# THE LEGISLATIVE COUNCIL SESSIONAL COMMITTEE, GOVERNMENT ADMINISTRATION 'A' SUB-COMMITTEE INQUIRY INTO RURAL HEALTH SERVICES IN TASMANIA MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE, HOBART ON FRIDAY 19 NOVEMBER 2021

**CHAIR (Ms Forrest)** - Welcome, Bill. To explain the proceedings, this is a public hearing. Everything you say will be recorded by *Hansard* and will form part of the public record. You are covered by parliamentary privilege while you are in front of the committee, but that may not extend beyond the committee when you go back outside.

The evidence you provide will be public. If you have some information you want to share that is of a private nature, you could make that request and the committee would consider it.

I understand you have some health conditions that make it more difficult for you to speak clearly, so please just do your best. If there is a problem with the transcript, that *Hansard* cannot quite pick up, we can send you the transcript for you to fill in any gaps or correct any errors.

If you wish to put something in writing to us after the hearing, you are welcome to do so. If there are questions that you cannot answer, we can write to you and ask you to provide answers.

Do you have any questions before we start?

**Mr DERMODY -** No. I would just like to say that it is a pleasure to be able to come here and discuss what I have seen over the past 40 years that have created a health crisis.

**Ms FORREST** - Just before you start, Bill, you need to take the statutory declaration. If you look at that bit of paper, could you read that before you start, because it is sworn evidence you are giving.

**Mr GAFFNEY** - Chair, just before that, is it easier for you, Bill, if we have a question to go through you, so that you are asking most of the questions instead?

**CHAIR** - You can do that. Just make sure you have Bill's attention.

**Mr DERMODY -** I am more than happy to answer any questions.

**Mr BILL DERMODY** WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

**Mr DERMODY -** First, I wish to apologise for any speech issues associated with my syndrome, due to muscle wastage of the muscles in my lungs, oesophagus, throat and mouth, that have caused issues with my speech. I wish to say that should anybody have difficulty understanding what I am saying, to inform me, and I will repeat what I have said. Should this issue be too consistent, then if could do it via a computer I would be happy to print out everything I have been stating and wish to discuss as to what is needed in relation to dramatically improving health services in regional areas.

First, I will provide you with the information as to my background and acknowledge how I came to my knowledge of the issues.

My wife and I moved to New Norfolk approximately 38 years ago. Second, I was an enrolled nurse who worked in mental health services, aged care, forensic mental health services and correctional health. Therefore, I have an understanding of health needs, having been a nurse.

I was involved with the Australian Nursing and Midwifery Federation, on its council and executive. I am no longer able to maintain my registration as a nurse due to major health issues. They provided me with an opportunity to set up and run the ANMF Information Centre, where we provided professional and industrial advice to nurses and carers, and represented them in workplaces, or before AHPRA when necessary.

This meant that I saw the impact on regional communities, especially the Derwent Valley and Central Highlands communities, over the 40 years that both the Liberal and Labor parties were in power, dramatically reducing services at regional hospitals and closing regional health centres - for example, at the New Norfolk Hospital, Ouse, Huon and the Peninsula.

When we moved to New Norfolk, the New Norfolk Hospital had an emergency department, a maternity ward, a fully functional X-ray department five days a week, and physiotherapists five days a week, as examples. They say my eldest son was the third-last child born at the New Norfolk Hospital. Two of his mates were the last two, and then the maternity ward was closed.

**Ms LOVELL** - How old is your son, Bill?

**Mr DERMODY -** He is 36.

Therefore, people were able to present at the New Norfolk Hospital 24 hours a day, seven days a week, and all the beds were for people from the Derwent Valley community - not as it is now, with the majority of beds being for the overflow at the Royal Hobart Hospital, and people not being able to present at the New Norfolk Hospital due to the fact that the emergency department and the maternity ward at the hospital are closed.

The X-ray department was reduced to only two days a week. The type of X-ray is being reduced as to what X-Rays are available. There is now only two days a week of physiotherapists.

With my background, it is worth being involved in the Australian Nursing and Midwifery Federation (ANMF). The closure of regional health centres meant that it centralised the health system to the three major hospitals. This dramatically reduced health services in regional areas, dramatically increased pressure on the major hospital emergency departments. Waiting times at the emergency department and ambulance ramping dramatically increased. This all coincided with the dramatic reduction in services at regional hospitals and the closure of regional health centres. With the dramatic reduction in health services in New Norfolk, the population over this period increased from around 6500 to now, with a population of over 12 000 in the Derwent Valley.

With housing expanding in the Derwent Valley and the retirement of the two long-standing general practitioners, Dr Peters and Dr Sweet, there are people who have lived in the Derwent Valley for at least 30 years, who are unable to and are still waiting to get on the books at the Derwent Valley Medical Centre.

**CHAIR** - Is there only one medical centre in New Norfolk?

**Mr DERMODY** - There is only one medical centre in the whole of the Derwent Valley and for people as far as Hamilton. The nearest one after that is Ouse or Brighton.

**Ms LOVELL** - Are you happy to take questions as we go, Bill?

**Mr DERMODY** - Yes.

**Ms LOVELL** - Do you know how many GPs they have at the medical centre?

**Mr DERMODY** - That varies because the majority of GPs at the Medical Centre are people who have completed their degree to become a doctor. Then they have to do a 12-month placement in a regional medical centre. That means for that purpose, New Norfolk is regional, and the majority of GPs there are those who, after 12 months, leave because New Norfolk is not then regional under Medicare. It is federal, the same as Sandy Bay and Hobart.

Therefore, those people are not going to be travelling from wherever they live every day to the Derwent Valley when they can be earning the same amount of money at a general practice closer to their home where they live. This causes regular turnover of GPs at the Derwent Valley Medical Centre. There are only four consistent GPs.

**Ms LOVELL** - Do they have any nurse practitioners or other nursing staff at that practice?

**Mr DERMODY -** They do have a nurse there but not a nurse practitioner. That is because of how they are scheduled under Medicare. It does not entitle them to the funding to be able to employ a nurse practitioner.

**Ms LOVELL** - Okay. Thank you.

**CHAIR** - Keep going, Bill. Are you all right?

**Mr DERMODY -** Yes.

May I also say that many of the people in the Derwent Valley, especially those who were unable to get on the books of the medical centre with the retirement of Dr Peters and Dr Sweet had to go elsewhere for GPs. They had to go to areas anywhere between Brighton and Hobart, Kingston, Sandy Bay, Sorell and Ouse to find a GP.

With the housing expansion that's taking place in the Derwent Valley and with the increase of young families who, if people who have been there for 30-odd years can't get on the book at the medical centre, the likelihood is those young families will not be able to get on the books at the medical centre either. With people regularly waiting anywhere from two to six weeks to see a GP at the medical centre and with there being no after-hours or weekend medical or health services in the Derwent Valley or Central Highland communities, this means that the only options that are available are for people to wait weeks to see a GP or call an ambulance or present at the emergency department at the Royal Hobart Hospital.

Nearly five years ago I foresaw that the waiting time was only going to get worse, so I did some investigation into health practices in other states. I did this because I was aware, as an example, in Queensland in most regional hospitals and regional health centres, they introduced nurse practitioners 24 hours a day, seven days a week. So, people were able to present at regional hospitals and regional health centres which they cannot do in Tasmania.

I spoke with the secretary of the Australian Nursing and Midwifery Association, Queensland branch, and investigated the implementation of nurse practitioners 24/7 in regional hospitals and most regional health centres in all other states. This is the only state where there are no nurse practitioners in regional hospitals, 24/7, and in regional health centres, and therefore people are unable to present. In other states it has reduced the need for people who are unable to see a GP to have to call an ambulance or attend a major hospital emergency department because they can be seen by a nurse practitioner.

This is one of the major contributing factors as to why, compared to other states, Tasmania has the worst waiting times in the emergency departments and ambulance ramping. If nurse practitioners were introduced 24/7 at the New Norfolk Hospital this would mean that when they are not able to see a GP, people can present at the New Norfolk Hospital and a nurse practitioner would be able to diagnose their health issue and then either liaise with the Derwent Valley or Central Highlands medical centres - whichever medical centre that they attend - or if necessary admit the person to the New Norfolk Hospital and intervene with the patient until they were able to liaise with the person's general practitioner or the general practitioner was able to attend to the patient at the hospital. Nurse practitioners through their training, in Tasmania, are able to do 99 per cent of what a GP can do.

Can you still hear me?

**CHAIR** - Yes, we can. You are doing really well, Bill. It is very clear, thank you.

**Dr SEIDEL** - Just a general question, Bill. You are a highly accomplished health practitioner and you have been living in the New Norfolk area for decades now. You gave evidence that in that time health services have been cut. There is no emergency service any more in the New Norfolk Hospital. There is a cut for X-rays, from five days to two days; and no maternity. In any of those changes that were made, were they consulted with the community or were they just made without even consulting with people who are directly affected by it?

**Mr DERMODY -** My understanding is that there were decisions that were made by the parties in power at the time and there was no consultation with the community.

**Dr SEIDEL** - So, over the decades you've been there, you do not recall that there have been community consultations to find out whether closing the emergency department is acceptable to a growing community?

**Mr DERMODY -** My understanding is that there was no communication. The decision was made and it was closed, and services were reduced.

**Dr SEIDEL** - You have your own personal health needs and I imagine if you were in a situation now 35 years back, you probably would be quite happy because there would be an emergency department, X-rays, physiotherapy, all the things you potentially need now.

**CHAIR** - And a maternity service, so the two children could have been born there.

**Dr SEIDEL** - That's right but you would be probably quite happy. How do you feel now where you think, 'Oh my god.'? Do you consider leaving New Norfolk because you don't have access to those local health services that you might actually need?

**Mr DERMODY -** Yes. May I say that there have been a number of events in my wife's family over the last month, when if people were able to present at the New Norfolk Hospital, as an example, not at the Royal, as she couldn't see a GP and she had issues with her breathing associated with fluid on the lungs, associated with a heart condition, her daughter was advised to call an ambulance. She was taken to the Royal where for two days she lay on a bed in the hallway of the emergency department where she was treated by a nurse practitioner. After almost two days she was finally seen by a heart specialist who said the treatment that had been provided was sufficient, and she was then sent home.

If there had been a nurse practitioner at the New Norfolk Hospital, she could have been taken to the New Norfolk Hospital when unable to see a GP. Everything that was done in the emergency department could have been done at the New Norfolk Hospital and there would have been no need to call an ambulance. I know there's going to be issues in the future and it would be great to be able to present at the New Norfolk Hospital to be able to see a nurse practitioner.

**CHAIR** - We're nearly out of time, Bill, I think. Our next ones are on WebEx but did you have any -

**Dr SEIDEL** - No, it's fine.

**CHAIR** - Would you like to make some closing comments, Bill, that you want to finish up with, that would be lovely?

**Mr GAFFNEY** - Bill, if you could suggest one thing that you think might improve the system in the New Norfolk area and Tasmania, in your experience, what one thing would you recommend to the committee?

**Mr DERMODY** - May I say, I would hope that if nurse practitioners were introduced 24/7 in the New Norfolk Hospital, it would then become a model for all regional areas in Tasmania - as it is in most regional areas in every other state - such as Ouse, Queenstown, Huon, the Peninsula as examples.

**Mr GAFFNEY** - Thank you very much.

**Mr DERMODY** - May I say that in other states, a nurse practitioner can do 100 per cent of what a GP can do. The only reason that isn't the case in Tasmania is because of the Workers Rehabilitation and Compensation Act and the Poisons Act. In the Poisons Act, there are some medications they cannot prescribe - which they can in some other states under their poisons acts and the workers' compensation act - and only a doctor can attend to a workplace-associated injury.

As an example, two people could present with exactly the same issue; they could both turn up with cuts. The nurse practitioner can then do suturing or treatments associated with that, provide medications, prescribe most medications and administer medication, and provide a certificate. Under the Workers Rehabilitation and Compensation Act, they can't do that in Tasmania, whereas they can in some other states.

It would only be a case of addressing the Workers Rehabilitation and Compensation Act and the Poisons Act, because nurse practitioners' training, their scope of practice, is the equivalent of a GP's. It is only those sections of those two acts that reduce what they can provide. When people present, a nurse practitioner can do suturing, organise X-rays, refer to a specialist. If someone was to present because they can't see a GP, they can look at the symptoms, diagnose, admit them to the New Norfolk Hospital or wherever, then liaise with the medical centre until their GP can see them.

If it was after hours and on weekends, and the person who presented had major health issues, they could admit the person, they could then do a video conference with a doctor at the Royal Hobart Hospital, as an example. If the doctor then determined that the person needed to be admitted to the Royal, all intervention would be taking place until an ambulance was available, and it would mean that the person would be immediately admitted to the Royal Hobart Hospital. This means it would reduce waiting times for people waiting for an ambulance, and it is going to mean better health outcomes, because all the intervention has been done immediately, therefore reduce ambulance ramping and pressure on emergency departments.

**CHAIR** - Thank you. We probably need to wrap it up because we are a bit over time, and other witnesses are waiting on line. Thank you very much for your evidence. If there is anything else you felt you wanted to say but have not, you could send us a follow-up by email to Jenny, our secretary. Feel free to do that.

**Mr DERMODY** - May I say, everything I have said I would be happy to put in a document and forward that too.

**CHAIR** - I think we probably have most of it. If there is anything you haven't said, and that you would like to, absolutely feel free to do that. I am pretty sure Hansard was able to get it all. We will send it to you, so you can check, just to be sure.

**Mr DERMODY** - May I say, thank you very much. Fingers crossed that what we have here will be an outcome, because I know that dramatically services in all regional areas around the state would take pressure off major hospitals and dramatically improve health services in this state.

**CHAIR** - Thanks, Bill.

**Mr DERMODY** - Thank you very much for your time.

**The witness withdrew.**

**Ms KYLIE MISKOVSKI,** NATIONAL STRATEGY AND POLICY ADVISER, WAS CALLED, APPEARED BY WEBEX, AND WAS EXAMINED; **Mr VINCENT POISSON**, RESEARCH INVESTIGATOR AND **Ms PAT BAINES**, SUPPORT STAFF, DEMENTIA AUSTRALIA WERE CALLED, APPEARED BY WEBEX, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

**CHAIR** - Welcome to our hearing. I am Ruth Forrest, the Chair of the Committee. Sarah Lovell, Mike Gaffney, and Dr Bastian Seidel, who is helping our last witness out to the door. Are you all based in Victoria?

**Ms MISKOVI** - No, I am based in Sydney. Vincent and Pat are in Tasmania.

**CHAIR** - We do need to ask the Tasmanian witnesses to provide an oath that you will tell the truth. We have no power to expect our Sydney witness to do that.

The evidence you are providing to the committee will be transcribed by Hansard and become part of the public record. If you wish to raise matters of a confidential nature, you could make that request to the committee and we would consider that.

All comments made in front of the committee - for the Tasmanians, particularly - are covered by parliamentary privilege, but that does not necessarily extend to comments made outside this meeting.

Do you have any questions before we start?

**Ms MISKOVSKI** - No.

**CHAIR** - Thank you. We have your submission and all members have read it. We would appreciate you introducing yourselves and telling us about the organisation and the reason for your submission, and point us to anything in particular in the submission that you would like to highlight, or to make any additional comments related to the matter.

**Ms MISKOVSKI -** I will make a brief opening statement on behalf of Vincent, Pat and myself. Thank you very much for the invitation to appear at the hearing today.

My name is Kylie Miskovski and I am National Policy and Strategy Advisor at Dementia Australia and I am based in Sydney. Vincent is the Tasmanian State Manager for our client services and Pat is an art therapist and a Dementia Friendly Communities Program Officer. I can talk to the broad policy and systemic issues but Vincent and Pat are the experts on what is happening for people living with dementia and carers in Tasmania. They can tell you about the challenges that people are experiencing.

Dementia Australia is the peak body for people impacted by dementia. We represent the estimated half a million Australians living with dementia, as well as their families and carers. I am sure you are familiar with what dementia is but I think it is worth noting that the term 'dementia' describes the symptoms of a large group of neurocognitive conditions which cause a progressive decline in a person's functioning.

Dementia is not just memory loss. Symptoms can also include changes in speech, in reasoning, emotional responses, social skills and physical functioning. There are many different types or causes of dementia including Alzheimer's disease, vascular dementia, frontal temporal dementia and Lewy body dementia, just to name a few. Dementia is a terminal condition and there is currently no cure. It is the leading cause of death of Australian women and the second leading cause of death in Australia overall.

There are an estimated 11 800 people living with dementia in Tasmania, including almost 700 people living with the younger onset of dementia - that is, people under the age of 65. Without a medical breakthrough, the number of Tasmanians living with dementia is expected to increase to an estimated 16 000 people by 2058.

People living with dementia are high users of health care services. They often have comorbidities so they are not just presenting to health services because of their dementia diagnosis and symptoms. Regardless of what people with dementia are being treated for, it is essential that health care providers understand dementia and how to support people living with dementia and their carers.

Some of the key issues for people living with dementia and carers in rural Tasmania include delayed diagnosis, lack of referrals and access to support services, transport accessibility, health care workforce capability and capacity. As outlined in our submission to this inquiry, Dementia Australia advocates for: healthcare workforce development and training, particularly for GPs and allied health professionals; effective telehealth technology, noting that there are limitations in telehealth for people living with dementia; adequate transport to access local health service and support; dementia enabling environments in hospitals and other healthcare settings; and developing dementia at family communities to build greater awareness and understanding of dementia. Thank you.

**CHAIR** - Thank you very much, Kylie. Do Vincent or Pat want to add to that?

**Mr POISSON -** We might add a few details to that. Our primary concern is the different age diagnosis. Our observation is that people in Tasmania tend to get it done quite late in the progression of the disease, which then means that they access our services and other services at a fairly progressed stage. This is quite problematic because then the interventions that we can put in place and the support that we could put in place are quite limited by then.

For example, we have a Living with Dementia program which is typically targeted at people at the early stages of the diagnosis and provides a group setting to provide cycloid education to the person with dementia and their carer. We see that in Tasmania we are not getting a lot of breakthroughs or demand for this. Our observation has been that it is because most people who access our centres are already past that stage. When we compare it to other states, that program is extremely popular. That is a fairly complete example for us. Pat, would you like to add anything?

**Ms BARNES -** Yes. I am privileged to be at the coalface. I have been discussing with families' caregivers and people living with dementia, what it's like for them and what their needs are.

I was in Bicheno on the east coast of Tasmania last week and it came through very strongly how much the community is depending on volunteers to support people living with dementia, mainly women.

The volunteers, led by one particular lady, have been able to set up a support group for people living with dementia and the community health service there has provided a facility. I discussed with them what their needs are. I think what came through strongly was that while the volunteers turn up every week faithfully, they do feel a little exploited. It's sad that there isn't more real support up there. Family carers are saying that they would really like more education and support, particularly over weekends and after hours. Dementia Australia does, in fact, offer online counselling till 8 o'clock in the evening but they're saying that it's at weekends and after 8 o'clock when they really feel they're without support. I think this is probably also COVID-related, that everybody's feeling more isolated than they were before.

Another thing that came through from Bicheno is that although we're talking about telehealth and online support and online information about dementia, people in that community are not necessarily computer literate or have easy access to computers. I was told that access an internet centre was closed down and that they no longer have a way of getting support to get onto the internet. So, that clearly is an issue. I'm sure it's not just Bicheno that suffers from this.

A real problem that is in our report that was reinforced again is the fact that our clients living with dementia have mobility problems. Some have dementia-related Parkinson's and Lewy body dementia, some have vascular dementia related to strokes, but they are expected to get to the specialists, not the specialists to them. This is a massive problem. In Bicheno they say there's only one volunteer driver to take them. So, we've got a double access problem. An access problem that it is very stressful for someone with advancing dementia to have to go to Hobart or Launceston, but also there isn't an easy way of getting there either. So, transport is an issue.

It is also an issue on the west coast of Tasmania, as we said in our report, where they don't even have dental services for people. That is a real issue with dementia because quite special dental care is required as dementia advances.

So, support for carers; the issue of volunteers. There aren't enough local coalface support workers. I’m wondering whether there's the capacity for government to provide some kind of training. It would probably have to be online but the people who would be support workers, are usually computer literate. Is it possible in the rural towns of Tasmania to train some of these volunteers in certificate III in aged care in one of the Wicking dementia care diplomas or degrees to make a greater set of local people who are able to support the people living with dementia.

A volunteer group in Bicheno already has six clients using it, in a small town of 990 people. It's only been going for about five months now. So, I imagine that there will be more people in that community. There are, of course, people in Swansea living with dementia too, who are not yet accessing that one. Swansea also has a volunteer group that wants to get an art group going. The key person, her husband's living with dementia.

I think it is very important to remember - and people mention this to me - that in small country towns, a lot of people are not on large incomes. People have quite modest incomes, particularly those who are retirees, and wouldn't think about how to support them and not expect them to do everything themselves.

Obviously, dementia-friendly communities are out there, encouraging communities to become self-sustaining in their support for people living with dementia. I think I have gone through my list of issues that are not necessarily in the report.

Another quick positive is that community transport seems to be improving. It is getting very good in Hobart, but obviously community transport is still an issue in the more distant little towns. Thank you.

**CHAIR** - Thanks Pat, Vincent and Kylie. It seems there is a heavy reliance on volunteers to support people, their families and carers of people living with dementia.

If there was a mechanism or model that would be more effective - we have trouble getting specialists at this level in the state, let alone out into the regions. Acknowledging that, and that there are distances to travel, with small regional communities all around Tasmania, do you see any other solution?

There are a lot of recommendations in your submission, talking about training of GPs, medical students and the like. In terms of supporting people living with dementia coming into the health system, whether it be in their small rural community or in a major hospital, what do you think are the key things that need to be focused on? It is like trying to eat an elephant - you have to do it one bite at a time.

**Mr POISSON** - I would probably say, again, starting with that education is quite critical for all levels; it might be people in care, it might be carers, people living with dementia. It is sort of providing that community education as a starter. Then, as you say, gradually moving to these other areas - for example, volunteers or your community organisations, and then moving to workers.

For example, the day before I was in Cygnet providing really basic education to workers who are part of SETAC, the South East Tasmanian Aboriginal Corporation. They found the information extremely valuable. For example, after the training they understood the difference between Alzheimer's and dementia. That is at a very basic level. People who are working within these sorts of healthcare settings themselves haven't got the basic education to understand what dementia is. A good starting point would be that type of community education.

**Ms BAINES** - I still think it is really important to train people who are living in these small towns, to have some trained support workers specifically for people living with dementia. There is simply a lack of that. I heard that from all the communities up the east coast - that there are very few actual local support workers, which is sort of the level above volunteers. They need basic training. If they train specifically in dementia care, it would be a real asset for the communities.

**Mr POISSON** - The training, for example, is something that Dementia Australia could provide, and is currently providing. We have our wing of Dementia Australia that provides training to professionals, for example, support workers.

There is one key issue with this. For agencies or businesses that employ support workers, for example in a residential aged care setting, very often their funding is really tied to that direct service delivery. They are fairly often reluctant to provide the extra hours to their workers to attend a training session, for example. So, the two to three hours that might be required, or the day of training that might be required, to attend our training is often unfunded.

If there was funding provided to agencies like a residential age care centre to provide training to their employees - especially casual staff - so that they could actually take the time to sit down and go through the proper training, that would be quite critical.

**Mr GAFFNEY** - I am just wondering, while the submission from Dementia Australia talks about the Tasmanian circumstances in spots, and identifies some Tasmanian things, I get the impression that it is quite generic. The recommendations 1 to 7 talk about mandatory dementia education for all medical students, GPs and whatever. Can you give us a context in Tasmania for that dementia training? Does UTAS do the medical students in Tasmania, or is this across Australia, that all medical students should be getting dementia training?

It is something we could ask of the UTAS medical school, but I would be more interested in the experience in Tasmania. Do they get any training, that sort of thing?

**Ms MISKOVSKI** - I will address your first comment. Yes, you are right. Some of these issues people experience across Australia, and I guess for people in rural Tasmania, the issues are heightened. A lot of the recommendations that we made, we would make regardless of setting, particularly in terms of education, because that is something that is a challenge, regardless.

Vincent was talking about the delayed diagnosis. We know that even in major metropolitan centres, people often have a delayed diagnosis. It can take up to three years, sometimes five years, to get a diagnosis.

There are common issues across Australia, but I guess the point is that people in rural Tasmania are experiencing these issues at an even heightened level.

I will let Vincent address the education component and UTAS.

**Mr POISSON** - To answer your question, I am not fully aware how much education UTAS provides to GPs. However, I can provide you two personal examples of tests that I have done in the community.

I went to my personal GP and my podiatrist. Both of them said that a large proportion of their patients are aged over 65. I asked my GP what they would do if they had a person presenting with dementia. The doctor didn't really know what to do, because, unfortunately, there is no treatment or cure for dementia, and therefore the doctor doesn't really understand how they can actually help dementia. It is critical for us to come to these GPs. Many times, GPs have said to us that they have done their training, and as part of that training, if they are lucky, they may have three hours training on dementia - if at all.

How it lands in practice is that we see clearly that GPs see a person presenting with dementia, but they don't really know what to do next, or the benefits of Dementia Australia providing the support to the family, and the person with dementia themselves.

I did the same test with my podiatrist, and she was saying that the vast majority of her patients are over 65, and again, she didn't really know what to do and where to refer them.

**Mr GAFFNEY** - Has Dementia Australia, or the Tasmanian branch, had the opportunity to present at conferences? I am surmising that the doctors you spoke to may have been elderly? I'm just wondering whether the current situation with our students coming through UTAS, whether you're aware, do they get more than three hours? Is it a unit of work they do, or don't know?

**Mr POISSON -** Personally, I don't know, so I won't be able to answer this question.

**Mr GAFFNEY** - That's fine. We can follow that up, but thank you for that. Have you been invited to present at any conferences to do with the medical profession about dementia and about some of the issues at all, or not?

**Mr POISSON -** Again, in Tasmania I won't be able to answer this question but I know that definitely in Victoria we have. Recently I met with James Vickers, who is the director of the Wicking Centre, but I haven't discussed that in detail to that level with him - so, again, I can't answer your question.

**Mr GAFFNEY** - That's fine. Okay. Thank you.

**Ms LOVELL** - In your submission you mentioned dementia-friendly communities and I heard you talk about that a little before. Could you give us a bit more information about what that involves, what sort of initiatives that includes, and what's required to establish a community as a dementia-friendly community?

**Ms BAINES -** Yes. We're really the community development arm of Dementia Australia. Our aim is to support communities to develop groups that are aware of the needs and to include people living with dementia. It takes different forms in different places. In Tasmania we have a very strong group in the Kingborough area where a group of volunteers coming out of aged care and having connection with working through the Bachelor of Dementia Care, started a group about seven years ago, in fact before Dementia Australia had a dementia-friendly community section.

I've been a volunteer with that group too since it started and we run things like expos, events with people living with dementia. Dementia Friendly Tasmania Incorporated got a grant from Dementia-Friendly Communities and ran art sessions and singalongs for people living with dementia after having a forum where they were things requested from the community. So, my role is really to support communities.

The Bicheno project, I've been supporting but not running. They wanted me to come over and do the art therapies with them but I can't. But I can train them to run art sessions for people living with dementia. We have a dementia friends program where people can either online or face-to-face become a dementia friend. Lots of little communities like the Fingal Valley, Smithton and some of the other north-west coast communities have lots of dementia friends but haven't necessarily formed into a group yet that is changing the community but each is a little step towards creating a dementia-friendly community and having understanding.

The Clarence Council has interacted with us and I assisted getting people living with dementia talking to the council about what a dementia-friendly cafe would look like for them, and we have another dementia friendly cafe run by volunteers in Glenorchy, the Golden Wattle

Cafe. My role is to support them and to help train their volunteers to cope with supporting and including people living with dementia. We're seeing very much now that the whole emphasis is on inclusion of, listening to, and hearing people living with dementia on what they feel they need in their community. Hope that gives you some idea.

**Ms LOVELL** - It does, yes. Thank you. That's good.

**Ms MISKOVSKI -** If I can just jump in quickly there, in terms of the Dementia-Friendly Communities program, next Wednesday we have an online event that I hope you all would have received an invitation to. We're holding a federal Parliamentary Friends of Dementia event that is showcasing the Dementia-Friendly Communities program, and the Dementia-Friendly Tasmania program is highlighted in that. If you would like to learn more about the DFC program there is an online event next Wednesday.

**Ms LOVELL** - We will probably be stuck in parliament.

**CHAIR** - One of our members here, Bastian, if you want to speak to that?

**Dr SEIDEL** - There is going to be the relaunch of the Parliamentary Friends of Dementia, for Tasmania on Tuesday so it is going to be in person with 80 people attending.

**CHAIR** - Just a question from me, then I will go to Bastian. I think, Kylie, you made the points earlier on in your comments, and it is certainly contained in your submission about the delay of diagnosis and the impact that has. I probably know the answer to this but I want you to tell me what you believe. Why is that the case, particularly in our regions? We all represent rural and regional areas of Tasmania, the members around this committee. Could you explain to us why that is the case and how can we overcome the barriers that create this issue?

**Ms MISKOVSKI -** I think there are a few issues at play. As Vincent said we do not know the level of education around dementia that GPs have. When people are presenting with symptoms it might just be dismissed. There is also the issue of referral to specialists, to a geriatrician or a neurologist, which can be very challenging. One thing we have heard - and I think Vincent and Pat can probably talk to this a bit more - is often people will have very longstanding relationship with their GP and then the GP is reluctant to diagnose them with dementia because there is currently no cure. They think, what is the point in making a diagnosis? But we know that if people do get that timely diagnosis, then they can get those referrals to support services such as those that Dementia Australia provides.

We know that if people get that early intervention and support, it makes their dementia journey - for want of a better phrase - much less challenging. We find that not just in Tasmania but across the country people don't get that timely diagnosis, they don't get their referral to Dementia Australia and they often just kind of bumble along and find out about our services often in a time of crisis. What we would love to see is that someone gets the timely diagnosis and gets an immediate referral to Dementia Australia to get the support they need to try to avoid those crisis points. Vincent, I know we have spoken about this before so you might to add to that as well.

**Mr POISSON -** Especially in rural communities there is a big fear of a diagnosis of dementia leading to the cancellation of a driver's licence, for example, and the stigma that comes with that. For a lot of people, professionals as well, they might be hesitant to go down that route to allow people to be able to have their licence at a practical level. I guess that Kylie has really described the relationship that many doctors want to keep with their patients. It is also about the stigma that is present in that community. For a lot of people, a diagnosis of dementia is often associated with a nursing home type of set up. There is this fear of leaving the farm or leaving the house if they have a diagnosis. Again, it comes down to this education of the professionals but also of the community.

**CHAIR** - That is a massive issue in our communities. If you take someone's driver's licence away, you take away their independence and you create a serious issue of isolation because there is no public transport for many of these people. It is a real thing so thank you for sharing that.

**Dr SEIDEL** - Access to specialist services is indeed a problem. You pointed out that patients need to actually be driven or transported to specialist appointments. In cancer care we have cancer nurses with subspecialties like prostate cancer nurses and breast cancer nurses. Do you see a role for dementia nurses who are embedded in the community? Is it something that has been trialled anywhere else? Is it something that you would consider as a model for Tasmania?

**Mr POISSON -** Definitely this model has been talked about on a number of occasions in nine-and-a-half years at Dementia Australia. I would say, definitely, this is something that will bring a lot of value because it would bridge that gap between the time of diagnosis and people starting to experience issues in the community or within their house. That person who walks along with the person with dementia from day dot would be quite critical.

**Ms BAINES** - It might also help reduce some of the stigma, particularly in the small country towns. It is very variable, some towns are very supportive, knowing that people have dementia but I know other towns in Tasmania where people tell me that their 'friends' cross the road rather than talk to them. Perhaps they don't know what to say. There is some fear that it could be contagious. That is all about community education and getting the message out there.

**CHAIR** - It saddens me to hear that, but I know it to be true. One of the aspects of this is a much broader community engagement and community education program. We just talked about the Parliamentary Friends of Dementia. Hopefully, not many members of parliament fit into that category of thinking that it could be infectious or have a stigma attached, but there are many in our rural communities who do have those fears for whatever reason.

In your view, what is the best way to start addressing that? Is this Dementia Australia's job? Should Dementia Australia be pushing out into these communities in some way? If that is the case, how is that work to be funded and supported? Or is that an issue in itself? If we don't address some of these misconceptions there could be potentially tragic outcomes for communities, where people are isolated even further because of these concerns. We need to respond to that as a community. Whose role is it and how is it to be funded?

**Mr POISSON** - Maybe it would be that it is everybody's role. Yes, Dementia Australia's role is to be out there at the forefront. We have seen one of our initiatives, the Brain Health Program, which has been designed by Dementia Australia to go towards the rural and remote communities specifically to develop this kind of dementia awareness program and capacity-building programs.

We have identified through this experience that a lot of remote communities are a bit hesitant to have an organisation like Dementia Australia come in to it. They want people to come and stay and be there for a long time. As an organisation we are saying yes, we can make that step towards the community but we need to be able to stay and provide ongoing service and support within that community. Often, this comes down to very practical issues like transport for Alzheimer's, having to find a staff member to drive three hours to go somewhere, go away for a number of days and then come back. There is a lot of cost involved in that. I guess, this is where the funding comes aptly as well.

**CHAIR** - Could you tell me how Dementia Australia is funded and how the staff of Dementia Australia in Tasmania are funded? I don't think that is in your submission.

**Mr POISSON** - We receive THSB funding, the Commonwealth health support program. We also receive funding from the national dementia support programs as well. Then we receive some funding via philanthropic trusts. I don't have the exact figure. Maybe, Kylie, you can provide that? I presume approximately 85 per cent of our funding is government funding - federal or state funding.

In Tasmania, for example, I think approximately 90 per cent of our funding is from the Commonwealth, or federal, and then we have a small portion of state funding. The state funding, for example, is only funding one specific program, which is still in infancy, which is called a café style program.

What we have been developing recently is this initiative for us to help people, who are living with younger onset dementia or have recently been diagnosed with dementia and are still quite young, you could say, to still be able to access the community, for example, a café or a coffee shop with other people living with dementia and their carers. So, we Dementia Australia meet with people, first of all, identify to which coffee shop locally they want to go and then we get in contact with the coffee shop and say, 'We have people living with dementia who will want to come to this coffee shop. What do you need from us to allow this to happen, so that they can come around and feel safe within that environment?' We've started this in Hobart and Launceston. Launceston is going very well at the moment. We've had a few issues in Hobart because of the lockdown recently but it's starting to go along.

This funding, for example, part of it came from Tas community funding and then a small portion of it from a private philanthropic trust.

**CHAIR** - This is only a very recent thing. Is this coming out of the COVID support funding? Is that where it's come from?

**Mr POISSON -** No. For this one, it's come from the Tasmanian Community Fund funding.

**CHAIR** - Which, notionally, is government funding but it's a one-off, isn't it?

**Mr POISSON -** It's a one-off, exactly right.

**CHAIR** - You can do this and then it all stops and those people are no better off.

**Mr POISSON -** Precisely right.

**CHAIR** - Vincent, you said that about 90 per cent of the funding that Tasmania receives is from the Commonwealth? So, 10 per cent is really just the community Tas fund.

**Mr POISSON -** The community Tas fund was just an example I gave you for the café-style program. The rest is coming from our private philanthropic trust and from the ad hoc funding that we receive from fundraising initiatives.

**CHAIR** - How much funding, in dollar terms, does the Commonwealth provide?

**Mr POISSON -** I haven't got this figure with me right now but I can come back to you with that.

**CHAIR** - It would be helpful to know how much. How many staff does that employ?

**Mr POISSON -** We have 34 staff across Tasmania, in Devonport, Launceston and Hobart. In Hobart we have approximately 15, in Launceston another 12, and then in Devonport we have two staff. The staffing is divided in terms of the different tranche services that we provide.

For example, we have a group of four staff here who deliver their support program, like the respite services, which we call Day Club. This is basically for people living with dementia and the health services we provide here. Then we have our dementia support specialists and our counsellors. Most of their work is to work with the family and the carers of people living with dementia and providing education, direct strategies to better support the person with dementia.

Then we have one staff member who provides training to professionals across the whole state. This person is based in Hobart and has to travel a lot of distance across Tasmania to deliver training to people in residential aged care settings, hospitals and other professional settings.

**CHAIR** - Once the borders reopen on 15 December, there is a very real risk for these people who are impacted by dementia, either as people living with dementia or their families and carers, to become very isolated again for fear of being out and about in the community where COVID will be circulating.

Have you any suggestions as to how that needs to be addressed? We'll have the Government in front of us in a hearing in the not too distant future and I'll be interested in how they're going to deal with some of these issues. Not just for people living with dementia but people who are vulnerable anyway, like elderly people and people with underlying conditions, particularly immuno-suppressed people. In terms of the funding the state government provides in supporting the communities in the so-called COVID-19 Recovery, if you were sitting at the table, what would be asking the minister for?

**Mr POISSON** - Especially in the context of what might be coming with the reopening and the potential risk, we will see people who will be isolated, most likely. There are two things that we can do. One is to go to those people and provide them support within their own house setting, to provide them the education and support and strategies and/or provide online services for them to be able to meet with us.

We know, as we discussed before, that online services are quite difficult to access in Tasmania, especially in remote regions. For us, the capacity to have the labour force, the funds and finance to be able to get enough workers to go out there and provide the support we are providing - like basic strategies for people, how to live well to dementia - would be a big step. Also, any kind of support that people could access to access online technologies.

Pat and I were discussing that, for a lot of people, they might have the skills to be able to join online, for example, but they might not have the finance to have a laptop and to pay for an internet connection, or they might have to have this specific spot in specific regional communities where they can go to access our services online.

**Ms BAINES** - I think the use of the mobile telephone is also really important. One thing we have always been able to do for very remote people is to stay in contact with the carer and, if possible, the person living with dementia to try to reduce their sense of isolation.

**CHAIR** - Has the Tasmanian division of Dementia Australia ever put a budget submission in to government to fund some of these necessary support structures, whether it be community education, training for health professionals, even just setting up dementia-friendly communities? Have you ever asked the state government for funding to support that?

**Ms MISKOVSKI** - We have provided pre-budget submissions over the last several years as Dementia Australia, as an organisation. As you are probably aware, Dementia Australia only became Dementia Australia four years ago. I am not sure what happened prior to that, but I know, since unification, our policy team has worked with the client services team to develop pre-budget submissions asking for funding. To my knowledge, we haven't yet been successful.

**CHAIR** - Okay.

**Mr GAFFNEY** - Interestingly enough, and I mean this in the best way, carers for dementia are sometimes a revolving door. I mean that in the case where I was recently invited to an aged care home in Ulverstone. One of the carers there - the son of one of the residents who has dementia - had started their own support network for carers and I was invited to present there and talk to them. They had 10 or 12, but as soon as his relationship with the facility finishes, when his mum is no longer around, that is what I mean by a revolving door, he probably won't be in that facility to help carry on that relationship he has been developing. I get the sense that the group will probably fold because, at this time, he is the driving force.

I suppose, one of the issues for Dementia Australia and Tasmania is how do you keep some of those good things going, that are happening in isolated pockets, once the person is no longer involved? How do your professionals, the two people you have in Devonport, do that? Do they take examples of good things happening in other places and try to introduce them? It is one of those issues you have to come to terms with. Any comments on that situation?

**Mr POISSON -** I think I know which group you are talking about and I was discussing this with our team leader there. It is a very common thing, you are right, and we see this all the time. We have these support groups which are created by very enthusiastic members and then when this person is no longer around or no longer available, that group falls. What we have discussed, and one thing that we have seen that works is for us to be present as a visible presence and not relying on the one staff member and to regularly send someone to meet with that group to really empower them have this revolving system within their own group to be able to lead and run the group when we are not around, so they are not dependent on us and not dependent on one person.

With the group that you are talking about, we were discussing coming back to them and saying, what about if we were to send one of our workers on a regular basis, let us say, on a three-month basis, to provide you with some education about dementia but most importantly to give you a face for you to contact whenever you need our support services so that we can keep in touch with that group and they are not dependent on us. For example, instead of them meeting at the residential aged care setting, we were thinking of empowering them to meet at the local cafe so they are not dependent on that location and they are in their community.

**Mr GAFFNEY** - I get the feeling they do get some support from the aged care service facility itself. We were sitting there and then they brought in biscuits and sandwiches so they made the group feel part of the place. I thought that was really nice. In discussion a couple of people there said they did not get that sort of reception in other aged care facilities where they had another member of their family where they weren't quite accommodated for. I found that really interesting.

**Mr POISSON -** This is exactly why we want to encourage these groups to be more in that community rather than to be reliant on organisations and the aged care settings like that because it is a picture that we see quite often.

**Ms BAINES -** It is also a benefit in supporting those groups to be aware of the sustainability issue that you are raising, and being sure that they are including new people in the group and empowering those new people to take on roles within the group so that there is already someone to attend to it. If someone withdraws for health reasons or whatever reason, we don't always find - because the person living with dementia has died, for example - that people necessarily drop out.

Dementia Australia has some volunteers. I have one in my group who has been with us 11 years. Her husband passed away about nine years ago and she finds it very rewarding because of the understanding and knowledge. It gives her a sense of being useful and contributing to the community. It is also about recognition of those groups too, which I think is one of the roles of Dementia-Friendly Community to be supporting and acknowledging those groups and giving them recognition.

**Mr. GAFFNEY** - Thank you. Around the group there it was interesting the different knowledge base that the carer or the people had there. It was quite amazing when somebody would say that and you could see the lightbulb moment with one of the others, 'I had never thought about doing that or I hadn't even heard that', so it was good. I was thinking, once that group folds, that crossover of information is possibly lost and that was playing a really important role.

**Mr POISSON -** Only one thing I want to add to this is - and we want to introduce that for this specific group that you are talking about - we found that it is important for us to have this conversation with the group that having a 12-month review of their membership can be quite beneficial for them and having an open-door approach to the group. We have found that if that is not articulated to the group standard, then they tend to be quite closed in themselves, and they then don't have the new blood coming in. This is why we want to introduce that kind of way of thinking in those groups, and facilitate that process because we often have contact with the carers in the community, and we can link those carers to these groups and introduce new people and those who need to retire from the group and retire basically.

**Ms BAINES** - It is probably worth mentioning our e-Library. We have a wonderful e-Library as a resource for rural communities. At the moment I am in the process of sending out information so through Libraries Tasmania as part of my Dementia-Friendly Communities role because they will never know about it unless I communicate with them. I have also sent information to the library about our Helpline which is available from 9 am to 8 pm during the week. It is important to make sure communities know that there are these additional resources that are available.

**CHAIR** - Thank you for that. We are slightly over time now. Is there anything you haven't said that you would like to say to the committee before we wrap up this hearing?

**Mr POISSON** - Just to go back to your question of funding, as I said to you I am sorry I couldn't provide you with the exact funding detail but if you want we could send that information to you just to give you a total.

**CHAIR** - Our secretary, Jenny, will write to you. Should that go to you, Vincent, to get that information? You would be the best place to provide that?

**Mr POISSON** - Yes.

**THE WITNESSES WITHDREW.**

**Mr ADAM STORMONT**, HEART HEALTH MANAGER VICTORIA/TASMANIA, **Ms KELLIE-ANNE JOLLY**, VIC/TAS CEO, HEART FOUNDATION, WERE CALLED, APPEARED BY WEBEX, AND EXAMINED.

**CHAIR** - We welcome both of you our public hearings for the Rural Health Inquiry. This is a public hearing and all evidence you provide today will be transcribed by Hansard and will become part of our public record published on the website and inform our report. Because you are not in the state, the evidence you provide is not necessarily covered by parliamentary privilege. If you have any concerns about that and wish to see the transcript before we publish it, we can do that if you wish.

If there is anything you want to tell us of a confidential nature, you could make that request and the committee would consider it. We've got members of the committee, Bastian Seidel, Mike Gaffney, myself Ruth Forrest and Sarah Lovell and the rest are our staff and the Hansard monitor.

Thank you for your submission. We invite you to introduce yourselves and speak to your submission and add any further information that you would like to. I invite whoever wants to go first to start.

**Ms JOLLY -** Thank you and apologies again for not being able to see me. You never know, I might just suddenly turn up, out of the blue. You never know with technology.

I would just like to thank the committee for my colleague, Adam Stormont, who is our Heart Health Manager, Victoria/Tasmania and, myself, the CEO of Heart Foundation in Victoria and Tasmania for the opportunity to speak at this inquiry today. I am going to start and then we'll go from there. Then, no doubt, you'll ask us some questions.

First, I think many of you would be very familiar with the Heart Foundation. It is a not-for-profit organisation. It's been around for 60 years and basically, we're dedicated to fighting the biggest killer of Australians, which is heart disease. That's no different in Tasmania as well.

As I said, we've been around for 60 years and our purpose is to look at how we can continue to save the lives and improve the heart health of all Australians. We do that through a number of ways, supporting and funding research. We are the biggest non-government funder of research for cardiovascular disease. We develop treatment guidelines and particularly focus on the educating and training of health professionals around heart disease and the risk and prevention of it and support patient care. We also help Australians to live heart healthy lifestyles, including through reducing their modifiable risk factors. You'd be well aware of those: smoking, poor diet, physical inactivity, high blood pressure and so forth.

Every year, as our submission indicates, 804 - give or take - Tasmanians die of heart disease and about 8200 are hospitalised. That's only going to get worse. We are seeing a growing ageing population in Tasmania. Unfortunately, your postcode and your socioeconomic status does impact on most health issues. Cardiovascular disease is not unique in that. We see higher rates of risk and the proportion of 45 and over who have higher risk factors for heart disease. That's particularly seen in rural and remote parts of Tasmania. Things such as obesity, smoking and physical inactivity are some of those. In fact, it's quite interesting to see that it's the only state or territory where we've seen an increase in the rate of hospitalisations for coronary heart disease since 2012, whereas across the nation we've seen the opposite happen. We've seen a fall of about 10 per cent. So, it has been going in the wrong direction.

We're very pleased to see the inclusion of mental health in the terms of reference. More and more we're seeing the link between anxiety, depression and heart disease. We see that there is a higher percentage of patients with coronary heart disease who are experiencing major depression. This is about threefold higher than the general population. It's really pleasing to see that was added.

We understand the purpose of this inquiry is to understand health outcomes and access to community health and hospital services for Tasmanians in rural and remote areas. Although we're not a service deliverer - there are plenty of other people who will be giving greater insights into specifics around services - we do have a couple of things that we feel we should be highlighting as part of our submission.

Also, we acknowledge that there is a range of other policy imperatives and platforms that can align with the outcomes and the recommendations of this inquiry, such as PESRAC, Our Health, Our Future, Healthy Tasmania Plan, all of which we believe need to be seen in entirety and be aligned to ensure we are getting a joined-up and much more integrated systems approach so that they're not all conflicting with one another. In our submission, we recommend continued investment in programs and opportunities that support patients who have experienced a heart event. Often, these people are forgotten when they are discharged from hospital and services.

Recovery is pretty critical to reduce readmissions of these patients back into hospital, which can be very costly, because heart disease is a costly disease. It goes beyond the episodic hospital-based intervention. We need a combination of targeted rehabilitation services, information and ongoing support to improve recovery and manage the condition beyond the event, improve quality of life, and also reduce, as I said, those subsequent events.

It is not only about those who have had an event. We also very strongly support the importance of prevention. Heart disease is largely preventable. About 90 per cent of it is - particularly risk factors for heart disease, which are modifiable.

When we are considering access to service in rural and remote areas, we believe we need to continue to focus on prevention and risk reduction. Again, this can often be overlooked, or there is less investment in this area, particularly in primary care. Given poorer outcomes in rural and remote Tasmania, one of the areas we have highlighted in our submission is the heart health check, or an absolute risk assessment, which really could give the opportunity to improve health outcomes in rural and regional areas where there is greatest risk. We know from our Heart Foundation heart maps - which actually map where the greatest risk is, and the greatest admission rates for heart disease are - that we can be much more targeted in the way we approach this.

Basically, we have recommended a greater investment in and consideration of how we address risk, and how we measure and monitor risk.

The Heart Foundation was involved in advocating for a specific Medicare item at the federal level to enable GPs, supported by practice nurses, to undertake heart health assessments, and to look at this in an absolute way, to really identify risk profiles and then tailor and target that need and manage modifiable risk factors in those who need to reduce their risk. We see that and we recommend that in our submission.

Over the last few years, the Heart Foundation has done a lot of work in really listening, engaging and co-designing with GPs and primary care professionals to provide resources and toolkits to enable the profession, and nurses, to undertake these heart health checks. We have seen significant interest in and uptake of these.

Before I finish the opening remarks, what is also probably highlighted most in our submission is the interest in looking at different models of care, particularly digital health. Through COVID-19, we have seen a real acceleration in the need and demand for digital health as a really important mechanism for health care delivery.

It is important to create, consider and test different models of care, and to really think about the way in which we do this differently and perhaps move away from the more traditional ways of delivering - recognising that digital health is not the be-all and end-all. We're certainly not seeking to replace it, but feel that it needs a greater investment in and consideration of digital health when we're looking at models of care, particularly in rural and remote Tasmania.

The PESRAC report highlighted that digital needs to be an essential service. It needs to be affordable, available and reliable. People need to have access, and a level of digital literacy to know how to use it, and all the things that go with that. I feel there's an opportunity for us to embrace digital health in a much broader cost-effective way, where it can be used; it can't be used for everything.

In other parts of Australia, one of the areas with the strongest uptake of virtual care is in heart disease. I feel there may be that opportunity to explore that and do that a bit more, going forward.

Cardiac rehabilitation is another important part of recovery for those who have experienced a cardiac event. In Tasmania that has been looked at, and a number of different models have been tested. As I said earlier, it is really important to look at the recovery of people who have had a cardiac event, not just when people are in hospital. We know we can reduce hospital readmissions if people do undertake cardiac rehabilitation, but at the moment it is very much underutilised and under-resourced, to some degree.

So, it is about supporting people living with heart disease by ensuring they have access to the information, support and management they need, to enable them to again live productive, quality lives - and also keep them out of hospital and reduce those acute service costs. I might leave it there.

**CHAIR** - Adam, did you want to add anything at this stage?

**Mr STORMONT -** No, I think Kylie covered that very well.

**CHAIR** - If I could open with a question. You talked about digital health, and access to it. On page 4 of your submission you talk about heart maps, which you referred to in those comments as well. For example, the electorates of Braddon and Lyons - federal seats that are the same as our lower House seats - have a heart disease and mortality of 84 per cent and

83 per cent respectively, compared to the national average of 66 per cent. We have known this for some time, and it is quite a concern.

You talk about this area of obvious need to pilot remotely delivered cardiac rehab. I hear from my constituents that access to cardiac rehab is almost a non-event, which means they often end up back in the system with another event that requires hospitalisation - and significant deterioration in their health and wellbeing.

How much of your cardiac rehab can be delivered digitally? Obviously, you are going to need good connection, digital literacy, and all those things which are a challenge as well. Providing cardiac rehab is not all about understanding what you have to do - it is actually getting out there and doing it. Can you explain how that works, and how you engage communities like the north-west coast to do that?

**Ms JOLLY -** There are a number of models around. I know Cardihab is being tested in Tasmania, and it is still early days to see how that goes. A lot of cardiac rehabilitation - in fact most of it - can potentially be done through a digital mechanism, because it is as much about information and psychological help and support. Even aspects of the physical activity piece can be done in a digital sense.

That may not be amenable to all, but not all people need the same level of cardiac rehabilitation. It does depend to some degree on the supports that people are getting, and how isolated they are. It is also about tailoring the individual's needs to the cardiac rehabilitation.

The majority of this could potentially be done through a digital mechanism, whether that is through video conferencing, phone prompts and all those different channels. Adam, you might want to add something to that?

**Mr STORMONT -** Thanks Kylie, you have hit the nail on the head. Cardiac rehabilitation post-event is critical to the recovery that a patient will have. The evidence shows us that if someone doesn't participate in rehabilitation, they are more likely to have a second event. It is really critical.

I think, as you can see from our submission, as Kel touched on, that sort of menu-based approach is not a one-size-fits-all. Some patients, for example, won't want to do a face-to-face cardiac rehab. They come in to hospital, post their heart attack. They have had that good care. They have then been discharged back into the community. They may prefer to do something digitally, remotely, using a device, because it suits them. Other people prefer face to face.

They are quite complementary in that sense. It is a both/and. We should be looking more broadly at how we can increase the participation that patients post-cardiac event have in cardiac rehabilitation. The 30 percent figure in our submission and that Kel mentioned is quite a broad figure. It varies, depending on where you are, in Tasmania and elsewhere across the country. It can be higher or lower. It is about finding where the areas are that you are trying to increase the participation and then work with those communities.

Elements around increasing participation we see through our walking groups, which are something the Heart Foundation also helps to coordinate through communities. We know that participation in a group setting can improve people's mental health. Because of the connection between mental health and cardiovascular disease that Kel touched on in the opening statement, we know that if people are more involved in a group setting they are more likely to have better outcomes from a mental health perspective, which will also flow into their cardiac rehabilitation.

To come back to your question. In those two electorates that have higher than the national average of heart disease mortality, you could pilot a cardiac rehabilitation program. It could be a combination of face to face and also digital and you would get the best of both worlds.

**Ms JOLLY** - Picking up on what Adam said, I think the other thing is that we can be a bit more creative and potentially innovative about it. It is the physical activity component that we have identified that often people do want to do in a group, face to face, or have some that is not so much digitally opportune. Different people have different views. Partly that is to do with being able to see and get the support from others in the group to measure how they are going in terms of their progress. They can identify with others. They can be motivated by others. Our walking program is just one example of where you might be able to look at complementing the cardiac rehab component, the digital piece, with something like engaging in walking, or using other local community programs to be part of that initiative.

**Mr STORMONT** - The other element that the literature strongly demonstrates is the element of peer support. The fact that cardiac rehabilitation - a patient who has had a cardiac event is with other people who have been through something similar. It is the element of peer support. That can be done face to face, but it can also be done digitally. That is really important in terms of somebody's recovery.

**CHAIR** - Is this something that you believe is automatically offered to all patients on discharge? It seems that it is not - both access to a digital program and/or a face-to-face program.

**Mr STORMONT** - It would be best practice for a referral to cardiac rehabilitation to be offered at discharge, whether that is a face-to-face program or a digital program. The reality is, with the pressure on the hospital system, and I'm not casting a judgment here, but sometimes that may not happen, or a patient gets a lot of information at discharge and that can be quite overwhelming. So, a patient may well be told that cardiac rehabilitation is available, and it is importance but it is not something they think about because of the amount of information they are getting. Then they are discharged home and those patients perhaps are falling through the cracks.

I think there are some system changes perhaps that could be made in how we can increase the awareness of cardiac rehab, be it a face-to-face or digital remote offering. That could be done very well in a pilot. A lot of these sort of initiatives, whether it's cardiac rehabilitation or other supporting programs, we mentioned the walking program, often in a pilot setting you can really hone that service and see what's working, what's not working before it's taken more broadly.

**Ms JOLLY -** Can I quickly pick up on that other question and just add that you might have also seen in our submission that we talked a little about the My Heart My Life program. That was, in some way, to pick up where cardiac rehab perhaps has been missing. We totally agree with what you're saying, that there are situations where that’s not being offered or provided for whatever reason, or even referred to.

My Heart My Life was really that opportunity to provide a six-week free journey for a patient when they've actually had an event in hospital. We were looking at how we could help support the system, I guess, to be able to provide that. We have had a number of hospitals in Tasmania that are involved. We ran a pilot and looked at the effect. That again has a number of offerings. It's got some text messaging, it's got a hard copy booklet. To some degree there's some telephone opportunity as well to have that conversation in that six weeks. Often we see that patients, if they're offered cardiac rehab, it can be up to a six-week gap from when they leave hospital to when they get to do heart out rehab and we know that's a critical period.

**Dr SEIDEL** - As you mentioned, heart disease isn't going to go away; it's only going to get worse. Yet, if you look at the programs we have and the funding for those programs, they seem to be coming and going, particularly in regional areas. We heard earlier in our evidence that there was a problem in Dover and that disappeared when the Royal Flying Doctor Service took over. Their funding is federal funding but it runs out next year. Then what?

How important do you think would it be to have continuous funding, regardless of where it comes from, to ensure those programs are staying on the ground? As you said, the problem isn't going to go away. It's not going to change. So, that's question number one.

The second question, which is almost a follow up: in your introduction you said that there were quite a few submissions made to programs like Our Healthcare Future and One Health and PESRAC. You said, and correct me if I'm wrong, we have to be mindful that the recommendations don't contradict each other. So, you are one of the national not-for-profits in health, do you think that's a risk? We now have myriad reports coming out, left, right and centre, and the recommendations are often more confusing or contradictory than anything else.

**Ms JOLLY -** I'll start with the last one first. Yes, as an organisation such as us, which is outside the system and we do contribute to a multitude of inquiries and submissions and consultations, I think that's always the risk. When you do have a lot of things that are all great, all terrific, all trying to do fantastic things, I think we need to be taking these recommendations collectively. Just from what we've seen because we're responding to many, there are some similarities in some themes that are across the board.

So, it's really important that we don't just see these as individuals, segregated, separate processes. Tasmania has the capacity to do that a lot better than even Victoria, for instance. I agree with you that we should be looking at that. I think it's going to get a better outcome in the long run, plus it's going to be more cost-effective to have a look at these recommendations. A lot of them are saying the same thing. So, it might be a little more targeted to rural and remote, which absolutely support, but I think that is the case.

In terms of funding, anybody who comes to this inquiry will probably say yes to that question. What we have struggled with - in the time that I have been with the Heart Foundation, and over the 60 years that the Heart Foundation has been around, it has been talking about the importance of recovery from heart disease, and that support. Yes, we think prevention is important, but people often do not think about this part. If you have a hip replacement or a knee replacement, there is not even any doubt that you need rehabilitation. It is part of your journey, it is part of your care, and what you need to have to get you through.

That is not the case with cardiac. The heart is a muscle. For people it is not physically seen, so it is really important that we continue this; we know the evidence. If we really are serious about making a difference, particularly for those who have unfortunately had a cardiac event - and we are seeing many of them in rural and remote Tasmania - we do need to invest in this, and continue to have it as part of the broader services that are being offered.

Recovery is as important as the actual intervention.

**CHAIR** - Thank you for that.

**Mr STORMONT -** Can I add to that, to answer Bastian's question around the different levels of funding. What we have found at the Heart Foundation, in the years we have been in this state, is that across both prevention, as well as the post-event care and support that the patient would need to get the best recovery, there are different types of programs that work at different levels.

We have a national program promoting the Heart Health Check, which is something that really helps with prevention - and broadly, at a high level, goes everywhere. In the cities and metropolitan areas, GPs are aware of it, and patients are aware of it, so we can get a good outcome there.

In more remote rural and regional communities, and more vulnerable Aboriginal and Torres Strait Islander communities, that is where you do need something to complement it.

As an example, in Victoria we have a national campaign for the Heart Health Check. We are working with a digital campaign in that space, but also with the Victorian Heath Department to go really deep into those regional and rural areas of Victoria, to work directly with the three regional primary health networks to promote the importance of the Heart Health Check - and working directly with GPs to improve awareness and to get more Victorians in those remote areas, where we know they have worse outcomes with cardiovascular disease, to have a Heart Health Check and to do something about it.

A similar approach would work in Tasmania. Basically, you are using funding to complement what is coming federally, if that makes sense. We acknowledge the fact that you will always have that federal funding, and there will always be some state funding. There are those different parts of the health system that are funded in that way, that is the reality.

There are challenges in that, but there are also opportunities. One of the biggest opportunities, particularly in primary care in Tasmania, is that there is one primary healthcare network. The Heart Foundation can engage quite well with those bodies to do some really good work in those areas that really need it.

**CHAIR** - You provided some comments on the term of reference relating to the health workforce, because workforce issues are a really important part of the rural health challenges. Do you want to elaborate further on the comments in your submission?

**Ms JOLLY -** Yes. Again, we need to think about who the workforce is, and be a little bit more innovative in the way we think about that.

We do get a bit caught up in disciplines, rather than looking at it in a much more multifactorial way. It is really about creating a flexible, collaborative and integrated workforce that can open up and adapt and work together to look at different models of care, look at new technologies, to really support different innovation, and tailor that to community and individual need.

Like any other part of the health system in Tasmania, I know it is really challenging to get cardiology and cardiologists and GPs to various areas. The role of nurses needs to be looked at, and whether there is an opportunity to increase the role of nurses, rather than necessarily always using the traditional model of providing service. To actually look at those sorts of opportunities, which I am sure it has been done.

We are pleased that another strategy that is being developed is Health Workforce 2040. We have spoken to the Department of Health in Tasmania about the need to include cardiology in that - which I believe has been included, which is good to see.

Again, it is about how we can use technologies to get specialist treatment, but also incentivise. There seems to be a mismatch between the workforce that is sitting in Hobart, potentially, and the workforce that is sitting where we know there is great need. Looking at where there is that potential to incentivise is not new; I am sure it is happening already. I guess we are reconfirming points that have probably already been made by others.

**CHAIR** - I don't know if you have a clear view on this, but what sort of incentives do you believe are necessary to attract staff to those regions - medical staff, nursing staff, other specialists, or people who need to provide service in this space?

**Ms JOLLY** - I am not sure exactly. I am sure there are professional bodies that would be able to answer that better than I.

**Mr STORMONT** - It is a tough one. I think some of it relates to where they train. When health professionals - be they GPs, doctors, nurses, physios, pharmacists - train at a university, they are more likely to stay in that area and be part of that community, and then go on to work there. That is part of the challenge. Quite often, as part of their rotations and their training programs, doctors who have trained in a metropolitan area will get sent to a rural hospital - but it might only be for six months or a year. It's not long enough to really embed themselves in that community. I think there is some evidence now that if their undergraduate training is completed in an area where you want doctors or nurses, where you want the health workforce to go, they are more likely to stay there.

Of course, you can't build a university in every regional town, so that is not going to be the answer for everything, but I think that is a part of it.

Coming back to Kellie's original point around that model of care delivery, and using that remote element of virtual tele-help, is I think is part of it, because not everything needs to be delivered face to face. We know that, and that really comes through in that patient-centred care. You are actually taking the care to the patient. The patient lives in a regional area. That is where they live. How do you connect them with a GP or a practice nurse, who may not live in that area, to still get them that care?

Obviously, that is not going to work with something like putting a stent in. They are going to have to go to an interventional hospital, and that will be in a major town. There are challenges in that space, but you can deliver some of the care and keep it connected.

I don't think there is one answer to that. It is something that will have to be worked on over the coming years, to really improve the outcomes there.

**Dr SEIDEL** - It's been put to us earlier that, in particular in rural areas, a generalist workforce model could be advantageous compared to a specialist workforce model. So, when it's about medical practitioners who would be potentially a GP with special interests in emergency care or cardiac rehabilitation or a generalist surgeon who also have an interest in emergency work, the same for nursing workforce, the same for allied health and occupational therapists who would also do mental healthcare. Do you see that is an attractive model for cardiac prevention, cardiac rehabilitation?

**Mr STORMONT -** I think that's a really good -

**Ms JOLLY** - Yes, I do.

**Mr STORMONT -** Good point, Bastian. I think you've really raised a really important issue. That that will be something that will help improve the delivery of care broadly but particular, in cardiovascular. It could be used for things around cardiac rehab and other prevention work. I'll use the heart health check as an example. When we provide health professional education around the availability of a Medicare item number and how a general practitioner can build that into their practice, it's about using the practice nurse as part of the model of care workflow, so the GP doesn't have to do it all. I think going down that path, it's really important - and I'm sure you would know this - to have those sort of professional bodies really engaged and on the journey. This is where you start to get in those sort of turf wars. It's like, 'I don't want that health workforce doing them, that's what we do' and et cetera, et cetera. So, I think it's a journey we have to go on. We've got to make sure we've got all those players in the room when we're putting those pilots together, when we're testing those models of care, so that we can get a really good outcome.

**Dr SEIDEL** - From your point of view, how important is continuity of care in those areas? There is a trend for fly-in fly-out, people have programs and some workers show up for 18 months or so and then they disappear again. Is there a benefit in offering continuity of care for patients who have cardiac issue or need cardiac rehabilitation or for prevention programs?

**Mr STORMONT -** There is evidence in medicine now that having that continuity of clinician can work to improve outcomes. There is certainly some benefit in that but it's not always going to be achievable, so I think it really does come back to how the program can be designed. So, yes, if you can get that continuity, great, but it won't be available for everybody. You don't want those people who can't get that to miss out. So, then how do you design that media-based approach, which we touched in our submission, to make sure you can cater for all parts of the population?

**Ms JOLLY -** I was just going to pick up on a comment before around the generalist. I think as Adam said, that's part of the challenge. I don't want to use the term 'turf wars'. There are professional or discipline boundaries that have been around and entrenched for quite some time. We need to break them down. There is also the potential to have that as being an incentive by broadening the role, broadening that opportunity to not just be a specialist in a particular area, and for argument's sake, whether it's cardiac rehab or even doing health checks for instance. From our perspective, there is that potential. That could be an incentive. I know money and somewhere to live is and all of those things are usually the incentives but to have the job satisfaction to broaden what you can offer and the work that you do could be seen potentially as an incentive.

**CHAIR** - Thank you. Just picking up on the point of the - for want of a better term - turf wars, that are well known and well understood -

**Ms JOLLY -** Sorry, I didn't really want to use that.

**CHAIR** - No, I've used it plenty of times.

**Mr STORMONT -** I think I used it first. I put it out there.

**CHAIR** - Yes, that's right. In many respects, I think the challenges around them are very real. I don't think anyone's denying that they're real. You talk to people in the community who say nurses can do exactly what the doctors do, so why don't we just have nurses, for example. We know there are scopes of practice for all our health professionals. What is the best way to overcome some of the misunderstandings about the various roles, and also help all the professions within their scope, and perhaps expand the scope for some, to demonstrate to each other the value of working together?

**Ms JOLLY** - I know this sounds an obvious point, but if we're coming from the premise of what is most important for the community, the patient or whoever and they are the centre of the conversation, I think it's the flip. Rather than me as the professional or me as my scope of practice and what's important for me, it's patient-centred. I know that we use that rhetoric a lot. I know there's an intent and it's easier said than done but we need to come at this from a patient- or community-centred perspective, they're in the centre.

If people come to the table to look at how we're going to make this better for them, then I think the proof is probably in the pudding. That's why it's a bit hard to talk about pilots and testing, but if you can get a run on the board or test something like this that enables you to cede the benefit to the patient, to the community, that might be a way to go. I think it can be done in some of the more remote or rural towns in Tasmania. It's about what we are trying to impact and what is most important, putting that at the centre.

**Mr STORMONT** - I agree with that.

**CHAIR** - One of the members of our committee is a former GP, and sadly soon going back to being a GP and I know his practice has put in a pharmacist and uses nurse practitioners. I guess, it's a matter of publicising those models as options for others when you see the patient outcomes. Is that what you're suggesting?

**Mr STORMONT** - Yes.

**Ms JOLLY** - Yes, absolutely. The other thing that we have seen is that you've got to bring the community with you. I think there are some entrenched views in the community. We've seen that with some qualitative work that we did with some patients about referrals. If the cardiologist tells them to do something, they'll do it, but if a nurse does, it's like 'nah'. It's that sense of having to bring the community along with the change in the model, not just the professionals. There are some entrenched views - that only the doctor can do this and only the doctor can say that. So, I think it's two side of that coin.

**CHAIR** - That attitude pervades the whole of our society.

**Mr STORMONT** - I think part of that professional boundary issue has come from the fact that health professionals train in silos. They come up through the university system, they do their placements and then they're on the ward. They're in the hospital in primary care and, all of a sudden, they're working with other members of the health profession. That's why it's challenging to understand how you could work together. How could you do some of what I'm doing? How could we work together to get that best outcome? I think now we're moving towards multi-disciplinary training.

When they do intakes now, they have doctors, nurses, allied health all in the same room. So they are doing some of the training together, so they see what they're all bringing to the patient, to the bedside, if you will. That could also apply in primary care. It's really about trying to start as early as we can in that training sense, so that doctors, nurses, physios, pharmacists, nurse practitioners, social workers, everyone who has a role to play to get that really great outcome for the patient and community care, can see their role and has a seat at that table.

**CHAIR** - Thank you. Some of that evidence has been really helpful for that term of reference. We are out of time. Is there anything you desperately wanted to say that we haven't covered?

**Ms JOLLY** - I think we have covered most things, but thank you very much.

**THE WITNESSES WITHDREW.**

**Ms SABRINA RAVAIL**, CHIEF COMMERCIAL OFFICER, SWOOP AERO WAS CALLED, APPEARED BY WEBEX, AND WAS EXAMINED.

**CHAIR** - Thank you for joining us. You're not based in Tasmania, I assume, you're over on the big island?

**Ms RAVAIL** - That's correct, yes. Normally, I'm part-time in Melbourne but border restrictions have made that a little difficult, so I am joining you from Brisbane today.

**CHAIR** - Thank you for attending the public hearing and for your submission. This is a public hearing, it is being streamed and Hansard is recording the evidence. It will form part of our public record. As you are not in Tasmania, notionally your evidence is not protected by parliamentary privilege, so just be aware of that when you speak, and it will be publicly available. If you do feel concerned about that or wanted to check the *Hansard* before we publish it, we could do that. Otherwise, if you are happy to proceed we can do so.

**Ms RAVAIL** - That sounds good, thank you.

**CHAIR** - We have your submission, so I invite you to introduce yourself, tell us a bit about what you bring to the inquiry and then speak to your submission. The members will then have questions.

**Ms RAVAIL** - First, thank you for inviting Swoop Aero to present to the committee today. We are very excited to be sharing the Swoop story and see where opportunities for our service and innovation lie in improving access to health in Tasmania. Before I jump in, I will provide a brief introduction to myself and Swoop and then I'll dive deeper into the submission we've made. Please feel free to interrupt me if you prefer a different approach. To be completely transparent, I have not presented in such a forum before.

**CHAIR** - That is fine, quite alright.

**Ms RAVAIL** - Briefly about myself, my name is Sabrina Ravail, I am the chief commercial officer at Swoop. I joined Swoop in 2019 and lead a commercial strategy, oversee its implementation and work closely with stakeholders to generate impact and growth. Before joining Swoop, I worked over a decade in commercial roles in multinational companies and during the refugee crisis I founded a not-for-profit to assist with the integration of refugees in Germany, working with the minister of the interior there.

Swoop was founded in 2017 by ex-air force pilot Eric Peck, and robotics engineer Josh Tepper, and our mission is to transform how the world moves, making access to the sky seamless.

**CHAIR** - Sorry Sabrina, we lost part of it. Can you go back a little bit, the connection doesn't seem to be brilliant.

**Ms RAVAIL** - The company was essentially founded on the back of a question asked by the Australian Government as to whether a drone could be used to transport chemotherapy medication in rural Australia. The answer to that one was 'yes', and it's still yes, it's technically possible but we found the real question to be, 'what did the full system look like to do that sustainably, reliably and safely every day of the week?' That's how our mission evolved and our goal became clearer, which today is to provide 100 million people access to sustainable drone networks in 2025. We are on the pathway to making that service accessible across a number of countries. What does that mean in practice? We essentially integrate drone logistics, and to the first and the last mile of the health supply chain, to transform its strength and agility. Where we don't deliver that service ourselves, we essentially provide a technology platform to partners.

In terms of partners that we've worked with, we've worked with organisations such as UNICEF, USAid and UK Aid, across a number of countries, so Malawi, Congo and Vanuatu, and we are launching operations in Australia in Queensland in the coming months. We are waiting for final regulatory approvals.

You might be asking why we are using drones to deliver our vision. One of the …

LOST CONNECTION

**CHAIR** - We have lost connection completely. We will wait for her to re-join. Can we stop the broadcast until she re-joins?

**LOST CONNECTION.**