41 public servants were directly engaged on the HRIS program system procurement, design, and configurations, and a further 44 provided subject manager expertise and system preparation activities. That doesn't mean that they - all of them were applied at any

given time, but that's the number of state servants that actually did some work on the HRIS program.

Ms O'CONNOR - Okay. Thank you.

CHAIR - We might then move on to 2.7. Cassy, you've got the lead on that one.

Output Group 2 - Health Service
Output 2.7 Public Health Services

CHAIR - Do you need to get Dr Veitch, sitting there patiently waiting? If you could just introduce Dr Veitch for us, please.

Mrs ARCHER - Dr Mark Veitch joining us at the table, Director of Public Health.

Ms O'CONNOR - Well, we might start with the public health budget, which has undergone a cut, or an efficiency, and perhaps the minister or Dr Veitch is able to explain what that efficiency means in terms of public health's FTEs or headcount, also the services it delivers, or programs?

Mr WEBSTER - So to work through the public health budget, firstly there's some ins and outs across public health. So, for instance, we've created a centralised Aboriginal health unit, and we've engaged a Chief Aboriginal Health Advisor to head up that unit, so it's moved from public health to systems management, for instance, that's one change: there are a number of other small changes like that across public health that account for that. The second part of it is, is that public health protection, which is the immunisation side, the state infection prevention control, policy work, et cetera, has in fact had a lift in budget from last year's budget and that continues as permanent funding. So my short answer is there is, actually, apart from the ins and outs - there's been no program of downsizing or changing staffing of public health.

Ms O'CONNOR - Is it the department's contention that there's no loss of dedicated public health staff as a result of the declining funding in the budget?

Mr WEBSTER - Yes.

Ms O'CONNOR - What infectious diseases does public health measure or keep an eye on or report?

Mrs ARCHER - Good one for you, Dr Veitch.

Dr VEITCH - Thanks minister, and through you, there's a list of, I think, around 80 diseases that we have as notifiable diseases, and they fit into a range of categories such as quarantinable diseases, gastrointestinal infections, vaccine-preventable diseases, a couple of hospital-related bloodstream infections, sexually-transmissible infections, infections you can get from animals. I've probably forgotten a couple of categories there, but they're all publicly available on our website.

Ms O'CONNOR - Okay, and are we seeing any trends in infectious disease rates?

Dr VEITCH - There aren't any particularly notable changes at the moment that we're tracking. A lot of our recent activity has been actually preparedness for diseases that we don't actually have. So, for example, we've spent a lot of time preparing for the prospect of avian influenza. Lately, we've brushed up our preparedness for things such as Ebola, even though the risk is very remote.

Ms O'CONNOR - Good, yes.

Dr VEITCH - So we do monitor those very closely. There's a weekly scrutiny of it, and there's a published report that provides a review of our communicable diseases.

Ms O'CONNOR - So the most recent Commonwealth report, an epidemiological Commonwealth report from the Department of Health confirmed that there's been 117 confirmed cases of diphtheria in Australia; have any of them been in Tasmania?

Dr VEITCH - No.

Ms O'CONNOR - No diphtheria.

Dr VEITCH - Actually, if I may, I might just mention one disease, if I may, minister, that we have been paying particular attention to because it has increased. You threw me for a moment with the vast scope of the question, but syphilis is a question - is a disease that's recently increased, including occurring amongst women of childbearing age, and the risk of congenital syphilis, or a baby born to a mother infected with syphilis, is real around Australia, and that's something that people have been struggling with in all of the jurisdictions.

CHAIR - Are we testing routinely antenatally?

Dr VEITCH - One of the major steps to address this is to ensure that women during pregnancy have preferably three syphilis tests: early, mid and late.

CHAIR - Swabs, or blood tests?

Dr VEITCH - They're blood tests for syphilis. So, syphilis is something which I think our activities in engaging the clinicians, the midwives and others involved in the care of people being pregnant has probably contained it. But we still haven't got rates of syphilis across the whole population down to the levels that we had about four or five years ago. The absolute numbers aren't very high, but they're higher and we're paying quite a lot of attention and devoting quite a lot of resources to doing that.

Ms O'CONNOR - I mean, it's one of those sort of diseases it seems like it's from the dark ages and that, as a modern society, we might have been able to really -

CHAIR - Knowing what safe sex was all about.

Ms O'CONNOR - deal with it. So, what is the current - do you provide numbers or rates for syphilis infection?

Dr VEITCH - We can provide both. The national data, well actually, you can look at the national dashboard; there's an interactive national dashboard that you can look at. It's a bit

fiddly, but you can get numbers out of that both as counts and also rates that take into account the population. When you do look at syphilis, as a rate, our rate is actually relatively low, even when we take into account the population. But it's just a disease that we really -

CHAIR - The outcomes are serious.

Dr VEITCH - The outcomes are serious and I think a few years ago we were on the verge of eliminating congenital syphilis in Australia. But at a national level, that has got away a bit and we're still trying to contain that.

Ms O'CONNOR - How do you contain it?

Dr VEITCH - It's about - there's two real aspects to it. It's, firstly, trying to bring the syphilis epidemic down in general, so that means access to sexually transmissible disease diagnostic services for people in different risk populations - it includes men who have sex with men, it includes the heterosexual population as well. So, we need to generally bring syphilis levels down, but also put a lot of focus through our partners in antenatal care on managing pregnant women.

Mrs ARCHER - Just for awareness, in 2025, there were 8950 cases of syphilis reported in Australia and, of those, 61 in Tasmania.

Ms O'CONNOR - 61 cases last year.

Mrs ARCHER - In Tasmania.

CHAIR - What's the preventative health messaging being done around this?

Dr VEITCH - We have engaged with sexual health services and I think some of the services that have outreach, particularly into younger populations, and obviously antenatal services. I can't remember off the top of my head the details of those things, but we have been engaging with -

CHAIR - If I went down the street in Hobart, down the mall, and stopped a few random people and asked them do they know that syphilis is a thing at the moment, how many people do you reckon would know?

Ms O'CONNOR - Pretty much zero.

CHAIR - I think I know the answer on this, Dr Veitch.

Dr VEITCH - Look, with respect, Chair, I might just not speculate. I don't think I can.

Ms THOMAS - Good answer.

Ms O'CONNOR - Can I check in on - we're also seeing nationally an increase in tuberculosis reports. What's the situation with tuberculosis in Tasmania?

Dr VEITCH - Through the minister, Tasmania has historically had the lowest rate of tuberculosis incidence per capita in Australia, which, given that Australia has one of the lowest

incidences of tuberculosis in the world, means that we've never had very much. But we've had a small number of cases over the last 20 years and it ranges between about 10 and 20 people per year diagnosed with active tuberculosis. I think there were around 20 last year or in the last financial year. The number of cases of tuberculosis that occur are very reflective of the makeup of the Tasmanian population.

Jurisdictions that have had more people born in countries with higher rates of tuberculosis will always have higher rates of tuberculosis because it's a long-term disease; people get infected in their early childhood and they don't - and many people who get infected will never manifest illness in the course of their lifetime and may actually go to their grave with a few germs of tuberculosis in the scar that had never caused them or anyone else any harm. But about 10 or 15 per cent of people in the course of their lifetime will progress from that dormant or latent stage to active infection. They're the people that we see in Tasmania; people who've acquired their infection elsewhere, get diagnosed here. There are screening programs for permanent residents coming to Australia, X-ray screening that helps pick up people who may need follow-up for the possibility of tuberculosis. Otherwise, I think it's very important that people, student populations for example, and so on, who might come to Australia from other countries have access to healthcare that way they can present and get that sort of condition diagnosed early. I think I would say that, even though tuberculosis numbers fluctuate, it's quite arguably a reflection of generally good pickup and care that we're actually finding the numbers we are.

Ms O'CONNOR - What about monkeypox? I mean, obviously, nationally it's one of those diseases that seems to be fluctuating but persistent. Are we seeing monkeypox cases in Tasmania?

Dr VEITCH - We have. I think we've seen a total of only three or four cases and I think they've been cases in some instances acquired in another state and there might have been I think one instance of transmission between someone and a known person within Tasmania. Again, well contained and, like many jurisdictions, Tasmania provided free mpox vaccine through particularly through sexual health services and laterally through general practice. And there was pretty good take up of that vaccine through people at the highest risk of mpox.

Mrs ARCHER - Ms O'Connor, I just might circle back if you don't mind, just to your question about diphtheria. Just to note that there is an outbreak of diphtheria in other parts of Australia, including the Northern Territory, Western Australia and South Australia, and primarily amongst Aboriginal people. I will take the opportunity to note that it is a vaccine-preventable disease, and it is a vaccine that's recommended and funded under the National Immunisation Program.

From 1 June 2026, a time-limited state-funded vaccine program is available to complement the National Immunisation Program Schedule for Aboriginal and Torres Strait Islander people aged 20 and over who have not previously received three doses or a booster in the last 10 years. I would take the opportunity to encourage people to check their vaccination status for diphtheria and, of course, other vaccine preventable illnesses as well.

Ms O'CONNOR - Thanks, minister. I'll move on shortly. I'm sure there's other questions in this output, but are we seeing any increase in hepatitis in children? Because it's certainly a trend that seems to be manifesting in Europe and the United States.

Dr VEITCH - I don't think I have enough detail at my fingertips to respond to that question.

Ms O'CONNOR - Do you mind if I put that on notice, Dr Veitch?

Dr VEITCH - You may. Which particular hepatitis were you referring to?

Ms O'CONNOR - Childhood hepatitis, I know there's a range of hepatitis and I'm very happy for it to be broken down, whether it's A, B or C or whatever.

Dr VEITCH - I'm sure we can do that. I would add that we've had a good program of hepatitis B vaccination including, importantly, a dose at birth, which pretty much eliminates the risk of hepatitis B in early childhood. It's a really important initiative.

Ms O'CONNOR - Are we seeing any identifiable trends in childhood diabetes?

Dr VEITCH - That's not something that I have access to data on. I think our colleagues in clinical paediatrics would probably be the people who would be well positioned to answer that question.

Ms O'CONNOR - Last question for now, exotic diseases, so mosquito-borne, tick-borne diseases, some of which will be coming from other jurisdictions, like Ross River virus, but also Lyme disease. Over in the United States there's a range of exotic diseases that seem to be trending upwards as the climate heats and pests move. Are we seeing an increased prevalence of any of those diseases?

Dr VEITCH - I don't believe we're seeing any notable changes. Ross River virus does occur in Tasmania. It often occurs in little epidemics when the environmental circumstances and weather make it right.

Ms O'CONNOR - I know I've had it, it's terrible.

Dr VEITCH - Between times it's quite quiet. We do have a disease called Flinders Island spotted fever which is spread by ticks, and we get a handful of the cases of that each year and we've seen that spread a little bit more towards the south of the state. One thing I might add, which I think is quite an important initiative that's been undertaken by Public Health and our colleagues at the university and I think Natural Resources, is surveillance for mosquitoes in Tasmania. We've never had a particularly good handle on the species of mosquitoes that occur in Tasmania and are distributed around the state and their potential for causing illness, because in the mainland, as you note, there've been diseases such as Japanese encephalitis and Australian encephalitis that have spread further south. We felt it was important we had a good understanding of the strains of mosquitoes that were in Tasmania to inform our understanding of the risk that may be posed to us by those diseases, and we're into about our third year of gathering information on mosquitoes. I think that's an important piece of work, and we're finding some species that we didn't know existed here. So that's sort of foundational, but it's a very important piece of work that addresses the sort of concerns you're expressing.

Ms O'CONNOR - Thank you. I have other questions, but I know others -

CHAIR - I will go to Clare.

Ms GLADE-WRIGHT - Yesterday, I raised antimicrobial resistance with the EPA and they referred a lot of my questions on to you, so I've saved them up.

CHAIR - In humans.

Ms GLADE-WRIGHT - Yes. The World Health Organisation says that antimicrobial resistance (AMR) is a global health threat, and that countries should monitor for AMR in aquaculture, track resistance patterns and include aquaculture in national AMR action plans; are we doing that?

Mrs ARCHER - I will ask Dr Veitch to make some comments. I think you did have some comments about this in a previous session.

Dr VEITCH - If I may, through you, minister, I think the importance of antimicrobial resistance is undeniable and the need to do an appropriate form of surveillance is also undeniable. It needs to be done as a team. You actually need to have the animal health, human health and, to some extent, the industry people and the environmental monitors all on board doing it and it's called a one health approach, you may have come across, and there is a national strategy for antimicrobial resistance, which touches fairly lightly on aquaculture but does emphasise the importance of agriculture. I think you can generalise from that to say that yes, there should be - it should be addressed in aquaculture also.

With the recent expansion of use of florfenicol in aquaculture, I think that's made a case that we definitely should be doing some sort of surveillance. It wasn't possible to put in place a prospective antimicrobial resistance plan at the time that the florfenicol was first used late last year, we had fairly limited notice of it, but our colleagues in the EPA, with some support from us, had the foresight to collect a number of samples from the environment around pens that were treated and pens that weren't treated at various distances and times, and they've collected samples that the scientists at UTAS IMAS are planning some studies to look at what the effect of florfenicol use was on the populations of bacteria there, and the work on - and also to see if they can find markers of resistance. It's kind of a preliminary piece of work, but I think it's probably an important piece of work that can inform the next sort of steps that might be appropriate to take.

Ms GLADE-WRIGHT - Okay. So I'm just interested in detection thresholds. Does that come from you? Who sets those thresholds?

Dr VEITCH - I'm not completely sure I understand the question.

Ms GLADE-WRIGHT - Yes, maybe I don't either, so -

Mrs ARCHER - Thresholds for residual antibodies?

Ms GLADE-WRIGHT - Yes, for finding the anti-resistant genes? There must be something - I guess my question is, what would trigger a public health response?

CHAIR - Do you need to see resistance in the fish to trigger a public health response?

Ms GLADE-WRIGHT - Or in the ecosystem?

Dr VEITCH - I think part of the current discourse, if I may, has become a little bit confused, if you like, by the focus on florfenicol and salmon. We know that retail samples of chicken, beef and pork in the FSANZ surveys all have - you can find pathogens in in those retail samples, and you can find evidence of resistance, up to 40 per cent resistance to tetracyclines in some samples. So it's out there.

Ms GLADE-WRIGHT - It's actually not the fish that a lot in my community are worried about, because they're already not eating salmon; it's actually to do with the environment and what's happening in the ecosystem. The anti-resistant genes in the ecosystem and whether that can be transmitted to humans.

Mrs ARCHER - Through wild-caught fish, or -

Ms GLADE-WRIGHT - Yes, just from being in the water.

Dr VEITCH - I think it's a relatively remote risk, but it's not something you can completely discount.

Ms GLADE-WRIGHT - So, what would trigger a public health response, then? That's that threshold thing you're saying, it's quite low, but it could happen?

Dr VEITCH - I think we need to actually get more data about what's actually happening out there before we can even get to discuss what a trigger or a threshold might be. I don't think you can kind of make it up without knowing enough about the environmental occurrence of genes. It's actually quite a difficult, complex scientific question that actually needs quite a lot of scientific work to inform a rational and proportionate public health response. So, I'm hesitant to try and make up a standard or a threshold without the hard work to really understand what's going on.

Ms GLADE-WRIGHT - But it's on your radar.

Dr VEITCH - I think that Tasmania could do more to monitor antimicrobial resistance and the work that I mentioned about IMAS and others getting together to plan a research project on the stored samples, I think is getting most of the right people in the room who might need to do the later work as well. I'm sorry I wasn't able to completely nail your question.

CHAIR - Did you have one on this, Bec?

Ms THOMAS - Not on this, but on this output.

CHAIR - Yes, we will go, just try and keep them fairly short. We've still got mental health and capital investment to go.

Ms THOMAS - On the Healthy Tasmania strategy, minister, the Health Revolution in the budget is allocated just $5 million per year. I'm interested to know what this funding will be expended on and I'm also interested to know why there are no clear actions to be implemented from the Healthy Tasmania strategy, and is it true that an action plan was developed but withdrawn from publication, and that that action plan included detailed pillar

content, supporting material and specific actions, but for some reason wasn't published with the strategy, and if so, why?

Mrs ARCHER - Thanks. I will have more to say, obviously, in the next few days. The first action plan is due to commence on 1 July and I think a couple of points about the question that you have made, which is around preventive health spend, and I think Dale can probably add to this. I think it is important to note that there's already a range of prevention activities funded through the Health budget now. What the 20-year preventive action plan seeks to do is to move beyond that.

I think the foundation that has been laid with the $10 million that was invested in the Healthy Tasmania five-year plan and the Healthy Tasmania fund grants, and I think move that to a new chapter, looking at how preventive health investment is a whole-of-government responsibility and how investment is made across all agencies for health and wellbeing. Sometimes people talk about a 5 per cent target of preventive health spending; I think that's the Productivity Commission targets, but if we do that, we miss the opportunity, I think, to recognise that prevention doesn't sit with Health alone.

That's what the new strategy seeks to recognise, and recognise that much of what shapes that sits outside of the Health system, including things like housing or food security, other things like that. When I released the strategy, which was at the end of last year, I talked about how there will be a series of those four-year action plans developed to underpin the strategy once that's finalised, and that they will work across areas that shape health and wellbeing, as well as outlining those practical actions and projects which will be essentially where funding will be directed, but it is about changing the way in which we do this, if you like, so rather than what we've previously seen, you know, a series of time-limited grants for different projects, which has been wonderful, and there's been some great initiatives come out of that, I think what the 20-year preventive health strategy seeks to do is to change the way that we do things and create a different governance structure that's going to support that whole-of-government approach. If we just sought to measure a 5 per cent target, we could probably find stuff in the Budget that we would already say that we're doing now. What the strategy will seek to do, in the first action plan in particular, is to move from the foundation that we've laid with the Healthy Tasmania grants, to then continuing to do the things that we are already doing in a preventive space, as we transition to what I think would be a more transformative approach. The first action plan will be released soon, so it hasn't been withdrawn; it just hasn't yet been released.

Ms THOMAS - So, thank you for that lengthy explanation. The strategy itself is comprehensive, it's extremely ambitious -

Mr WEBSTER - It's the draft.

Ms THOMAS - It covers just about everything you could possibly think of being related to Health, which is warranted, and I understand the whole-of-government approach, but my concern is the devil is obviously in the detail, and I understand that there were consultation sessions held, a number of consultation sessions, where a number of stakeholders put considerable time and effort into providing feedback into what those action plans would look like, and had some insight into what they would look like. Then the concern is why weren't they released with the strategy, what was the hold up, what was the reluctance to release the action plan with the strategy?

Mrs ARCHER - Well, you've only seen the draft strategy. I think at this stage, the final hasn't yet been released -

Ms THOMAS - Right.

Mrs ARCHER - and the first action plans would be then intended to commence from 1 July. There has been an extensive amount of consultation, really broad consultation, and really good buy-in from right across the community, and it's, I think something that is shared by everyone in this place as well, the need to focus on prevention. So, the final strategy will be released with the action plan shortly.

Ms THOMAS - Will that outline what that governance structure that you just mentioned looks like? I mean, there has been, for some time, a Premier's Health and Wellbeing Advisory Council. Is that the plan, that it will go through there, or is it going to be something new established?

Mrs ARCHER - Well, what we would seek to do is to make sure that the preventive health strategy works with other strategies as well, Rethink and Beyond, for example, tobacco strategies, for example, as well. That action plan will establish the framework, I think, for - you're right, it is an ambitious - and we've said at the outset, having a 20-year strategy is bold and ambitious. The action plans will be important in turning the dial, if you like, from some time-limited grant programs, and things that we have previously done, to embedding more of a whole-of-government approach.

Ms THOMAS - Will it be a new governance structure established?

Mrs ARCHER - We will need to set the governance and the architecture for this preventive health strategy to succeed through the first action plan, and I will have more to say in the next couple of weeks.

Ms O'CONNOR - Can I just ask a quick question, public health, Chair, thanks. So, the government has issued a discussion paper that deals with proposed amendments to the *Public Health Act 1997*, particularly relating to section 14, emergency declaration powers of the Director of Public Health; so, at the moment we have legislation that allows an independent expert to assess the nature of the public health emergency, the risk to the public, and so an independent expert person, the Director of Public Health, can issue an emergency declaration, and the government's discussion paper proposes that this power be put in the hands of a politician, that is, the minister for Health. What is the genesis of that proposed change to the emergency powers of the Director of Public Health, and why would you do that?

Mrs ARCHER - I will ask the secretary to -

Mr WEBSTER - Through you, minister, so, following the COVID-19 emergency, a number of reviews were undertaken about how we managed the emergency, what legislation was used, some comparisons with how it was operated in other jurisdictions and things like that. This is a series of amendments that matches to the outcomes or the recommendations of those reviews and, as you said, we've now put that out as a draft to reflect that we've had the recommendation, here's what it looks like in legislation and we've sought feedback on that.

Ms O'CONNOR - If parliament at some point in the past has agreed you need to have an independent expert person, that is, the Director of Public Health, have the ability to move beyond the politics and populism and declare an emergency in order to protect public health, why would the government want to put that power in the hands of a politician? Does the government believe - and this is not a question for Mr Webster, this is a question for the minister - does the government believe it is in the greater interest of public health, should there be an outbreak, for example, of Ebola -

CHAIR - Let's get to the question, Cassy.

Ms O'CONNOR - Thank you - that that be put in the hands of a politician?

Mrs ARCHER - I think that post the pandemic, the department reviewed the application of the act and, based on that recommendation, have proposed amendments to the act. They largely relate to their centralisation of powers and provide for greater democratic accountability and improve public confidence in government in managing future public health emergencies.

Ms O'CONNOR - What they allow for is greater populism and decisions that are based on political perceptions, rather than the protection of public health.

Mrs ARCHER - But what I would note, very clearly note, is that it is currently in draft and we are seeking public engagement, public feedback on that and would welcome that engagement, including from elected members as well in the formation of that.

Ms O'CONNOR - Thank you. I think it would be a big, big mistake to take that power away from the Director of Public Health.

Output Group 2 - Health Services
Output 2.5 Statewide and Mental Health Services

CHAIR - Minister, I did ask a question in relation to the north-west mental health precinct and the plan for that, that's been a long-needed change there. So, what is actually happening with that?

Mrs ARCHER - Yes, so, pleasingly, the development application for the North West Regional Hospital mental health precinct did get development application approval last week from Burnie City Council. The tender has now been invited for its construction, which will, of course, bring that a bit closer to delivery. The construction of the new mental health precinct is expected to start later this year and to be completed in 2028.

CHAIR - Is there adequate funding to fund it in the Budget, or are we waiting for that to be put in?

Mrs ARCHER - Yes, it's funded.

CHAIR - Fully funded? So, it can be fully delivered by 2028?

Mrs ARCHER - Yes.

CHAIR - I do want to ask, though, just about the budget for this line. This covers like a massive area of healthcare and we still see challenges around the state of people getting timely access to care.

Mrs ARCHER - Mental health care?

CHAIR - Yes, mental health care. Whilst the budget expenditure goes up - and I accept there is no doubt federal funding that comes in here - but it's not increasing at a very high rate at all: you're probably hardly keeping up with CPI. You are required to make savings across all areas; are you expecting to make savings across here, and how and where?

Mrs ARCHER - Well, I think we're continuing to invest in this area and including in some new initiatives, particularly the roll-out, or the expansion, if you like, of Youth Mental Health Hospital in the Home, a really successful pilot program in the north-west: two years, I think.

CHAIR - What's the take-up of that?

Mrs ARCHER - I think there's about 100 young who accessed care through that pilot in the north-west and we made a commitment in this Budget for additional funding to roll that program out in northern Tasmania as well. It's had great success and has been really successful in keeping people out of hospital, which I think goes to part of the question that you're asking, is the focus in mental health shifting from in-hospital settings -

CHAIR - Especially while we're still using Spencer Clinic.

Mrs ARCHER - and acute settings to more care in the community as well.

Mr WEBSTER - Through you, minister, as the Chair would be aware, we've embarked on reform programs across all of the streams of mental health here from 2020, the first of those and rolled out across the streams. The current budget level, and you'll see that it stays steady through the appropriations, reflects significant additional funding in mental health over the last five years but secondly, significant changes to the way we deliver mental health over the last five years. So, in that sense, this is the tail end of having already done the increase to match the reformed Mental Health Service.

Mrs ARCHER - I was saying investment in mental health infrastructure across the state, north, south and north -west with mental health precincts, but also that funding into those things that sit outside of hospital, whether that's youth mental health in home, and continuing to support the community sector as well throughout this.

CHAIR - Can I just ask you about Gidget House? There's $40,000 which sounds like quite a small number in many respects, but I understand from the budget papers it's to support a program for eight graduate positions of the perinatal mental health service there. What positions are we talking about there?

Mr WEBSTER - The Gidget House initiative extending in Tasmania was a federal government initiative, but they operate here in Hobart out of the Peacock Centre as part of our Integration Hub. They indicated to us that as part of their futureproofing their workforce, they'd like to bring on a graduate and the state Budget has funded that graduate position.

CHAIR - One? It mentions eight graduate positions.

Mr WEBSTER - It's a combination of placements, if you like, through their program and using existing funding they have from the Commonwealth. It is an additional boost to make sure there's no shortfall.

Mrs ARCHER - So, it supports eight postgraduate positions per year, 32 in total over the four years, to work under supervision, around 10,000 hours of additional support for perinatal mental health services in Hobart and Launceston.

CHAIR - Are these mental health nurses or mental health medical professionals?

Mr WEBSTER - Through you, minister, mental health clinicians, so they might be allied health or nursing.

CHAIR - It's a mix, are you saying?

Mr WEBSTER - Yes. As we do across mental health services, our case management load is shared across nursing and allied health.

CHAIR - How many beds are there, remind me?

Mr WEBSTER - In Gidget?

CHAIR - Yes.

Mr WEBSTER - Through you, minister, no beds through Gidget House.

CHAIR - Where do women get support now for puerperal psychosis?

Mr WEBSTER - Through you, minister, that is through - at the moment, we have two beds at the Royal Hobart Hospital. We also have the four Tresillian beds in the north and we're expanding to the six intensive residential parenting beds at St Johns Park, which are on schedule for practical completion of the building works in the next few weeks and then opening later this year.

Mrs ARCHER - For clarity on the Gidget House postgraduate positions, they're mental health accredited psychologists, counsellors and social workers.

CHAIR - Okay. I don't know if you can provide this at a later time perhaps, but how many people from the north and north-west access the services? Just a breakdown of the families who access that, in Gidget House, as well as in the beds. Are you happy to take that on notice?

Mr WEBSTER - Just very quickly, Gidget House actually outreach as well to the north and north-west.

CHAIR - I am interested to know how many families from the different regions are accessing the services?

Mr WEBSTER - Through you, minister, I think, for completeness, because you're talking about the perinatal infant mental health space, there is the separate acute service and we can give you the data on that as well.

Mrs ARCHER - The data for Tresillian and in-patient.

Mr WEBSTER - And PIHMS.

Output Group 92
Capital Investment Program

Ms THOMAS - Minister, I'm just wondering how much is allocated to the St Johns Park health precinct and what the timelines on the development of the new fit-for-purpose facility are. Also, noting the decision to purchase Rosary Gardens, how does that fit in here and what advice was sought from Treasury prior to the decision to purchase Rosary Gardens and what is the cost of redeveloping the facility and what are the timeframes on that one as well?

Mr WEBSTER -Through you, minister, there's a number of initial initiatives for St Johns Park, but the broader master plan is about to be released that outlines a broader strategy for the park, but in the -

Ms THOMAS - And sorry, does that incorporate Rosary Gardens?

Mr WEBSTER - Yes, sorry. So, if I go to that first, Southern Cross care have a contract for sale, and it's not yet completed to the state government, of land at St Johns Park that includes Rosary Gardens. So, it's more than Rosary Gardens that we're purchasing and part of what is referred to as Rosary Gardens will be adapted and refitted to accommodate older persons mental health, which is the Roy Fagan Centre but also at Roy Fagan Centre is, in fact, some geriatric evaluation and monitoring beds as well, particularly aimed at high-level behavioural issues. So, those will also transition from Lenah Valley to St Johns Park.

Ms LOVELL - Will that increase at all or will it be the same number of beds?

Mr WEBSTER - Through you, minister, it will be a slight increase in the number of bits. Secondary to that is that the minister's undertaken to the Council on the Ageing (COTA) and others that we will do a community consultation about the balance of Rosary Gardens beds and how we might use those going forward so we can develop a model of service for the 94 beds that are there, given that it's unlikely, in fact, older persons mental health and GEMs will probably take up less than half of that number. So, we'll do a consult.

In addition to that, we have the residential parenting unit at St Johns Park that will open within weeks of now, which is a six-bed unit. Work, we've got through plenty for the 12-bed eating disorders unit and also a 15-bed community-based residential unit similar to Peacock at St Johns Park. In the Budget, there is also funding for the initial planning stages for a bill to have a child and youth mental health unit on the St Johns Park site as well. So, they're the initial steps if you like, for St Johns Park and they expend over the next, with various steps in those with builds, that's probably a five-to-six-year program of building that I've just outlined.

Ms THOMAS - Minister, I appreciate you came to visit the renal clinic at St Johns Park. I just wonder whether there's any funding in this Budget to look to relocate the renal unit from the first floor to a ground floor tenancy or occupancy, given the risk to staff and patient safety that exists if a fire breaks out while people are undergoing dialysis.

Mrs ARCHER - I'll just ask the secretary to make some comments about renal dialysis.

Mr WEBSTER - At this stage, we're not advanced on planning to move from third to first floor at the Carruthers Building at St Johns Park, as you just outlined -

Ms THOMAS - Sorry. Third to first, I had that wrong.

Mr WEBSTER - However, there is a strategy around renal more generally across the state. Renal is, in a sense in a transitional phase, there is increasing technologies and supports for home dialysis and things like that. So the number of chairs is, you know - we're doing a clinical services planning around those changes to service delivery, but also mapping where we might put them. At the moment we have a major centre at St Johns Park that's basically the whole south and we do a similar in the north at Kings Meadows. We need to move them to where the community are rather than have it as a centralised site. So, our planning is more about where we have the chairs into the future, and indeed at the Kingston centre there will actually be chairs, we have that ability already at Glenorchy with chairs. And also what's our need for chairs going forward when the technologies and the models of care are modifying to home-support type arrangements.

Ms THOMAS - I appreciate that planning and the forward thinking, but my concern is immediate now, for the safety of the practices there for patients and for staff. What concern do you have about that, minister? Are you satisfied that it is a safe place to actually have that renal dialysis going on, given the difficulty in getting out should there - let's hope there's not - but a fire there, while people are undergoing dialysis on the third floor?

Mrs ARCHER - Yeah. So as I said when I came to visit and I understand we're catching up with that group again soon, we will continue to communicate with you and with that group and have sought assurances from the department subsequent to that. Did you want to make any further comments?

Mr WEBSTER - So well, I guess to say that it is a safe environment. We haven't left people in an unsafe environment. Is it an ideal environment? I think I've indicated that we don't believe that it is. That's why we want to plan for what the future is, and it may not be just to move to level one. It may be a dispersal of chairs across the south. We want to make sure we're reflecting that so we're not just doing a stopgap.

Ms THOMAS - Thank you.

CHAIR - Okay. There's no other questions. Well, thank you, minister, that covers the Mental Health and Wellbeing portfolio. So we'll take a 15-minute break, and come back at 3.55 p.m. for the Minister for Ageing.

The committee suspended from 3.42 p.m. to 3.55 p.m.

Ageing

CHAIR - (cont) - Thanks, minister for appearing in your role as minister for Ageing. If you could introduce the people at the table for us, and then if you wish to make some opening comments, we will then go to questions.

Mrs ARCHER - Thank you, Chair. At the table I have Dale Webster, secretary of the department of Health; Jen Duncan, deputy secretary of community mental health and wellbeing; Noelene Kelly, deputy secretary of community and government services; and Corrina Smith, director of community services, DPAC.

CHAIR - Did you wish to make an opening comment?

Mrs ARCHER - Yes, thank you, and I will keep my remarks brief, noting the limited time allocated to this portfolio. I'd like to start by acknowledging the Tasmanian government's commitment to older Tasmanians who are immensely important in our community. In January 2025, we launched A Respectful, Age-Friendly Island: Older Tasmanians Action Plan 2025-29, which details our vision for respectful, age-friendly island, where older Tasmanians are valued, connected, and supported. The plan seeks to enable an environment that supports the wellbeing, potential, and value of older Tasmanians, and address the unique challenges associated with ageing in Tasmania, along with incorporating actions to progress Lifelong Respect: Tasmania's strategy to end the abuse of older people 2023-29.

A key priority of the action plan is the establishment of the Older Tasmanians Ministerial Advisory Council to provide oversight of the plan's implementation, and advice on issues affecting older Tasmanians. I'm pleased that the council members have now been selected, following an expression of interest process, with the first meeting in the coming months. I look forward to working with all the council members, to achieve our vision of a respectful, age-friendly island, where older Tasmanians are valued, connected, and supported.

Ms LOVELL - Thanks, minister, and appreciate, as we said, there's no appropriation line for this portfolio, but obviously it's a portfolio that crosses over most other portfolios, so that's really a whole-of-government thing that we're talking about here. We've had lots of conversations with ministers over the week about operational efficiencies, and a reduction in the size of public service, and there has been talk about voluntary redundancies in a number of portfolios. So, I'm just wondering, as Minister for Ageing, what input you're having into those conversations with other ministers around safeguards that can be put in place to ensure that older public sector workers are not being directly or indirectly pressured, or targeted, to apply for those voluntary redundancies, or to be retiring or moving on from their positions. Before redundancies are approved, will agencies be required to assess the risk of losing experience, and relationship, and skills, and corporate knowledge from the state service, and will you have any input into that as Minister for Ageing?

Mrs ARCHER - Well, I would have a clear expectation as Minister for Ageing, or indeed at all, that any Tasmanian would be free from discrimination on the basis of their age, or any other attribute, in relation to their employment. So, I would say that as a first statement. In relation to this portfolio, there will be some changes as part of the machinery-of-government changes that were announced, with responsibility for Ageing moving from DPAC to the department of Health, which will actually strengthen - enhance, in fact, the resources available for Ageing, and focus on Ageing.

CHAIR - Will we see a line item for it, at that point, or will it be subsumed into other areas?

Mr WEBSTER - Through you, minister, it's likely it will sit within systems management.

CHAIR - Right.

Ms LOVELL - Okay. We heard yesterday that there will be a transfer of a role from department of Communities into Health, and that was, I think, was it 0.4?

Mrs ARCHER - 0.4.

Ms LOVELL - 0.4 FTE: so, presumably that funding will transfer across for that role as well into the Health budget?

Mrs ARCHER - Yes. It's not going to make much of a dent.

CHAIR - That's a clear expectation.

Ms LOVELL - Still, I think every dollar, at this point. Is there anything more that you're able to share with us about what that change in structure will mean, because -

Mrs ARCHER - Yes, so I might the secretary to just talk about - so as he has just said, it will sit within kind of systems management -

Ms LOVELL - Because there is some concern around it, and the fact that Ageing is not a Health issue, necessarily. So, I know that having a separate portfolio has always been really important, and if you can maybe talk about that transfer and what that means and what that will look like in reality.

Mrs ARCHER - Look, I think you're right. I agree with you. It is very important that we don't pathologise ageing and that we recognise that, you know, ageing is - and older Tasmanians are indeed an important part of our community and add value to our community across a whole range of areas, and that when we talk about ageing, that it isn't just framed as a health or an aged care issue. I think that's really important. That's the ongoing conversation I have with the Council on the Ageing (COTA) and others in relation to this, and you're right to acknowledge that there is a whole-of-government component to that as well, and indeed a whole-of-community responsibility, I think, towards that-age friendly island.

From a practical point of view and an administrative point of view, I think, with the machinery-of-government change, that 0.4 FTE resource will move across to Health. I had a meeting with both COTA and the secretary together to reassure COTA about what the changes might mean for them. I might just ask the secretary to kind of detail a bit of that discussion for the committee as well, because I think it reassured COTA, and certainly I think that there's an opportunity to strengthen the work that we do in Ageing by moving it to that larger department.

Mr WEBSTER - Thanks minister, and through you, we've been very careful in bringing Ageing and Disability as well into the agency, that we didn't put it into the health service operations side of the agency, which is why I've made the comment that the line item would be

under systems management, because we see it is a very different role to that of delivering a Health service. So, we don't want to have Ageing as a subset of Health; we want it to actually have its own set. Our systems management area is sort of where our policy people see it. It's also, you know, where our planning side of our agency sits. So, that's why we've chosen to create a new unit - yet to be named - because we don't want to have the same name as DPAC, but a community-services-focused team within systems management to pick up this area: but, the other thing about it -

CHAIR - Just on that, when we get the breakdown of this funding under that - which we asked for in that output group, will we see in the forward Estimates, like whatever it's called as a line item in the forward Estimates? Well, not a line item, but a component.

Ms LOVELL - Is it already in there, in there for this Budget?

CHAIR - Yes, is it already in there, like, will we see it?

Mr WEBSTER - Through you, minister, I don't believe there's going to be a change to the outputs just to show that.

CHAIR - No, I'm not saying the outputs. In 1.1 you took on notice a breakdown of what sits in that larger number -

Mr WEBSTER - Yes.

CHAIR - so one would hope that there will be some visibility of this in that.

Mr WEBSTER - Through the minister, because the machinery-of-government change hasn't actually occurred, it's not actually in the Health budget at the moment, so it is a transfer in.

CHAIR - Everywhere we hear that.

Mr WEBSTER - But what I can say is that we already have policy role within broader ageing because of our intersections with the Commonwealth, our membership in the senior officer group at the Commonwealth level, or the Commonwealth and state and territory level. So, we will be taking the opportunity to actually - it's 0.4 and we smile about that, but in fact, the amount of policy resource available going forward would be much more than 0.4, because we will be combining the existing 0.4 with the existing resources within Health, to create, if you like, an Ageing policy team within that unit. I think that's the important thing, and I've sort of poorly explained this in the other place, but what that also gives us access to is, you know, we've got data analysts within that portfolio that can actually turn their mind to what is this, what are the inputs we can do, and sharing that with COTA and things like that. So, acknowledging that COTA are independent of us, but giving them access to a greater resource within systems management.

Ms LOVELL - Okay. Thank you. Speaking of COTA, and I know again it's not under this - there is no line item, it's under a different portfolio - but just as Minister for Ageing, COTA receive peak body funding, so around $167,000 plus indexation, to represent older Tasmanians. Older Tasmanians, so people over the age of 50, make up around 40 per cent of the population in Tasmania. So, as Minister for Ageing, have you looked at, or assessed

whether, that peak-body funding is enough to adequately enable COTA to provide that independent policy advice, and consult statewide and represent older Tasmanians across the state?

Mrs ARCHER - Yes, it includes that peak funding and then there's additional funding as well, including for key programs such as what was Seniors Week is now Seniors Month, which is great, and digital inclusion. There's $400,000 worth of funding to continue those programs, as well as additional funds for elder abuse awareness programs.

I think importantly as well is, and I alluded to it in my opening statement, is the priority from the action plan to establish that governance group to contribute to the oversight and implementation of the action plan and advise on issues that are relevant to older Tasmanians. We concluded an expression-of-interest process for those community members on 27 January, and we've just appointed five older Tasmanians and two community organisations to their inaugural Tasmanian Ministerial Advisory Council, of which COTA will obviously be involved as well to help do that.

I think those things combined with the machinery-of-government changes, which I think will help to support COTA. Acknowledging their independence, but I think it'll also provide access to a greater resource, noting their advocacy as well.

Ms LOVELL - I'm understanding all of that and acknowledging the project funding they've received for specific projects, but their base core funding doesn't enable them to employ a dedicated policy officer and given their independent policy advice role, is that something that the government would consider funding through the older persons' action plan or through a future budget submissions?

Mrs ARCHER - We're always open to having conversations and considering things through future budget processes. I think it's also important to recognise the advocacy of COTA and particularly in relation to the free transport initiative that has been announced by the government and extended by the government. COTA has been a key advocate for that for a long time and we welcome their advocacy in relation to these issues as well.

Ms LOVELL - They do a lot with not much. Imagine what they could do with a little bit more.

Mrs ARCHER - I think that you could legitimately apply that argument to so many of the community organisations. We're really proud to support them and to continue to work closely with COTA, I have a great deal of respect for the work they do and work closely with them on their work.

Ms LOVELL - In relation to the older Tasmanians action plan, so the Budget provides $281,000 per year over three years towards the action plan, are you able to tell us which actions will be funded and which agency is responsible for each of those?

Ms KELLY - Through you, minister, we have 27 actions in relation to the action plan and we have lead agencies identified for each of those. In terms of the allocation of the $281,000 against those actions, that hasn't been done at the moment, because what we really waiting for is, it's being done in a very general thinking, 'Oh, we could allocate something to

this and something to that,' but we're really conscious of the role of the Ministerial Advisory Council and that one of the primary initial things that they will do is help inform on that.

I'm happy to sort of run through and say which agency, just noting that a number of the actions might be the lead at DPAC's doing at the moment, because it's the lead agency, but that will transition to Health, but DPAC will retain some of the actions because they're specific to the things that we might be doing within our agency.

Mrs ARCHER - We would provide that high level, but I think the Ministerial Council which will meet for the first time later this year will be able to give you some more direction.

Ms LOVELL - Is that something you could table maybe if it's got the - or provide later, if it's got the - or provide later, rather than reading through it all? I'm just conscious we only have half an hour for this.

Mrs ARCHER - Take it on notice?

Ms LOVELL - Yes, that would be great. Thank you.

CHAIR - Does anyone else have any other questions on Ageing? The only thing I'd talk about, minister, I noticed that one of the things COTA has raised is about the loneliness of older people and digital exclusion. What are you particularly doing in that space because we all like to be connected and older people - not just older people, but it is a particular risk group.

Mrs ARCHER - Yes, that's right. We have provided some funding to COTA around digital inclusion and they ran a really amazing program with young people and connecting young people with older Tasmanians around digital inclusion. They had a film - I can't remember when they launched the film, earlier in the year, I think, or may have been the end of last year - where they captured some of those stories from the interactions. And young people have gone on to form enduring friendships with those older people that they were matched through -

CHAIR - This was done years ago in Wynyard High, when we had some disengaged grade 7 kids. And they took them to the aged-care facility where they were actually the teachers and that changed the way they saw the world. So, it's not new.

Mrs ARCHER - I think that was definitely true with these young people as well and it's been a really successful program. I think the wider point that you raise, too, is not confined to older Tasmanians and I would argue one the epidemics of our time is loneliness -

CHAIR - Loneliness, yes.

Mrs ARCHER - and social isolation. I think it's focus across mental health and wellbeing, including in Ageing. We know that it has really significant health impacts for people and I think it should be a focus of those prevention pillars going forward as well.

CHAIR - This goes back to your Health portfolio a bit - looking for an aged-care bed can be a barrier to some people who are medically ready for discharge, they're unable to discharge. But sometimes if an older person is going home on their own, with limited supports,

that's also a risk to them. Is this something that - it's basically in your portfolio - that you'll look at more carefully?

Mrs ARCHER - Yes, and I think we all have a responsibility to this as well. I think these are things that are very easy to say and, of course, government does respond to these things, but communities need to respond to these issues as well. I think we all have a responsibility to that.

Ms LOVELL - That program that you mentioned before, the technology together program, that's funded until when?

Ms KELLY - Through you, minister, it's called Generations Connect, and there's funding in the 2026-27 Budget of $400,000 that the minister was talking about that is to be provided to COTA around Seniors Month, also digital -

Mrs ARCHER - And digital inclusion.

Ms KELLY - Yes. So, enabling COTA to continue that program.

Ms LOVELL - Do you know how long that will allow them to continue that program for?

Ms KELLY - Through you, minister, I think that funding was for another 12 months, but the full funding from the previous year may not be fully expended, so that might be something that we will talk to Health about through the transition about whether we need to roll funding over and additional funding.

CHAIR - So, rollover funding?

Ms LOVELL - Additional funding. At the moment there's funding through - it's through to the end of this year, isn't it?

Mrs ARCHER - Through to –

Ms KELLY - End of next year.

Ms LOVELL - End of 2027?

CHAIR - And then it ends, at this point?

Mrs ARCHER - It'll be budget dependent, obviously, but, at this stage, to 30 June 2027.

Ms LOVELL - Oh, okay. I thought there's -

Mrs ARCHER - But there's some unexpended funds from this year.

Ms LOVELL - I thought it was just the election commitment was just through to December 2026?

Ms KELLY -Through you, minister, the original funding goes to 31 December 2026 because the program started later. Then there's the funding from 2026-27, which will be for this financial year, but if it's not spent in the full year, then it'll carry through.

Ms LOVELL - So, is that to - because that was for a pilot project - is that to continue that project?

Ms KELLY - Through you, minister, yes.

Ms LOVELL - Okay. Sorry, just needed to clarify that.

CHAIR - That's alright. Are you good now?

Ms LOVELL - Yes.

CHAIR - Any other questions for anyone? No. Thanks minister, appreciate your time, and I know it is - we didn't have a lot of time allocated anyway, but without any dedicated money, it's a bit hard.

Mrs ARCHER - We might need some, then, next year.

The committee suspended from 4.15 p.m. to 4.22 p.m.

Aboriginal Affairs

Output Group 6 - Heritage
6.2 Aboriginal Heritage

CHAIR - Thanks, minister. We're just moving on to your portfolio of Aboriginal Affairs. I invite you to introduce the team at the table and maybe make some opening comments if you'd like to, on this. Then we will go to questions.

Mrs ARCHER - Thank you, Chair. At the table I have Jason Jacobi, secretary, NRE; Louise Wilson, deputy secretary, environment, heritage and land, NRE; and Will Joscelyne, general manager of heritage with NRE.

I acknowledge with deep respect Tasmanian Aboriginal people as the traditional and original owners of the land on which we meet today, and pay my respects to elders past and present, and to those who sadly did not reach elder status.

We remain committed to working in genuine partnership with Aboriginal people and communities to improve outcomes and deliver on our commitments under the National Agreement on Closing the Gap. We know that lasting change cannot be delivered by government alone and we continue to work closely with our Coalition of Peaks partner, the Tasmanian Aboriginal Centre, alongside other Aboriginal organisations across the state. We also continue to invest in initiatives that strengthen Aboriginal leadership, community capacity and self-determination. This includes supporting our Coalition of Peaks partner in its extensive national and state Closing the Gap work, as well as other organisations such as the Tasmanian

Regional Aboriginal Communities Alliance, the Elders Council of Tasmania, the Aboriginal Land Council of Tasmania and Reconciliation Tasmania.

We're also investing in economic participation and community strength with funding for the Palawa Business Hub to support Aboriginal small businesses and create greater economic opportunities for Tasmanian Aboriginal people. We also continue to support important initiatives, including the implementation of stage 2 of the Nukara strategy and the work of the Truwana/Cape Barren Island Steering Committee where government agencies work directly alongside the Cape Barren Island Aboriginal Association to improve essential services for the community. In closing, we remain committed to better life outcomes for Tasmanian Aboriginal people and will continue to deliver practical reforms to ensure this occurs in genuine partnership with Tasmanian Aboriginal people.

Ms O'CONNOR - Minister, I know you fielded a number of questions on proposed changes of the *Aboriginal Heritage Act 1975* in Estimates in the other place. Without trawling over that ground, necessarily, too much, how is the government proposing to resolve this? It's a moral question, really. Isn't it about who owns and has authority to decide on matters of Aboriginal heritage?

Mrs ARCHER - Yes, thank you. Well yes, as I have previously said both this week and previously, the government is very committed to progressing new heritage legislation to modernise and reform what I think we all agree, and the Aboriginal people agree, is an outdated and no longer suitable act. That work has been underway for some time, as you know, I think going back to around 2019, I will be stand corrected. This has escalated in recent months, and we spoke about it in November, that it was a priority for the government, because we identified that it's a priority of Aboriginal people. That, I think, took a significant step forward with the decision of the parliament, the unanimous decision of the parliament for a draft bill to be released for public consultation by the end of March, and to be in the parliament by the end of this year. So that has necessitated that work that had been taking place over time be completed, and be able to be in draft form for the community by the end of March.

That's what has occurred. Now, I note that there is, and welcome, and accept, that there are a range of views around this. That's why it is a draft bill, and we seek to get engagement on that bill going forward. I have worked closely with Aboriginal communities and communicated closely with Aboriginal communities, leaving the door very much open in terms of what they want that engagement to look like, or how they want to participate in that process. I think really importantly, and from my view, the important step forward in this heritage bill, amongst other things, is taking that decision-making, which currently sits with the minister, and that decision-making transferring to Aboriginal people. I think that's most important feature of the draft bill; but I do note it is a draft bill, and I really want to encourage participation and engagement on that.

Ms O'CONNOR - Yes, thank you, minister. So, you did talk about welcoming engagement and participation. A key representative body, if not the primary representative body of Tasmanian Aboriginal people, which is the Tasmanian Aboriginal Centre, has made its position very clear. I mean there's not necessarily a need for further engagement on it; the position is that the Palawa people own their heritage and have a right to determine how it is treated and managed. Now, what I heard you say at the end there indicated that, to a significant extent, you accept that.

Mrs ARCHER - Of course.

Ms O'CONNOR - So, what's the government's thinking about what the ultimate proposed structure will be, because as you know, at the moment, it's the director of Parks who makes a recommendation to the minister, who then makes a determination on how the heritage is treated. What's the government's position on how that structure will work, and those lines of responsibility and ownership?

Mrs ARCHER - Will, did you want to speak?

Mr JOSCELYNE - Certainly. Through you, minister, so what you've just articulated is the way it works in the current 1975 act -

Ms O'CONNOR - The current, the old act.

Mr JOSCELYNE - The old act, 50 years old. So, under the new act, the way the draft bill - it's not an act -

Ms O'CONNOR - Yes.

Mr JOSCELYNE - Under the draft bill, the intent is that that decision-making on permits or management plans will resolve with the Aboriginal Heritage Council. So, that is the key difference -

Ms O'CONNOR - There's the question of the representation on the council, obviously.

Mrs ARCHER - So, important to note that that doesn't mean the current Aboriginal Heritage Council either.

Ms O'CONNOR - That's what I assumed, which is where representation becomes an issue.

Mr JOSCELYNE - Certainly, and through you, minister, the transition arrangements in the new bill provide for the continuation of the council and then the appointment of a new council. That also entertains the possibility that it should be done in consultation with the council as well. So, it's not being done to the council; it's something that is provided for to be a genuine engagement and empowering approach under the draft bill. Then they are Tasmanian Aboriginal people that form the council. It's very clear, explicitly, provided in the constitution of the council under the draft bill.

Mrs ARCHER - Noting, again, that it is a draft and we know, from the consultation or engagement that we've had already, that there are a range of views about how that might occur or how that might be constituted, those are the conversations that we want to continue to have.

Ms O'CONNOR - Thank you. To your knowledge, minister, has there been a single instance - say since 2014 or in the past 10 years - let's say in the past 10 years, where a recommendation has come up from the director of Parks and Wildlife to the minister to not permit the removal or destruction of heritage?

Mrs ARCHER - Look, I'm not sure, and I'm not sure if Mr Jacobi can provide details.

Ms O'CONNOR - Mr Jacobi has been there for some time. He might know.

Mrs ARCHER - What I would say is that it is exactly what the new legislation would seek to overcome: to, as I said, move decision-making from the minister to Aboriginal people.

Ms O'CONNOR - Noting that in the past three years more than 80 permits to destroy Aboriginal heritage have been approved by the minister.

Mr JACOBI - Through you, minister, I might go to Will in a minute. I thought I actually had the figures for the number of permits that have gone through me to the minister that have been approved or not approved. By and large, the majority of the permits are not contested by the Aboriginal council, and it is only a very small number that have been overturned. In the 2025-26 financial year, permits issued by the minister, the number of which were opposed by the Aboriginal Heritage Council: there's 22 permits have been issued by the minister and only three of those were opposed by the Aboriginal Heritage Council.

Ms O'CONNOR - Can we just check: are they the Robbins Island permit, the Arthur-Pieman Conservation Area and/or Arm End? What were those three examples?

Mr JACOBI - I don't know that I should disclose the actual specifics of those permits, but none of the three that you mentioned were the ones that were opposed by the AHC.

Ms O'CONNOR - Okay. So, when the Aboriginal Heritage Council takes a position, following an assessment, on how their cultural heritage should be treated and if that position is to advise you that they don't want to permit the removal or destruction of heritage, what leads you, as the director advising the minister, to believe that that advice can be ignored? Which is what must have happened at least in those three cases.

Mr JACOBI - I think it's important to distinguish the nature of the permits, because the nature of permits can vary from something as simple as a backyard garden shed and someone wanting to extend the shed by a metre on their own freehold property, to something much more significant and substantial. In all of those cases, the Aboriginal heritage officers and Aboriginal Heritage Tasmania and the cultural specialists there provide advice to proponents or applicants for a permit and that advice is often at the beginning of a permit assessment process. So, very often, the nature of the permit is amended before it even goes to the Aboriginal Heritage Council, so negotiations and consultations occur with the proponent to try and mitigate the impacts to Aboriginal cultural heritage. If those impacts cannot be mitigated, for whatever reason, it goes to the Aboriginal Heritage Council, the Aboriginal Heritage Council consider the application and they may oppose it or not contest it for a whole variety of different reasons.

On the rare occasions that I'm aware of, that the Aboriginal Heritage Council has opposed a permit for a particular reason, the team in Aboriginal Heritage Tasmania provide me with advice and that advice will spell out the nature of the permit, purpose of the permit, how critical it might be in its relationship to critical infrastructure, for example, if it's a pipeline to supply water or sewage, is it a power line that supplies electricity to the population; they are all the different types of considerations that I have to take and bear in mind before I provide a recommendation to the minister; and there have been occasions where, despite all the efforts of the proponent to do what they could to mitigate and avoid Aboriginal heritage, I haven't been

satisfied that they've done enough and I send the permit back to my team and ask them to work with the proponent to work harder to avoid Aboriginal heritage.

Very often they will go back and work with the proponent and look at ways that they can maybe avoid a particular artefact scatter or they can avoid a site of significance and then the permit will make its way, either back through the Aboriginal Heritage Council to me and, at that point in time, if I am satisfied that they have done everything that is feasibly possible to avoid and mitigate risks to Aboriginal heritage, notwithstanding the decision of the Aboriginal Heritage Council that they might oppose the permit, there are some very rare circumstances where I have made a recommendation to the minister to approve.

Ms O'CONNOR - But has there ever been a situation in your time as director where you have accepted the Aboriginal Heritage Council's objection to the approval of a permit and recommended to the minister that it not be approved?

Mrs ARCHER - I think it's important to also -

Ms O'CONNOR - Sorry, minister, but through you, minister, I mean, I'm happy for you to answer that question, through you, but the question's pretty legit, because -

Mrs ARCHER - Yes, I think it is also important to note that the minister can request extra mitigation measures as well, even if the even if the director recommends that it be approved, and that has happened on occasion.

Mr JACOBI - Correct. To answer your question, I can't recall any time that that has occurred because I've always gone back to the proponent and sought for them to find additional ways in which to mitigate the impact and by the time it's come back to me, I've been satisfied that everything has been done.

Ms O'CONNOR - Even if the Aboriginal Heritage Council isn't satisfied?

Mr JACOBI - In the very rare instances that there have been that they have not been satisfied, yes, I made a recommendation of the minister that the permit be issued.

Ms O'CONNOR - So, and just to clarify that, and this is to the best of your recollection - I'm sure you'd remember if you'd made a recommendation to accept the Aboriginal Heritage Council's advice and not approve a permit - so, to the best of your recollection, you have never advised the minister to reject a permit?

Mr JACOBI - That is correct, because, in every instance, I've been satisfied that everything has been done, and I restate that in the majority of cases the permits come to me, the Aboriginal Heritage Council have not opposed or contested the permit being issued.

Ms O'CONNOR - Thank you. So, has there been before you a permit application for works on Robbins Island?

Mr JACOBI - I would have to take that on notice.

Ms O'CONNOR - You'd remember that? Surely, you'd remember that?

Mr JOSCELYNE - Through you, minister, not as yet, in terms of the final requirements for Aboriginal heritage approvals for Robbins Island are still to be the subject of a permit application consideration and through the standard process.

Ms O'CONNOR - So, the agency is expecting that application to arrive, so there must be - has an assessment commenced under the act?

Mr JOSCELYNE - Through you, minister, so we're aware of some early work done in relation to Robbins Island in terms of where heritage is and one of the - in line with standards and procedures that we have at the moment, the opportunity is obviously then afforded to the proponent in a project like that to redesign where they might put things to avoid heritage, because of the scale and the nature of it, that you can model what you call a microsite - the infrastructure, whether it's the roads, the pads, et cetera. So we would be anticipating, at some point in the future, an application for a permit under the current legislation that would take account of where the physical heritage is on Robbins Island, and we would anticipate, to the largest extent possible, it will demonstrate that it is avoiding that heritage.

Ms O'CONNOR - Okay.

Mr JACOBI - Through you, minister, I will add a correction to my comment before, because I think it's important. There are cases, and there is a particular case I can recall, where the Parks and Wildlife Service wished and submitted to make an application to do works at Freycinet International Park, and the Aboriginal Heritage Council opposed the permit. So, I made a determination that we wouldn't proceed with the project.

Ms O'CONNOR - I mean, I guess that's very different, because when government or an agency is the potential developer, you're not offending the developer class, so it's a different - it's kind of no skin of the agency's nose, really.

Mr JACOBI - No. The works were actually intended to protect Aboriginal heritage. So, it was a difficult decision to make, because the works were intended to actually protect the site, which is regionally significant, they were well-intentioned, but because the Aboriginal Heritage Council felt strongly about the nature of the works and location, we put the project to the side. There is another example that I've been presented with, but I'm just seeking some further detail on that.

Ms O'CONNOR - Is there an assessment underway currently for track extensions or construction in the Arthur Pieman region?

Mr JOSCELYNE - Through you, I will need to take some advice on that - through you, minister.

Ms O'CONNOR - You're happy to take that on notice, minister?

Mr JOSCELYNE - I will see if we can get some advice quickly; if not -

Mrs ARCHER - Yes. We can take it on notice.

Mr JACOBI - Can I just clarify, through you, minister: is that for works on existing tracks?

Ms O'CONNOR - No. That's the government's intention to create the new four-wheel-drive tracks, or extensions to the -

Mr JACOBI - There is no intention that I'm aware of to create any new extensions or new tracks in the Arthur Pieman. One of the fundamental -

Ms O'CONNOR - Not the APCA, necessarily, but in the area.

Mr JACOBI - One of the fundamental principles of the sustainable access strategy work that was done recently was no new tracks would be developed. It was certainly, though, improvements to the existing tracks to protect Aboriginal heritage, and it's my expectation that a permit would be sought and issued for those works, but there should be no new works, as such, other than the existing tracks.

Ms O'CONNOR - Okay. This is my last question - sorry, Will.

Mr JOSCELYNE - Sorry. To be clear, through you, minister, I am unaware of any application or assessment currently before Aboriginal Heritage Tasmania at this point in time.

Ms O'CONNOR - Okay. So, I'm going to put a scenario to you: the Tasmanian Aboriginal Centre has made its position on a potential cable car up Kunanyi very, very clear. The TAC, Palawa people, regard Kunanyi as sacred Aboriginal land, and are vehemently opposed to the cable car and the privatisation of the pinnacle. Given what is understood about the Palawa's position on a cable car up the mountain, if the Aboriginal Heritage Council says to government - says to the director of parks, we are vehemently opposed to that kind of development on Kunanyi because it will cause irreversible damage to our cultural heritage; how would the government respond to that?

Mrs ARCHER - I think we're probably playing a little bit with hypotheticals there, Ms O'Connor.

Ms O'CONNOR - I think it's a likely hypothetical though, given the review of the mountain.

Mrs ARCHER - It is still a hypothetical, it sits outside of - and certainly, there would be decisions that sit outside this portfolio as well in relation to this, and I would probably go back to my previous point around Aboriginal heritage, which is the importance, in my view, of new heritage legislation, and many of the questions that we're talking about and that you've had relate to the current legislation, that 50-year-old act. So, I think it's not helpful, in my view, to sort of go to kind of hypotheticals, but what I would say is that our focus remains on contemporising the legislation.

Ms O'CONNOR - I think it's a realistic hypothetical, given your government's review of development on the mountain, and the future of the mountain, and its stated intention to create a development pathway for a cable car on Kunanyi. Anyway, Chair, I'm happy to move on for now.

Output Group 1 - Policy Reform and Government Priorities
1.6 Aboriginal Affairs

CHAIR - Minister, I will get you to introduce the new team members to the table. Do you want to make any opening comments in relation to Aboriginal Affairs?

Mrs ARCHER - No additional ones.

CHAIR - We will go straight to questions after you've done that.

Mrs ARCHER - Thank you. At the table now from DPAC I have Melissa Gray, deputy secretary, policy and reform; Caroline Spotswood, director of Aboriginal partnerships; and welcome to Emile, who is a policy graduate who's joining to observe today.

CHAIR - Lucky to get us at the end of a really long couple of days; I say that not in the best way. Over to you, Clare, sorry.

Ms GLADE-WRIGHT - Can the minister please outline progress in delivering Tasmania's Closing the Gap Implementation Plan 2025-28.

Mrs ARCHER - The Tasmanian government has committed to delivering better outcomes for Tasmanian Aboriginal people and their families, and Closing the Gap is a top priority for me as minister. It's been encouraging to meet with a number of Tasmanian Aboriginal people and listen to their views on how we can work together to achieve this. The national agreement, developed in partnership between state, territory and federal governments and Aboriginal and Torres Strait Islander people, commits to a new way for our government and Aboriginal community-controlled organisations to work together in partnership to improve the lives of Tasmanian Aboriginal people.

This approach, developed with Aboriginal people, recognises that Aboriginal people are best placed to determine and deliver services that meet the needs of their community members in a culturally-appropriate and effective way. The government works in partnership with its Closing the Gap Coalition of Peaks Partner, the TAC, and as a commitment under the National Agreement for Closing the Gap, all jurisdictions provide funding to their Coalition of Peaks Partner to participate in Closing the Gap.

I'm pleased that $1 million was provided to the TAC over four years in last year's Budget and the government also works with other Aboriginal community-controlled organisations to ensure that their perspectives and priorities are considered within the Closing the Gap architecture. Funding across the forward Estimates of $600,000 has been provided to TRACA to support engagement, advice and input into Closing the Gap actions as an alliance representing these organisations, and the 2025-26 Budget also provides $650,000 for project and program initiatives that align with Closing the Gap.

The Closing the Gap Dashboard was most recently updated on 18 March 2026 and the updated dashboard showed that Tasmania is performing better than the national average against 11 targets and the same as the national average against one. We're on the right track overall across targets and their associated indicators, but I acknowledge challenges in some areas, in particular housing, adult incarceration, out-of-home care and early childhood development, which is similar to other states and territories. The government will continue working with our

Coalition of Peaks partner and Aboriginal community-controlled sector to close the gap in life outcomes for Aboriginal people in Tasmania. Do you want to talk to the more specifics of the dashboard, Mel? I'm not sure what level of detail you wanted to -

Ms GLADE-WRIGHT - You mentioned 650 for projects that align with Closing the Gap. What sort of projects are they?

Ms GRAY - Yes. Through you, minister, thanks for the question. As the minister said, we work with the Tasmanian Aboriginal Centre as the Coalition of Peaks partner under Closing the Gap and other Aboriginal organisations. We work directly with them and fund them directly to address targets that are a priority for them, and minister mentioned out-of-home care as one of those targets.

The release of the Nukara strategy for the transfer of child safety responsibility into Aboriginal community control is a nationally-leading strategy that was funded from the capacity building grants in previous budgets and was fully funded in this financial year, after, I might say, extensive consultation by the Tasmanian Aboriginal Centre; because we know that when Aboriginal people are the architects of their own solutions, we actually get better outcomes and, as a result of the commission of inquiry, we know that there is a lot for the government to do better in this space.

So, as I said, it's a nationally-leading strategy and part of our expenditure review work involves working with other government agencies to identify program and services that can be transferred to Aboriginal community control. In addition to the funding for Nukara, we actually have the Department for Education, Children and Young People working directly with other Aboriginal organisations - not the TAC - to look to where they can transfer existing funding from that agency to those organisations. There is about one, two, three, four, five other organisations, six other organisations that the department is in direct conversation with about those. I'm not sure if, Caroline, you wanted to add anything about Nukara from an Aboriginal perspective, or potentially?

Ms SPOTSWOOD - Through you, minister, I think I might just start with Cape Barren Island and then maybe mention a little bit about Nukara. The government, DPAC and the Department of State Growth are working very closely with Cape Barren Island Aboriginal Association in regards to essential services and also leveraging Commonwealth funding to support the island in regards to power and water, food security and fuel. So, in regards to the relationship we have, it's a good one. We have a steering committee which is chaired by Ms Gray and Mr Gillies from State Growth and lead people; but more importantly, is that we have the CEO and the Chair of Cape Barren Island who lead us in the committee because they're the ones that live on a remote island, and they're the ones that know their community and what the needs are.

We seem to be working well together and directed by them; and in regards to Nukara, I'd say that the government is a mechanism that the Tasmanian Aboriginal Centre has used in regards to funding and that has then developed their own community-led approach to a strategy to support Aboriginal children to be from out-of-home care to community control. So, it's their strategy, not ours, but we were the vehicle to support them, yes.

Ms GLADE-WRIGHT - And is SETAC one of the organisations?

Ms SPOTSWOOD - Yes, it is. It's one of the six.

Ms GLADE-WRIGHT - And my next question, unless anyone else has anything on there, so the government has chosen to prioritise a truth-telling and healing process over progressing a treaty framework; can the minister please provide an update on the timeframe for a truth-telling commissioner?

Ms O'CONNOR - No funding for it in the budget, we should note at this point, for a truth-telling commission.

Mrs ARCHER - Yes, I might just get Mel to speak to that, but while they're looking for that; yes, I would say I understand the significance of truth-telling and treaty to Tasmanian Aboriginal people and that's why, in line with the advice received from the Aboriginal advisory group, we remain committed to embarking on truth-telling and healing journey for the whole Tasmanian community, that will assist in progressing our other Closing the Gap outcomes and forms part of the government's broader commitment to Closing the Gap. We believe, and I believe, that truth-telling is a necessary part of a journey to healing, and indeed to treaty, if that were to be an outcome, but we also acknowledge, and you would have all heard from reconciliation breakfast, et cetera, in recent weeks that there are a range of views around whether truth-telling needs to occur at all or whether truth-telling has occurred. So, I think there are a range of views. We remain committed to truth-telling commissioners and - here we go -

Ms GRAY - Sorry.

CHAIR - She will eventually, she just wants you to keep talking.

Mrs ARCHER - I can keep talking, but I was waiting for you to - but yes. There is funding for truth-telling commissioners, which Mel has found now.

Ms GRAY - So, thank you very much, minister -

Ms GLADE-WRIGHT - So sorry, before you get to funding, just the timeframe, did you answer that?

Ms GRAY - Thanks, and through you, minister, I will deal with the timeframe first and then go on to funding. We had hoped to - and I think I reported to the Legislative Council committee this in November - we had hoped to be advertising for commissioners in the first half of this year. Now, as minister said, there is a diversity of views around - at the time of the announcement of truth-telling, there were at least six or seven positive media releases. That then shifted; that's a sign of a healthy democracy, people don't always agree. You know, we want to ensure that, as minister said, we make the first steps together as much as possible with Tasmanian Aboriginal people and we don't want the first steps to be the wrong steps, and we are continuing to be in conversations with Tasmanian Aboriginal people about what those first steps should be. We're also expecting, and this was reported in November as well, the final report of the Aboriginal Advisory Group by June this year, and I think it was a matter of interest last estimates as well; that report would then be made public. So, once we have that report, then based on all of the conversations minister has been having, we may make progress in the second half of this year.

Ms GLADE-WRIGHT - So, are you sort of alluding to differing opinions within the Aboriginal community about the necessity for a commissioner, I assume?

Mrs ARCHER - Yes, or what it looks like or what the model might look like, and I think that goes to the question from Ms O'Connor earlier around - which I responded to the other day, about we often say that we move at the pace of trust. We have to build that trust and build those relationships, continue to listen to people and moving - I mean, this is very important to get right and so, I think listening to those views, at a minimum, waiting for the report from the advisory council as well, and continuing to have those conversations about what it might look like, what a model might look like and, indeed, then timeframes or how that might look, I think, are still ongoing conversations.

Ms GRAY - And so, through you, minister -

Mrs ARCHER - There is funding.

Ms GRAY - the funding - so, the funding allocation, some of it's allocated, and some of it's flexible for Closing the Gap projects, or for truth-telling. So, I can take you through the parts of the funding that are allocated. So, in last year's Budget there was $1.4 million for Closing the Gap and other - Aboriginal truth-telling and other Closing the Gap priorities, I think it said. So, the funding profile, over the forward Estimates from 2025-26, is 1.4 million. So, there's 1.4 million in this financial year as well, and then 800,000 and 800,000. Now, the 1.4 million last year, and now this year, was broken down by 250,000 per annum, as I think minister said in a response to the Tasmanian Aboriginal Centre, to participate in the enormous architecture that is nationally driven around Closing the Gap; 150,000 for the Tasmanian Regional Aboriginal Communities Alliance to also participate and be part of Closing the Gap; 200,000 per annum for the Palawa Business Hub, which held an event in parliament house recently for reconciliation week and now has a network of 54 businesses, and is a wonderful story of progress on target -

Ms GLADE-WRIGHT - Eight.

Ms GREY - eight of Closing the Gap, but more importantly, of Aboriginal self-determination. We know that when we invest in employment for Aboriginal people, the multiplier effect, I think Sarah said, for every dollar invested there's a $4 return.

Ms O'CONNOR - I bet that's conservative too.

Ms GREY - Yes. So Palawa Business Hub - the Elders Council of Tasmania to undertake a truth-telling project: 50,000 per annum over four years, and 100,000 per annum for Reconciliation Tasmania over four years. That leaves some funding leftover every year for either Closing the Gap projects or truth-telling and healing. So, should we seek to establish commissioners or a commission, there will be funding available in this year's Budget to do that work.

Ms O'CONNOR - Can I just double-check there, Clare, just listening, and maybe I missed something in your list, of that quantum of funds that you sort of unpacked a bit there, the money that's currently dedicated to the truth-telling process is allocated to the elders council; is that correct? The $50,000 to the elders council, and that's the primary body of work that's being undertaken on truth-telling at the moment.

Mrs ARCHER - Yes and no. So, there's also the Elders Council of Tasmania, Reconciliation Tasmania, and then there is this balance of funding for either truth-telling activities, as Mel said, if we are at a position where we can stand up commissioners, that's what that would be used for; but, it can flex for other Closing the Gap initiatives, if we obviously are not ready for the truth-telling commissioners at that point in time.

Ms O'CONNOR - Okay. What's the government's expectation of the work that Reconciliation Tasmania is doing on truth telling? What does that look like, structurally? I'm happy to -

Ms GLADE-WRIGHT - No, I'm done now.

Ms O'CONNOR - Okay.

Ms GREY - Through you, minister, we've got a grant deed with Reconciliation Tasmania. I don't have it with me at the moment, so I'm - can you recall the types of key performance indicators that are in the grant deed?

Ms SPOTSWOOD - So, very broadly, reconciliation will be working with Aboriginal people across the state to get their views, ensuring that when they work with the wider community that there's a really deep understanding of what truth-telling is about.

CHAIR - For the different communities, you're meaning?

Ms SPOTSWOOD - Yes, so reconciliation is working with the wider community on truth-telling, but to do that they need to talk to Aboriginal people, to get Aboriginal people's views and perspectives, and so it's about that understanding, and changing the deficit discourse over to a deeper understanding on why truth-telling is important.

Mrs ARCHER - I think it's also capturing the - and this was a theme, I think, through Reconciliation Week - an acknowledgement that Aboriginal people don't necessarily have anything to reconcile and that -

CHAIR - They prefer the term 'reckoning'.

Mrs ARCHER - and that perhaps needs to occur in non-Aboriginal communities.

Ms O'CONNOR - That's right.

Mrs ARCHER - That is the impetus behind the funding for Reconciliation Tasmania, is that that is the work that needs to be done with non-Aboriginal people.

Ms O'CONNOR - Yes. just as sort of a question to you, minister: why do you think engaging with the non-Aboriginal Tasmanian community on that question of reconciling with the truth is important?

Mrs ARCHER - Look, I think it's important for lots of different reasons. It is because I think that Aboriginal people do not have anything to reconcile. I spoke about this the other day in terms of, in some cases these are relationships that never existed in the first place, or

they were badly damaged by non-Aboriginal people. I think, if we are - and I think that's the important thing about truth-telling, is that it requires truth listening as well, and I think that's the important distinction in a way that, yes, we can move towards truth-telling initiatives and we can move towards agreements and treaties; we can't move to agreements and treaties if we won't listen to truth.

CHAIR - Or listen with an open heart.

Ms O'CONNOR - And be prepared to change, yes, with the open heart, as the Chair said.

CHAIR - And willingness to believe and take it on board.

Mrs ARCHER - And I think, fundamentally, if you don't acknowledge or understand, how do you reach agreement? You have to do that bit first.

Ms O'CONNOR - Yes. So, I was just having a look at the schedule at the back of the *Aboriginal Lands Act,* and it's at least 20 years, I think, since any lands were returned, and I believe the last -

CHAIR - Before I arrived in this place, Cassy, that is how long it's been.

Ms O'CONNOR - Before you arrived, well there you go.

CHAIR - There might have been one just after.

Ms O'CONNOR - Well, you'd remember a bill that in government we tried to get through this Council, but the Council held it up, to return Larapuna and Rebecca Creek and it was clagged up in the Legislative Council and the land was never returned, which I'm sure you remember, honourable member for Murchison.

CHAIR - I do remember that. There was not agreement within the Aboriginal community either.

Ms O'CONNOR - Okay. Jack didn't like it, I remember that, but I think the last return was Clarke Island. Is that correct?

Ms SPOTSWOOD - So, Lungtalanana and Cape Barren Island, 2005.

Ms O'CONNOR - 2005: so, 21 years since lands were returned.

Mrs ARCHER - Since Crown lands were returned.

Ms O'CONNOR - Since Crown lands were returned, and we should acknowledge here at this table that there are some fantastic Tasmanians, private individuals who have returned lands. What is the government's plan for land returns, because, we know that there were proposed changes to the *Aboriginal Lands Act* that the community found quite offensive. What's the plan? Because we're just here, Estimates after Estimates, oh yes, we're looking at it, we're talking about it, we're thinking about it, we're engaging, we're in consulting; no land is returned.

Mrs ARCHER - Yes. Look, I think the point that, in fact all of the points that you just made are relevant, I think, to this in that there has been unsuccessful attempts at returning land, Crown land, to Aboriginal people and you've identified some of the reasons why; because ultimately the parliament is going to make that decision, is part of the answer to that. There has been some fantastic philanthropic returns of land to Aboriginal people and I'd like to acknowledge that as well. There are no plans to change the lands act and, as I said to you at Estimates last year, and I will repeat again in the context of the conversation we're having about truth, is that we have heard from Aboriginal people that there is very broad agreement around reform of Aboriginal heritage legislation and land return. Those have been the two things that I, as a minister, have prioritised since coming to the portfolio that I remain committed to progressing. NRE have left and they are the group that are doing the work around, obviously, the parcels of land, of which there are many, that have been identified by Aboriginal people that they would like to see returned or are interested in seeing returned, including I think, from the event in here last week with the Palawa Business Hub. They, in that event, identified some additional parcels.

The department is working through those parcels of land, as I said, of which there are many, and they will have various degrees of complexity in terms of whether they are able - how easily able they might be, noting that it's not necessarily easy at all, to progress those. So, I remain committed to working through that. I note the challenges of that and, ultimately, in part, the parliament will decide, but I very much hope that we can do that work and get to the point where we can see very overdue land returns, not just because it's the right thing to do, not just because Aboriginal people asked us to do it, but also it is critically an important part of meeting our Closing the Gap obligations as well, which I think is also important to mention.

Ms O'CONNOR - Is there a list, is there a table of lands, areas of Crown lands that the government is collating and engaging with the community on, or is it, at the moment, sort of a desire on the part of you, as minister?

Mrs ARCHER - There are a range of - but certainly, I think there just is a desire to progress it and we, as I've said, acknowledge that, that has been named up by Aboriginal people as a key priority along with the reform of the heritage legislation. There is, and has been over time, a whole range of different parcels of land that have been identified by Aboriginal communities and organisations that they may like to see returned, and they have a whole range of, I guess, complexities and diversity to each of those parcels. So, the department will work through those. I think it would be really unhelpful to just –

Ms O'CONNOR - Put the shopping list out there?

Mrs ARCHER - To put it out there -

Ms O'CONNOR - Yes, no, I understand.

Mrs ARCHER - because I think that work needs to be done in a way that looks at what are any potential impediments, what are things that might need to be overcome. I know many of these things are also about relationships and communication as well. So, I think all of those things need to be considered to hopefully then progress to that point where we can initiate the process, which includes consultation more broadly with communities and whatever, about what some of those potential parcels of land might be. It might also be worth mentioning, and I'm

sure Mr Jacobi would have, if he was here, that there are, whilst not land returns, I think the idea of leases and licences is also important, and important to Aboriginal people, and there has been a lease recently transferred for Prime Seal Island to - out as well.

Ms O'CONNOR - That is a positive. I was just mulling over, there's been broken promises and heartbreak for Palawa people because there were two premiers who in the sort of mid-to-late 2000s promised to return Wukalina, Mount William to Aboriginal people; nothing ever came of that. There's the bill for very small parcels of land at Larapuna and Rebecca Creek; nothing comes of that and so, each year there's these conversations and it just seems like it's something that it's easy for governments- because it's a hard thing to do. You know, you've got all sorts of competing tensions there. It's easy for government to sort of kick the can down the road and I just wonder if, you know, we will be here next year, having exactly the same conversation the year after, exactly the same conversation; and how strong is the will on the part of government to see lands returned?

Mrs ARCHER - Well, I think that what you've acknowledged and what we've seen previously is that it's not always the will of government and, ultimately, it's going to be the will of the parliament and there are a lot of competing priorities. I'm not going to make promises to people that I may not be able to uphold. The promise that I will make will be the same one that I made to you here at the table last year: that we will continue to work closely with Aboriginal people, that we will listen, and that we will try to do what they have told us are priorities for them, which is new Aboriginal heritage legislation and progressing land return. We will listen to truth, and we will sit. I promise I will sit and listen to uncomfortable conversations and difficult conversations. That's the promise that I will make, because that is how we will move forward: that is the promise.

CHAIR - We need more people to do that who are not Aboriginal.

Ms O'CONNOR - So unfortunately, and I know it's just the way sort of statutes and schedules work, but the lands that have been returned to date that are in the *Aboriginal Lands Act*, very few of them have their true name, their first name, and I wonder if that's something that might be examined, because the schedule at the back of the act still describes Cape Barren Island as Cape Barren Island. We know its true name. So, I wonder, minister, if that's something you could have a look at. Risdon Cove, Piyura Kitina, is in here as Risdon Cove.

Mrs ARCHER - I think there is more work to be done, and in fact, in preparation for this meeting I was asking is there a Palawa Kani name for Prime Seal Island. I'm not sure that we found one.

Ms SPOTSWOOD - I'm unsure at this moment.

CHAIR - Which island?

Mrs ARCHER - Prime Seal Island.

Ms GRAY -Through you, minister, that's a wonderful suggestion and one of the key priority reforms of Closing the Gap is transforming government, and we have an authorising environment from central agency to work and make the systems change that we need, to, wherever we can, transform government; and that would include looking at legislation and that's something that has not crossed my mind and it's -

Ms O'CONNOR - Well, I have to say it hadn't crossed mine until I went to the schedule of the act itself, what are these places, because it's such a beautiful language.

Ms GRAY - It's a really good suggestion.

Ms O'CONNOR - We should be doing everything we can to engage -

CHAIR - Normalise it.

Ms O'CONNOR - Normalise it. Like in New Zealand where Māori is integrated into conversation. Non-Māori people have much language in their daily discourse and -

CHAIR - In the New Zealand Parliament, you can speak in either Māori or any language.

Ms O'CONNOR - Isn't that beautiful?

CHAIR - The *Hansard* will record it regardless. You don't have to have it translated.

Ms GRAY - I'm always indulged by this committee, and through you, minister -

CHAIR - Too tired to resist.

Ms GRAY - We always have you so late. I've been reflecting as well, and Caroline is actually from Cape Barren Island, and so I just want to acknowledge that this is sometimes an emotional conversation for you as well, Caroline, and just to say that from working with minister, 100 per cent I know and I have conversations with minister all the time about future-generations thinking, and that for Tasmanian Aboriginal people, care for country is actually care for kin, and the commitment is real.

Ms O'CONNOR - We can all learn from that.

CHAIR - Don't start Cassy on that just now, because she will cry.

Ms O'CONNOR - When are we likely to see the next nomenclature board - or when are we likely to see more of the first names, true names come forward under the dual-naming policy?

Ms GRAY - Through you, minister, review of the Aboriginal and Dual Naming Policy is an action in the implementation plan for Closing The Gap. We have had a couple of preliminary conversations - it's to do a review, so we've had a preliminary conversation with the CEO of the Tasmanian Aboriginal Centre. I've also had conversations with TRACA about the timing of that review, and also what the review looks like from an Aboriginal perspective: like are we going out with a discussion paper? Is it your usual colonial, standard review process or -

Ms O'CONNOR - Let's hope not.

CHAIR - Well, that doesn't work for anyone.

Mrs ARCHER - Is there a transformation-of-government opportunity?

CHAIR - That doesn't actually work for anyone.

Ms O'CONNOR - No, it doesn't.

Ms GRAY - or what's the end product, and should we work back from an end product?

Ms GRAY - And what international examples are there to look to, is the other conversation we've had.

Ms GRAY - Yes. Actually -

Mrs ARCHER - What else is there that we can look to, that we could learn from internationally in this regard as well, in terms of the academic rigour that sits around it.

Ms GRAY - There is a timeframe, through you, minister, for undertaking that review by 2027-28, but we've started the conversation.

Ms O'CONNOR - So we're likely to see a pause on further declarations of true names before that review is complete?

Ms GRAY - Through you, minister, by the end of the - what do you want to say?

Ms SPOTSWOOD - Through you, minister, action 61 in the Tasmanian government's implementation plan, and is to end 2026-2027.

Ms GRAY - And through you, minister, yes, by nature of the need for the review, there has been a slowing of naming, though we have seen local councils - Pataway/Burnie, we've seen the adoption of some Palawa Kani, but through the formal process, yes, there has been a pause until that review's undertaken.

Ms O'CONNOR - Is there any further talk within government about Palawa representation in parliament? We did a - there was a parliamentary committee that looked at restoration of the numbers, probably five years ago now, of the numbers in the House of Assembly; unanimous support for restoring the numbers and, thankfully, they've been restored; but apart from our recommendation, which was to restore the numbers in the House of Assembly, the second recommendation was to allow for two seats, potentially in this Council, to provide representation for Aboriginal people. Is that something that's coming up in your conversations, minister, with community representatives?

Mrs ARCHER - It is not a conversation that I have had at all. I think it's a conversation that could potentially be had as part of that truth-telling process. Again, I think there's probably a range of views about how to achieve that. In fact, we would have had a similar range of views around how do we achieve greater representation for women at some point as well. So, I don't think it's -

CHAIR - We're actually doing the deed in the Legislative Council, lifting the number of women.

Ms O'CONNOR - What's the proportion again?

Ms GLADE-WRIGHT - Nine.

Ms O'CONNOR - It's good.

CHAIR - Yes, good.

Ms LOVELL - Nine out of 15, I think.

Ms O'CONNOR - That's right. I think we've got the gender balance of this table just right.

Ms LOVELL - We think it's the first one - the first all-woman committee.

CHAIR - Particularly an Estimates committee. There may have been smaller subcommittees of just women in the past, but not an Estimates committee.

Mrs ARCHER - I think, without being flippant about it, though, those are not new conversations either around how do we get greater representation and diversity in our parliaments and in everywhere.

CHAIR - We all look pretty much the same when we come down to it, don't we?

Ms O'CONNOR - In this parliament.

CHAIR - All look tired at the minute.

Ms O'CONNOR - That's it from me, thanks, Chair.

CHAIR - Does anyone else have any other questions they want to follow up with? No. Well, thank you - did you need to add anything or say anything before we close off?

Mrs ARCHER - I'd just like to say, in the spirit of the conversation: nayri nina-tu.

CHAIR - Thank you very much, minister. Thank you for your time today.

The witnesses withdrew.

The committee adjourned at 5.24 p.m.