PUBLIC

LEGISLATIVE COUNCIL SESSIONAL COMMITTEE ON RURAL HEALTH SERVICES IN TASMANIA MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE, HOBART ON MONDAY, 7 OCTOBER 2021

Dr HELEN McARDLE, PRESIDENT and **Dr JOHN SAUL**, VICE PRESIDENT, AMA TASMANIA (WEBEX AND CR2), WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Ms FORREST) - Welcome to the hearing. This is a public hearing and we are pleased to have you here to talk to your submission. In a moment, I will get you to take the statutory declarations. We are taking sworn evidence. It is part of our public hearings. It will be broadcast and it will be transcribed and potentially form part of our report. If there is anything you wanted to discuss that you believe was of a confidential nature you could make that request and the committee would consider it.

I assume you have read the information for appearing before parliamentary committees. You don't have any questions about that?

What you say in this room is covered by parliamentary privilege but it is not when you leave this room so bear that in mind if you speak to the media following the hearing. I ask you both to take the statutory declaration and invite you to introduce yourselves and to speak to your submission which we have all read.

We have all read your submission and appreciate the supplementary submission you lodged in regard to the mental health inclusion in our terms of reference.

It would be helpful, during giving further evidence in relation to your submission, if you could identify terms of reference in particular. They are quite broad and there are a lot of them. It helps us to contain information related to those terms of reference when preparing a report.

I invite either of you to make an opening comment and then the committee will have questions. Please include anything in particular you want to draw out of your submission or add to your submission.

Dr McARDLE - I will make a few opening comments and then I will hand over to John to focus particularly on rural and general practice.

So, thanks for inviting us to come along and thanks for inviting us to put in a submission. You'll have read our submissions. We tried to cover each of the terms of reference and they were quite detailed. So, I will not go into them all but we are able to answer any questions.

The inquiry is particularly around rural and remote access to health care but in fact Tasmania is basically rural throughout and so the same issues that affect the rural areas also affect the metro areas, although to a lesser extent.

Although we acknowledge that many of the issues, particularly in relation to general practice, fall within the realm of the Commonwealth and they do then have a flow on effect to the state and the state's ability to provide services.

As we are all aware, Tasmania has a very rurally dispersed population. We also have an ageing population and an increasing prevalence of chronic disease. We know that in the north-west we have an older poorer population with poor health literacy and a high level of chronic disease, including cancer and heart disease. As I said, the inquiry is particularly focused on primary care but obviously problems in secondary or tertiary care affect the ability for primary care to undertake their activities.

General practice continues to have problems related to the Medicare freeze and also the relatively recent introduction of the modified Monash model, which therefore impacts on funding into general practice depending on the site of the general practice.

Also, there are significant problems with access to allied health, particularly in rural areas. In the north-west, it is virtually non-existent. This is impacted by the NDIS and the fact that a number of allied health practitioners who were in the public system or providing general private services have moved over to the NDIS activities.

Access to psychiatrists and psychologists is also very poor in most of the state apart from the south. That has huge impacts with long waiting lists and a reliance on the acute hospital sector. One of the things that we believe would help would be a telehealth support network from psychiatrists to GPs to enable GPs to manage more of the patients with mental illness in their rooms.

An example is in the north-west. There is only one child and adolescent psychiatrist for the whole of the north-west. If she wants to take leave - annual or professional development leave or whatever - a locum is required. They are not available at the moment. This has huge impacts on both the ability to provide the service and also her wellbeing.

Some services, such as drug and alcohol services, are non-existent in a lot of Tasmania, even in those areas where there are significant drug and alcohol problems like the north-west. Access to private specialists' services is very limited in rural areas. Because of the conditions in the public system, most of the specialists work in the public system and either have very limited or no private practice. This means that people wanting to access private specialist services have to travel either to Launceston or to Hobart.

CHAIR - Which would be cost prohibitive, from your assessment, particularly from the north-west, which is where the serious problem is.

Dr McARDLE - Yes, it is. A lot of people don't have transport or the easy ability to gain transport and also have mobility issues. Although PTAS covers some of the costs, it doesn't cover everything. You can't safely come to Hobart and back again in a day. I know a lot of people do but it's not a safe way to do it, so there's always accommodation and so on. They're some of my opening comments. I will ask John to expand on the GP side of things. It's a huge issue, as you know.

CHAIR - I would appreciate it. Dr Bastian Seidel is probably all over this, but could you describe the modified Monash model more fully? I have had discussions with some of the GPs in my area who are directly impacted by this. Could you help the committee fully understand what it is, what the changes have done and why it's such a problem?

Dr SAUL - The Monash model has a really interesting impact on Tasmanian general practitioners. It varies. It's hard to understand and it's hard to follow as to how that impact is going to occur. It impacts on grant income for general practices. In many ways we're not going to know the exact figures for three, six, twelve months, until we see what our grant income is and how it's reflected. The Monash model has resulted in quite a lot of Tasmanian general practices being dropped down a level in terms of their level of rurality.

CHAIR - What's the impact of that?

Dr SAUL - In terms of pure dollars, we know one practice in Launceston will lose up to $100 000 a year.

CHAIR - Of income?

Dr SAUL - Income, pure income.

CHAIR - Start with Monash model 101. Tell us what it is and how it works.

Dr SAUL - The Monash model breaks areas into seven categories, ranging from inner city to the most extreme rural areas. In Tasmania, we now only have about four areas that are categorised as level 7. A lot of areas, including Launceston and Lilydale, have gone down a level. Launceston might be classed as a city but, as I said, one practice has lost up to $100 000 a year.

CHAIR - Talk to us through how changing levels affects the funding that you get.

Dr SAUL - Again, it's hard to understand, Ruth. I find it very difficult and challenging. Effectively, with the Monash model, a lot of areas in Tasmania have been downgraded in their level of rurality.

CHAIR - Which means?

Dr SAUL - Which means less income from funding.

Dr SEIDEL - Dr Saul, can you explain what financial incentives the Commonwealth offers to practices under the Modified Monash Model? In particular, can you explain the support the Commonwealth offers towards bulk billing and the tiered bulk billing incentive? The other is how GPs can be retained. What does the Commonwealth offer and what has changed under the Modified Monash Model?

Dr SAUL - Very little and in a very confusing manner. We get funding from the federal government in terms of the Monash model. Certain areas with increased rural zoning will get more money, more retention grants for GPs, greater subsidies for GPs if they stay in those areas, greater bulk billing rates for those areas, additional funding for what we call the SWPE, the Standardised Whole Patient Equivalent, which is a figure that each general practice achieves in terms of consistent patient loads. As a result, in each of the eight or more things it relates to, Tasmania has come off second best and has a reduction in funding.

Dr McARDLE - There are some practice incentive schemes, aren't there?

Dr SAUL - Absolutely. They've disappeared for some practices, simple as that.

Dr McARDLE - That went to funding some nurses, is that correct?

Dr SAUL - Yes, it's a constantly shifting base. Often we're just shuffling the same amount of money around different areas.

CHAIR - How are the decisions made around, say, Lilydale, which you've mentioned, or a town like Wynyard? Part of the problem as I understand it from GPs in my area is the way that the catchment area is defined. Is that part of it? How is that worked out? What criteria would see a town, region or an area move from one level to another?

Dr SAUL - Madam Chair, you are asking me to put my head into the mind of a Canberra bureaucrat here. I will do my best.

It is a complicated process where services are allocated based on distance from a major hospital or from a major centre. No allowance is made for the fact that Nubeena is an hour and a half away from Hobart but by distance of circumference it is only about 40 or 50 kilometres. No allowance is made for Lilydale being well outside of Launceston with a difficult convoluted road that is prone to ice in the morning.

CHAIR - The assessment is done as the crow flies.

Dr SAUL - Yes. I have seen this over the years. South Arm was rated as inner city at one stage.

CHAIR - Wynyard is too. Only Wynyard, but Burnie's not.

Dr McARDLE - How could that be?

Dr SEIDEL - May I ask specifically, Dr Saul? The AMA was supportive of the Modified Monash Model, understanding that the regional context differs quite substantially from state to state. What role did the state AMA branches have to inform the Modified Monash Model? Would the AMA Tasmania consider asking for an exemption of the model when it comes to Tasmania knowing that, for example, Kempton is classified the same as Bridgewater now, which doesn't make any sense to anybody who lives or who wants to practise medicine there.

The implications are quite substantial. If you are downgrading the Modified Monash Model you are losing out on the bulk billing incentive payment. That means patients that will be out of pocket. If you are downgraded in the Modified Monash Model as a practitioner, it means you will have an income cut quite substantially in all the years to come as well. Saying that, because all medical associations including the AMA, that supported that model from a commonwealth level, it is unlikely to change, isn't it, because you have to change the methodology? What is the AMA Tasmania arguing that we spend?

Dr McARDLE - You are correct. The AMA nationally supported the model and in most other states it works well. Ever since people became aware of the impact here we have been lobbying the federal AMA to say that we have to do something about this because it is unfair. The way it applies in Tasmania just skews things.

They are not particularly interested in it so we have decided that we need to lobby ourselves in settings like this. When we speak to the minister we raise it; when we speak to the secretary we raise it because, for whatever reason -and it is probably that 'as crows fly' thing - it is distorted here. We have a lot of winding country roads and it is difficult to get about. Whereas in other states you have the big urban centres and then you have the remote centres. You do not have the same mix that we do. We have been lobbying, but federally they are not interested because for most other states it works. An exemption, if that is a possibility, would be excellent.

Dr SEIDEL - Do you believe, Dr McArdle, that the Modified Monash Model is not fit for purpose when it comes to Tasmanian health funding for all areas?

Dr McARDLE - That is what we are hearing from our members. The reason I deferred it to John is I do not totally understand its impact.

Dr SEIDEL - It's not fit for purpose for the Tasmanian context, right?

Dr SAUL - It has certainly been detrimental for all Tasmanian GPs.

Dr SEIDEL - It's made it worse. Introducing the Modified Monash Model nationally has made it worse for Tasmanian patients who live in rural Tasmania and made it worse for Tasmanian health practitioners, not only the ones who are living outside the metropolitan centres but even the ones in Launceston, which is meant to be classified as rural as well.

Dr SAUL - I totally agree with what you have just said.

CHAIR - Dr McArdle, you mentioned you have been talking with the Health minister. When they have their national Health ministers' meeting - I am not sure what they are called now because things keep changing - has there been any willingness to take that forward on Tasmania's behalf?

Dr McARDLE - There has been a lot of interest in what we are saying. We've only met with the current minister on two occasions, but he is certainly very interested in the concerns we have raised and was going to raise them further. I don't know if that has happened.

CHAIR - He will be appearing before the committee at a later stage so we can ask him about that. Is there anything else on that? Is there some sort of document or website that you could provide or direct the committee to?

Dr SAUL - We could certainly find one, yes.

CHAIR - Sometimes you have to get this on the record. That's why he was wanting you to answer that question.

Dr SAUL - I suppose it just adds to the fact that we are classified the same under the Monash model as regional Victoria yet we have a little thing called Bass Strait that makes our recruitment more and more challenging. Especially in view of COVID-19, trying to get a locum from rural Victoria for Nubeena at the moment is just impossible.

Dr McARDLE - I think it is impossible with our two weeks quarantine. I don't think they are letting anyone in.

Dr SAUL -Yes.

Dr McARDLE - The other thing, apart from the Modified Monash Model, I thought if John could talk a little bit about the pressures in general practice particularly in rural areas, both with the ability to recruit or not recruit. It's not only rural but metro, because I understand there is something like fifty GP vacancies around Hobart. If you could expand on that?

Dr SAUL - We have substantial GP advertisements across Tasmania and I would wager we have multiple surgeries that have just given up advertising. We are really under pressure at the moment in terms of our recruitment. Just one more thought on Tasmanian rurality, we do have a slightly different approach to our locality in Tasmania. There will be people on the Tasman Peninsula who have not been north of Dunalley for 10 years. There will be similar circumstances down at Dover and Esperance and Geeveston where people really stick to their area.

CHAIR - It happens all around the state.

Dr SAUL -Yes. Very much a Tasmanian aspect, that makes it even more challenging to provide health care services for these people. With recruitment, I would say Tasmania could at least do with another one hundred GPs. I could be here all day describing some of the problems we have in general practice. One is we are training beautifully competent, excellent GPs, but they are choosing a different work pattern than we're used to. Instead of working a 40 to 50-hour week like the previous generations, they are now choosing 20 to 30-hour weeks. They are choosing lifestyle opportunities with their partners. They are staying in inner city areas, or fringe areas at best. They are not going to the rural areas.

Dr SEIDEL - Why do you think that is, Dr Saul? Why do you think that's different now compared to how it was, let's say, a generation ago?

Dr SAUL - A generation ago we either had old crusty doctors who seemed to be able to survive it, or doctors that died young and didn't survive it.

CHAIR - And they were mostly males?

Dr SAUL - Usually males, yes.

Dr McARDLE - I think the other factor that we hear from our members, is that the pressure in general practice is so much higher; the quick turnaround, the demands on general practice. A lot of them cut hours purely as a self-protection thing. It is not necessarily just lifestyle, it is to protect their ability to keep going.

Dr SAUL - I wouldn't even say it is lifestyle, I would say our doctors are now adopting safe working practices.

Dr SEIDEL - That is an interesting point because as you said, there seems to be a reduction in available clinic hours but it is almost a preservation thing, isn't it?

Dr SAUL - Yes.

Dr SEIDEL - I think the concerns of burn-out are real, aren't they? You are operating doctor support services at the AMA as well, so what are you hearing from your members who particularly work in rural Tasmania and the pressures they are facing on a daily basis?

Dr SAUL - They would like to work less than a 10-hour day. They would prefer an eight-hour day.

Dr SEIDEL - And what would happen if they do that, because when patients are lining up, you can't just say, 'Shop's closed.' What does it mean, compromising the availability of a practitioner, in particular when you are the only GP in a rural area? How do GPs cope these days?

Dr SAUL - We are prioritising emergencies; and similar to other parts of the state's health system, we unfortunately are not covering off on the very challenging preventative health measures that these areas provide.

We have higher smoking rates, we have higher alcohol abuse, we have lower health literacy in our rural areas. The stats are all there in our submission. That makes rural health so much harder. We don't have the ability to handball in rural health like we do in the city practices. You think you are going to get away at 5 p.m. Monday. A bike accident turned up at Nubeena, another half an hour. These things just happen. The city gives us opportunities to shut at 5 p.m. and handball to ED departments. In the rural areas we don't have that.

Ms LOVELL - What impact is that having on other health services and particularly tertiary health services and elective surgery? If you aren't able to intervene in those early stages of chronic disease and other issues because you are dealing with those emergency cases, what impact does that have down the line?

Dr SAUL - It's a domino effect. We are not getting to them early enough. We are not referring them early enough, and they are also not being seen early enough. We are also being bogged down by repeat consultations by people needing these services. At the moment we have over 50 000 people on the waiting list. We have 9000 people waiting to be assessed. Of those 9000 people waiting to be assessed, I have probably already seen them. I've done an X-ray of the hip, I know the hip needs replacing. They have a positive stool sample for blood and I know they need an urgent colonoscopy to rule out cancer. I've already assessed some of those 9000 people, yet they are still technically sitting on the side of the fence, so I am slow to get to them.

Dr SEIDEL - That is inefficiency within the system that is also frustrating?

Dr SAUL - Inefficiency is one word; but lack of process might be a better word. We are not putting enough resources into getting these things done.

CHAIR - Can I go to Mike? I want to come back to the GP shortage in a minute but Mike, with regard to this area?

Mr GAFFNEY - Recognising what you just said regarding the shortage of GPs and professionals, how does the AMA Tasmanian Branch view, perhaps, a full scope of work for

our pharmacists, nurse practitioners and paramedic practitioners, and increasing the numbers of those in the state to help alleviate some of the problems you are finding? Does the AMA have a policy position on perhaps increasing the number of nurse practitioners and paramedic practitioners in GP practice?

Dr McARDLE - I'll make a few comments and then hand over to John. As with any membership organisation, we have a broad range of views. I would say in general, particularly from the GP sector, there is a reluctance to go down that expanded scope of practice for other health practitioners. My personal view, it is not AMA policy, is that it can work really well if there is a good working relationship, if there is a good relationship particularly, say, with a nurse practitioner and a GP, or a specialist or someone else, where they can work as a team. But there is opposition from a number of our GP members. Emergency physicians, for example, love the thought of having nurse practitioners because they have worked with them and they can see how it works really well.

CHAIR - Maybe if we had more of them in the system there would be a greater acceptance and awareness of the capacity. In relation to Mike's point, you said there were a variety of views around extending the scope of practice. Really, what Mike is talking about is allowing these people to work to their full scale of practice, not extending beyond what they are actually qualified to do. It is just there are limitations placed on some of these other professions, sometimes barriers. They don't need to have a whole new extension of their scope to allow them to work more fully. I think that is what you were referring to in some regard.

Dr McARDLE - Some people would debate whether it is the normal scope.

CHAIR - Prescribing, for example.

Dr McARDLE - Extending and extending; and there has been an extension. In some of the other allied health areas there has been extension of scope so it wasn't the original scope. Some of that is appropriate, some of that is debatable. Nurse practitioners are trained to that level of scope but there aren't very many of them. I know some paramedics have that extended scope or training, some don't. I was talking to one of the retrieval people the other day. There were concerns about extending too far without that teamwork arrangement. John, do you want to talk as well?

Dr SAUL - Yes, we have some great relationships with nurse practitioners and community pharmacists. There's such a range of skill sets and abilities with these guys. It's so different, a pharmacist working in a supermarket discount service versus a community pharmacist at Nubeena. There's such a range in what they do and how engaged they are in the community. I have the utmost respect for what they do, but if you've got a job for a GP, why don't we just support our GPs better? Why don't we just get more GPs? Why splinter the service? Why risk poorly coordinated services by having a pharmacist do a diabetes check when it should be a GP surgery role?

Mr GAFFNEY - John, I thought you said a minute ago that we were 100 GPs short, yet we have nurse practitioners and paramedic practitioners out there who, if given the opportunity, would be able to fulfil some of the things you are talking about when you can't get GPs.

From my point of view, from a pragmatic point of view, aren't we better off to look at what could work in some of our rural communities, where nurses are set up as part of the

community, and not a locum flying in to do the work? I understand what you're saying, but on one hand you are saying there's a shortage and we can't get anybody, yet we're a bit reluctant to allow those practitioners to do their whole scope of work.

Dr SAUL - One of the problems I see is that unless we support solid general practice services, we're going to get a shrinking pool of GPs. We're not going to have that level of training, that 10 years of training, to support this type of service. By all means, you might be able to plug holes here and there, but you're not going to have a solid coordinated service unless we can increase our GP service. You might be recommending something that might help solve a few problems, help fill a few gaps, but it's a bit like emergency funding to reduce the waiting list in the public system. It's only a short-term solution. What we need is really well-trained GPs.

Mr GAFFNEY - I have to go back to the point. Wouldn't having those professionals around a GP who can take on some of those roles and support that GP, so they wouldn't have to have days off or time off to look after themselves?

Dr McARDLE - I think that's the fundamental thing about a team, and having a team working as a team, instead of having a lot of silos. The concern in some areas is the silos. You've got a nurse practitioner over there working as an independent nurse practitioner with no relationship to the GP or the specialist in the field they're working in. That's where a lot of the concerns arise.

CHAIR - If they were more coordinated within the GP practice. John, you talked about the approach you're required to take now with such a shortage of GPs. You treat the most urgent cases - and the other more difficult and complex cases that require someone to sit down with them and go through a range of things, a lot of those things are within the scope of a nurse practitioner trained in that area. Potentially, if it's a medication matter, it could be the pharmacist attached to the GP practice, for example. We've seen the benefits of having pharmacists in the Royal Hobart Hospital ED, for example.

Dr McARDLE - From a broader AMA perspective, there is great support to have pharmacists connected with practices to give those medication reviews, to support the patients, to advise and so on. I'm not sure how the funding works there, and that's a problem.

CHAIR - These are the problems that could be overcome with a willingness to do so, potentially.

Dr SAUL - We're seeing some great coordinator work going on now. We're seeing good local community pharmacists contributing greatly to the GP's day. You could use the word 'nurse practitioner', but a quality nurse contributes so much to a general practice.

CHAIR - A practice nurse, as opposed to a nurse practitioner.

Dr SAUL - Either is good. A nurse practitioner has a few extra qualifications, but a quality nurse contributes so much.

CHAIR - And a broader scope of practice.

Dr SAUL - A broader scope of practice from a government point of view -

CHAIR - And from a clinical point of view?

Dr SAUL - And a clinical point of view, true, but we have quality nurses running our immunisation services in practices. We have our nurses really stepping outside their boundaries in rural areas doing extras, whether they have the nurse practitioner qualification or not. A good team approach is where we are headed. If we go into silos, we are really going to have disjointed care.

CHAIR - I am not sure that's what Mr Gaffney was suggesting.

Mr GAFFNEY - No, I am looking at it the other way. I am a bit concerned that the doctors want to go into silos instead of branching out, because a paramedic practitioner pointed out to me that about 50 per cent of people, I think they said, who get into ambulances do not have to stay in hospital overnight, but it does put more strain and stress on the hospital. Whereas if the paramedic practitioner was there at the time, they could put a better course of action, or plan of action, for the individual, which would then have flow-on effects down our hospital lines.

CHAIR - Avoid taking them to a hospital.

Mr GAFFNEY - Yes. I am definitely not suggesting it is silos. I suppose I am looking at a more integrated approach.

Dr McARDLE - The example you have used there is an important example, because one of the comments from some of our GP members is that a paramedic will go and see a patient, decide that they don't need to go to hospital, and tell them to contact their GP - but there is no information given to the GP by the paramedic, so the GP just gets this call and they are a little bit at sea. Whereas if there had been better communication and better coordination -

CHAIR - Sharing of data. The paramedics have the same problem. They go and pick up a patient with no information about them. If they are unconscious, particularly, they cannot really tell you anything.

Ms LOVELL - Can we explore that a little? I understand that information sharing is very difficult between services - particularly paramedics to hospital, hospital to GPs, GPs to hospital. Can you talk a bit about that, and what challenges it presents?

Dr McARDLE - One of the things we put forward in the election bid, and also the budget bid, is to get an integrated electronic health record and therefore improve communication.

Ms LOVELL - How does it work at the moment? What happens now?

Dr McARDLE - GPs get informed when their patients have been discharged some of the time. They get informed when their patients have been discharged from the emergency department.

CHAIR - They get their COVID-19 test result. They can do it with that. They get it when you get it.

Dr SAUL -It is a lucky dip. Sometimes a patient will ring at 8 o'clock in the morning and say, 'I saw a paramedic last night. I need an urgent appointment before 10 this morning.'

Ms LOVELL - And you have no idea or no way of finding out.

Dr SAUL - No idea of what is going on. Other times, down at Nubeena for example, Meg or Matthew will give you a call on your mobile and you will be able to discuss it directly with them.

Ms LOVELL - Meg or Matthew being the paramedics?

Dr SAUL - Yes, and they are sensational. They are really top local operators.

CHAIR - So we need some structure around that, yes?

Dr SAUL - There is no structure.

Dr McARDLE - And an electronic system to make it easy, because the hospital system doesn't talk to the general practice system, that doesn't talk to the ambulance system, that doesn't talk -

Dr SAUL - Again I get back to the grubby subject of funding. If I get a call-out to a nursing home on a Sunday night, my hourly rate is three times less than seeing a sore wrist from Ingham's Chicken at 9 o'clock on Monday morning. The funding for a bulk bill call-out on a Sunday night is atrocious.

CHAIR - That is a federal government matter.

Dr SAUL - It is a federal government matter, but it impacts on you, because you are paying for the paramedics, you are paying for the $2000-$3000 visit to hospital at night, because there wasn't a GP available to make a decision on keeping their patient in the nursing home.

CHAIR - Where they want to be, mostly.

Dr SAUL - Yes.

Ms LOVELL - I have some more questions on workforce before we move on.

CHAIR - I have Bastian, and one other; I will come to you then.

Dr SEIDEL - I'm specifically asking about the Rural Medical Practitioners agreement, which you said is really not sufficient to cover the costs at all for those doctors who are working in those rural district hospitals. The AMA is the direct industrial party involved in that agreement. What does the AMA want to see to improve funding for visiting medical officers through medical practitioners and what conversations have you had with the Minister to improve the funding for those services?

Dr SAUL - We had a substantial review 12 months ago and we did get some traction happening there. Having said that, there are 17 different ways of being paid under the Rural

Medical Officer award. After 18 months I understand about 13 of them. So, it is a complicated document. Having said that it is trying to be fair and it is trying to be reasonable, but it is just not right.

There are so many different aspects of it. A simple one is that each rural medical officer or group get allocated a certain number of hours for routine work in a hospital setting. In Nubeena we have four beds. At times we will have one person and two hours a fortnight is quite adequate. When we have six people, especially if we have emergency palliative care in there - we are only allowed four but thankfully we can sneak in six at times - we are hopelessly inadequately covered for our routine checks.

Dr SEIDEL - Does it mean you are expected to work for free in those circumstances? That's not helpful in attracting doctors to work in those hospitals if you are meant to be working for free.

Dr SAUL - Absolutely not.

Dr McARDLE - I am not right across the rural medical practitioners, but I understand that it is quite complicated to work out how to claim the money. So, there may be provision but people are not aware how to claim it and therefore there is a shortfall.

CHAIR - The administrative burden is quite onerous, which takes doctors away from treating patients.

Dr SEIDEL - So, the RMP agreement is not fit for purpose either? So, we have heard the Modified Monash Model in terms of funding is not fit for purpose for Tasmania. Here we have something called the RMP, which is a Tasmanian scheme that also doesn't work. Then we are surprised that doctors don't want to work in regional areas.

Dr SAUL - I wouldn't necessarily say it is not fit for purpose but I would most certainly say there are major holes in it and there are major challenges.

Dr SEIDEL - You mentioned getting called out and there is hardly any funding from Medicare. Can you give us an idea of what the funding would be like if you were called out to see a patient in the Nubeena Hospital in the middle of the night?

Dr SAUL - Ironically, the rural medical officer award is not too bad for call outs at 2 a.m. It is four times or five times what it is from the federal government.

CHAIR - How is that funded?

Dr SAUL - That's funded by state government. So, there are aspects of it that are good and there are aspects that aren't good. Our paperwork burden is just getting bigger and bigger. Our pursuit of quality paperwork and quality notes, as it should be, is getting higher and higher. As a 61-year-old GP I would say I am not that good at paperwork to be honest, but it is good that our standards are being raised. But our routine payment under the Rural Medical Officer Award is not high enough for what we have to do.

Dr SEIDEL - Maybe you should do urgent paperwork in the middle of the night; at least it pays.

Ms LOVELL - A question about the workforce. You mentioned before, Dr Saul, that Tasmania is 100 GPs short. Is there a formula or a best practice ratio? What would be the ideal GP to population ratio?

Dr SAUL - I could probably give you 30 different figures for 30 different areas in Tasmania. It depends on the way the GP practises as well. We have GPs at the Lauderdale surgery where I work at who practise as if they are in an inner city area. Yet at Lauderdale we have GPs who do their own after hours, do their own palliative care, do their own nursing home patients and practise in a semi-rural area in a semi-rural way.

So, the ratios vary completely. As I said before, we have people in areas of Tasmanian who have not travelled more than 30 to 40 kilometres from home in the last 10 years, so it makes it hard to say.

Ms LOVELL - It makes it hard to look and say this is how many GPs we should have in Tasmania in these areas.

Dr SAUL - Good supply creates plenty of demand. At Swansea at the moment we have a cracking couple who perform magnificent medicine who attract patients from Triabunna and Bicheno. They have a practice group that desperately needs another GP as per our documentation. That is because they offer such a crackingly good service that they attract so many patients to their surgery. Each area has various factors and it is a hard one to put a figure on it.

Ms LOVELL - Is there any formal obligation or responsibility at any level of government to ensure that there is a GP - For example, we have had instances we have seen recently in Tasmania over the last few years where we have had practices closing down, doctors retiring and entire regions potentially being left without a GP. It always seems to be a bit of a scramble to find someone. Is there anyone who that responsibility falls with? Any one level of government or any one obligation to provide that service for the population?

Dr SAUL - No, there isn't but in the same breath I have seen some good activity from government to help where it has to. Each GP effectively runs as a small business. Each GP is primarily funded by Medicare, federally funded as running their own small business. As the bureaucracy has increased the challenges just keep building. Having said that, I have nothing but compliments for where governments and councils have come in and tried to find funding to prop rural general practices, but they are very ad hoc, confused funding arrangements.

CHAIR - It is crisis management.

Dr SAUL - Absolutely.

CHAIR - I saw in Smithton when that incident occurred OCA came in, but you also have to look after Smithton Hospital so there had to be negotiations at state and federal level.

Dr SAUL - We are working on crisis funding at Nubeena at the moment. We are getting very well subsidised for the first year, it trickles away quite quickly. Heaven help us when we have to negotiate year four because these small two-doctor rural practices, even with state government support for the Rural Medical Officer award, they really need additional top up

funding to survive. Very few of them are functioning without a lot of charity work done by the doctors, a lot of unpaid work done by the doctors.

Ms LOVELL - I have a question about finding GPs to work in some of those rural and regional areas. You have talked about some of the challenges in your submission. Funding can be an issue but isn't always; sometimes there can be good incentives and GPs can be paid quite well. What are some of the other challenges that you are hearing about from doctors? Is it housing? Is it jobs for their partners? Is it access to services?

Dr McARDLE - If I talk a little more broadly than just general practice, it is things like housing, schools for children and jobs for their partners, whoever they are. I have more experience of the acute system in the north-west but if the partner isn't able to get a job that they like and the children can't go to a school that they like, the people may be there for a year and they are gone. That is in a city like Burnie, which is different to Queenstown. To attract a GP to Queenstown - as we know OCA provides the service there - if they have school-age children or they have a partner with a profession that's not easily accommodated, then they will not stay. You then add in the housing problems, in some settings, buying into a practice and then maybe having to sell a practice, it's is a real disincentive.

I know in some of the mainland states, I always forget what it is called, something like 'easy come, easy go', the council basically owns the surgery and the houses the doctors live in. The GPs come and run the practice for three to five years. When their children are in high school and they need to move, they then don't have to sell everything; they don't have to sell the properties or the practice. They can just go and then the council maintains it and they get someone else in. That certainly has worked in some rural mainland areas.

Dr SAUL - Having said that, it is a case of just trying to find that unique tipping point. We have recruited a doctor by finding a home for two Alsatians. We are working on a doctor and the key bargaining point will be finding a job for his wife, as well as two Jack Russells. We're just looking at all alternatives and how we can recruit. We talk of councils propping places up as well, but we must note that we've got a health system in crisis on the east coast at the moment, except for Swansea, based around the -

CHAIR - That's dual-person dependant, though. If that couple decides to go -

Dr SAUL - There's no succession plan for Swansea at the moment; and that's an area where you add 10 or 20 years and we've got the same problems as everywhere else.

CHAIR - General Practice Training Tasmania put a submission in, raising concerns about changes to the training model. They say it's not the right time, particularly at the moment, where you can't easily move people around because of COVID-19. Do you have a view on the training model?

Dr McARDLE - Certainly, from a national AMA perspective, there's been a push to try to delay the changeover by a year or two years. I can't remember when it's supposed to change over, but it's fairly soon.

CHAIR - I think it's supposed to change close to now.

Dr McARDLE - The model is that the training will go back to the colleges from the current RTOs, but there's a lot of work to be done to build up the expertise and the capability of either of the colleges to do it. I think the colleges probably think they can do it quite well, but there's a lot of concern from the federal AMA and from us, and also from GP registrars.

CHAIR - General Practice Training Tasmania suggested it hasn't been very well consulted. Do you feel the new model has been well consulted?

Dr McARDLE - As an AMA, both locally and federally, we don't think it's been very well consulted.

CHAIR - Thank you for your appearance. There was the information about the Modified Monash Model you were going to provide to the committee, if you wouldn't mind doing that. If there's anything else you want to add later, you can always send us something if you thought it might be helpful to the committee.

Dr McARDLE - Most of it is in our submission and we were very pleased the terms of reference were extended to include mental health, because that's a huge issue everywhere. Even in Hobart, it's a huge issue.

CHAIR - Yes, it was a very detailed submission and we appreciate that. The reason mental health wasn't initially included was because of the way our committees are structured. We have to look after the portfolios of particular ministers; Committee A has some areas and Committee B has the others. Health and mental health were spread across the committees. Now, they both sit with Mr Rockliff, so we can include them. It wasn't a deliberate exclusion.

Dr SAUL - I suppose, too, we are just looking at individual deficiencies in individual areas. We need a podiatrist at Nubeena, simple as that. We need to care for our diabetics. We need pain specialists there.

CHAIR - We need pain specialists in the north-west too.

Dr SAUL - The cost is another major problem. I am negotiating with a Hobart-based psychology service to provide additional services at Nubeena. We think there's going to be about $14 000 to $15 000 a year funding required to fill the gaps that aren't being supported properly by federal bulk billing rates. I hate to come back to funding but it's a significant issue.

CHAIR - We have a federal election coming up soon.

Dr McARDLE - If you have any questions later, come directly to us.

CHAIR - Thanks very much for your time.

THE WITNESSES WITHDREW.

Ms MONIQUE MACKRILL, PGOA TASMANIA, AND **Ms BELINDA BIRD,** PHARMACIST, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Thank you for coming. This is a public hearing. All of the evidence you provide today will be transcribed as part of the *Hansard* of the committee. You are covered by parliamentary privilege while you are before the committee but that doesn't necessarily extend beyond the committee meeting.

If there is anything you want to discuss in camera you can make that request and the committee will consider that. You have received the information about attending before committees. Do you have any questions about that at all?

Ms MACKRILL - Not really, we will see how we go.

CHAIR - If you have any questions please ask as we get to them. The hearing is being broadcast and one of our members, Nick, is on the screen sitting in his mobile office. We will get you to take the statutory declaration and then invite you both to introduce yourselves, give an overview of who you are and then speak to your submission.

Thank you. Sarah Lovell is here. You know Bastian Seidel, Ruth Forest (Chair) and Mike Gaffney and *Hansard* and secretariat support.

Could you tell us a bit about who you are, and if you want to speak further to your submission or raise any other matters we would appreciate that.

Ms MACKRILL - I am the Branch Director of the Pharmacy Guild here in Tasmania. The Pharmacy Guild is a peak body representing community pharmacy. Essentially we are a membership organisation. In Tasmania, 121 of the 164 pharmacies are members of the Pharmacy Guild. Our role is broadly to advocate for advancement of community pharmacy practice in the state to ensure we are better able to serve our consumers and our patients, and look at opportunities where pharmacists can be used more broadly in the health care system. That is my role - basically, the support function of the actual branch. We have a committee. They are elected officials. Our president is Helen O'Byrne. There are 10 people on our committee and we have been around for nearly 100 years as a national organisation. Part of what we would like to see is to recognise the broader role of community pharmacies that are embedded in their community and able to better serve their patients.

Ms BIRD - My name's Belinda Bird. I am a pharmacist and owner of New Norfolk Pharmacy and I am here because it keeps me awake at night when patients are waiting six weeks to see a doctor. It keeps me awake at night when people are going to the emergency department for things that could be managed within pharmacy or GP practice, if we were able to use our full scope of practice. Also, I wanted to illustrate for you some of the issues that my community faces and some of the ways that pharmacy is kind of invisibly holding the seams of the health care system together, and hopefully make some solutions and get some better care for my community.

CHAIR - If I could start from there. You have made a comment in your submission - 'the Guild believe that appropriately trained community pharmacists should be formally recognised and remunerated as part of locally initiated, early intervention strategies'. You also

mentioned in your opening comments, Belinda, about being able to work across your full scope. When you did your degree, I imagine you thought you probably would and that is why you do a degree in a particular area. What are the limitations and barriers, how do they play out in practice, and what do you believe needs to happen?

Ms BIRD - We need to make permanent continued dispensing arrangements so that pharmacists aren't individually taking on the financial and legal vulnerability of supplying emergency medication to people. We need an extended list of pharmacist-only medications to deal with the acute and urgent care situations that come up every single week.

CHAIR - That's a federal government matter? It is not through the Poisons Act, is it?

Ms MACKRILL - It can be changed through the Poisons Act. There are instruments in the Poisons Act that can recognise where pharmacists in the state could supply items based on a list, and I guess that is how the supply of vaccines is done. They are generally seen as a prescription medication, but through the instrument in the Poisons Act, they have been pulled out of that and able to be delivered by pharmacists.

CHAIR - So there are more medications that you believe could be dealt with that way?

Ms BIRD - Absolutely. Another thing, speaking on vaccinations, is to make the national immunisation program available through pharmacies. That would free up an awful lot of GP appointments. Also, make some other injectables that are non-vaccine - like Prolia, which is for osteoporosis, and things like that - available to be administered through pharmacies as well, and free up appointments that way, too.

A minor ailment scheme would also be amazing. As I was just saying to Monique, I really need a second pharmacist on Saturdays because I am dealing with so many burns and wounds and severe allergic reactions and things like that, which means I need to sit in the consult room with someone - and that means the rest of my huge workload is being ignored. Do you mind if I check my notes?

CHAIR - No, that's fine.

Ms MACKRILL - When we talk about a pharmacist's scope of practice, it really sits within competency. Yesterday we had a discussion with Palliative Care Tasmania and people involved in the palliative care space, recognising that there is a real increased workforce need - a 135 per cent increase in the need for palliative care, because of the ageing population, and more people wanting to be able to die in their own homes if they choose to be palliated. There is simply not enough community support.

People die seven days a week. They don't just die 9 to 5 Monday to Friday. There are just not the supports available, so a lot of people end up dying in a hospital situation. Pharmacists can't do anything with syringe-drivers. That can't be touched unless it's done with a nurse. Those sorts of things are where the pharmacist's scope -

CHAIR - But any member of the public can give a bolus dose into a subcut line.

Ms MACKRILL - So this is where, as there is a bigger need, pharmacists are already place-based into the communities, and have been looking after many of these people who are

going into palliation for the last 30 years of their life. Then when they get to palliation, they want to be palliated at home, but the pharmacists are currently restricted to be able to assist in that space. It comes back to having the right sort of training to support - not really an expanded or extended scope, but being able to practise that full scope. But it has to be supported by training, and that can be easily done through -

CHAIR - This is what you have to do for vaccinations, too, don't you?

Ms MACKRILL - Yes. It's similar. That's an example we would use. In terms of training through the Pharmaceutical Society of Australia to do that clinical piece, working with GPs, nurses and so on, we would work out what's the limitation, and how it is done, and in what settings.

Ms BIRD - Another huge issue is patients bouncing back to the Royal, back to us, back to the Royal. Often, they will have a couple of visits before they've had a chance to see their GP, and often the feedback from the GP once the patient gets there is that they still have not received any information about why they are in hospital, why the changes were made, and what the plan is.

So, we are spending a lot of time. First of all, the hospital calls us, and we have to provide a history, a patient profile if they are a Webster pack patient - which they often are. Then the hospital will call back and say, 'They are going to be discharged in an hour. Would you mind fixing up their Webster pack and dispensing all their prescriptions?' and blah, blah, blah. So we do that for them, and try to explain those changes to the patient when they come home as well, and hopefully reinforce the discharge communication that has happened. We are also taking it upon ourselves to then transfer that information to their GP practice so it is there, and also asking if they could please prioritise an appointment for those people.

I could give you the names of half-a-dozen patients who literally go to hospital three times a month for things that could be managed through their GP, like weight fluctuations in heart failure, blood sugar fluctuations. Sometimes it's just adherence issues if they haven't had access to medication, or they're not taking it for some reason and they end up critically unwell.

A hospital discharge medication reconciliation service that is standardised across the state and is remunerated would make a huge difference in preventing most people from returning to hospital again and again.

I had other things on my list. I throw no shade at GPs because I work really well with the doctors in my community, and they're really supportive. They send private vaccinations to us, they send absence and work certificates to us, they send their COVID-19 vaccinations to us, and they're supportive of a minor ailment scheme. We work really hard together, but there's no incentive - in fact, there's a financial disincentive to leaving urgent care appointments available.

CHAIR - With the GPs?

Ms BIRD - Yes. Something Primary Health Tasmania could fund is to provide a safety net for practices so they could leave six appointments open each day, for example. If these weren't filled, by some miracle, there'd be an ability for them to top up the fees they've lost by

keeping that open. A program like that would be an absolute game-changer in rural communities.

The other thing is encouraging GPs and supporting them to use tools like My Script List. Instead of the patients getting a prescription, they have a list of all their authorised prescription items in the Cloud. They can go to any pharmacy, the pharmacy can get permission to log in and see what they have been prescribed, and then supply it based off that. I don't know if you know this, but the average 70-year-old takes 12 tablets a day - and then there's injectables, patches and things like that on top of that.

It is a huge issue to manage all that paperwork. A lot of appointments are taken up with people going back for that one thing they forgot to ask for when they were there a month ago. There are some really commonsense things that, if we could get everyone on board with, would take out the red tape and bureaucracy that's getting in the way of clinical work.

Ms MACKRILL - What Belinda is referring to with the active script list is basically the second phase of e-prescriptions. So, you've got the token, and the next phase was to consolidate that. Older people get a token, and what generally happens is that they walk in and say, I've got this thing on my phone; the doctor said you'll know what to do with it. The pharmacist is spending that time explaining what happens. There's no paper prescription, or you're printing out the token for them. Having initiated the active script list means they don't have to worry about anything when they go to the pharmacy; it will all be there. They can see everything.

It's a bit like that 'scripts on file' thing, where pharmacists had drawers of prescriptions - but it exists in the Cloud.

CHAIR - I think that grew out of COVID-19, predominantly, or was it available before?

Ms MACKRILL - It was fast-tracked through COVID-19. They really sped it up, which added an extra burden to doctors and pharmacists, because so much was going on in that space.

CHAIR - I am interested in the minor ailment scheme. Do you believe the majority of pharmacists in the state would be willing to participate in that sort of scheme?

Ms MACKRILL - They would if there was wraparound remuneration. What we generally see happen is that pharmacists will do some of these first-aid things - people come in on a Sunday, receive treatment and they don't pay for it. It's kind of like, thanks for that.

Ms BIRD - It's $4.95 for the dressing.

CHAIR - Hopefully, they buy some other product before they go.

Ms BIRD - I don't know if any of you have needed to utilise a community pharmacy. I am sure, Bastian, you have a really good understanding of how we keep the seams together. Unless you really needed us, you don't know what we can and will do. It's just what we do. We have a service value, so we subsidise all those services ourselves.

CHAIR - Who should fund that?

Ms MACKRILL - It could be recognised at a federal level if they said something; a bit like the federal level should really remunerate pharmacists for NIP vaccines. At the moment it is done through GPs, they get the payment for administering the NIP. The NIP is provided free. In Tasmania, we are going to get access to NIP for the flu season into the future. I have had a chat with the minister and that has been put on the table. We can do it privately; for example, a 65-year-old comes in and we can say we can give you your NIP vaccine for influenza but it will be $20 - or whatever it is going to be - because there is no equivalent of the MBS item.

Through COVID-19 we have seen that happen, because that is how the COVID-19 injection has been remunerated for pharmacists. Our state Government should be pushing COAG to recognise that pharmacists should be remunerated under a similar system to what is happening now with the COVID-19 vaccine to provide national immunisation program vaccines to all those people that need it.

Two of the largest potentially preventable hospitalisations in the state are due to vaccine preventable diseases - pneumonia, flu, and others like UTIs. If the federal government was to fund pharmacists to provide those; but what is happening is that when pharmacists log onto the Australian Immunisation Register (AIR), they are looking for the history for COVID-19 vaccines because that is the protocol. You can see the gaps. All these people that should have had vaccines that have not had influenza vaccine, not had the shingles vaccine; Aboriginal and Torres Strait Islanders. That ends up kicking back into the state system, putting people into hospital and costing a fortune. It is $4500 a night for a hospital stay and it is not the best place to end up.

Ms BIRD - It's such a different model in pharmacy, it is so opportunistic. You talk to someone about something else and they will say, 'have you got your flu vaccines', or 'have you got the COVID-19 vaccinations', 'do you want to do it right now?' There is no way. We are seeing a lot of people where otherwise it was a huge mental burden to get online and book an appointment, as well as the barriers to actually get into a clinic in town. They are in the pharmacy doing their normal shopping anyway, so we can get them vaccinated. It has been amazing. I will steal Mon's good news, which is that a million COVID-19 vaccinations have been delivered through pharmacy as of today. We have only had it for three weeks.

CHAIR - Excellent, congratulations.

Ms MACKRILL - Not just in Tassie, but nationally.

Dr SEIDEL - You mentioned you are providing plenty of work after hours; you mentioned weekends as well. As a rural pharmacy owner, do you receive any particular funding support through the Community Pharmacy Agreement or from a state source?

Ms BIRD - I don't actually.

Dr SEIDEL - You are telling me you have received no funding whatsoever for the work you are doing on weekends?

Ms BIRD - That's right.

Dr SEIDEL - How sustainable is that, considering that you are a pharmacy owner and you have to pay staff, as well as all the medications you have to purchase? You are the only pharmacy owner in New Norfolk?

Ms BIRD - There are actually two pharmacies in New Norfolk. We used to be classified as a rural zone, and once upon a time I did get some funding, I think it was about $600 a quarter for being rural. When the Monash model was modified it was deemed that New Norfolk is too close to Bridgewater, which is a suburb of Hobart, to be able to access any rural funding anymore. That flow on effect means that I don't get any extra rural funding for doing HMRs.

CHAIR - HMRs?

Ms BIRD - Home medicine reviews. Also, there is no additional income for enticing workforce. There is a subsidy for interns in rural areas, for example, which I cannot access. As you know, there are not any health services in Bridgewater and I might be based in New Norfolk but my patients are certainly much broader than that. I am dealing with Maydena, Ouse, National Park, Derwent Bridge.

Dr SEIDEL - What you are telling me is that if you wanted to offer a home medicine review - which we all know is so important in terms of medication safety and engaging with patients - you are forced to travel to Maydena. There is no extra funding for you to travel there either? The remuneration for the HMR is exactly the same isn't it?

Ms BIRD - I haven't done a rural HMR myself so I couldn't answer that fully; but certainly for HMRs in New Norfolk, Molesworth it is the same thing.

Dr SEIDEL - It is the same thing isn't it? Although your patients are more rural and you have to drive further compared to if you lived in a city, in Melbourne or Hobart.

And so again, for the services you offer on the weekend which arguably would save patients from attending the GP practice or attending the rural district hospital, you also do not receive any funding from the state government?

Ms BIRD - No, we don't and the rural district hospital is not available for people to walk in. It is only available to be admitted by local GPs, and it is usually used for overflow from the Royal for older patients who live in the area so that their family can see them more easily.

Dr SEIDEL - So, a patient who needs to be seen on a Sunday morning or Saturday afternoon is either going to call GP Assist or have access to a GP, then they could potentially decide whether they need to be seen in the practice or admitted to hospital, or they come to you.

Ms BIRD - They usually come to me. There is no after-hours care in New Norfolk at all or in all of the Derwent Valley, so they will come to me. Say someone has what I suspect is shingles, because I cannot diagnose it, I will explain to them how important the next 72 hours are in getting anti-viral care. I will try and find them an appointment at an afterhours in the city, but often they don't have the means or the transport to actually attend that.

My next option is the online Call the Doctor service which is done through a phone consultation which obviously is not ideal, particularly when you are dealing with something

that is a physical presentation; but it is better than nothing. Often there is 6-7 hours waiting for a call-back - they are calling back at 11.30 p.m. The script comes through during the night and then that patient can come and get the medication the next day. There is a huge lag in care and also there is no continuity. When that patient has started their anti-virals but the pain from the rash has ramped up, they still have to find an appointment to see a doctor about the pain and then get some medication on board for the pain.

It is a really fragmented system. It brings up some of these issues for my patients, which is why it is extremely frustrating when people suggest they could just pop down to Hobart or Glenorchy and see someone - but they can't. They have people they are caring for at home, whether it is a special needs family member, or young children, or an elderly relative, or a spouse with dementia. They have work and they cannot afford to give up a shift because they have casual and unstable employment. They don't have money to put petrol in the car and get down there, or they are simply too unwell to go. There is nothing; we are it.

Dr SEIDEL - You mentioned you don't have any incentive payments or any incentive to have pharmacy, which in turn must make it difficult to attract or train your future workforce. We all know we only attract them if we train them into regional areas. If you can't train them they are not going to come.

Considering that we are all quite rural in Tasmania now, is that a huge issue for Tasmanian pharmacy owners in particular? You also mentioned in your submission that it is also quite attractive now for pharmacists to work in other areas - to be employed in the hospital system because work hours are even, you don't have to face the weekend calls of 'what do we do now'? Is that an issue for you as a profession?

Ms MACKRILL - The workforce report has been released; you have probably seen that. Workforce is a major issue in all of health, and specifically pharmacy. It is a big problem.

We feel there is a real inequity in the public system in terms of private enterprise in pharmacy, because it is essentially a small business. They just cannot compete with the public system, the conditions offered, salary packaging. Obviously, pharmacies are highly feminised now, so there is the consideration of when I am going to have children. The public service is a great option because there is maternity leave, much broader than what exists in private enterprise. There's a lot of part-time work that is available, where private enterprise does not have that flexibility.

When you employ an intern, of course their first year they are employed at a lower rate because they are not qualified. But there should be some sort of incentive for our pharmacists to take on interns and get them trained. Often what happens in rural areas is that paying the intern wage is not sustainable, even though it is cheaper, but you never get them into rural practice because you can't afford to employ them. It is just a cycle. They never get to experience rural practice. There are discussions about overseas-trained pharmacists. They do their CAPs and they get their knowledge assessment and their knowledge clinically is the same as Australia. That is one tiny piece of the whole puzzle. There is no support for those people from our members who may want to take them on.

What happens is if you have two pharmacists, one's from overseas, one is local, domestic or whatever you want to call them, and it is kind of about what is easy. The easy way is to take the domestic person, and the overseas person who is probably really happy to work in a rural

environment doesn't get a look in because culturally it is so different. You get a male pharmacist from Egypt to work in an area like New Norfolk and a female walks in for emergency contraception. None of that is explained. We've tried to push an opportunity for the Guild to have bridging funding for a person who wants to come to Australia and practice, have done their CAPs, and become a provisionally registered pharmacist and then, before they do their intern, they have a contextualisation of pharmacy in Australia. There is that piece of the puzzle.

We are bringing in more overseas-trained pharmacists but often they end up wanting to go into those more populous areas. The workforce is a massive issue at the moment in pharmacy.

Dr SEIDEL - In some rural areas in Tasmania you basically have pharmacies who are owner operated, whether it is Nubeena, Bothwell, Dover, Geeveston. If the pharmacist is sick, that is it. What sort of locum support services are in place? Are they internally arranged through the Guild? Are there any formal or informal networks? Is there any state or federal funding to provide locum services for the solo pharmacists?

Ms MACKRILL - There's Rural LAP. It provides locums for rural pharmacy. Rural LAP is more broadly health care. Still you can't get people. They choose not to go to Dover or Geeveston even to do a shift or two. We had the issue of the pharmacists in Strahan who passed away suddenly. He had a stroke and died. His wife was not a pharmacist.

CHAIR - She couldn't even have the pharmacy open.

Ms MACKRILL - There is a bit of a grace period. We went wide and far in the state to try to find her somebody. We could get somebody for three days, real emergency, and that was all done through localised, 'Hey, can you do this? Can you help me here?'

Dr SEIDEL - We use informal networks through the Pharmacy Guild.

Ms MACKRILL - There are two Facebook pages, Locum Pharmacists of Hobart, one in Launceston. They 'cross-pollinate'. There is Rural LAP. There are a couple of people, like Ravens. Through informal networks we ended up getting a guy from South Australia to come over for three weeks to do a block of locum work. It has even become harder to get interstate people, obviously Queensland, Sydney, Melbourne, because of COVID-19. They can't physically get here.

Ms LOVELL - Who funds the locum work?

Ms MACKRILL - The owner of the business.

Ms LOVELL - So there is no funding support for that at all?

Ms MACKRILL -Rural LAP.

Ms LOVELL - What's Rural LAP?

Ms MACKRILL - It is a federal government program. Rural Local Assistance Program. I think they will pay for travel costs but the owner still pays the wages. They try to coordinate.

You can register on Rural LAP as a pharmacist to be a locum and then as an owner you register to see if you can find anybody.

Ms LOVELL - Is that an award salary or is it something that is negotiated between pharmacists? Is there a locum salary or is it just the normal pharmacist salary and they negotiate with the owner?

Ms BIRD - With programs like Rural LAP, you have a nominated salary that they have to offer to get people on their books. I believe they get some funding to cover the flights but then the actual salaried hours would be my cost. The couple of times that I have made contact with them, I've found the lead time that you need to organise something doesn't suit an emergency. What happens is that we sort of donate pharmacists to each other. My colleague went into labour really early, pre-term, so I lent one of my pharmacists to her for a few weeks. I worked their extra shifts. Another colleague who was having bowel cancer treatment; the same thing again. I lent one of my pharmacists and she was fortunately willing enough to do it, but then I cover the extra hours.

Mr GAFFNEY - You said 120 of the 160, or 75 per cent, are members?

Ms MACKRILL - Yes.

Mr GAFFNEY - What other organisations in Tasmania represent pharmacists? Can you explain that very quickly so that people listening know that is the Pharmacy Guild? I know there are a few. I think it would be helpful to give a snapshot of the relationship between the guild and the other group.

Ms MACKRILL - The Pharmacy Guild represents the owners of pharmacy. We are, for all intents and purposes, we are an industrial relations organisation, but we are broadly enmeshed in the whole system of pharmacy. It is about the owner but it is about the profession and the viability of the community pharmacy network.

The other peak is the Pharmaceutical Society of Australia. They represent all the profession; the clinical aspect and the profession per se. They are the professional body, like the Chartered Accounting or Engineers Australia. Then there is the pharmacists' union, Professional Pharmacists Australia. They are a union representing pharmacists' rights and so on.

Mr GAFFNEY - Is each of those three groups represented in Tasmania? They have Tasmanian branches?

Ms MACKRILL - The Pharmaceutical Society of Australia does. They are a national body. We are a federated body and I don't know about the union. I think they just exist as a union body but I don't think they have representation here.

Dr SEIDEL - Isn't it crazy that you have some locations in Tasmania where you can only have one pharmacy and there is no back-up plan in case an essential health service has to shut down. It does not make any sense. There's no back up plan whatsoever. So it is probably different in New Norfolk, and with two pharmacies it's great, but there are quite a few locations where you only can have one pharmacy under the law and there is no back-up plan if the pharmacy shuts down.

Ms BIRD - With the two pharmacies in New Norfolk, I have been in a situation where the pharmacy down the road has had to close for half a day while they get someone to drive down from Launceston to fill in. I do not have any history for those patients. No-one is allowed into the pharmacy without a pharmacist. They cannot even have someone sitting at the computer telling me this person has had Sertraline 50 milligrams before so that I can give them an emergency supply. They literally just have to go without. Their scripts are on file down there. Luckily we have been able to secure people at different times but if we did have a real workforce shortage, which I think is predicted to happen pretty soon, there will be dire consequences for the community.

Dr SEIDEL - Because it is the smaller solo pharmacies that close first, isn't it?

Ms BIRD - No, I think it is us that close last because the other pharmacy in New Norfolk is owned by a Melbourne syndicate. I turn up even limping or in pain or I will call a million people and find someone. I just won't stop until I can open the doors because I have that personal responsibility to my community.

CHAIR - Going back to the potential looming shortage, UTAS does train pharmacists. They don't train them in the north-west at the Cradle Coast campus. They have this beautiful facility where you can do a full nursing degree. Have you had any conversations with UTAS about expanding it?

Ms MACKRILL - We sit on their pharmacy committee, the PSA, myself, a couple of the other primary health, et cetera. When we are talking about how you attract young people into the degree, the guild has a job to do there. I have recognised that we need to be talking to young people in schools, years 9 to 12. What is community pharmacy? What does it mean to be a pharmacist? What are the jobs in pharmacy? What does it mean? Trying to keep people in their communities.

Kids used to like to go off, but now I think they kind of want to stay. They don't want to leave home, it's too expensive. They want to stay with mum and dad. When you're offering a pharmacy degree and you've got a kid from Burnie who has never been far, and all of a sudden, they have to be sent down to Hobart to do their degree, with all the other costs associated with that and being out of home - and the mere fact they're only a 17 or 18-year-old, however old you are when you go to uni. They're not overly familiar. It's a massive jump.

In Launceston, they've done nursing for years, and I did ask if there is any opportunity to do at least first year uni in Launceston. It is not a huge impost to travel from Devonport or Burnie, maybe three days a week depending on how many contact hours there need to be. My feeling was that they believed you don't want to spread the teaching staff. It's better to have one good school here, versus -

CHAIR - Aren't these fully connected lecture rooms now?

Ms MACKRILL - Personally, I think it would be wonderful. I did hear somebody the other day talking about this very thing. I know they're looking at speech pathology and physiotherapy out of the Cradle Coast. If we want to try build up a local - you can't rely on international students anymore. There's been this pot of gold here with the internationals, but

we need to really work on the domestics. We need to be able to get into schools and really push up, and talk about the scholarships.

CHAIR - The Cradle Coast and Launceston campuses both have really good labs for teaching nursing students - fully integrated models, fully injectable models that you can control from the control room, who can vomit on you and all that sort of thing. They're fabulous. What would the barrier be? Would there be a diminished experience for students in those centres, that they wouldn't get in Hobart - except perhaps someone standing in their room with them every day they're having lectures?

Ms MACKRILL - Personally, I don't know because I haven't done a pharmacy degree, but as technology advances and we become so much more used to this style of learning, I would like to think not.

CHAIR - Do you have a view on that, Belinda?

Ms BIRD - I think we have to move with the times and embrace what we can do. Yes, face-to-face you can develop a relationship with your professors and mentors and things like that, but there's no reason why you couldn't still have that relationship and still have opportunities to meet with the people delivering lectures, even if you're not seeing them every single day. For people changing their careers later in life, it would be a much more convenient way to deliver education.

Ms MACKRILL - On Belinda's point, earlier this year, I think 100 paramedic graduates came out of UTAS. The average career lifespan of a paramedic in Tasmania - I don't know if it's nationally - but here it is five years. They do a three-year degree, they work for five years and then they run away. These are the pathways that you could potentially develop and try to move some of those people into looking at pharmacy into the future - being better connected across the school or schools, to look at the opportunity for people.

I believe the uni operates in a silo, it's a bit of a vacuum. That's how I feel. I sometimes get frustrated about things I think are simple in terms of connecting with potential students and family members about the School of Pharmacy, and the opportunity that a career in pharmacy can offer, not only in Tasmania, and all the different things pharmacists can do.

They don't all have to work in community pharmacy. I wish they did, but that is the reality. I don't think we are getting that cut-through about what the degree offers.

CHAIR - If it was more accessible in the regions, it might make it more attractive.

Ms MACKRILL - Absolutely.

CHAIR - You made some comments here that these have been COVID-19-initiated processes, mainly through orders under the COVID-19 emergency legislation, which show things can be done, which is helpful sometimes. On page 8 of your submission, you say how emergency measures allow community pharmacies, under strict conditions, to give patients up to one month's supply of their PBS medicine, once in a 12-year period without prescription. That is supported under the emergency management act, under the COVID-19 legislation, but it doesn't mean the outcome is the same.

With some of those things that have occurred, including the COVID-19 vaccine, I believe it is a commitment from the Minister for Health to progress NIP vaccines through pharmacies - which might have been on the table before COVID-19?

Ms MACKRILL - We were pushing for it, but it hadn't been announced.

CHAIR - So, some of these COVID-19-related measures have been put in place, which really are helping our communities. What do you think should be maintained and continued? These will stop once those orders expire.

Ms BIRD - Continued dispensing is one of the things that is due to expire. That frightens me, because under the Poisons Act, I am allowed to give three-days' supply of medication without a prescription, and that is laughable.

Being able to give a full four-week supply or a full pack of something, while we organise an appointment for them and are doing a lot of that care coordination, is amazing, because it keeps patients adherent to their essential medication. It also removes that financial and legislative vulnerability that is there, because if the pharmacy authority were to come and look at how many own scripts I have at a time without continued dispensing, I would be in a lot of trouble.

Ms MACKRILL - There are two parts to that particular legislation. The federal government instituted the continued supply under the PBS, so when a patient gets their continued supply, if they are a concession patient they'd get it for $6.90, and it goes towards their safety net, or they get it for the co-payment price. In Tasmania, all we did was ensure that our legislation matched, and that yes, you can do this in Tasmania.

When the federal government removes that, we can still do it; we hope to still be able do it through the state. They leave that legislation in, so the pharmacist can give 30 days - but it is not covered under the PBS. There is still a financial burden because you can't give somebody their medication. It is a private prescription. That is a real issue. It would be great to be able to do it because it gives flexibility, but we need the federal government to say we can do this forever.

CHAIR - You need the PBS to allow that?

Ms MACKRILL - Yes. We know that emergencies happen every day for people. COVID-19 or not, there are still emergencies, depending on what you personally believe is an emergency. If it means somebody hasn't been able to get a doctor's prescription because they can't get in to see a doctor, we should have that recognised in our federal legislation, and our state legislation should recognise that as well under the Poisons Act.

CHAIR - I think I am hearing you say that the Poisons Act will need amendment to achieve that, in addition to the federal government enshrining the change that has occurred as a result of COVID-19?

Ms MACKRILL - Yes, that is correct.

CHAIR - Have you had discussions with the minister about amending the Poisons Act to do that?

Ms MACKRILL - We spoke with the minister two weeks ago.

CHAIR - Is that likely to occur? Is it the act or the regs that need to change?

Dr SEIDEL - The act.

Ms MACKRILL - I don't know. I would like to think so.

Ms BIRD - I don't think they are across how crucial it is.

Dr SEIDEL - It is interesting because one of the commitments was to allow pharmacists access to after-hours funding as well, so they probably do this for emergency reasons. The question is wha are they going to do with those emergency scenarios then?

Ms MACKRILL - The thing about access to funding for after hours, that is fine but you have to able to do stuff.

Dr SEIDEL - That is what I am saying - the funding is one thing for election purposes but what are we actually going to do here? There needs to be a backup plan.

Ms MACKRILL - That's about the scope. It is about enabling pharmacists. I know you are a doctor so I am not sure how you sit with that. We have seen a fabulous UTI trial, in Queensland. Pharmacists have been able to diagnose, prescribe and dispense for minor UTIs, or whatever the wording is. It is finished now and the trial is being evaluated, so we should have the results of that trial. I think there was 5000 occasions of service for the standardised treatment for UTIs that happened, primarily for women, that have not had to wait or end up in hospital.

It is one thing to be open, but then you have to able to do stuff otherwise it is like - here is a pharmacy go and see them; but actually, you would probably need to go to the emergency department anyway.

Ms BIRD - It is really hard when someone does come to you and you see them and they really do need to see a doctor. There are three responses - there is a laugh, because it's comical to think that you could get in and have a timely appointment; there is anger, because they have been calling all the practices in the area for days begging to get on the cancellation lists; or there is just helplessness and despair, show me how I can get to see a doctor. It really is distressing in some cases, the amount of time that people are having to wait to get things addressed.

Dr SEIDEL - It puts you on the spot because you are there face-to-face, you have to do something for me now. Everybody else has been online or on the phone and not really there. You actually are there.

Ms MACKRILL - I have spoken to Mr Ferguson, being the tech, stem, digital fellow now, and when he was the Minister for Health, and also to Mr Rockliff, as the health minister, about the opportunity for pharmacies to provide a coordination of Telehealth; but to ensure that it is done via video. It can be done within the pharmacy because they have the infrastructure, it is already there. The pharmacist would coordinate that with the person and introduce the

person that needed the care to the doctor, and potentially say, 'Mrs Smith has come to see me, she has this thing on her arm'. Out of the 55 million Telehealth appointments that have happened since COVID-19; only 7 per cent have been done by video

Dr SEIDEL - People don't use video.

CHAIR - Why is that?

Dr SEIDEL - It is not a surprise; it has been known for decades now that people do not use videos. There is almost no added benefit for a video component. It is internationally known. People do phone or text based as synchronised consults but there is often no added benefit for video. It has been a myth forever that it is great for video but the evidence does not support it.

Ms MACKRILL - I guess it was a way of maybe helping pharmacists, being more or less place-based they could have the infrastructure, and then you work with an organisation that does video Telehealth to have eyes on the person. The pharmacist is there and can say, 'if you need me to come back in for any kind of clinical oversight I am happy to provide it; if you need me to come in to talk about medication initiation I am happy to provide it'.

Triabunna is about to lose their doctor. I think the doctor up there is retiring. The doctors in Swansea are both pretty close to retiring. Bicheno has a revolving door of locum doctors. It is not just those areas - it is broad. There are all these people that go to their pharmacy as a way of being able to maybe triage and get people the care they need but again, we need funding to do it. People and ministers mention 'That would be good for you because you get the script.' It is not like the script has another $150 attached to it over here, there is this bucket of money that nobody knows about. It is just simply not enough to be able to offer those extra services.

CHAIR - I think that may be a public perception issue too. I was informed of a person who says that they may have been, what we will call 'vaccine hesitant' for the purpose of the discussion, and thought that the only reason the pharmacists were getting into it was for the money. I informed that person that's not the reason you get into it because it is not really covering your costs, as I understand it. How much do you get for delivering a COVID-19 vaccine?

Ms BIRD - Sixteen dollars for the first one, $19 for the second one.

CHAIR - You can see why pharmacists get into that, can't you?

Ms BIRD - Yes, but the amount of time you spend with informed consent and booking and rebooking and things like that, just evaporates that remuneration almost immediately.

Ms MACKRILL - And the pharmacists definitely wanted to be a part of the delivery of something that is going to help get people back on track, in terms of public health benefit. A lot of this is about public health benefit, but you can't do it for free. I think that the other thing for the profession is that there would be more fulfilment out of the profession if it is tied to practising at full scope, and if there's a remuneration aspect that sits around that, because they can do more. I think, for people thinking about the profession, that gives them a bit more fulfilment in their role, about being able to broaden out what they can do in a community environment as well. We think it would be better for the profession for people who are

currently in it, to be able to do more. You can't just do more and not get anything for it. It is about doing more -

CHAIR - No, we don't expect it of anybody else.

Ms MACKRILL - Yes.

CHAIR - All right. Thank you very much for your time. It has been really helpful.

Ms MACKRILL - Thank you for giving us the opportunity. We really appreciate it. It has been fabulous.

CHAIR - Thanks for the work you do.

THE WITNESSES WITHDREW.

The Committee suspended from 10.47 a.m. to 10.51 a.m.

Dr ALEX WODAK, VIA WEBEX, WAS CALLED AND WAS EXAMINED.

CHAIR - Thank you, Dr Wodak, for attending our committee hearing. The hearing is being broadcast. It is a public hearing that Hansard will be transcribing as part of our report. We have received and read your submission and invite you to introduce yourself and to speak further to your submission. Members will no doubt have questions for you.

Dr WODAK - Thank you for inviting me to appear before you to give evidence.

I would like to start by emphasising that making it as easy as possible for Tasmanian smokers to switch from deadly cigarettes to much lower risk vaping is the single policy change offering most to improve the health and wellbeing of people living in rural Tasmania. I will explain why that is the case.

First, how is rural health different from urban health? It has: shorter life expectancy; higher disease rates; less access to health services; lower income; poorer education; higher unemployment and higher smoking rates.

Second, how does Tasmania differ from other Australian states? It has: the shortest life expectancy; the lowest per capita income; often the highest but now equal second highest smoking rate with 14.7 per cent smoking above the age of 14. I'll remind you that no doctor in Tasmania is as yet willing to prescribe nicotine for vaping under the new arrangements which began operating last Friday. Tasmania is the only state with prohibitive fees for pharmacists.

Third, why is smoking still so important for public health? Again, there are several reasons. It is the most important cause of preventable deaths in Australia. There are more smoking related deaths than the combination of deaths from alcohol, prescription drugs, illicit drugs, HIV, road crashes and suicide. Also, the lowest economic quintile has a smoking rate which is about twice as high as the highest quintile; they smoke more cigarettes per day and they have a lower quit rate. Smoking exacerbates poverty and widens the health gap between the rich and the poor. An Australian smoking 20 cigarettes a day spends $12 500 a year. A vaper spends less than $2000 a year.

Fourth, why is vaping such an important breakthrough in tobacco control? Smokers switching to vaping reduce their health risks by more than 95 percent. Vaping is now the world's most popular and most effective quit smoking aide. That combination is very important. Vaping is a form of tobacco harm reduction. The concept of tobacco harm reduction has been proven by Swedish snus over many decades. Where smoking and tobacco harm reduction options, including vaping, are allowed to compete with cigarettes, smoking rates or cigarette sales tumble.

Fifth, is tobacco control doing well in Australia now? The smoking rate decline has been 0.3 per cent per year in Australia since 2013. It's been three times that in the UK at 0.9 per cent. In the US, it's been more than double that at 0.8 per cent. Vaping is more common in the UK and the US than in Australia but tobacco control is much more aggressive in Australia than in the UK or the US.

Australia is the only western democracy to ban the retail sale of nicotine liquid and requires doctors' prescription for nicotine for vaping. The restrictions for nicotine for vaping

increased on 1 October, but deadly cigarettes are still readily available for adults from 20 000 outlets.

Sixth, could Tasmania adopt vaping policy that works best for Tasmania? Yes, you could. You would need to shift nicotine for vaping and the Tasmanian poison standard to a lower schedule to allow it to be sold over the counter from approved outlets, just like tobacco products. You'd need to make sure the adverse effects of this would be minimised by risk-proportionate regulation. South Australia already has different policies from the rest of the country.

Seventh, what should Australia do? Vaping should be regarded as a consumer product in competition with cigarettes. We should make it very easy for older smokers to switch to much lower-risk vaping while minimising vaping in young people.

Why is there so much opposition to vaping in Australia? There's always trenchant opposition to new drug harm-reduction interventions. For example, methadone treatment, needle-syringe programs and drug consumption rooms all faced vehement opposition, which lasted for many years. The criticisms of vaping are dishonest, unscientific and unscrupulous, just as criticisms of previous new drug harm-reduction interventions were. A good example of this can be seen in the recent case report in the *Medical Journal of Australia*, of a young woman who had developed a severe respiratory condition wrongly attributed to vaping cannabis. This is really a debate between pragmatism versus nicotine prohibition. We have a huge problem that there's been an excessive focus on small and theoretical harms for young people and that's led to a neglect of adult smokers, who are at immediate and known risk. Thank you.

CHAIR - Thanks, Alex. Could you take the committee through the difference in the way South Australia regulates? You made a comment about South Australia having a different framework.

Dr WODAK - These were the arrangements they had before 1 October, when there was a ban on any nicotine availability through the internet. That made a huge difference. Since the nationwide tightening of restrictions last Friday, 1 October, there's less difference. The point I wanted to make is that South Australia did have a different policy from other states and territories, and from the Commonwealth.

CHAIR - What was their policy? It seems from what you're saying it's been overridden by the national changes.

Dr WODAK - Yes.

CHAIR - So, South Australia is now the same as every other jurisdiction.

Dr WODAK - Yes, but they did have a different policy for several years. In other words, if Tasmania wanted to have a different policy, it wouldn't be the first time in this area. There is a precedent.

CHAIR - The question I am asking you, Alex, is if the South Australian policy and approach was different before last Friday, 1 October, when the national framework changed and that has been overridden, how could Tasmania now go it alone?

Dr WODAK - By shifting nicotine for vaping from schedule 4 to schedule 2 - that would be the national schedules; I don't know the Tasmanian schedules. If it was in schedule 2 in the Commonwealth schedules then it could be sold over the counter, and you could restrict the outlets to tobacconist shops, vaping shops, or whatever you like; and you can impose age restrictions - and I would hope you would impose age restrictions.

CHAIR - Would that also require a federal government change to the rules that are now imposed?

Dr WODAK - No, it wouldn't. Each state and territory have their own poisons schedules which generally closely mirror the Commonwealth schedule, but sometimes depart from it.

CHAIR - You are probably aware of comments from our health minister saying the jury is still out on the safety of vaping; not so much in comparison with the - you can't say safety of smoking, there is no such thing - we know the negative health impacts of smoking. His comments have been, as I understand them, that there is still not enough evidence that you are not trading one known harmful practice with another because there is not enough research to support the safe use of vaping in the broad sense. Can you comment on that?

Dr WODAK - Yes, I can. Sixty-eight million people around the world now are estimated to vape in dozens of countries. The market really began in 2007, but really started taking off around about 2010 to 2012. There are thousands of articles published every year about vaping and there have been few, if any, deaths from vaping - despite the fact that there has been such a large uptake around the world of something that admittedly is very controversial but is therefore closely scrutinised. We should really be looking at the relativity of the risks from vaping versus the risks from smoking. After all, one of the commonest forms of harm reduction that - I see one of our members of the committee has a safety belt, I am not sure whether it is on at the moment, in his car.

CHAIR - No, he's not driving, he's sitting still, yes.

Dr WODAK - There are deaths attributed to the fact that people wear safety belts, but it is relatively much safer to wear a safety belt. Every now and then a driver or a passenger dies because they are wearing a safety belt. It doesn't happen often. It's the net benefit that matters; and the net benefit for vaping is very clear. Cigarette smoke contains about 7000 chemicals including 70 carcinogens - that is, cancer causing chemicals; a number of toxic chemicals. These are in high concentration. Vaping aerosol contains about 300 chemicals. These are generally at low concentration, and many are at trace concentration. It is hard to believe that vaping could be anywhere near the huge risk that smoking has. Many prestigious organisations around the world, and indeed many countries now, accept that vaping is much less risky than smoking - not harmless, but much less risky - and therefore we should encourage smokers to switch from the much riskier option to the much less risky option.

CHAIR - Being the devil's advocate here, if that is the reason you want to do it, and as an additional tool to assist smokers to give up, what is so bad about the federal government's move to require the intervention of a health professional to provide a prescription to enable that person hopefully to switch from smoking cigarettes to vaping as a smoking cessation program? They are also getting advice from their medical practitioner at the time. Why is that such a negative thing?

Dr WODAK - Because it is making the much safer option much harder to get than the much deadlier option, in a nutshell; and it gives the appearance that nicotine for vaping is still available, but in fact it is much harder to get than cigarettes. People can go to 20 000 outlets - some of them are available 24/7 - to buy their cigarettes, and these are very easy to get. To get a prescription, a smoker has to make an appointment with a general practitioner, they have to find a general practitioner who is willing to prescribe nicotine. There are none in Tasmania. This is smoke and mirrors. It is a negative development.

Ms LOVELL - Thanks Alex. A question about point 11 in your submission around switching the responsibility for regulating nicotine fluids to the ACCC rather than the TGA. What guarantee or safeguards would that provide? You've talked about the relative safety of these liquids compared to smoking products and cigarettes; what safeguards would be in place to ensure that the product is a safe product for consumption, or a relatively safe product? As Ruth referred to earlier, one of the concerns is that people are still not convinced that it is a safe product.

Dr WODAK - Whatever the intent of the current arrangements, the effect is to guarantee that most people who vape will obtain their nicotine for vaping from the black market. That is what 99 per cent of vapers do at the moment; and now we have made it hard for smokers to now want to switch to make that change. It gives the appearance that the market is being regulated, but it has delivered the market to the black market - which is unregulated, of course.

We are the only western democracy to have these arrangements. In New Zealand the four major parties - governing Labour; New Zealand First; the Nationals, equivalent to the Liberal Party in Australia; and the Greens -all voted on 10 August last year to have sensible arrangements like the UK, and that is what we should do.

Ms LOVELL - My other question was about how people, particularly in Tasmania, were accessing these products before 1 October. There wasn't a legal way to do that, was there?

Dr WODAK - There was the appearance of a legal way, but it was much more difficult. Vapers who were determined to keep vaping, rather than switch back to smoking, unfortunately obtained their supplies from the black market.

Ms LOVELL - This is prior to these changes, prior to 1 October?

Dr WODAK - Yes, and I submit that it is not going to change all that much after 1 October. The difference is now that many of the vapers in Australia have become quite fearful of the new arrangements, and an overwhelming majority of them have huge stockpiles in their deep freeze which they have bought in advance - knowing it was going to become more difficult after 1 October. The major difficulty experienced from now on is going to be by smokers who want to switch to a less harmful option.

Dr SEIDEL - Do you have any data on how many people vape now in rural and regional Tasmania?

Dr WODAK - I don't think anybody has that information. We know that smoking is more common. When I look at lung cancer incidents in the Cancer Atlas of Australia, 80 per cent of lung cancer in males is amongst smokers, 90 per cent in women. The north-east tip of Tasmania glows bright red, meaning the highest incidents.

I don't know enough about the demographics of Tasmania, but I assume that is where a lot of low-income people live. Around the rest of Australia, the areas with the highest incidents of lung cancer are low income areas, and areas with a high proportion of First Nations Australians.

Dr SEIDEL - You also mentioned that medical practitioners are reluctant to prescribe nicotine products. Have you had conversations with medical colleges and the AMA with regard to providing education, or understanding why medical practitioners are reluctant?

Dr WODAK - My colleague Dr Colin Mendelsohn had those discussions, or at least tried to. I am reminded of the experience we had with medicinal cannabis, which the House of Representatives and the Senate legalised in February 2016. For many years, although it was legal, it was virtually unobtainable. And it was unobtainable because doctors were reluctant to prescribe it in large enough numbers to meet demand - and doctors were reluctant to prescribe it because they have been sitting there for decades while cannabis was demonised, and any potential benefits were pooh-poohed, and any harms were exaggerated.

This is exactly the experience we have with vaping, where we have nine health ministers, nine chief health officers, nine health departments, all of the health charities - apart from the college of psychiatry - vehemently anti-vaping. It is no surprise to me that at the moment only 25 doctors in the whole of Australia are prepared to prescribe nicotine vaping. We know what is going to happen. Those numbers will build up slowly, and when they do, the politics of this will change.

But right now, if you are a smoker and you want switch to vaping, it is going to be incredibly difficult.

CHAIR - Any other questions? I don't have anything further, Alex. Did you want to add anything in closing?

Dr WODAK - On a personal note, I want to say I have never lived in Tasmania. One of my sons bought a house in Hobart and hopes to move there. I have been coming to your state since I was about nine or ten. It is a gorgeous part of the world, and the comments I made about Tasmania make me very sad, to be honest. I am 76, and I would love to see change while I am still alive.

CHAIR - We do have our own challenges here, as you have identified. Thank you for your time Alex, we appreciate it. Thank you very much.

THE WITNESS WITHDREW.

The Committee suspended from 11.14 a.m. to 11.30 a.m.

PUBLIC

Mr MICHAEL BAILEY, TASMANIAN CHAMBER OF COMMERCE AND INDUSTRY, AND **Mr ROBERT MALLET**, TASMANIAN SMALL BUSINESS COUNCIL, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Welcome to our committee hearings, Michael and Robert. We appreciate you coming here and the submission you provided. Both of you have appeared before parliamentary committees, but just to remind you, everything you say is protected by parliamentary privilege while you are in front of the committee. It is a public hearing, it is being broadcast, and the transcript will be transcribed and put on our website. If you do have matters you wish to raise of a confidential nature, you can make that request to the committee and the committee will consider that, but unless you have any questions, I will get you both to take the statutory declaration and we will move into your evidence.

Thank you. If you would like to make some opening statements, introducing yourselves and what brings you to this committee.

Mr MALLET - I am the CEO of the Tasmanian Small Business Council and I know all of you, although I have not met Bastian often, unfortunately. We have provided a submission before. We provided a submission today, which you all have copies of. We continue to prosecute the case that if Tasmania wants to become healthier, one thing we can do is reduce the rates of people who smoke tobacco.

It is unequivocal that it is harmful, but it is a legal product, so we need to come up with some innovative ways to encourage people to stop smoking tobacco products.

We contend that one of those ways is that Tasmania should introduce the opportunity for people to use a liquid nicotine vape. Numerous studies demonstrate that it is less harmful than burning tobacco paper and other bits and pieces and inhaling them. We have plenty of evidence that this is the case, but unfortunately, overall it seems a bit sort of schizophrenic that the federal government is quite happy to pass a law, which came into effect on 1 October, that if you do want to use a liquid nicotine vape, you must go to a doctor and get a prescription, and that prescription is then filled by a pharmacy.

It seems odd that on one hand we are arguing - and we can demonstrate - that it is a less harmful way for people to have the effect of nicotine, but there are so many barriers to being able to access it legally in Australia now. It just does not make sense.

To my knowledge there are no doctors in Tasmania registered with the Therapeutic Goods Administration who wish to prescribe the nicotine. I don't think you have seen any more recent figures, Michael? Similarly, I don't know of any pharmacies in Tasmania that have chosen to pay the $1200 tobacco licence fee that they need to stock the nicotine liquid and then supply it to those people with a prescription.

So, in Tasmania, if you wish to take a less harmful approach to smoking or using nicotine, you are obliged to go to the mainland. Telehealth appointments are available, I understand, but you then have to buy the product from a pharmacy interstate.

From a small business point of view, it makes no sense whatsoever that we are pushing business away from Tasmania, and to us it makes no sense at all from a healthy Tasmania aspect. If the healthier alternative is the hardest thing to access, it's more than likely the people

in areas with our largest smoking percentages - Bridgewater, Derwent Valley, Claremont, Rokeby, where over 30 per cent of people smoke - will take the easier option. They will go to their local newsagent, local supermarket or local service station and purchase the more harmful alternative of tobacco. We think there is time for doing something else. I will pass over to Michael.

Mr BAILEY -I am Michael Bailey, CEO of the Tasmanian Chamber of Commerce and Industry and thank you so much for the opportunity to present today.

One of our focuses during the last 10 years of my time as CEO at the TCCI has been to work in areas other than just economy because we understand that for the Tasmanian economy to grow we need to have great health and education systems. Quite clearly our health system focuses on the acute care and not as much on the preventative care of Tasmanians. We see this product as being one that could be very disruptive in the preventative care of Tasmanian smokers. We know from looking at the data and looking at the Mitchell study results, Tasmania hasn't really impacted its smoking population in data comparing 1979 to current. For example, Bridgewater/Gagebrook, according to 1979 data, had a 40 per cent smoking rate. Now it has a 43.4 per cent smoking rate.

What we are seeing is increasing taxes hasn't impacted the smoking rate of the most vulnerable Tasmanians, Tasmanians in the most difficult suburbs, Tasmanians with lowest income. What we are seeing is taxation increasing cost and increasing poverty in Tasmania. If you look at the areas of Tasmania that have the highest smoking, they are essentially areas of greatest social dislocation and areas of greatest poverty. What we are saying is that it is time for us to be more disruptive in this space. It is time for us as a state to look at what other countries are doing and the research from other countries.

For example, British Public Health says that vaping is 95 per cent less harmful than tobacco products. When I am saying it was not harmful, the situation we have at the moment is a little like me. I don't drink alcohol because I know and we all know that alcohol is unhealthy. At the moment the situation in Tasmania, and in Australia generally, essentially says that I can access full strength beer easier than I can access light beer. In fact, accessing light beer is going to be so difficult for me that it is going to be easier for me to pay more to get full strength beer than to try to get light beer. That is the situation we have in Tasmania, which is totally illogical. So, what we are saying is that it is time to be disruptive.

It is time for us to face up to the fact that we have not impacted smoking in the most vulnerable areas, even though tax rates have gone up dramatically in the time since 1979 to current. It is time for us to be disruptive. What we are calling for is for this committee to do two things.

First, we urge the committee to do a study tour, when we can, to New Zealand to see how New Zealand are using vaping products to approach this situation. If you can do it, and I know it is difficult with COVID restrictions, let's go to the UK, Canada and Japan to look at some of the data there. For example, the American Cancer Society have looked in depth at the impact of vaping in Japan. Between 2015 and 2018 there was a steady decline in smoking in Japan of about 2 per cent per year. When vaping products were brought in as a healthier alternative to what is clearly dangerous tobacco products, they saw an annual 10 per cent decline, so five times better result when vaping products were brought in.

CHAIR - Did they do anything else at the same time?

Mr BAILEY - As far as I know, no, but I don't know that. It's a good question. That's why I would urge this committee to do a study tour. Go first to New Zealand when the borders open and see what New Zealand is doing in this space and then, if you can, go further abroad.

Mr GAFFNEY - You said there was a 10 per cent decrease in Japan between those years from people who were originally smoking.

Mr BAILEY - That is on tobacco sales.

Mr GAFFNEY - What was the increase in the numbers of people vaping?

Mr BAILEY - I don't know but I suspect it would be countering that, which is good because what we are seeing is a decrease in the health impact of those people.

Mr GAFFNEY - But it could have been greater than 10 per cent. There is no stat there.

Mr BAILEY - I haven't got that stat so I can't answer in a learned way.

What we would love to see is for this committee to recommend a pilot to be run in a Tasmanian community and transplant the New Zealand system into that community for a period of time and see if it does impact cigarette usage in a difficult community.

If you pick a suburb like, for example, East Devonport or Bridgewater, high poverty communities. We know that the use of cigarette products has not changed in those communities over the years of increasing taxation. If we were to pick those communities - even one or two, or as I suggested today in my editorial in *The Advocate* and say four - right let's use the New Zealand model, put it into this society, see what happens over three years to see if we can reduce the amount of the more dangerous cigarette products transplanted with less dangerous vaping products. Again, I use the full strength beer to light strength beer analogy. What we are doing at the moment is making it easier for people to access full strength beer than to access light beer.

I also argue that nicotine products have been available in Tasmania for many years, in sprays, in chewing gums and patches. Those products are available even in supermarkets. The argument that vaping somehow encourages young people to take up smoking I think is completely illogical when it is easier for a young person now to go and buy a branded nicotine chewing gum that tastes the same as non-nicotine chewing gum from a supermarket. If that happens I would be very surprised.

What I am suggesting is that we pick up the New Zealand model, we put it into three or four communities in Tasmania. We regulate it very heavily of course. We need to make this product more accessible for communities that need it. They use cigarette products now; they pay more for them than they would for vaping products and they have a worse health outcome for the cigarette product they are currently using. Again, we have not affected the percentage of smokers in those communities in the past 20 years. It is time to be disruptive.

From the economic side of things, when vaping products are sold I would like them to be bought from Tasmanian not from mainland businesses. I think that is good for our economy

too but fundamentally the important thing here is how we can affect those numbers. Just continuing to put the price of cigarettes up is increasing poverty in these communities. Vaping products can be cheaper, they can be more accessible and they will be better for the person. Still not healthy, like light beer still is not healthy for someone but a solution, a disruptive option to try. That is the reason for our push for a pilot to see what happens. Use what New Zealand does.

To finish, I urge this committee to go New Zealand when the borders open. Do a study tour, see what they do and why they do it and how we could then use it in Tasmania as a pilot in one or two communities. If it doesn't work, fair enough, but if it does work we could come up with something that could make a difference.

CHAIR - In the submission you referred to an analysis taken by an Australian Retail Vaping Industry Association. I am interested in that because I couldn't find the source document to read it. There is a risk of conflict of interest in many respects if they are looking at their own benefits. I went searching and I could not find it.

Mr BAILEY - I will get a copy sent to you. I haven't got a copy with me at the moment but I will make a point to have that forwarded to you.

CHAIR - It is listed in footnote no. 4 but I couldn't find it.

Dr SEIDEL - Earlier you mentioned that nicotine replacement products are already quite widely available in supermarkets. I was wondering how available they are in smaller retail environments and what the experience is when it comes to offering nicotine replacement versus tobacco products.

Mr BAILEY - I'm no medico so I probably cannot answer that in a learned way. We do know that a lot of people use nicotine replacement products, even some of our most high-profile politicians in Tasmania use nicotine replacement products.

We suspect that the reason that people in really difficult circumstances smoke is because smoking is a release for them. It is a way of reducing stress; a whole range of things. We also understand that mechanical movement of smoking has some sort of psychological benefit, hence the vaping product is not so different.

As far as availability goes, I am not sure I can answer that other than to say that when I visited those communities, I haven't probably looked in depth to see if they are there. I have shopped often at the Mowbray supermarkets and they have nicotine replacements in those supermarkets.

Dr SEIDEL - Is it your understanding that most tobacco retailers also offer nicotine replacement products at this stage?

Mr BAILEY - I don't know the answer to that, sorry.

Dr SEIDEL - Is that something you could find out from your membership base?

Mr BAILEY - Yes, I certainly can.

Dr SEIDEL - The rationale for the question is, if retailers are now offering a newer or different nicotine replacement product, we need to understand what the area of expertise is for retailers, and if you are specifically interested only in vaping products, or if there is already some retail expertise in offering another form of nicotine replacement - and if that is not the case, what is the real driver? Is it less profitable to have other nicotine replacements in there? Is it difficult, is the distribution different, display, expiry dates?

Mr BAILEY - I would be surprised if they didn't offer it, to be honest. In a lot of these communities, the people they deal with are faces they see often. That's why I think a pilot in smaller areas like that would be really beneficial, because you know the shopkeeper could easily ensure that the person they're selling the product to is someone who lives in the community. So again, you can quarantine that pilot really quite nicely, but I would be surprised if they didn't offer nicotine replacement.

Dr SEIDEL - It would be good to know what the data says.

Mr BAILEY - Yes, we will find that out.

Mr MALLET - If you talk to some smaller retailers, newsagents in particular, who also sell tobacco products, they would be quite keen to sell nicotine vaping products for a range of reasons. One is that there is no margin in tobacco, really. It's a convenience line. People stop off and pick up the fags, but they also grab the newspaper and maybe a few litres of milk and something else and off they go, so it's not invariably their only purchase. It's a basket that they take away with them. Some businesses have been getting out of the category, because it is expensive to insure.

Tobacco products in Australia are the most expensive in the world, purely and simply because of the taxation component. The real cost of a packet of cigarettes is about $3; that is what the retailer pays to the wholesaler. The rest is tax, plus GST. There is about a 10 per cent margin in it for the retailer, because it's fairly competitive.

If a retailer had the opportunity to stock and sell a liquid nicotine vaper, the cost would be less to them, and they would have no less margin in the overall sale. The risk to their staff for armed robberies, et cetera, is significantly less - because cigarettes are highly desirable on the black market - and their insurance costs would go down. So, there's a range of reasons why smaller retailers would in fact prefer to sell a liquid nicotine vaping product.

Earlier, you asked about the expertise of the people in the retail. I can't comment definitively, but I would suggest the vast majority of smaller retailers would put the product on the shelf, and when you come in as a customer, you can either choose to buy Marlboros, or go along and buy your nicotine replacement product. It goes in the basket. I don't know of any smaller retailer who would try to counsel a customer one way or the other.

Mr MALLETT - We have lots of different ideas about what these vaping products really are. There is the health component, but there's also the public perception that this person is going to have clouds of smoke. That's what we see sometimes outside of buildings, but more modern iterations of this are 'heat, not burn'. You don't actually set fire to these things. I will pass it around. This is a modern sort of heating product. I will just pull it apart. There is a little plastic vial that goes in there. There's a heating element. It just injects. When you push the button the light comes on, it heats the product, you get the nicotine component coming

through to your throat, and it emits virtually no vapour whatsoever. It's amazing how little comes. From a public perception view, it's not like those old-fashioned big clouds of smoke, et cetera, but as Michael was talking about, it is also that opportunity for that hand-to-mouth thing with the cigarette. It's as small as that.

Dr SEIDEL - Earlier, you mentioned we should trial the sale of availability of vaping products. Have you approached research institutions or the minister for any exemptions for a trial over a limited period?

Mr BAILEY - No, we would like to take that further. I think this committee supporting at least that would give us more clout to be able to push for that. Again, as I have said, I would literally transplant the UK or New Zealand model into a community. I would use a local retailer as a way of distributing a vape replacement product instead of cigarettes. Can they know their community, and the people who shop there? And then see what change we have in cigarette purchases over a two- or three-year period.

Just answering your previous question, too. I might be wrong, but I wonder if retailers are allowed to sell nicotine replacement products if they are classified as health products, rather than products they are allowed to sell?

Dr SEIDEL - Supermarkets are.

Mr BAILEY - Supermarkets and also chemists can, but I am not sure if a tobacco retailer or newsagents can sell what are classified as health products. I may be wrong, but something in the back of my head is ticking away.

Mr GAFFNEY - I am interested in the pilot project suggestion. The pilot project would have a time line to work on those, and the product would be available from so many retailers within that area.

Mr BAILEY - That's what I'd do.

Mr GAFFNEY - Robert just said that you don't make any money out of that, you make money out of the newspaper or what else they buy. When all roads lead to Rome, how would your other retailers in the Devonport area feel if you had two or three places in East Devonport selling vaping material and not anywhere else in Devonport or on the north-west coast?

Mr BAILEY - That is a good question. What we have seen across COVID-19 is that business, as well as community, have been fabulous when they understand the health need of a decision. I think there would be support across business for trying to reduce smoking rates in Tasmania. I think we could message that in a way that businesses would understand the rationale and the reason for us doing this.

Again, across the course of the pilot, I am not suggesting we create a model where retailers make an absolute swag of cash out of it. I would rather have a model where we are trying to transition people away from cigarettes into vaping. It could be a very different thing, where government pays for vaping products to be provided to smokers in the community who we know are long-term smokers. This is an idea that we would need to run through bodies such as Menzies to work out the right model.

With the pilot, we are trying to see whether we could achieve in Tasmania what other countries have seen - a reduction in the use of more dangerous cigarettes to vaping products in the community. The idea for that pilot is not to increase the profitability of a local business, it is the other.

Mr GAFFNEY - I am quite open to the idea. I would like to see more information from the TCCI and small business about how that pilot project will work. Who would run it? What might be the time line? How would that be managed? It is alright to come up with an idea, but how do you put that into practice?

I am interested if you have any more information that you could provide to the committee, about how you would see that pilot project working.

Mr BAILEY - I think more the other way - that if the committee was able to give support to the idea, we would then have the ability to go to somewhere like Menzies and say let's work through what this would look like, and build something to present to government. At this point, we feel going to government with this idea would be a complete waste of time.

Dr SEIDEL - Potentially you would have to fund it, put it to an independent body like Menzies or whatever, and then stay out of it and let researchers do their work.

Mr BAILEY - Yes, and let it go; that is absolutely fine. We do want this to be done properly. This needs to be proper scientific medical research. Again, I would love the health minister to be driving this, because I think we could do something really disruptive in the state. It seems to us really frustrating that it is having to come from us.

As I said, the numbers are not changing in these communities. Putting tax up has just increased poverty in those communities. Let's try something different.

Mr GAFFNEY - One of the reasons given earlier for having the person go to the doctor or whoever, there's some regulation to say, perhaps, that someone smoking for 10 years wants to decrease that by vaping. That is different from the 16- or 17-year-old kid who wants to get into that before they are addicted to it. I know an 18-year-old kid can buy cigarettes, which is fine. If they had to go through the GP to get it, the GP would say, you're not addicted yet, whereas a 35-year-old male or female who has been smoking for 15 or 16 years would be.

From that point of view, I understand how the Government is trying to regulate it a little. Do you have any fears that vaping might be seen as trendy? It has been raised with us; that it is seen as the trendy proposal other than cigarette smoking.

Mr BAILEY - What we know is that 95 per cent who smoke started before 18. We know that our current cohort of smokers started before the legal age. I find that extraordinary. Something is clearly breaking down in our system somewhere. I don't think people will see vaping as being the new, trendy cigarette. If all the people who started smoking started on vaping rather than on tobacco products, we know, according to UK Health, it's 95 per cent less harmful. At least, it's better. I don't think anyone below the age of 18 should be smoking at all. So, we need to fix that.

People who are smoking, that 43.4 per cent in Bridgwater who are smoking, if they're smoking vapes rather than cigarettes, we know it is better for them and for the health system.

Again, it's not good - don't get me wrong. It's like light beer compared to full strength beer, it's still not good for you but it's better than the other one.

Mr MALLETT - I remembered what we were going to tell you. Bastian, you asked if we had spoken to the minister of the Government about this and you've just heard from Dr Wodak. Prior to Ivan Dean's bill, Alex met with a number of people, including yourselves. I'd spoken to the minister, to Jeremy Rockcliff, at that stage when he was with Mental Health and Wellness, because there's a component to the tobacco stuff that people do it from a stress point of view - to stop them from being able to -

They're going to do it one way or the other, so to make it not as healthy, I was going to say. That's not what I really mean, it's just not as harmful, then, in that case, we could have done it.

At that stage Jeremy had agreed to meet with Dr Wodak. He said, we'll wait for the T21 business to go through. That happened. The legislation failed. Ever since February I have been trying to contact Jeremy in both capacities, now as the Minister for Health, to meet with Dr Wodak, to have a discussion about minimising health impacts of tobacco but he has been uncontactable. He has been refusing to choose to meet with and acknowledge an international expert in the issue. Very disappointing, I have to say.

CHAIR - Can I go back to the evidence Dr Wodak gave us, including his written submission but also the evidence he just provided? He was predominantly talking about this being the most effective quit-smoking aid. In my discussions with him in the past, and again today, he was saying that this is not about you smoke or you vape, it was about vaping as a smoking cessation tool. You're not talking about that.

Mr BAILEY - That's the aim, absolutely.

CHAIR - That's not what you've said.

Mr BAILEY - Well, certainly, the aim is for that but, again, if all we do is transition people from cigarettes to vapes, that is a win but the aim is to get people off completely, absolutely, no doubt about that.

Mr MALLET - From that part of our submission, the Cochrane Review demonstrates that, as a reduction method, using vapes is significantly more effective than using other nicotine replacement therapies.

Mr BAILEY - You're right, Chair, I'm sorry, I should have made that very clear from the start. I don't smoke either, not that it's about me, but our aim is to have nobody addicted to nicotine. Don't get me wrong. Everything I have said needs to be seen through that prism but the reality is that currently we are not impacting. The smoking rates in the community are the poorest in the state. We need to try something disruptive.

CHAIR - You talked about the UK study saying it was 95 per cent less harmful.

Mr BAILEY - Yes, UK Health.

CHAIR - Do you have that research?

Mr BAILEY - I can have it provided to you.

CHAIR - Who conducted that and where was it published?

Mr BAILEY - In my notes I don't have it but I will get that sent to you.

Mr MALLET - I am surprised it hasn't been provided in the earlier discussions.

Mr BAILEY - We will have it provided to you, along with footnote 4.

CHAIR - You have said yourself many times across the table that this is a less harmful alternative. Giving up smoking altogether and not vaping either is the ideal outcome in terms of our health and wellbeing of Tasmanians.

This flows on from Mike's question: that if you have a trial it then enables people in a community to buy a nicotine vaping product who may not be smokers. You might get some transitioning from cigarette smoking to vaping but you could also have other people start vaping because it is novel. How do you ensure that only current smokers who have an addiction problem use this as a method to quit?

Mr BAILEY - That would have to be established in the pilot. I agree that it should be people who are long-term smokers who would have access to the pilot. What we are trying to see is whether we can transition long-term smokers from tobacco through to vaping and hopefully out the back door completely.

CHAIR - Isn't that then better delivered through a support program? Only a couple of days ago I attended the wrap up of the Live Well, Breathe Well program in Smithton where financial incentives were provided to smokers who gave up. They had their carbon monoxide monitoring done regularly. They had a 40 per cent success rate in Smithton, which is the best of all three pilots they have done in the state to date. The final data has not been data crunched yet but it was pretty impressive. That cost $350 - not much. Those people have also influenced others not on that program to give up smoking. That is pretty good value for money. Those people stopped basically cold turkey. It might take a little longer for some of them to give up because they can't stop completely initially but they do.

I am trying to read between the lines of the minister's hesitancy. There is a concern, and it's been expressed by others, that you are trading one bad thing for another rather than looking at a supported mechanism to enable someone to give up. Would it be better if a pilot were to be done within the supportive preventative health framework, rather than making it available on the shelf in the local newsagent or whatever?

Mr BAILEY - You are probably better to make it available to all people. You want a young person, and my son is one, who has for some bizarre reason taken up smoking at 18, to have an option other than cigarettes. I would far prefer my son to be smoking a vaping device rather than smoking a tobacco product. We know that people are taking up smoking every day. Thinking this pilot through more clearly, anyone in that community who goes to buy a packet of cigarettes should be asked whether they would prefer to have a vaping product instead. It should be that sort of discussion. We need to stop people from buying cigarettes.

CHAIR - Isn't that better done within the health framework? That's not something that you deliver at the newsagent.

Mr BAILEY - The reality is that someone at East Devonport or Bridgewater is going to go to the place they buy their cigarettes from and that is where you need to intervene.

Dr SEIDEL - Would you as an organisation support making tobacco products illegal if you make vaping products legal? If you change vaping for the current tobacco products.

Mr BAILEY - The difficulty we have with that in Tasmania is until it is a national decision, you can't have one jurisdiction that has a legal product across the country.

Dr SEIDEL - I am asking you would you be supportive?

Mr BAILEY - No, I don't think we could; because what do we do with tourists coming in from China, what do we do with people from other states coming into Tasmania? How could you manage the fact that you can bring cigarettes in from Victoria into Tasmania? It becomes impossible.

Dr SEIDEL - The argument would be you can bring them in, you just can't purchase them here. If you are addicted to nicotine, here is your sweet or effective nicotine replacements including vaping. Would you, as an organisation, from a health prospective then be supportive of saying that tobacco products will no longer be available for sale in Tasmania, however, vaping products would be?

Mr BAILEY - No, I don't think we could do that. If you look at what happens with tourists, how can a tourist buy cigarettes in Tasmania if they are addicted to cigarettes?

CHAIR - It's the nicotine they are addicted to.

Mr BAILEY - I would probably need to think about that in more detail. At this point in time, no, but we would certainly consider it.

Mr MALLET - I would need to check with some of my major members; but, yes, if vaping product was to be available so people who needed nicotine because of their addiction had unfettered access to that.

Mr BAILEY - It could be quite powerful, couldn't it?

Mr MALLET - Yes. Ruth, I think you were talking about the trial which I had read about; and it's a fantastic one and very cheap to do. I would imagine it takes a lot of work. Whilst the cash might have been cheap, the monitoring work by people, I am not sure how much that ends up costing the community.

CHAIR - I think it is within the current health services that are available. In Smithton it was delivered by Rural Health and by CHAC. These people are already employed and they also provide other health and other services to those people, so they get a double whammy.

Mr MALLET - I'm sure, after his many years in rural clinics, Bastian would also recognise that going cold turkey for a few quid works for some but it is not going to work for

everybody. There will be a number of people who have tried this time and time again. As the telly ad shows us, this person has tried to quit so often and it has not been successful so you have to keep going.

CHAIR - It is not the be all and end all by any means but it had a good rate of success.

Mr BAILEY - I think you are right here, there needs to be a range of different options available to people when the end game is trying to get people off these products completely. We see this as another tool in the tool kit to try to reduce smoking of tobacco products in Tasmania.

CHAIR - Any other questions?

Mr GAFFNEY - I'm going to have to ask the question. I like the approach. You know where I stand on the T21 because I made a speech towards that. You say we need as many tools in the toolbox as we can, and we are looking at game changers and, yes, the vaping could be. There were enough studies to show that changing the age to 21 could also be a game changer and effective for some of those people; and yet both of your organisations came out firmly against that as a game changer. So here we have a game changer and you have just made the statement, we need to try as many different tools as we can. Could you provide a comment on that situation?

Mr BAILEY - Certainly, as we said at the time I think it was a very noble endeavour but it was never going to work and the reason it is not going to work is that, when is an adult an adult? I think an 18-year-old has every right to decide what they do with their money and with their body. Also, how do you police it? How do you manage it with interstate travellers and international tourists? The detail is where this collapses. The idea is a really noble one, but the reality is impossible to manage.

Mr MALLET - Logistically, it was never going to work. Something like including the vaping, including the cash for no smoking, et cetera, have opportunities and at least they are less harmful opportunities overall. We also discussed during the T21 one that the cohort which is really most at risk is that 30 to 50-year age group. They are the ones we really wanted to change their minds because they have been at it for too long. On one hand, providing liquid nicotine use seriously supports people who have gone down many years of lung degradation; similarly for those younger ones, if they are going to end up smoking and burning tobacco in their mouth, in that case then for God's sake, let's do it with something that is not as harmful. Again, during the T21 it is our young ones who are getting their tobacco products from family and friends. It is not coming from retailers. Similarly with the liquid nicotine. Retailers have not been prosecuted in Tasmania for years and years for selling tobacco products to underage people; another reason why businesses, supermarkets are ideally placed to at least ensure that the law, as much as we can, is adhered to because they are well-practised in not providing nicotine products to people who are underage.

CHAIR - Can I make one further point because I think there is a bit of contradiction in some of the things that have been said and referring again to Dr Alex Wodak, his final comment in his summary was,

> The aim should be to make vaping readily available for older smokers but hard to obtain for young people who have never smoked.

And you're saying the opposite here. You are not him - he makes his own decisions about what he says. If you are serious about moving people away from smoking, Dr Wodak is saying let's help these people who are older and addicted and have perhaps tried other things that haven't worked, and it is a mechanism for them to give up; not to make it easy for young people to take up because it is a harmful product - as you've said.

Mr MALLET - And it may well be, and this is pure speculation, that the tobacconists, the supermarkets are well used to dealing with 30, 40, 50-year olds who are doing that, they'd probably be quite happy not to sell it 18-year olds. So, if at the end of the day they ended up transitioning the older smokers to nicotine and as I explained before their margins are not reduced, their cost of holding stock is significantly less, their insurance costs are likely to go down and the grief on some of their staff in the event of potential armed robbery et cetera is reduced, I would imagine that a smaller retailer, newsagents et cetera would get out of the tobacco category altogether - even though they may lose some sales of 18 to 25-year olds - and just have the nicotine vapes.

CHAIR - And you're saying just sell the nicotine vapes to older people?

Mr MALLET - Yes, I don't know we are going to determine how old -

CHAIR - Because then you are going against the T21 approach.

Mr MALLET - Yes, I don't know how old you are going to have.

Ms LOVELL - How do you do that?

Mr MALLET - Yes, and how do you police it?

Mr BAILEY - As I said at the end of the day no-one below the age of 18 should be smoking anything. We know currently 95 per cent of people start before 18. My view is, if someone goes into a store to buy a packet of cigarettes, the shopkeeper should have the ability to say, 'Would you prefer to have this?'

CHAIR - Over 18?

Mr BAILEY - Over the age of 18, yes. 'Would you prefer to have this? It is still bad for you but it is going to be better for you, it is going to be cheaper for you. It is going to be a better solution.' Health for the person, surely that's a better outcome. The light beer analogy versus the full-strength beer analogy.

CHAIR - Thanks very much.

Mr BAILEY - Pleasure. Thanks for the opportunity.

Mr MALLET - Have you spoken to any people who have gone off tobacco products and started to use nicotine vaping?

CHAIR - I have; I don't know whether other members of the committee have.

Ms LOVELL - Personally, yes.

Mr MALLET - And have you found their stories have at least confirmed, in fact, that they actually feel less encumbered after taking up vaping than by using tobacco products?

CHAIR - Some of have gone back to tobacco.

Mr MALLET - Okay, and now of course they're more likely to do that because the vaping product is not available in Tasmania, so they have no choice.

Ms LOVELL - The thing for me that stood out is they're still addicted to something.

Mr MALLET - Yes, that's right.

CHAIR - Thank you very much.

The witnesses withdrew.

JENNIFER HADAWAY WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Welcome, Jennifer and apologies for the short delay. We welcome you to the committee. We have received your submission. Before we start I need to tell you that this is a public hearing. It is being recorded for *Hansard*. It is being broadcast. Everything you say before the committee is covered by parliamentary privilege but that may not extend beyond the hearing, just to keep that in mind. Do you have any questions before we start about giving evidence to the committee?

Ms HADAWAY - No, none at all.

I have lived in Dover since approximately 2004. We were very fortunate to be able to buy land there before the land boom took off in Tasmania. We love the place. My husband and I are very happy and have no intention of moving. We would like to be carried out in boxes if need be.

We were very fortunate again in that when we first moved to Dover we were accepted by the local community which is quite rare, even today, for blow-ins. I had teaching experience and training experience, had known and worked previously in Tasmania with various industry bodies including automotive and furniture, as had my husband. He transferred his membership from the Olinda Volunteer Fire Brigade immediately to Dover and this gave us an 'in' into the local community that a lot of other people don't get.

The other thing that we noticed when we first moved there was the Huon Valley Council was really active in supporting the introduction and acceptance of newcomers into the local community. They had programs where newcomers were introduced; there were barbecues and all sorts of local activities. That has gone. There is no more of that which is a pity. We are now getting a number of people into Dover who are newcomers, younger families which we need but there is really limited access to any sort of activity that draws the older local families and the newer incomers together. That is an enormous pity and it has a social impact that carries through to health and wellbeing. A number of people do not stay, they move into Dover but they feel isolated so they go. That does no good at all for incomers or new people who do stay. We end up with a social problem that I believe is part of the ongoing problem in terms of regional health.

I have worked in and out of Dover for roughly the period from 2006 up until last year. I have worked both professionally and informally with nearly all of the areas throughout the Huon Valley. My own background is a weird mixture. I am qualified to teach and train in art, English, speech and drama and science. For those very reasons I have been readily employed and been able to move around the community. I have also been heavily involved with community activities, again up until the end of last year.

I come this afternoon with a feeling of disquiet. I feel that there is very little connect between the far south communities, including Dover, and the state Government. My experience tells me, and I have spoken to a number of people about this, that there is a problem in terms of anybody coming to speak to this type of inquiry. I find it disconcerting but I also find it quite sad that when I have said to people that I am going up to talk to the state Government about rural health and the potential for making the Dover situation better, they

have looked at me askance and said, 'Why would you do that? There is no point. Nobody takes any notice of us down here. We are too far away. We would put up with what we have'.

That leads on also to the fact that a large number of the community, particularly the aged, don't move out of Dover, don't go for the care they require, have great difficulty in accessing health care of all kinds, not just general services. The service that is now provided by the GP clinic in Dover I would find faultless. Sometimes one has to wait for a bit longer than expected for an appointment. My health has not been so that I have needed to contact doctors regularly. Up until the end of last year I didn't have health problems. When I did I went into the GPs in Dover and was referred to Hobart, hoping that my own personal problem would be able to be dealt with their very smartly. It couldn't be. I then had four consultations with the private sector and was horrified at the time I had to wait, the amount of money I was expected to spend and the fact that they were not going to do anything more for me than the Royal could have done.

I then transferred to the Royal and I had better service from the Royal Hobart, better service from the public system, than I had from private system. I was seen quickly. I was given far better and far more accurate information, not good. I have a need for some surgery. It is not life threatening but my condition will only get worse. It will affect my mobility and it will eventually affect my general health. It will affect my caring for my husband who has recently been diagnosed with short-term memory loss. All of those things come into play as far as I am concerned. I find it quite difficult to come to terms with some of that but I am in a good position compared with a number of people in the local community.

The things I have said in my submission were correct at the time of my writing in March. Some of them are not quite so at this point. I made a comment about the state Government last year ceding land for housing to Catholic Care and saying it was due to open in June. They are running behind, like most government buildings and/or whatever. They are hoping to be open before Christmas. I understand there is a waiting list which has almost tripled in the time since they have started those buildings.

Mr GAFFNEY - Does this year still stand? Or does that change as well?

Ms HADAWAY - They are hoping to allow the first residents into the social housing before Christmas this year.

Mr GAFFNEY - That is good.

Ms HADAWAY - Whether they will make it or not, given the state of the dwellings at the moment, driving by this morning, is debatable.

There is no doubt that it's needed. There is also no doubt that there is general acceptance that these people need housing, but again there is little understanding that we are going to import approximately 50 people at least, possibly more, depending on how many families and couples are allowed in to the area, who bring with them their own difficulties and their original problems. Sending them to Dover strikes me and most of the community I speak with as being a wrong decision at this point. Although they might need housing, we don't have sufficient capacity in the Dover clinic to support them. We only have three doctors, but that won't last; we usually have two. We don't have capacity for just ordinary, everyday GP contact. We also

don't have capacity for allied health. We don't have any support at all in Dover for mental health, and a lot of these people will arrive with those sorts of problems.

Unless they are treated and helped to join the local community, there is going to be difficulties with those newcomers.

I believe that the majority of the Dover community hasn't any real disagreement with the decision that the housing should go there; but there is growing concern about how these people might be accepted, and what can the community to help with that. And, again, that goes to health and general community services with allied health.

They will suffer the same as we have all suffered. There is no ambulance service closer than Huonville. That is erratic; it used to be permanent, but isn't any longer.

We used to have an ambulance stationed at Dover and we used to have ambulance drivers in Dover. As people have moved out of the area, that has dissipated to the point where we no longer have an ambulance stationed in Dover and we don't have ambulance drivers and paramedics who are available when they are needed.

CHAIR - Do you know if that is under review in light of the fact that they are expecting 50 people who are likely to have ongoing health needs, because I understand they are still to house long term homeless people. These people often, sadly, have a range of health issues because of their circumstances that are beyond their control.

Do you know if there has been any review of the medical need in the community as a result of that, including ambulance services?

Ms HADAWAY - To my knowledge, there hasn't been a review and I believe there should be, in relation to health services. And I believe that the Huon Valley Council who controls or owns the Dover Medical Centre and the Geeveston Medical Centre which is the next port of call, should be involved in a review, as well as Ambulance Tasmania.

CHAIR - Are you aware whether the Huon Valley Council has actually approached government about that?

Ms HADAWAY - Yes.

CHAIR - What was the outcome that?

Ms HADAWAY - I have read the report, which listed a new need in the Dover area. It is not a new need, it has been there since we have lived there; but the council has said that they will now look at attempting to redevelop the Dover Centre so there is more room available and so that there is a possibility of a third GP being placed there.

I also understand that part of that development will be an improvement to helicopter ambulance. That would be good, because a helicopter was down there the other day and could not land because it was so wet.

I have spoken to Ambulance Tasmania for the simple reason that we were involved in a life-threatening situation in August. My husband had to be raced to hospital, and we waited four hours for an ambulance. They were wonderful. They phoned continually to ask whether

his vital signs were ok and how we were coping. But, they couldn't get an ambulance to him for four hours.

CHAIR - Obviously, the fixed wing aircraft and the helicopter both have challenges in adverse weather conditions; but where is the nearest fixed wing landing option for a light plane?

Ms HADAWAY - You can land a light plane at Southport which is too far from Dover.

CHAIR - How many kilometres it that?

Ms HADAWAY - 18 kilometres.

CHAIR - You still need an ambulance to transport though?

Ms HADAWAY - We still need road transport and the road itself is just so awkward. If you have a really ill patient you are not going to race at 120 kilometres through all the bends from Dover up to Huonville. It is just not feasible.

That difficulty continues and, again, that has of course to do with ongoing planning and facilities not being made available.

I firmly believe that there needs to be less focus on Huonville and more focus, possibly on Dover, further south because we service Lune River, Southport, all of the fishing fleet. Anybody who lives further south than Dover itself has then got additional worry and time et cetera, before they can be reached. I just feel that a continual focus on Huonville as a centre is not appropriate. In terms of regional hubs or what might be possible, we should be looking at Dover.

CHAIR - If you had a magic wand what would you do in Dover?

Ms HADAWAY - I would like to see - and I have talked about this to a number of other people - the equivalent of a health hub in Dover. I would like to see an expansion of the general practice to at least three GPs. We have two at the moment, who share a week's work. They are available between 9 and 5. Both of them will go out of their way and have done, and will visit, if there is an emergency in the community that they can alleviate and not send to Hobart. I know that happens.

The big problem I suppose is that anything that does occur, especially after hours in the evening, creates enormous difficulty in terms of transport. Once it gets dark it's nearly impossible. The locals themselves hate driving that road. They would prefer not to go. For that very reason again we end up with some people who are critically ill who just don't get to hospital.

I would like to see that hub contain practice nurses as well as the GPs. I would like to see at least visiting ancillary services, for example, hearing, vision, podiatry, possibly physiotherapy - all of which used to be there, when we first moved to Dover. They are no longer there.

CHAIR - That was 2004?

Ms HADAWAY - Yes.

CHAIR - Do you have a rough figure of the population then that is served by the catchment, compared to what it is now? Is it much more? Is it much less?

Ms HADAWAY - I haven't got the statistics. Dover accounts for approximately 1400 in the Dover area itself but I don't have the up-to-date statistics for the far south.

CHAIR - Has it changed a lot in that time? Since you were there when these other services were there, has the overall population in number, as well as demographics, changed? Can you talk me through that a bit?

Ms HADAWAY - I haven't got statistics as I say. I believe the stats I looked at are about five years old; the far south of Tasmania has tripled in population and the demographics have changed. We were at least a 75 per cent aged population. There are newcomers now with families moving into the area. Five years ago, I got the stats because I was looking at what was being planned for education. I think the population in the far south had tripled, going back to about 2017.

CHAIR - But you have lost services?

Ms HADAWAY - We have lost services but the population has increased. I think that's right. It's very rough, but I think it's right. We have lost services over that period and of course we have lost our ambulance. I believe if we were able to set up something there would be a greater community demand for it than there was.

CHAIR - That's right; you open the door and a lot more people come in, don't they? You need to plan for the future. As I say, if your magic wand was working, would it just be three GPs or would it be more - because you know as soon as you make the -

Ms HADAWAY - It would probably need to be more eventually but immediately, today, we are using three GPs fully booked between 9 and 5 every day. We clearly need more as the population increases. The other thing about the number of people there is that because it is an ageing population, a lot of people have chronic conditions and require far more time for a GP visit than just the short-term, cheap visit. All of this of course adds to the cost of running a GP clinic in the area. I understand all of that, and I know funding isn't always readily available.

If the statistics I've read are correct, that 77 per cent of state government funding goes to urban areas - particularly the three main population centres - this leaves very little going to any regional area at all. That needs to be seriously considered. That's unfair, unnecessary as far as I'm concerned, and it would save an enormous amount of time, effort, worry, et cetera, on the part of the population if they didn't have to travel from the far south to the Royal.

I believe you will probably take all of these things into account, and I believe they should be taken into account. There's not one particular issue, there's so many of them, and they're all related.

Dr SEIDEL - Thanks, Ms Hadaway, for presenting to the committee today. I think it's really valuable. You are one of the few private submissions. Often submissions are from organisations, and they're represented by CEOs who come and go. As you've said, you've been

in the community since 2004. The committee went to Dover to look at their general practice and aged care facility. It was important for me to do that, because I wanted the committee to experience the drive down and to understand the set-up there.

Uniquely, the GP practice there is run by the Huon Valley Council - the same entity that approves developments, and really has a lot of data relating to population growth, employment and so forth, and are approving those developments. But you said, since 2004, although the population increased, services have decreased.

Again, for the record, TASSAL and Huon Aquaculture now have huge facilities there and are attracting more people to move in, but access to GPs in particular is basically one full-time equivalent, right?

Ms HADAWAY - I think it sits at 1.4.

Dr SEIDEL - Yes, that's right, so not much has changed there. Other services, and you mentioned exercise classes, have disappeared; allied health has disappeared. Ambulance services are pretty much volunteer-based more than anything else.

What does it mean to a community member, ratepayer, taxpayer, who is committed to the community, who then witnesses that services that used to be there aren't there anymore, at a time when you'd like to have those services because of your own health needs, for example?

As you said, you want to stay there for as long as you can, but what decisions are you making as a long-term community member about staying in the area?

Ms HADAWAY - It's a very difficult question because, as I have stated, both my husband and I would prefer to stay in Dover. We don't want to move. A very large number of our friends, particularly our peer groups, have moved purely for health reasons. At this point, neither of us needs to consider moving into Hobart or closer to health services.

Dr SEIDEL - Your friends moved into Hobart, or metropolitan -

Ms HADAWAY - In the last 18 months, we have lost six really close friends, close families, who have moved, in the age range of 60 to 75. That's only a very small proportion of the community in that age group that has been concerned, and have taken that step. That, again, creates its own problems. New friends at that age, at my age, are very hard to make - probably something we don't want to contend with.

We have looked at what opportunities we believe there are. We would like to see an upgrade to aged care, particularly. I am not talking about living in aged care, but we would like to see an improvement in aged care services that would allow us to remain in our own home. That's what we would hope would be available to us. We know, at this point, that's highly unlikely.

Dr SEIDEL - So, you're talking about aged care packages for home care, for example, and home support?

Ms HADAWAY - That's only one of them. The community itself, although in lots of ways unsophisticated, already cares for families. The population of Dover is 81 per cent

related. We have a strong Indigenous background as part of that, of around 33 per cent. There is 66 per cent illiteracy in the area. The idea of somebody coming from Dover to explain what they want to do and how they'd like to stay with their families until they die, and the fact that the family is able and would provide care is difficult, because we are blow-ins and our families all live on the big island. We are very isolated, as COVID-19 has shown us.

We have families saying to us, for god's sake, what are you doing down there at the bottom of the earth, why don't you move up here with us? We can keep an eye on you, et cetera. That is another option, which we do not want to take.

We are seriously considering that, especially since my husband was just recently hospitalised and was critically ill. We might have to consider more carefully, but the general population do not want to do that. It is the newcomers who come to the far south for a short period who are prepared to move out if they need to, not the long-term locals.

CHAIR - They don't have the deep connection.

Ms HADAWAY - No.

Mr GAFFNEY - I really enjoyed your submission, because it is quite pragmatic in a lot of ways, and I appreciated that, especially coming from a smaller council area like Latrobe.

One of your interesting comments, earlier on, was about how when you arrived there in 2004, there were community events and activities to welcome new people, and that's one of the issues. You have highlighted the fact that community support is really important for a community to survive, especially one that is isolated from services. Has there been a marked decline, do you think, from council's involvement in either providing those events or activities, or decreasing council support for some of their health services?

Initially, councils were told they have to become more effective, they have to fine-tune, and all that sort of thing. I don't think a lot of places really understand how important councils are in providing some of the events that now no longer exist. My question is, have you been able to go to council and say, these are some of the concerns we have about what is happening - especially with potentially 50 more families or people coming into the area?

Ms HADAWAY - You raise, again, an issue that I believe is very important. The Huon Valley Council, as you all know, has gone through a period of dysfunction. It is currently facing another one with the appointment of the new general manager and the conflict of interest, which has been openly publicised. The Huon Valley Council, when it was sacked, was replaced by a commissioner; Adriana stayed for two years and genuinely attempted to get the council back on track. I think everyone - even the long-term families who have little time for council or any of the political structures - hoped the new council would be more efficient and more communicative and more able to support the communities.

My personal experience would be that this has not happened. There are no longer any community-based structures within council, but there were. Council had community subcommittees. They met regularly. Some of the previous councillors made their own time available so that one could go and speak with them, for example for a few hours on a Tuesday afternoon. All of that has gone.

The current council doesn't communicate, or structure communication for any sort of face-to-face discussion, about health, or anything else. The Huon Valley Council, at the moment, depends almost entirely on questionnaires that are generated online, and structured in such a way that they tend to get the answers they want. It is not an appropriate way to contact a regional area like the far south. It might work well in the more urban areas and in the city areas, but it doesn't work very well down there. I think the council has been derelict in its social responsibility. They don't respond to what they are asked to do under the act and there appears to me, at this point, to be no intention of ever changing. There is more an inclination to prove to the general community that council is functioning as a council, rather than show any consideration to the general community that council is functioning in their interest.

CHAIR - We are pretty much out of time, but we will reiterate Bastian's comment. It is good to hear from an individual who brings her own personal experience, but also a deep knowledge of the community and the challenges which are covered in your submission as well as what you have said today. Is there any closing comment you would like to make?

Ms HADAWAY - There is a comment I would like to make. I don't believe this relevant data about regional areas. I couldn't find some of the information I would have liked to be able to compare and present to you. Council doesn't keep relevant data. I did go through a lot of the paperwork and I couldn't find it. I don't believe the state Government or the health system has sufficient relevant data on which to make planning decisions. I don't think it is available - unless I have looked in the wrong areas.

CHAIR - What sort of data are you talking about?

Ms HADAWAY - Particularly, a very simple one, stats for example that plot the wait times for an ambulance. They are kept in urban areas but to my knowledge they are not kept in regional areas. Stats about what local people would use in terms of preventative care; I don't believe they are there. I could find information about how what is available is used, and their request for more; but not statistics about what is required or into the future for planning purposes. That lack of relevant data is very important because if we could get it, it will affect capital and recurrent health expenditure as well as planning overall. I don't think it is there. Again, is anyone keeping stats about the introduction of telehealth? I find that doubtful; unless somebody goes around all of the clinics and asks for how many telehealth consultations there have been. The clinics themselves would have them, but I don't believe they are being collated; and that would be of some value in relation to whether or not that is an appropriate accessory to a general GP visit. It shouldn't be in place of a GP visit, in my opinion; but it certainly could be an accessory to a GP visit.

I don't know that there are any statistics kept, and I couldn't find them, about the number of locums that are employed or how many changes there are to local staff. I believe that's very important, because a community like the far south becomes dependent on knowing and accepting and having trust in their local staff; not just the GPs, but the practice nurses and the other people. I couldn't find statistics which give any information at all about the changes in local staff. I would like to make that point, that I don't think it is possible to do appropriate future planning from the structures that are usually employed in planning and the methodology without having those statistics.

Ms LOVELL - We can ask that question when we have the minister.

CHAIR - There may be some there but obviously not easy to access.

Ms HADAWAY - I don't know how relevant it would be, that is the other thing. If there is any it may well be too old.

Dr SEIDEL - Ambulance response times in regional areas is a hot topic. You are absolutely right. If you don't have concurrent data you are not going to act upon it.

Ms HADAWAY - Don't get me wrong about that. They saved my husband's life. The two paramedics that came were wonderful young men.

CHAIR - There will be some information coming out of another committee at some stage in the review that talks about this too, and you may find that interesting.

Thank you for your time and travelling all the way from Dover, and sharing that personal experience because it is valuable to the committee. Thank you.

Ms HADAWAY - Thank you very much. Thank you for listening and very best wishes that something practical comes out of all of this.

CHAIR - Yes, indeed.

THE WITNESS WITHDREW

Mr RAY BANGE OAM, VIA WEBEX, WAS CALLED AND EXAMINED**.**

CHAIR - I will give you some information about the committee before you start. The members here in the room are Sarah Lovell, Bastion Seidel, myself - Ruth Forrest - and Mike Gaffney. Nick Duigan is another committee member, who is on screen with you. The other people in the room are our secretariat and *Hansard.* This hearing is a public hearing. It is being recorded and the transcript will be made available and published on our website at a later time. We have received your submission and your supplementary submission. We appreciate that. It is very detailed and we appreciate the effort you have put in to producing that. Do you have any questions before we start? Otherwise I will get you to introduce yourself and then make your opening statement and we will have questions for you after that.

Mr BANGE - That is fine. I have provided a statement and I have suggested that I will read that statement, say the first half page or so and then you may consider that it could be read into *Hansard* as presented. Would that be satisfactory?

CHAIR - Sure. The committee can deal with that.

Mr BANGE -

Chair, committee members and other participants and members of the public, I acknowledge the traditional custodians of the land on which we meet and I pay my respects to the elders, past and present. I extend that respect to Aboriginal and Torres Strait Islander people present today.

I swear that the evidence I will give will be the truth, the whole truth and nothing but the truth.

My name is Ray Bange. I am here as an individual with an abiding interest in health. I declare no direct conflict of interest but I do share what I call an indirect conflict of interest in common with every other member of the community. When I am most in need of care I want to be looked after by paramedics, nurses, medical practitioners and other persons supported by a health system that enables them to perform to the full scope of their expertise.

My primary submission is entitled 'Meeting the Healthcare Needs of Rural Tasmania.' It contains 27 recommendations. These reflect contemporary views about the options available to improve the quality, access and equity of rural health care. This is via two main mechanisms. Firstly, by better mobilisation of the paramedic workforce and secondly, by further developing the role of Ambulance Tasmania.

I have also prepared a supplementary submission which expands that discussion and outlines mechanisms for the avoidance of transport of patients to emergency departments with the provision of timely care and potentially reducing costs and the prevalence of ramping.

Those submissions emphasise the interconnected nature of health and the gatekeeper roles played by ambulance services and primary care providers.

> I highlight the role of ambulance services operating as part of an integrated health system. They show the benefits of preventative primary care and the untapped potential of the paramedic workforce.

If I may stop there, I would ask the remainder of my statement be read into the record.

CHAIR - Thanks Ray. Your submission is very comprehensive. From what you have said, you have reiterated a number of points you have made. We have had some discussions with a previous witness about ensuring that all health professionals, whether they be paramedics, pharmacists, or whatever, can practise to their full scope of practice. What do you see are the key barriers to that, and how will that better improve access and remove barriers to timely, effective care?

Mr BANGE - We find ourselves in a situation where in Tasmania, the workforce is ill-distributed and a lot of primary care practitioners are not really available to your residents in the regions of Tasmania.

The problem starts with the availability of practitioners, and also the effectiveness of those practitioners. Work with community paramedicine, undertaken by other jurisdictions including overseas, has shown that paramedics can provide a considerable amount of the routine care for chronic and aged care closer to home. This would enable the available practitioners, the GPs, to expand the amount of service and role which they could provide to the population. Of course, that may be done either through expansion of the role of Ambulance Tasmania or through the direct engagement of paramedics.

CHAIR - Currently, as I understand it, one of the barriers to more full participation of paramedic practitioners, is that our Ambulance Service Act requires that all ambulance officers are employed within Tas Ambulance. Is that not right? They can't be employed outside the ambulance service as a paramedic?

Mr BANGE - We need to go back a little bit into the history of paramedicine, where the paramedics have really come through the ambulance services over the last 30 to 40 years. It's only in recent times that they have been registered health practitioners. Registration brings a completely new framework of regulation and it is the approach that has been adopted for health practitioners in Australia under the AHPRA framework and the national law.

One of the recommendations I have made is that the Ambulance Service Act needs to be reviewed. If you look at the current act, it starts with the premise of regulation that paramedics work for ambulance services. If that is valid for the nationally registered profession for paramedicine under the national law, and they carry a protected title in law, then you might argue that it should also apply to other employed health professions in Ambulance Tasmania like medical practitioners and nurses.

Why do you define paramedicine in the context of the ambulance service? That may have been the case previously but it is not the case now, because paramedics are an independently registered and regulated health profession. That means they should be able to practice in the same way, or in a related way, to that of nurses and medical practitioners.

There are several aspects of the act itself which I can provide, but these tend to assume that paramedics only work for ambulance services. That is not the case. That may have been

the case when the ambulance services determined the engagement of employment and the criteria for practice as a paramedic, but that is no longer the case. We now have a national regulated health workforce.

As well as amending the act, and taking those aspects out of the act, so that the act looks after the provision or the provider aspects, and separately you look at the practitioners which are regulated under the national law. That is not easy because there is a whole background of regulation based on the assumption that paramedics only work for ambulance. What is needed is a review of the regulatory impediments that prevent paramedics from working in other sectors within health.

CHAIR - Have you had any discussions with our health minister, or the Ambulance Tasmania CEO, who is only fairly new, about that matter and the need, as you see it, for legislative and regulatory reform?

Mr BANGE - Yes, I have. They are not personal discussions, but I have certainly been in contact with Mr Rockliff. I have also been in contact with the health work force planning division and I have submitted somewhat similar documents as the submission you've seen, but considerably shorter because those documents have been advocacy-based, and I've raised that with them. I'm also in reasonably regular contact with the Chief Executive of Ambulance Tasmania and we do discuss matters of this nature.

CHAIR - What has been the outcome, in your mind? Obviously, there hasn't been a change; I am not aware of any draft legislation. Do you believe that is something they will consider? We'll have the minister in front of the committee at a later time. I'm wondering what your understanding is of their willingness to consider that.

Mr BANGE - I'm afraid I can't really make a considered observation on that. I know that there has been considerable change within Ambulance Tasmania in recent times. The health work force planning division has certainly had extensive communication with me, and teleconference. The planning within government is something that I can't really comment on, because government tends not to say too much until it's fairly certain of what it wants to do and I'm not privy to that detail.

CHAIR - Okay. Another point I wanted to go to was your recommendation no. 12, which says, 'The revised Ambulance Tasmania legislation should provide', assuming that it is -

> …for the implementation of electronic data collection, storage and dissemination/sharing (with appropriate security safeguards) that will facilitate the seamless delivery of patient care.[quotes ok]

A review of the act could incorporate that; but isn't this something that should happen anyway? Does it need a review of the Ambulance Service Act to progress something like that? We've heard from other people, too, about the importance of sharing data, particularly for paramedics having some awareness of the medical history of the patient they're attending.

Mr BANGE - I would see this as one of the impediments because if you don't recognise paramedicine as an independently regulated health profession, access to some of the patient records becomes very restricted. The way in which access is provided at the moment is that

paramedics who do use that information tend to operate under the umbrella of Ambulance Tasmania.

This, again, brings up the dichotomy between the ambulance service on the one hand and a practitioner on the other. The practitioner working for Ambulance Tasmania might have a level of access. The practitioner who does not carry an independent authority to practise as a health professional does not have that kind of access. The same thing applies with medications which are covered by the various state and territory drugs regulations.

CHAIR - The Poisons Act. Does anyone have any questions at the moment?

Dr SEIDEL - Thank you for your submission. My question is about the ambulance workforce. In your submission you mentioned that the Tasmanian ambulance service would probably recruit half of the UTAS graduates, and that would leave roughly 40-60 graduates unemployed. On the other hand, you said we have more than 500 Australian paramedics working for the London ambulance service alone. In terms of workforce, to me that doesn't make any sense. We have graduates who should be finding work in our state, but there is no employment so they leave, and it is doubtful they ever come back.

In an earlier submission here today, we heard that in some communities such as Dover, there is no ambulance service, there is no paramedic there. Communities are desperate to have access to those essential services.

Can you comment on how much sense it makes to have a university degree that graduates people into an almost unemployment situation, or they are forced to go overseas? How efficient a process is that?

Mr BANGE - It is a very complex issue, because enrolments into university courses are not restricted by any kind of workforce planning restrictions. This applies not only to paramedicine but to other courses as well. You have a situation where the total number of graduates coming through right now is around 2500-2800. I can't give you more exact figures, because that is a very fluid and dynamic number, but the total number of students enrolled in paramedicine across Australia is in excess of 9000. You can see that the number of graduates coming out each year is going to be uphill of 2500-3000. That will continue while they can get employment, or while paramedicine is perceived as a field that will give gainful employment.

The intake into ambulance services throughout Australia is considerably less, and again that has been affected by the COVID-19 pandemic. Quite a few of the ambulance services have brought forward their recruitment. I can't give you an exact figure right now because it is so dynamic. That's why I have quoted in my submissions the figures from the government services, and they're the latest figures that I can obtain.

That particular point brings up the issue of data. Data is very important for planning right across any workforce, particularly the allied health workforce, medicine, nursing and paramedicine.

We have potentially 1000 or more students who are not likely to be immediately placed in the ambulance sector. The ambulance sector could take more, but that is a matter of restricted funding and capacity to absorb the numbers.

Dr SEIDEL - If I could interrupt, you don't think it is restricted by demand? So you believe the demand is there for more paramedics to be in the service nationally, but on a state level it is just a funding issue?

Mr BANGE - Again, the question is, what do you call demand? The demand may come from the health system as a whole, or it may come from the ambulance sector. There are consistent calls for additional resources in the ambulance sector - so, yes, there is a call for a demand from the ambulance sector itself, and that will be restricted by the funding that is available to the ambulance sector.

Outside the ambulance sector, this brings up the point once again that paramedicine is independent of an ambulance sector or an ambulance service. They work together. It is symbiotic. It is an extraordinarily close relationship, but they can, and are, employed in other areas, in industry, in retrieval services - even to the extent, would you believe, of Crown Casino seeking to employ a paramedic. They're on oil rigs, they're on mining sites, they're on the Royal Flying Doctor Service.

I will now give you a personal example. I have suffered prostate cancer, and the prepping and the surgery work that I undertook was performed by a paramedic. They can be used in emergency departments, they can be used in community services. I argue they should also be employed as adjunct or as additional resources within general practice under the same kind of system as applies in England, Wales and Scotland. Does that answer your question okay?

Dr SEIDEL - Yes, thank you.

CHAIR - In terms of one of the recommendations, number 26 -

> That Tasmania provide financial incentives to paramedics for upskilling in low-acuity specialties and accepting roles in rural and remote locations.

As Mr Seidel said, there is no presence in Dover, and that's the same for a lot of our regional and remote communities. When we talk about incentives, often different incentives work for different people. Do you believe there is a model we could look at to see how that might work - because sometimes it's money, but often it's not money, it's other things that might encourage a person to move to and work in a more remote location?

Mr BANGE - Yes, there are both incentives and disincentives. The incentives include position classifications or salaries and living expenses and lifestyle.

The disincentives I see are the ability to maintain the skill sets of the practitioner and maintain the ability to practise. This is not unique to paramedicine, of course. It applies to allied health practitioners and general practitioners. One of the reasons my friends and our specialists say they don't work in more remote regions - they fly in and fly out because that keeps them in contact with more tertiary services, and with more support in the metropolitan regions.

It's a question of lifestyle, funding, accommodation, practice support, things like education for the children. That's a very strong incentive for people to stay in particular locations, but also keep in mind the disincentives - what do they have to forego, and what is more challenging? If I may extend that aspect, it is most disconcerting, when you look at the

Commonwealth Government scholarship support for continuing education and similar activities, you actually find that paramedicine is quite often left off the list, and they are a registered health profession.

You see 12 or 13 other allied health professions listed as being eligible for practice support or scholarships, and I look in vain to find paramedicine, so that argument underpins my reason for recommending that it is time that governments, Tasmanian and federal, formally recognise paramedicine as one of the health professions and allied health professions.

Of course, they recognise it in national registration, but in the paperwork and in the minds of people they still don't come to grips with that reality.

Dr SEIDEL - Just specifically on this, and for the record, Professor Bange, it would be a no-cost option for the Commonwealth Government to include paramedics or paramedic practitioners as part of the Workforce Incentive Program list of practitioners? Then, it's up to individual GP practices to decide whether a paramedic practitioner or paramedic would be suitable as part of their health practitioner team.

Mr BANGE - Yes, we're looking at, effectively, an administrative stroke of the pen. I'm not suggesting that paramedics should be given particular preference but they should, at least, be within the group of eligible professions for this support. That's a low-cost option.

Dr SEIDEL - Thank you.

CHAIR - I wonder, looking back, I can't think which year it was we did the national health registration act, was it 2012? Whatever it was, it's a few years ago now. I don't recall, and I read right through the national legislation at the time, that this was raised as a potential problem, that paramedicine was still going to be caught up in other acts and unable to be recognised as a stand-alone profession, if you like, a registered profession. You might have been involved in the discussion. I'm not sure if you were, but do you know whether the impact this would have was ever considered? Perhaps it is an oversight? Was it a deliberate approach for a reason? It doesn't seem to make sense in many ways. I'm trying to understand how we reached this point without that being addressed.

Mr BANGE - Yes, I have been involved in the legislation for registration. In fact, I wrote many of the submissions and presented a number of cases to COAG and to the Health Council. I'd like to put it slightly differently. It may not be deliberate but is simply out of sight, out of mind. Let me give you an example. What we have is a perception in the minds of the public, a perception in the minds of many practitioners, nurses, a perception in the mind, even, of the medical profession, that paramedics work only for the ambulance sector.

That was quite a valid perception but it has changed. There's been extraordinary change over the past 25 years. We've gone from in-house training to education through university. We've gone to the situation where Australia has some of the leading university programs in the world. We've got master's degrees, we've got PhDs coming through our paramedicine programs.

What has been slow is that realisation to seep into the paperwork and into the minds of bureaucrats and others working in the health sector. That's an actual issue. It is disappointing that when the federal government did a review through Professor Worley just a couple of years

ago on rural health and allied health, there was a specific exclusion of paramedicine being considered as one of the health professions that could provide support to rural communities.

CHAIR - It doesn't make any sense.

Mr BANGE - Of course it doesn't.

CHAIR - It's a bit like splitting GST from tax reform. Sorry, I shouldn't have mentioned the war.

Mr BANGE - You can see why, at times, I become somewhat frustrated. But I can rationalise as to why that may occur. One of the reasons one of my recommendations is that Tasmania and other jurisdictions and the federal government, and the Commonwealth generally should have a chief paramedic officer is to get the expertise up where people know something about what is done and how paramedicine works.

Another rationalisation that I've come to grips with is that the Commonwealth doesn't fund the ambulance sector directly. If it doesn't fund the ambulance sector directly, this is done through the states and territories plus fees and the like laid by the state, it means it has no direct responsibility for the professions that work in the ambulance sector.

If you are not dealing or funding or having direct involvement with that, I am talking $4 million plus for incidents annually, then it is out of sight, out of mind. We have to have people in the decision-making area who have worked in or know of or are cognisant of the role of paramedicine before it can start to be recognised. When it is not recognised even at that level, I think that will be a strike against general health and welfare and I find that they have virtually no documentation, no consistent data collection that looks at the patient generally and looks to paramedicine as a health workforce.

They don't collect that type of data. The only data that I could really get that is absolutely reliable is registration data. That registration data doesn't easily match up with the data that I can find from the ambulance sector because the 6000-odd members who work outside the ambulance sector are not covered by the report on government services. They only report the ambulance services. So, you have got, if I may say, a gap and it is time somebody started to fill that gap. One way is to recognise paramedicine as a workforce. Once you recognise it formally as a workforce then the federal government and state governments will have to begin collecting the data and analysing the data and consider how that workforce can be best used.

CHAIR - Thank you for that.

Your submission was very thorough. Obviously, the whole issue here has been going on for a long time but I reflect on your comment about when paramedicine was recognised as a profession, it was registered under AHPRA. Nursing started off in hospitals too. There were no degrees, there were no masters, there were no PhDs but that's changed and we still have a nursing act in Tasmania and a poisons act that all health professionals have to abide by so it doesn't seem like an impossible task. Is it something that we need national leadership on to make a change or can we get it going in Tasmania for the benefit of our service particularly and the people of Tasmania and hope the others follow? How is it best approached?

Mr BANGE - There is no quick, cut and dried answer. This is something I found when I started to look at the registration of paramedics back 15 years ago. Every state looked after their own practitioners. Not only that, the states had different views. New South Wales, for example, wanted to hold out to still have diploma as an affecting threshold registration. All the other states agreed on a minimum of a bachelor's degree, which is not surprising but which is leadership when you look across the world. That's the situation in the UK. That's the situation now in every state. It is also the situation in New South Wales under the final national law. An alternative pathway was made available for New South Wales but it just gives you an indication of the difficulty in getting change.

No one person is responsible. That is the reason why in identifying impediments to practice I have suggested that those impediments vary across the states, in some cases it's no legislation at all, like in Western Australia or Northern Territory. By that I mean no legislation for ambulance services. There is the legislation or national law for the practitioners. Western Australian and the Northern Territory have certain regulatory positions, have drugs and poisons acts which are different in every state. The only way I can really see to get around that is that Tasmania and the other states come together and actually have a taskforce, identifying impediments and looking at what is necessary to bring about change. I am talking about paramedicine in particular

But there are some things that Tasmanians, for example, can do immediately. If you

CHAIR - We just lost you, Ray; can you start that sentence again?

Mr BANGE - Tasmania can do certain things without waiting for the rest of Australia. One of those is to develop practice fact sheets which could be made available to, for example, GPs or other clinic groups, pointing out that paramedicine is a registered and an available workforce and nominating ways in which they can be used within general practice.

It could also be a situation where the health department is actually encouraged to employ paramedics in emergency departments, in surgeries, in wards as necessary - particularly in smaller hospitals in more remote areas, because in some cases the paramedic or the nurse practitioner may be the most senior health clinician available because there is no GP available for a period of time. They may be there during office hours or they may be there on a visitation basis. Those are two things that could be done.

The state also could take up with the federal government a review of the funding relationships and, because of the essential role of free hospital care, get the federal government to reconsider whether they will fund the ambulance sector as part of federal funding; perhaps at the base fund.

This brings up a rather interesting aspect of the role of a private sector provider. In Western Australia we have St John Ambulance as a private provider, and they received funding for the operation of a number of clinics. St John Ambulance looked at them somewhat like transit centres; patients might come to a clinic, be triaged, looked after, treated and sent home. Only those cases requiring transport would then be forwarded onto a tertiary or definitive facility.

That is feasible because the funding by the federal government to a private sector provider is available under the various schemes. That's not readily available in Tasmania to

set up transit centres or virtual care clinics, but it could be done through the health department. Again, that brings to mind the need for integration of the ambulance service and ambulance activities with the broader health service.

I think there are about three or four options there.

CHAIR - Does it make a difference that the funding models are different around the nation? Some states have ambulance levies and things like that. Does that make any difference to all of this, because ours is free? You call an ambulance, it comes. It is funded from the government.

Mr BANGE – The major distinction I just drew between St John Ambulance and Ambulance Tasmania is the private/public sector divide and the funding which may be directed to a private entity as distinct from a state-based entity. The funding is a matter of political decision. In my situation, living in Queensland, I can get looked after by the ambulance service and I don't pay a fee. It does vary with every state. There is also reciprocity in my case, because of the relationship between Queensland Ambulance Service and other services.

That decision to fund the ambulance service completely by the government is a matter of political decision. It doesn't necessarily change the level of service or the quality of service, because that really depends on how many practitioners you have, what kind of support, how many vehicles you have, how many centres - all of which is a funding issue. The source of the funding is not critical, except that it's likely that private sector bodies like St John's will find it more difficult to have the same funding base as the public sector organisation.

CHAIR – Any other question from members? Thank you, Ray. We appreciate the evidence you provided and the lengthy submission. Is there any closing comment you wish to make before we finish up?

Mr BANGE – I've only really attempted to answer part of the brief that your committee has, and it is not that I don't think you don't have an enormous task ahead of you. I wish you well in coming up with the recommendations. The points I emphasise are those in my statement this morning. It is vital that you review the Ambulance Service Act. It is vital that you see the distinction between the ambulance service and the practitioner. It is vital that the practitioners be used more effectively, because that affects people. What we should be looking at everywhere is to get the best possible people in locations, and be able to provide the best possible care. If you do that then more strength, and thank you for listening.

CHAIR – Thank you, Ray.

THE WITNESS WITHDREW