GOVERNMENT ADMINISTRATION COMMITTEE A, SUB-COMMITTEE INQUIRY INTO RURAL HEALTH SERVICES IN TASMANIA MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE ON FRIDAY, 20 AUGUST 2021

DR GABRIELLE O'KANE and LUKE SARTOR, NATIONAL RURAL HEALTH ALLIANCE WERE CALLED, APPEARED BY WEBEX, AND WERE EXAMINED

CHAIR (Ms FORREST) - Good morning. We appreciate you providing a submission to us and for being willing to appear before the committee. We have 45 minutes, we have your submission and members have read that. We hope you can speak directly to our terms of reference, which I appreciate are quite extensive. It helps us to keep the information contained.

The information you provide to us will be recorded in *Hansard* and published on our website. As you are in another jurisdiction it does not attract parliamentary privilege as we cannot swear you in. If you would prefer to see a copy of *Hansard* before it is published we are happy to provide it to you on that basis. If there is anything you wish to say in confidence to the committee, you can make that request and the committee will consider it. That information wouldn't appear publicly. It would remain with the committee. Do you have any questions before we start?

The hearing will also be broadcast and that enables the media to watch. They may well contact you after the hearing. I invite you both to introduce yourselves. If you wish to make some broad opening comments about the inquiry and the terms of reference, then members will have questions for you.

Dr O'KANE - My name is Gabrielle O'Kane and I am the CEO of the National Rural Health Alliance. With me is Luke.

Mr SARTOR - Hello, I am Luke Sartor, also from the National Rural Health Alliance, as policy and research officer.

Dr O'KANE - The National Rural Health Alliance thanks the committee for the invitation to attend this committee hearing and welcomes the opportunity to speak with you today. The alliance is the peak national body for rural and remote health in Australia and it comprises 43 member organisations. It is committed to improving the health and wellbeing of 7 million people living rurally. Our vision is for healthy and sustainable rural, regional and remote communities.

The alliance's membership is diverse and geographically dispersed. This reflects the complex nature of rural health. Our members include consumer representation through the Isolated Children's and Parents' Association of Australia; the indigenous health sector, which includes NACCHO and the Australian Indigenous Doctors' Association and two other indigenous groups; professional organisations that represent medical practitioners, nurses, midwives, allied health professionals, dentists, pharmacists, optometrists and others; and service providers such as the Royal Flying Doctor Service and Royal Far West.

The alliance is a national organisation and as such is best placed to discuss overarching evidence and strategies. Other witnesses, we think, will be better placed to provide detailed commentary on circumstances or programs that are specific to Tasmania.

Based on its geography and population the entire state of Tasmania, including Hobart, is comprised of inner and outer regional, remote and very remote communities. We show in our submission that compared to major cities on the mainland of Australia, there are significant disparities in current and expected health outcomes and access for patients in Tasmania.

Compared with people in major cities, people in Tasmania have shorter lives, poorer self-rated health, higher levels of disease and injury and poorer access to and use of health services. They face a higher burden of disease from cancers and diseases of the cardiovascular, respiratory and endocrines systems, as well as concerning rates of suicide - over 50 per cent higher than the national rate.

Coinciding with the disease burden across Tasmania, the risk factors of disease and injury generally increase with remoteness within the state. These include smoking, alcohol and illicit drug use, and occupational and physical risks, such as agricultural accidents and road injuries. They also include non-medical risk factors such as lower income, education and employment pathways. Waiting times for medical treatment are generally longer in Tasmania, including emergency department waiting times compared with other parts of the country. Medicare services are less readily available, particularly as remoteness increases. The Tasmanian health workforce is less able to meet demand for services, both inside and outside the public hospital system. The state also suffers from an ageing health workforce, impacting on the long-term sustainability of the system.

These issues are persistent in that they are not improving over time. The alliance views this situation as unacceptable. We believe it is important for all levels of government to work together to address this inequity. Fundamental to these issues is a systematic problem: the Tasmanian and commonwealth governments need to collaborate more in the design, funding and management of services across the whole health system. Reducing demand for Tasmania's overcrowded hospitals requires reducing avoidable hospitalisation, which would be achieved by strengthening primary health care services by GPs, allied health providers, pharmacists and other community health professionals.

The separation of powers and funding responsibility for hospital services, primary health care and public health activities leads to gaps, duplication and fragmentation in service delivery. Joint planning and funding for health services would help to provide coordinated patient-centred care from a wide breadth of health professionals to address patients' health needs over time. The primary health networks and the Tasmanian health organisations are an excellent point of reference for this collaboration. Lessons from initiatives and models of care both within Tasmania and more broadly show how it may be possible to overcome these issues. We would be happy to discuss any of your questions in relation to our submission. Thank you.

CHAIR - Thank you. I might pick up where you left off. It relates more to the terms of reference (4) and (5) regarding staffing and planning systems. You referenced that we may have an opportunity through the THS and the primary health networks to overcome some of the issues you outlined, in terms of the challenges that we face. You also talked about joint planning and funding to focus on patient-centred care. Can you elaborate on those areas in terms of the planning systems, projections, outcomes measured and use to determine provision of community health and hospital services and perhaps some of the staffing issues in those two terms of reference?

Ms O'KANE - In some of the things in our submission we talk about how there is a need for more infrastructure, or more equipment within hospitals. Say you were talking about maternity services in rural areas, first your staffing needs to be available to do some of those things. You also need to have the necessary equipment to be able to do their job properly. Some of those things are part of what we were talking about. Even with our addendum with the mental health services -and there have been some quite good collaborations between the state-based services and the primary health network. They have been able to work together to find out where the gaps in those mental health services are, and being able to do more of that. Potentially, that's required across the board. Better links between the state-based services and GP services, and other primary health care services, would be better as well.

This is an opportunity for us, as an alliance, to talk about what we've been moving towards across the entire country. Our Rural Area Community Controlled Health Organisations, or RACCHOs, are essentially trying to broadly mimic what happens with an ACCHO, where there is some block funding. This could be pooled funding between the states and the Commonwealth to ensure there is some sort of block funding, but also being able to use MBS and the WIP payments as part of a more sustainable primary care system.

We are looking at ways in which this could be implemented, not just in Tasmania, but other parts of the country as well. There is a huge need to ensure that if we are going to have better services for rural people - and this applies in Tasmania as well - we need to have a strong primary health system. We think that needs specific funding, because we know there are thin markets in those parts of rural Australia. There needs to be an employment model.

We are also aware that many GPs are reaching retirement age in Tasmania. That happens elsewhere, but when surveys have been done, it is looking pretty clear that many of those GPs in Tasmania are looking towards potentially retiring in 10 years. We know there has been a shift. New graduates with medical degrees don't necessarily want to put up their own shingle. They don't want to run their own business, they want to be employed.

That's not everybody, of course, but we think that's why a RACCHO model, which has an employment model, would be useful to solve some of these problems as well. It needs to be well funded, and it needs the right infrastructure. We think telehealth infrastructure is probably going to be very useful for the Tasmanian system as well.

Luke, did you want to add something?

Mr SARTOR - Thanks, Gabrielle. I'd like to second that. You are probably already aware of this, but reviewing the 2019 measures of how long medical practitioners are intending to work in the National Health Workforce Data Set, Tasmania has the highest rate of medical practitioners in the country who are determining to finish within less than 10 years. Almost a quarter of the workforce is in that situation. That is their intention.

It shows that need for succession planning, for considering the future. It looks as though Health Workforce 2040 - the Tasmanian Health Service's longer-term strategy in terms of the health workforce - does recognise the staffing challenges and where there are shortages, particularly certain health professionals, allied health professionals and nursing sub-specialties. We understand there are a few different pieces of work happening within that strategy, which is currently under consideration. We hope the recommendations from this inquiry do get incorporated into that strategy.

Mr GAFFNEY - Thanks Gabrielle and Luke. You mentioned earlier that there has seemingly been no improvement in Tasmania for a number of years. In Tasmania we keep hearing how there has been increased funding into our health system, but you've said there seems to be an established pattern where there's been no great improvement.

Given you have a more global overview, are there other states in Australia where there have been observable improvements? What can Tasmania learn from some of those states in trying to get better bang for our buck, so to speak, to improve our overall health statistics?

Ms O'KANE - You've raised a really good question. From the alliance's perspective, we've estimated there's a $4 billion deficit in spending in rural, regional and remote communities, and that's because rural people are not actually drawing down on the MBS items and the PBS in the way people do in metropolitan areas. Often this is due to the fact that there actually aren't health professionals they can go to. Even though there might be more money being injected into the system more generally, when we've actually done our analysis, it's not going to rural people.

I think that's fundamentally the issue. We know that for rural people, there hasn't been that improvement in their health outcomes over time. That's why we're looking at those sorts of solutions. We're saying we need a specific program for rural people, so we have a strong primary healthcare network within those rural communities, because once we get to the acute care sector we know that people's general health, and their health outcomes overall, aren't going to be so good.

The whole way in which we fund has to be more about prevention, at least at a secondary prevention sort of level, and that's where primary health care services need to be strong, to stop that entry into the hospital services. We know that in Tasmania there are problems in the health service itself, with waiting times in EDs and so on. We need to improve on that at the prevention end and the primary care end - so that's where the injection of money needs to go.

I never want to say you have to shift money out of the acute care sector and put it into the primary care sector, but there has to be some level of switch in the way people think about the importance of those things.

I hope that answers your question?

Mr GAFFNEY - That was very helpful. Thank you.

CHAIR - Following up on the workforce planning and the funding, it's all tied together a bit. Gabrielle, you talked a bit about workforce planning, for Tasmania's GPs particularly, but I'm sure we need to have workforce planning across all allied health. Have we done enough workforce planning work to understand the demographic of the workforce, not just GPs, but broadly across rural health? And if we do need more, what do we need to know before we can actually take real targeted action?

Ms O'KANE - Thank you, Ruth. I think you raised a really good question. There has been some workforce planning in the medical space, but that hasn't been released yet at the national level; it will be released about January next year.

For the other professions, across the board, there hasn't been a huge amount of workforce planning going on, and allied health and nursing professionals are certainly looking for that sort of workforce planning.

Some of the issues that come up with the allied health space is the groups that are registered and those that are self-regulating allied health professionals. There is so little data on those self-regulating groups: the social workers, the speech pathologists, the dieticians and several others. There's very little workforce planning in all of that. Do you act on anything now or do you wait until all of that happens? My view is that you start doing things now. You can push toward making sure that planning happens. You can make some improvements in that area for Tasmania.

At the same time, we know, rurally, it wouldn't matter where you went, you'd be pretty certain that you don't have the workforce that you need. The Primary Health Networks are very good in having some needs assessment about what the communities need. With that, we are fairly certain you'd be able to identify the health professionals that need to be in place to address some of those issues. I think they have to be done in tandem.

Where Tasmania is probably worse off than other states and territories is your training programs and having sufficient training programs for all your health professionals within your state. What often happens, having taught in a couple of different nutrition and dietetics programs within universities on the mainland, is that we used to get quite a few students who had come from their undergraduate training at the University of Tasmania and then they do their postgraduate training on the mainland and they stay. They're not necessarily going back. That's an issue for Tasmania, more specifically.

I know you have a rural health, is it a UDRH, a university department of rural health, that Judy Walker is director of? You do have that, which I think is a great resource, but I know that in many of your nursing areas there's not the sort of training that needs to be there. Like nurse practitioners, for example.

CHAIR - As you've said in your submission, there are very limited pathways in Tasmania to go on the nurse practitioner path. A lot of our allied health professionals can't do their undergraduate degree in Tasmania, so they leave the state for that.

A body of work needs to be done on workforce planning issues, particularly in allied health and potentially nursing, to a degree. Did I hear you correctly, that you think the primary health network would be the body to do that body of work?

Dr O'KANE - Oh, no, they tend to do more of the work around looking at needs assessments for communities, looking at what the health issues are and where there are gaps in services but they don't tend to do the workforce planning. The Commonwealth does a lot of that workforce planning. Luke, would you know how much workforce planning happens within state jurisdictions? I'm imagining there is planning at that level.

Mr SARTOR - I can say, it's more of a broader comment, it's the question, do you wait until you have the information and then act; or do you begin to act and gather information while you're in the process of implementing a solution?

Four local council groups have submitted submissions for this inquiry. There is strong momentum at the local level to implement solutions to the workforce challenges they face individually within the councils. It needs to be a multi-pronged solution that involves not just one primary stakeholder group such as the PHN but also local governments and the state government to help drive the change. The proposal for the rural area community control health organisations is one solution, to have that level of organisation integrating the different bodies within the health system in Tasmania and more broadly within other states to try to tackle these workforce shortages. I understand that within Health Workforce 2040 there is a lot of work in regard to planning and projections for the workforce. It is promising.

Tasmania has an advantage in being a relatively small state with more than half a million people and it can work with some of the administrative efficiencies and coordination that go with being a smaller state and having fewer of the local health networks and only a single PHN. So, that's just some comments in regard to some of the advantages that are there for Tasmania.

CHAIR - Thanks. Bastian, did you have something?

Dr SEIDEL -Yes, thank you. That's under term of reference (5). Thank you for making yourself available today. You are the peak national body. You represent over 40 rural health and medical groups. So, you are ideally suited to compare what works in one state against what may or may not work in other states.

I have two specific questions. The first one is in your submission on page 11 you talk about medical training and the RHMT program, that's the Rural Health Multidisciplinary Training program. You said that UTAS is doing that specifically in the north west of Tasmania and the evaluation was published nationally, I think, earlier this year.

It's quite a long-established program now. What's your experience of how the Tasmanian program compares to other states, understanding that we probably still don't have the workforce in the north west of Tasmania specifically that we would hope to have at this stage. What do you think worked for Tasmania and what didn't work for this particular program?

Ms O'KANE - Luke, I think I might have to ask you. Do you think you can answer that question? It's specific to the rural -

Mr SARTOR - I'll have to hold off from making any further comments than what's in the submission. The question is a really good one. Unfortunately, I'm unable to provide any comments. I can post hearing, if that's possible?

Dr SEIDEL -I would welcome that because you mentioned it in your submissions.

CHAIR - Our secretary will send you a further question, if you can provide further detail following the hearing. Thanks, Bastian.

Dr SEIDEL -Another concern is that of rural generalism, which originally was rural generalist doctors but it's now much broader. We talk about rural generalist nurses and midwives and rural generalist allied health practitioners. Could you explain what that entails and how rural generalism, for example, works in states such as Queensland and how that would compare to where we are in Tasmania?

Ms O'KANE - Well, rural generalism started in Queensland. It was a state government initiative to get the rural generalist pathway for medicos up and running. With rural generalism, there's an opportunity for GPs to have two sub-specialties. That's what a lot of that work is all about. I can see that in Queensland it seems to be working quite well. We're very supportive of that and the National Rural Health Commissioner, Ruth Stewart, is very supportive of the rural generalist pathway because it enables people to get the necessary experience and training to cover all the generalist things that people working in rural areas need to be able to undertake. Regarding the allied health generalist pathway, there is a component of academic work that's linked to people's day-to-day work. It is trying to build their capability, and their ability to work in a generalist fashion, but it is also about having mentoring arrangements with more senior allied health professionals in their rural areas. All of these things are really designed for peer support, and there is real benefit in doing that. I think it has some real strengths, particularly for retention of people into rural areas.

For nursing, the medical workforce and allied health, people need to be professionally supported, no matter where they work - and in rural places that can be very isolating. So, these are the strengths of the generalist pathway. It supports people to get a better understanding of what it means to work in rural areas, certainly giving the doctors scope in those two different subspecialties. It makes a huge difference to those rural communities to have someone who may have obs and gynae, or may be an anaesthetist, as part of that rural generalist pathway.

Because it started earlier in Queensland, I think that is where it is strongest at the moment, but these things have been rolled out in other parts of the country, and I can see some real applications of it being useful in Tasmania as well.

I am not aware of the extent of that rural generalism in Tasmania, or how many people are actually part of a rural generalist program at the moment. One of our members, Services for Rural and Remote Allied Health, are rolling this out more broadly. I think they are offering up to 90 places, 30 of those being in Aboriginal Community Controlled Health Organisations. Whether there has been an uptake in Tasmania, I do not know.

Dr SEIDEL - In Queensland, are rural generalists employed by the state, or is it an industrial award for rural generalists? Is that working for them? What is your experience there? You mentioned earlier that the MBS and PBS are a bit of a problem in rural areas, but if you are employed by the state, that would make things easier to a certain extent, because you are an employed practitioner who can work without constantly looking at MBS items, I would assume?

Ms O'KANE - Yes. It is interesting how the set-up in Queensland is quite different to the set-up in New South Wales. It has been an interesting observation. The way some of it has been explained to me, in Queensland the rural generalist is employed by the state government, and they do both hospital services in a small rural hospital, as well as GP services. The 19(2) exemption also applies there. In my understanding, that is working quite well; I think it is still undergoing evaluation.

From what I understand, in Queensland there tends to be more of an emphasis on working within the hospital and doing some GP work. In New South Wales, with the 19(2) exemption, the GP works generally tends to work in their GP practice, but then has VMO rights within the

small rural hospital. It tends to work in a slightly different way in those kinds of environments. It could even be different in other parts of the country as well.

So, the way the 19(2) exemption works can be a bit different and a bit flexible. In some places, I believe, the GP gets a portion of the MBS item - MBS money - whereas in Queensland I think all of that money goes back to the state government. I am not a complete expert on all of this, but that is my understanding of how some of it operates.

Luke, are you able to add anything to that?

Mr SARTOR - Queensland is an example where the state government is employing quite a lot of primary healthcare professionals. They have several state-run community clinics - also called primary healthcare centres - as well as community multipurpose centres or multipurpose services, and those hybrid-type models where they're more primary healthcare or prevention focused. Acute care may also be performed in these centres, but more primarily in the community hospitals.

It would appear there are some benefits to the state health system in having the burden of avoidable hospitalisations addressed as early as possible. Being able to employ health professionals within these primary health areas is one of those ways.

CHAIR - I am interested in the funding models that support those community clinics, the primary health centres. How are they funded? Are they different for different jurisdictions - and if you had a preferred model, what would that be?

Ms O'KANE - They do seem to vary. That is my understanding but, as I say, I'm not an expert. We are learning more about how some of this funding operates as we talk more to the Commonwealth Department of Health, but we do get the sense that things vary across the country to some degree.

In rural areas - and this is where we go back to our RACCHO model about the way we fund some of these things - we would like to see some sort of funding arrangement between states or territories and the Commonwealth, whether it be pool or block funding.

It could actually be the employer of a GP, in the same way that ACCHO employs GPs through their ACCHO system, but they also draw down on the MBS items and use WIP payments. However, they also have block funding, and that's what helps to support a more sustainable system, and the wraparound care they're able to give through other allied health professionals - their Aboriginal health workers, drug and alcohol workers, mental health workers. All of that is supported through a block funding mechanism.

So, whether it's state and territory money alongside Commonwealth money, it's about collaborating and making sure everybody has a vested interest in ensuring that the primary healthcare needs of communities are met effectively.

Returning to some of Luke's comments about the LGAs in Tasmania, I was recently at a meeting in Queenstown that was brought together by the National Rural Health Commissioner and the Chief Allied Health Officer for the Commonwealth, Anne-marie Boxall, to talk about allied health. Certainly, local governments are interested in looking into their role of primary healthcare and preventive health, which is really encouraging.

Mr SARTOR - I'll just make another comment on funding. Under the National Health Reform Agreement, a number of small rural hospitals are primarily block funded, as opposed to activity-based funding, which is a model we support where there is an inability to sustain small community hospitals and small primary health clinics purely based on activity, based on number of services, the MBS model or the ABF model in the hospitals. Often it is difficult to sustain these practices with all these hospitals using service volume as their means.

CHAIR - Just before you finish, in the submission and in your recommendation you talked about investment and infrastructure. When you talk about infrastructure could you define more clearly what you are talking about? There is a whole range of matters that this could be, so I am interested in what specifically is your view?

Ms O'KANE - I will go back to some of my opening remarks, and it is about making sure that there is sufficient equipment available. The bricks and mortar in Tasmania are probably there to run good health care services, but do they have the equipment - the IT equipment, the things needed to do procedural work in some of the smallest hospitals, to be able to deliver babies, that sort of infrastructure or equipment that might be necessary, as well as equipment to do reasonable telehealth services? I want to be clear that we do not think that telehealth is the answer to rural people's health needs, we see it as an adjunct and something that is useful. We need to make sure that the connectivity is available and that there's digital health literacy, but you must have decent equipment to do those things.

Luke could you add anything to my comment?

Mr SARTOR - Yes. There is the infrastructure to support procedural work in rural areas, as well as the telehealth-related infrastructure. Infrastructure is also hospital beds and facilities. It is noticeable that Tasmanian's two main hospitals - Launceston and Hobart - have very poor statistics in terms of wait times and access blocks, ambulance ramping. That primary finger-pointing is about the number of beds available to ship patients into the hospital. Infrastructure also encompasses the hospital system in Tasmania as well as the primary care and community infrastructure.

CHAIR - Regarding mental health, which is mostly covered in your addendum, Gabrielle, you made the comment in your opening statement that Tasmania also has concerning rates of suicide. Suicide is only one aspect of mental health, but obviously a very tragic one. In terms of the concerning increase in demand in this area, what do you think are the most appropriate or effective measures to address this growing issue?

Ms O'KANE - I have been in the mental health workforce taskforce group within the Commonwealth looking at this issue. There are a whole range of things that are a problem. The lack of psychiatrists in rural areas is a major one. What might be useful in rural areas is making more use of a peer workforce. This came through strongly in the development of the draft strategy for mental health across the country. In rural areas where educational levels aren't so good, people getting mental health training through the vocational training sector is something that could be done. I think more training for mental health work workers is also useful.

Something raised through the workforce taskforce around mental health was making mental health an attractive option in people's interests and areas of speciality. Part of the

problem with that is the payments. People working in mental health don't always get paid particularly well. That's one of the issues that needs to be addressed. In rural areas, we could train some of the nurses that are currently available in mental health issues, making sure that all nurses, allied health professionals, are working to their full scope of practice and that they get invited and involved in mental health issues.

MBS items are quite good in the mental health space, particularly for the psychologists, social workers and OTs. That's useful. The issue for Tasmania is, do you have those trained professionals, sufficient numbers of them to be able to do that work? There are a number of things that need addressing in that space.

Mr SARTOR - I understand we are running short of time. I recognise that yesterday it was announced that a mental health peer workforce coordinator was appointed, jointly funded by the Tasmanian Department of Health and Primary Health Tasmania. That's where the collaboration of investment can be towards bringing together workforce solutions to integrate the mental health services in a more coordinated fashion. I wanted to highlight that as another solution that's being implemented. It is something we support. More broadly there is a national rural and remote mental health strategy being developed that we're aware of. That's something that is in the works as a priority in terms of developing solutions over the longer term.

Ms O'KANE - I should add before we finish that paramedics are in many parts of rural Australia more available than many of the other health professions. Many of them are keen to work in the primary health space and they could have a role in addressing some of the mental health issues if they were employed through the state system. Through community health, for example.

CHAIR - Okay. In closing because we have run out of time, if you were the Health minister what are the priorities in dealing with the challenges we face? What would be the key areas of priority to address the challenge we face in rural health generally in access and in removing barriers and getting better outcomes for people living in those areas?

Ms O'KANE - Well, there's no doubt that we need a skilled workforce and we need access. A lot of the mechanisms of trying to attract more people into rural areas are good and strong. Things like the generalist pathways that we've been talking about are useful. The rural health multidisciplinary training program is helpful.

There's the one-employer model in the Murrumbidgee area that is employing GP registrars, but sometimes what I see and we see in the alliance is the missing link in all of this. Once you're through your GP training, as we've been talking about with the Murrumbidgee one-employer model, what then helps you get integrated into the local workforce?

This is where I think we do need some sort of employment model, a bit along the lines of the ACCHO model, where we have dedicated funding. We argue that we have this $4 billion deficit being spent in rural Australia at the moment. Why can't rural Australians be given the opportunity to get better access to healthcare? Why can't we have a bucket of money that sits with rural health, and have a specific funding model program that enables us to then have team-based, localised care?

We do always say that we can't say that every rural community is the same. It very much needs to be locally driven, and it needs to address the specific problems of those smaller areas.

We think these ACCHO models would be very well placed to start in MMM4 or MMM5 to start with, and employ doctors, nurses, allied health professionals in those places, because there are thin markets, and we can't expect that people are going to go from metro into rural unless there's a job to go to.

After we've done all of this training - people go through all sorts of rural options, practising during their training in rural areas, but in their first and second year postgrad, the medicos often go back into the cities, into metro. In fact, we're told by the department that 90 per cent of the first and second-year postgrads are back in metro areas. So, they've already done some training in rural, they get whipped back into metro areas, they partner up, they don't want to move.

We have to actually do more of that training and rural stays, and then we employ them through another system, other than expecting people to do it all in private practice. That's what I would do if I was the health minister.

CHAIR - Excellent. Thank you very much for your time. We appreciate your submission and your contribution today. I hope things improve where you are, that you can get out and about soon. We're a bit lucky here but we'll see how long that lasts. Thank you very much.

Ms O'KANE - We've been very lucky ourselves here in Canberra, but finally we've succumbed. Thank you very much for your time as well, and thanks for the opportunity.

CHAIR - Thank you.

Mr SARTOR - Thank you very much.

THE WITNESSES WITHDREW.

CHAIR - Thank you both for coming. By way of introduction the committee members are Sara Lovell, Bastian Seidel, myself Ruth Forrest, Nick Duigan, and Mike Gaffney. This hearing is being broadcast. It is also being recorded and transcribed in *Hansard*. Anything you say here before the committee today will be protected by parliamentary privilege. If you speak outside the meeting it does not necessarily apply. All the evidence is public, the media is probably watching the stream. We will ask you to take a statutory declaration, but I ask if you read the information provided for witnesses for the committee? If you have any questions before we start, I am happy to address those. No? Okay. Could you both take the statutory declaration?

Ms MINKE HOEKSTRA AND Mr MYLES CLARKSON-FLETCHER WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Thank you. If there was evidence you wanted to provide to the committee of a confidential nature you can make that request to the committee and we would consider it. Otherwise it is all public. It will be transcribed and published on our website and inform our report at a later time. We have your submission, thank you, and invite you to speak on that submission. Members will have questions for you from that. We ask when you address particular matters, if it is not clear which term of reference you are talking to could you indicate that? There may be some you don't want to comment on and that's fine.

Ms HOEKSTRA - Thank you for the opportunity to talk. Diabetes Tasmania is a charity and our purpose is to work with the community to prevent and reduce the impact of diabetes. We are in a position to talk about some of the challenges faced by some rural and remote Tasmanians in our service delivery. We know about the demographics of rural and remote Tasmanians in that they are twice as likely to be admitted to hospital or die because of their diabetes. Their diabetes rates are higher, their risk factor rates are much higher than their city counterparts. As a state-based organisation we are funded to provide clinical services state-wide. We have been able to do that over the last three years more effectively for people in rural and remote areas because of some changes we have made to our internal structure - the way we receive referrals and look after people.

Access is one of the big barriers that has come up for people living out of the main centres. Myles can talk a little bit more about that. One of the things we have done over the past few years is to change the way people can access our clinical services, their face-to-face or one-on-one appointments with diabetes educators and dieticians rather than relying on GP referrals. We know there are towns without a regular GP, locums or no GP at all, so people can now self-refer, allied health professionals can refer, GPs can refer and we now triage the referrals to provide the best care for the patient. Myles can talk more about that.

We also hear past speakers talking about the importance of a multidisciplinary team. That is something we have tried to provide more by appointing both a social worker and a nurse practitioner to our clinical services. This provides more of that holistic care that people, especially in remote and rural communities, can't access because of lack of specialists or waiting times. We also have our telephone health coaching program, the COACH Program, which is one way we have been very effectively able to support people at risk of diabetes throughout Tasmania. We have just been promised ongoing funding for two new streams of that program for heart health and women who have had gestational diabetes. That will help us to bring people into a multi-disciplinary type of care that’s delivered by telephone, so it’s far more accessible.

CHAIR - Is that during the pregnancy for the women with gestational diabetes or following or both?

Ms HOEKSTRA - It was initially designed for post-pregnancy but we do get a small number of referrals for pregnant women as well. That’s because of the difficulty for pregnant women to access dieticians in hospital in a timely way.

CHAIR - Why only some women with gestational diabetes?

Ms HOEKSTRA - They're all offered the option to join. It's often women from non-English speaking backgrounds that we're getting now, the pregnant mums who just need the extra support the hospitals can't provide. They're coming to the COACH Program because the COACH Program is staffed by dieticians. Myles, do you want to talk about our clinical services?

Mr CLARKSON-FLETCHER - Yes, thank you. The main point of our submission is to highlight how our organisation is an example of tackling not only the barriers but even our availability of services across the state. Diabetes, we know, is about self-management. Ideally, we're teaching people how to look after their diabetes; it's a chronic illness.

How people access that education, how they access that support is really tricky in rural communities. We have three main hospital centres that provide specialist care. The GDMs is an example of that care not always being accessible for everyone, either geographically as they can't come in and attend appointments all the time or the pressure that is on the hospital system itself.

Our model of care and what we're developing is aimed at trying to overcome some of those barriers for rural communities by providing access to dieticians, diabetes educators, the specialist health services, as well a nurse practitioner, which has proven in a very short period of time to be very effective. We have a social worker that underpins our team environment.

What we've identified and what international guidance would highlight is the need for psychosocial care. It's all very well for us to ask someone to look after their diabetes but if they are facing other pressures, other priorities in their lives, it's very difficult to make those changes or to commit to self-management. Diabetes has never been able to be managed by one person alone or via a GP on their own, they need that specialist support.

One of the problems is you can't continue to supply the number of diabetes educators across the state considering the growth of diabetes in the state. We have one of the higher rates of diabetes, we have one of the highest rates of insulin use per capita. With diabetes we talk about the 5.4 per cent prevalence but it is very age related. Some of the work we've done in aged care has shown that within residential aged-care facilities it's almost 25 per cent. But we're looking at 40 per cent of people in their 70s and 80s. That's a huge number and it's not just the numbers, it's the complexity of care that becomes the challenge.

Access, as Minke was highlighting, is one of the issues to specialist care. What happens in primary care, in rural areas especially, because of the lack of access to specialist care, there is a burden on GPs, for example, to start someone on insulin. It is not a very easy medication to start because it doesn't just take one appointment. You have to teach someone how to use the device, you have to teach them how to monitor, you have to teach them how to stay safe. Then you need to adjust that dose. No insulin dose should stay the same over time.

So how do you implement that? How is it funded, through MBS? We need to see access to diabetes educators. Telehealth with videoconferencing is one thing we've introduced, resources to support practice nurses, to support GBEs, so we can work in an integrated team care environment across the state.

CHAIR - Can you tell us more about what diabetes educators' training requirements are, who they are, how they're trained, where they're trained, and why there's a problem?

Mr CLARKSON-FLETCHER - Yes. We're a mystery. Diabetes educators are essentially specialists in diabetes care. They are predominantly from a nursing background but you don't have to be a nurse to be a diabetes educator. You have to have a qualification - a postgraduate qualification in diabetes education. So pharmacists and allied health can do it. There is a national body that oversees the credentialing, which is the Australian Diabetes Educators Association (ADEA). We can be credentialled. That is not universal, I don't think they have it in the UK, for example. We come under a professional body that directs our professional development requirements and ongoing credentialing.

The jobs we do are varied but essentially our job is to support people self-manage their diabetes, teach people from kids with type 1 diabetes and parents, right through to elderly people with type 2.

CHAIR - So, where's the training done and how long does it take?

Mr CLARKSON-FLETCHER - You have to have a primary qualification in health care. It's a one-year postgraduate course. To become credentialled you need to do 1000 hours of practice and go through a six-month mentoring program.

CHAIR - And who runs the training program?

Mr CLARKSON-FLETCHER - The universities provide accredited training programs, but not in Tasmania.

CHAIR - So, it's not available in Tasmania?

Mr CLARKSON-FLETCHER - No. I think Deakin University is the most popular. There's one at Curtin University. There are a couple of the universities on the mainland that offer that course and it is recognised by the ADEA. You can also do that course remotely. So there are educators and nurses currently doing the course within the state.

Ms LOVELL - Myles, you were talking about - and Minke you mentioned in your introduction - that in Tasmania people with diabetes are twice as likely to be hospitalised. Is that right?

Mr HOEKSTRA - I think that's actually from the Australian Institute of Health and Welfare wellbeing report, so it's across Australia. People with diabetes in rural, remote areas are twice as likely to be either admitted to hospital or to die from diabetes.

Ms LOVELL - So, it's not specific to Tasmania?

Mr HOEKSTRA - I don't think so.

Ms LOVELL - Do you have any information on the statistics for Tasmania compared to other parts of the country?

Mr HOEKSTRA - No…

Mr CLARKSON-FLETCHER - The hospitalisation rates?

Mr HOEKSTRA - I'm not sure.

Mr CLARKSON-FLETCHER - One of the other things we do is administer the NDSS, so that when people are diagnosed with diabetes they are registered on the national register. Those numbers are underrepresented because not every person is registered. We know that the prevalence is higher in rural and remote Tasmania. Type 2 diabetes specifically generally follows your social determinants of health in any country. So it is very much overrepresented in our poorer communities and our remote communities. Those communities in Tasmania happen to be older as well, so you have that exacerbation of that prevalence.

Mr HOEKSTRA - And we know that hospital admissions and deaths from heart disease are higher in the rural, remote and older populations and many people with diabetes end up being hospitalised for heart disease.

Ms LOVELL - Okay. Thank you.

CHAIR - I think you mentioned, Myles, a moment ago about telehealth being used by the diabetes educators. Then you talk about this being an issue more prevalent in our older community and in aged-care facilities. Some of those are also in rural areas. Digital literacy and access to decent internet speeds are obviously issues for a lot of these people. How are you overcoming that?

Mr CLARKSON-FLETCHER - If I may, I'll give you a quick history of what we did. The first thing we introduced back in 2019 was a triage system. One of the issues around access is relying on GP referrals and asking GPs to then decide what service the person would need. We introduced a triage system, so any referral comes through to us and that health professional in the triage team will phone the person with diabetes and talk through what they might need. It's taking the time to meet the person over the phone and decide what service will best suit them. Telephone was the first step. The second thing was when COVID hit we very quickly were able to transition to a telehealth-based care out of necessity. Traditionally what we would do was send a dietician or diabetes educator out to rural clinics every four or six weeks. That means you can only access our services in a very limited window of time. It also meant we had to allow for drive time, travel time, so it limited the number of people you can see. Telehealth has opened up not only how flexible you can be, you can see an educator anywhere in the state and our wait-times have gone from nine weeks to now seeing someone within two to three weeks. That has improved our access, it also means our failure to attend rates have dropped because people can conveniently access through telehealth, and we are able to see more people within a day, because we have reduced the travel time.

But, what you highlighted is exactly the problem we have. We recently did a group education session in Bruny island, not one of the people had an email address nor access to the internet. We still have to provide face-to-face clinics and that is something we continue to do. What we are able to do better now is, rather than sending our technicians in at set dates, we are able to put people into a waitlist for a face-to-face visit, and we actually get better attendance rates by then lining up that clinic according to need. We can target our face- to- face care according to need. The issue is not just the technology issue; there are people, especially old

people, whose hearing ability excludes them from using the new technology, so we are very mindful of that.

I think, the other important member of our team is our engagement team. So, we have people, representatives in the state who go out and meet with GP clinics, pharmacies and community groups to discuss these issues. We are aware we have presence in the community even though we are not always sending clinicians out as we used to do.

Dr SEIDEL - You use some strong language in your submission, you know, the future looks dire, our system over-relies upon GPs and hospitals, the theatres are swamped and waiting lists are too long, you know some of the strong words you are using. But you actually are right, despite the best efforts, nothing really has changed that much. I think we know what the problem really is, and the solutions actually are there. It almost sounds like either some kind of implementation failure, or funding issues going on. But I want to go back again to the need for face-to-face educators in rural communities because often you need to see the pain, you need to see how the patients can actually show their pains, can actually see what they are meant to be seeing, you know. I would imagine it is quite hard to do this via telehealth.

Mr CLARKSON-FLETCHER - Not necessarily, so there are two things. One, Diabetes Tasmania is the only state-based organisation NGO in the country that provides clinical services. That is just unique, because of the funding through Primary Health Tasmania. The other is that we are also the only state-based organisation that has a program of developing staff and workforce. We bring in, we run an internship, basically. One of the challenges of diabetes educators that you can get the qualification, but you are basically in a chicken-and-egg situation. How do you get your hours if you do not get a job as a diabetes educator? How do you get a job in diabetes education if you have not yet got your hours?

So, there are a lot of people who go and work for free to get their time in hospitals on the mainland, where the people just volunteering can get their hours up. We offer a program where we bring in recently qualified educators and train them. We currently have two completing that program. The reality on the ground though, is that we will never have enough diabetes educators to sit in every corner of Tasmania, and part of our job is to actually encourage nurse practitioners working in that area. I think it always is going to be an integrated approach. If I am going to teach someone, we can supply resources, and ideally, we would aim for a video appointment with a practice nurse, the GP and the patient, and anyone else who wants to be involved. It depends very much on the person's literacy and their willingness. I mean starting is always a bit of a tricky one. But I think the reality is that we need to partner with, we need to encourage that sort of combined approach to practice nurses, with GP clinics, with pharmacists. So, there is a multidisciplinary angle that we need to tackle.

Dr SEIDEL - So, the problem there is funding again? It is not that you do that combined GP practices and also MBS numbers for diabetes educators but again, it's only five as part of the quality of this management plan. So, you use three for your diabetes educators, you only have two left you know, for the dietician also. Can you see a role for co-sponsoring or funding from the THS, from the state government to actually ensure those services can be delivered by, for example, an allied health generalist who is the nurse practitioner, diabetes educator - may have other qualifications as well - knowing that the main cost potentially is this patient ending up in the hospital system with poorly controlled diabetes and organ damage?

Mr CLARKSON-FLETCHER - Yes. In a word, yes. I mean, it's like anything, if you just reverse the funding, if you said, "Well, how much money are you going to spend on this person in a hospital bed or in an ambulance, versus how much are you going to then spend paying for that health service and primary care?" Obviously, we're very much in favour of upstream and funding upstream. One of the challenges is working with the hospital service. They provide the care to the specialist, to the more complex patient, type one, pregnancy and complex type twos. For them to come up for air and actually provide service, even just in Glenorchy for example, from the Royal, having more community-based rather than centralising it all in hospital. I think there are some small steps that could be taken to fund, to de-centralise some of the hospital service and then to look at how you'd partner up our specialist service, for example, with practices.

Mr HOEKSTRA - I know you've mentioned before navigating the health systems, having better embedded in the streamlines referral pathways, both to prevent hospital admissions and out of the hospital, with community organisations like ours. We know that both in our diabetes clinics and also in the coach program, we're getting far more complex patients coming through who really should be seen by someone who's sort of intermediate between the hospital and us. They're not your plain lifestyle modification, they have multiple comorbidities, but there's a gap. There's nothing in between. They're lucky if they land with us because we can do something to refer them back. Many fall through, so it's about clear pathways: both to prevent hospital admissions, and then post-discharge back to a community organisation like us, which is then ideally funded to deal with those more complex patients as well as the regular patients.

Dr SEIDEL -You mentioned this in your submission. You say your referral pathways have been available and have been available for years, but obviously are poorly defined. And then you say patients often have no idea how to navigate the health system to receive the care they need. So, some money's being invested in developing those pathways and then they still don't meet the need of the patients, and patients don't know what to do next.

Mr HOEKSTRA - For example, we were working with a PhD to review the diabetes health pathways, which is fantastic. We're identifying opportunities for us to better link, to get patients referred to us at multiple stages for newly diagnosed, ongoing, starting insulin, whatever we can do to refer them to us, but there's no equivalent pathway for people with diabetes. There's nothing they can refer to other than their local GP to say, "What happens, I've been diagnosed with diabetes. What happens?" Rhere's the annual cycle of care. A comprehensive GP will tell them all of those things, but not everybody does. If people don't have the health literacy to look up reputable websites or to even take the initiative to contact us and find out, they can fall through. We've had referrals come through, for example, we coach patients who are then so complex that we'll ask the social worker to help them. The social worker spends so much of their time sending off referrals and then having to chase up, "Did you get the referral?" "No, I don't know where it went." "Okay." Follow it up again. Follow it up again. And linking back to the patient. So, there are gaps everywhere in terms of both the sharing of referrals and patient information, and also the navigation - how to navigate that. Especially for the individual.

CHAIR - Why do you think this is not - clearly, someone who sends a referral or whatever it is, if it's a GP sending a referral or a nurse practitioner or a specialist sending someone to someone else, you expect that it's received and actioned, and you don't expect to

spend half your life following up. So, what's the problem here? How is this happening, do we know?

Ms HOEKSTRA - I don't know, no. It's not across the board, but definitely for some organisations it's almost like the procedures and policies aren't in place to send back an automatic receipt of referral, a procedure to action it. That's my experience from what the social worker said.

CHAIR - Can we name some of these, so we know where we're looking?

Mr CLARKSON-FLETCHER - There are two things. What our social worker has done is highlighted that there's fragmented care. For some person living in the north-west vs the north, what are the services available? That local knowledge isn't always available to everyone. In a system like Tasmania, there's probably an over-reliance on personality-driven care; some people who've been there for long enough who know. It's relationship-based care rather than using a pathway.

CHAIR - So it falls down with the use of locums, for example?

Mr CLARKSON-FLETCHER - Exactly. So, there's that issue. There's the issue of their being inundated. We referred someone recently to the hospital team for follow-up, but that referral sat there for a week and we had to chase it up. That's simply because their waitlists are so long, their acting on getting someone to see them.

We know there's a specialist, a nurse practitioner, who does a Tuesday morning clinic. That's an emergency clinic that has spaces that are specifically designed for hospital prevention. We know that. I don't know if GPs always know that. Whenever we talk to GPs about these complex patients, we highlight the fact that there is a way in to the specialist diabetes centres for people who need to be seen very soon. That's through the nurse practitioners within those services who do offer a clinic rather than waiting for an endocrinologist's review.

It's linking it all up. It is the health professionals actually knowing what's out there. Our social workers spend a lot of time educating us about what is and isn't available across the state. That's been a huge benefit for us, and we didn't know what we didn't know.

CHAIR - No-one does.

Mr CLARKSON-FLETCHER - No. The answer, in a sense, is what the health professionals don't know, that these things exist.

CHAIR - How do you fix this? It's clearly a major problem.

Mr CLARKSON-FLETCHER - Our approach is through our communications, through our engagement team, through our communication through our clinicians back through to GPs. That's obviously not a lasting solution. I'm not too sure. It needs to be centralised -

CHAIR - Whose responsibility is it, then, to fix it?

Ms HOEKSTRA - Speaking from the perspective of the COACH Program, there are lots of worthwhile, especially smaller, community-led initiatives that come up, be it Strength

to Strength exercise classes and that sort of thing. To keep track of them, and they disappear after a period of funding, is really, really hard. Our COACH Program for people with or at risk of diabetes has been running for 11 years. A few years ago we did a GP survey to see how many GPs knew about the program and it was at 50 percent. It takes a long time to establish the knowledge of particular services. Reliability of funding and longer-term funding for the right programs helps to create awareness and embed those programs into the health pathways.

CHAIR - So, surety of funding means that things don't disappear overnight.

Ms HOEKSTRA - Yes.

Dr SEIDEL - Going back to the nurse practitioner clinic, is that a clinic that is just then face-to-face onsite in Hobart? If that's the case, how accessible do you think that is for people who live in Southport, or -

Mr CLARKSON-FLETCHER - No. So, it was opportunistic for us to get a nurse practitioner. It was one of our educators who qualified. We had some funding available through PHT. We ran it as a pilot and she is based in Launceston. So she does see some people face-to-face but a lot of the stuff she does is telehealth. Our triage process is really - she only does two days a week, so it's not a huge volume, but it takes some of the pointy end, the really tricky patients, the people we know where there's clinical inertia, which is that failure to intensify treatment as it's needed. We see a lot of people with A1Cs that are very high. She is able to do that assessment, do medication changes, start insulin or other injectibles -

CHAIR - And monitor the insulin?

Mr CLARKSON-FLETCHER - And monitor - because it's funded. It's mostly telehealth. We set it up as time-limited, so hopefully after three months she then goes back to the GP. So it is those intensive care moments that are needed, that is ideal.

When we looked at her clinic, it wasn't huge numbers but we saw the average A1C of people coming in was around 9 per cent and it was a 1.5 per cent drop within three months of those who shared seeing. It is a very effective way of dealing with clinical inertia and especially in high locum area GPs where we have that ongoing. People are just circulating out there.

Dr SEIDEL - That is the problem you find with PHG support. It is not a state -

Mr CLARKSON-FLETCHER - It is not a state -

Dr SEIDEL - You mentioned you are trying to get a patient in urgently and that referral was -

Mr CLARKSON-FLETCHER - We have relationships with the tertiary centres and they have MPs and those MPs are access points. It is not always appropriate for us, or we might not be able to get our nurse practitioner to see someone. Our relationship - and this is the referral pathway again back into the tertiary centres - while we know we can get people in on a Tuesday morning, for example, it is knowing the person and informing them. That needs to be formalised and that needs to be made. We know the THS are involved in the health pathways and they are very much seeking clarity for GPs and who do I refer, how do I refer, when do I refer and to whom? There is us. There are the tertiary centres.

If we were all linked up with formal pathways then it almost wouldn't matter if you got it through to us, then we would refer back in if it wasn't appropriate. We triage at that point of contact which makes it easier as well.

The other unsaid thing under all of this is: whose responsibility is it? One of the things that is going to help, and I think the THS is very aware of this, is IT system support. That is the elephant in the room. The current DMR and the hospital system, access to timely histories and care, into and out of hospital, is an ongoing challenge.

CHAIR - Do you have challenges associated with accessing discharge summaries or even outpatient records that are relevant to the care of the person?

Mr CLARKSON-FLETCHER - It is not a huge problem for us because we mostly receive referrals from GP clinics. I have previously worked in the THS and I am aware of those gaps. Even with another project on ambulance attendances for diabetes highlighted the fact that people might be attended to by a paramedic at their home and left at their home after a severe low. There is no formal referral back to the GP or anyone knowing about that. That is currently being sorted out by Ambulance Tas through a pilot program.

CHAIR - That pilot program is funded by Ambulance Tas?

Mr CLARKSON-FLETCHER - No, that was something I was previously involved in. It was funded through a grant.

CHAIR - To clarify, if a paramedic attends a patient at home who has had a hypoglycemic attack episode -

Mr CLARKSON-FLETCHER - And they are safe to leave?

CHAIR - They haven't transported them, there is no follow up to either Diabetes Tasmania or to anyone?

Mr CLARKSON-FLETCHER - No one, or to the GP. There is a disincentive for these people to refer to their GP because there is a chance you might lose your licence for a while. The biggest risk of having another hypo. I am mentioning this as only a highlight that there are gaps in referrals; there are gaps in services and the solutions to them probably aren't too tricky. But just saying, okay, let's get a referral from an ambulance driver in rural Tasmania, how is that going to happen? That is currently being looked at, as I said. These are issues.

CHAIR - Just go back to the patient that had the hypo, would their GP even know?

Mr CLARKSON-FLETCHER - Not unless the patient told them. Similarly, if they were transported to emergency and then discharged without admission, there might be no referral to the inpatient service.

CHAIR - No discharge summary?

Mr CLARKSON-FLETCHER - And the discharge summary would go electronically to the GP clinic, but that doesn't necessarily guarantee follow up.

Dr SEIDEL -Do you get a notification if any of the clients presents to the Emergency Department or has been admitted?

Mr CLARKSON-FLETCHER - No, but there is now an automatic notification system through Track-ED we set up. So, the Diabetes Centre at the Royal receives an electronic notification of any patient who is coded with a diabetes code, ICE code, on it at as soon as they're discharged from emergency. That follow-up -

CHAIR - When they've been admitted to hospital or discharged home?

Mr CLARKSON-FLETCHER - Only if they're discharged home. If they're admitted to hospital then they would ideally get an internal referral through these referrals systems there.

CHAIR - Going back to the women with gestational diabetes. It's a long time since I've worked in maternity areas. It seems there was an increase in percentage of women in Tasmania who have gestational diabetes, predominantly in our more rural areas. That goes along with some of the social determinants as well, obviously. What sort of uptake is there of support for these women, regardless of whether they're non-English speaking background or not, in terms of managing that? There are implications not just for the woman but for the baby.

Ms HOEKSTRA - There are massive implications, absolutely. In the NDSS report through to the end of March, there were 754 women diagnosed or registered with the NDSS for gestational diabetes in Tasmania. Over the last two years, the health coaching for women with or after GDM has been a pilot program. We've recruited just under 400 patients over two years, so 200 per year. I think the barriers that prevent these women from engaging are just parenthood. They're tired, post-baby. They're basically well women, especially once the gestational diabetes has gone away, so there's no real reason for them to engage other than a higher future risk of type 2 diabetes.

CHAIR - Or subsequent pregnancy risk.

Ms HOEKSTRA - Or subsequent pregancy risk, absolutely. They're a difficult cohort to engage because they're young, they have so many other competing priorities. As a mother, you put yourself last. Once baby comes along, eating habits and physical activity are a lower priority but, from a prevention point of view, they're a really, really important group to work with.

CHAIR - Isn't it easier, then, to work with them while they're pregnant and get them on board?

Ms HOEKSTRA - Yes, absolutely.

Mr CLARKSON-FLETCHER - Most women will receive a letter from the NDSS post-partum, to remind them to go off and get screened. That's where competing priorities can take over.

CHAIR - Do we know what the uptake of that is?

Mr CLARKSON-FLETCHER - No, I'm not aware of it.

Ms HOEKSTRA - The NDSS has trialled this system of reminder letters and SMSs to encourage women to get their six-week follow-up glucose tolerance tests done, and to get screened for diabetes every year for the first five years. The report into the effectiveness of that found that there wasn't a great uptake. It wasn't that effective. I could find more details about that, nationally.

Personally speaking, I think women really respond well to the vocal connection. We contact all newly-registered mums on the NDSS and say, look, we've got a local program here for you and they love the idea of having a local dietician to talk to, who understands where they live and their situation.

CHAIR - In that, do you also talk about nutritional advice for the baby as they start on solids and so on? That could be the hook to get them in.

Ms HOEKSTRA - Absolutely. If they join while they're pregnant, we'll give them three or four COACH sessions during the pregnancy, a couple of months' break while they have the baby, and then a couple of follow-up calls. If they join after that point, yes, we can be working with mums all the way through to remote ongoing breastfeeding, starting the baby on solids, through to those family issues of fussy eating and managing allergies.

Many of the mums, as a cohort, compared to, say, our type 2 patients, have high levels of body image concerns and disordered eating. Not necessarily diagnostic but the impact of maybe not growing up with a strong role-modelling of healthy eating habits and the influence of social media and diet. So many mums are restricting on keto diets and low-carbohydrate diets that then extends to the whole family, including young kids who are watching their mum and what she eats. They're a really important group to work with.

Mr CLARKSON-FLETCHER - The bulk of gestational diabetes is managed by the tertiary centres. Like diagnosis, you tend to group education at the Royal or the Launceston General. They will generally follow the bulk of them up. Endocrinologist appointments, you know, they do it combined with the obstetrics team. The ones who have to start on insulin, or are just a bit trickier to manage, they have regular phone clinics and they will attend face-to-face clinics. So, we're basically theoretically picking up supporting that system because that is a very busy system. The diabetes centres are really busy in the GDM space.

Part of the increase in diagnosing GDM was a change in the criteria of diagnosing a few years ago. So, there's a bit of that, but there is just this growth.

CHAIR - So, again, the whole issue with referrals becomes crucial to all of this.

Mr CLARKSON-FLETCHER - Yes, referrals and this interservice connectivity that -

CHAIR - A multidisciplinary approach.

Mr CLARKSON-FLETCHER - Yes. At the moment it kind of works because our educators know the educators in - it's a smallish state, so we all kind of know each other. I think Tasmania's relied on that, as I said before. Whereas we probably need to get more onto more formal pathways that are supported by an across service IT system. The Health Pathways through Primary Health Tasmania is definitely going to be useful because it will clarify that.

They're working with the tertiary teams as well to clarify for GPs, who would you send to the service and when?

CHAIR - Any questions - no? Okay. I think we've used up our time anyway. So, did you want to make any closing comments or anything you feel like you haven't covered that you wanted to?

Mr HOEKSTRA - I don't think so.

Mr CLARKSON-FLETCHER - No. Just -

CHAIR - The number one priority if you were in charge, what would you do?

Mr CLARKSON-FLETCHER - Probably the IT systems. Yes. I think we've got the health professionals. I think we've got good clinicians working in diabetes. It's getting that efficiency. We're always going to be faced with a tsunami of - there's so many people growing up with and coming into diabetes, we're never going to have enough specialist people. We need to support primary care workers, practice nurses, Allied Health and GPs. We need to be better at our systems and our connectivity to make that a reality.

Mr HOEKSTRA - I agree and I think that's supported by more of a shift of the funding towards the prevention. So the IT systems and also the incentive to work in the prevention space.

CHAIR - Okay. Thanks very much for your time.

Mr CLARKSON-FLETCHER - Thank you, we appreciate it.

THE WITNESSES WITHDREW.