PUBLIC

THE LEGISLATIVE COUNCIL SESSIONAL COMMITTEE GOVERNMENT ADMINISTRATION A SUBCOMMITTEE INQUIRY INTO RURAL HEALTH SERVICES IN TASMANIA MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE ON THURSDAY 31 MARCH 2022.

Ms ALISON SPICER, AND **Ms LEAHANNA STEVENS** WERE CALLED, MADE THE STATUTORY DECLARATION AND APPEARED VIA WEBEX.

CHAIR (Ms Forrest) - Welcome to the committee. What you say is part of our public record and everything you say before the committee is covered by parliamentary privilege. If there is anything of a confidential nature you wish to discuss you can make that request to the committee and the committee will then consider it, otherwise it's all public. It is streaming as well once I get them to turn the broadcast on.

I assume you have the information for witnesses as well that was sent to you?

Ms SPICER & Ms STEVENS - Yes.

CHAIR - I will ask you both to take the statutory declaration and if you have any questions feel free to ask them at that point. Following that I will ask you to introduce yourselves and then speak to your submission, noting that we are talking about your private practice and not any work you are doing with the Tasmanian Health Service (THS).

Ms SPICER - I am Alison Spicer, I am an RN nurse practitioner student and I work in paramedicine on the north-west coast, and have done for 22 years.

Ms STEVENS - I am Leahanna Stevens. I am a nurse practitioner in both the public sector with the Mersey Hospital in Latrobe and in my own private practice in Devonport, north-west Tasmania. I will leave it with Alison to begin.

CHAIR - We will leave it with you Alison. We have got your submissions and I have read them, if you would like to add to them more or elaborate further, that would be great.

Ms SPICER - I was just going to read through it, but if you have already read that, then I am happy to just summarise and take some questions.

CHAIR - If you wanted to summarise the key points that you wanted to bring to the committee's attention particularly, that would be great.

Ms SPICER - Yes, so ostensibly, I have worked on the north-west coast for 22 years. I have a broad range of experience across both Tasmanian Health Service, primary practice and indeed in the ambulance service, having more than seven years experience there and 22 years in the Tasmanian health sector. I have worked across all levels of enterprise within the Tasmanian Health sector. I understand the policy incumbrances and so on. I am speaking as a concerned paramedic and also as a passionate advocate for the community of north-west Tasmania.

I remain very concerned about the poor access to quality healthcare on the north-west and specifically the west coast. We are currently serviced around 30 per cent by locum GPs and locum doctors within the two services. Ochre provide the services to the regional areas

and agencies support the emergency departments and the hospital sectors directly. As someone who has worked alongside doctors and believe me, I believe in doctors, I have two sons who are doctors so I believe in the model, I just don't think that locums are the sustainable answer to the health system.

I would like to direct the committee to look at alternative models of care, I am quite passionate around that, around nurse practitioners, paramedic practitioners, I know you have heard submissions from those people, Emma Kate Thornley for paramedics and also Kerry Duggan presented on behalf of nurse practitioners as well. We are out there, we are working really hard. We go through a lot of training and experience to get to the peak of clinical nursing and we need to be considered as a viable, sustainable and affordable solution to the health system. I believe we can fill those voids in GP clinics. I do not believe we should do it alone, I think it should be a multidisciplinary model and we should support a training ground in Tasmania to grow and sustain competence and speciality care in our health sector. That is pretty much it in a nutshell.

CHAIR - Did you want to add anything, Leahanna, at the moment?

Ms STEVENS - No, that is good.

CHAIR - Did you have a question, Mike?

Mr GAFFNEY - Yes. Alison, you mentioned your experience in the Northern Territory. Was it the NT?

Ms SPICER - No, in northern Tasmania. In north-western Tasmania.

Mr GAFFNEY - Okay, north-west. How do you find trying to get more presence in the system as a practitioner? Has it been difficult to get acknowledged or find a way of furthering the cause or are there roadblocks there all the time? What are some of the obvious roadblocks that you think the committee can perhaps ease or bring to the attention of people to try to get more nurse practitioners and paramedic practitioners as recognised and funded as well? Are there some easy steps that you can see?

Ms SPICER - On the last page of my submission I talk about how the legislative system might directly help this. We need to recognise paramedics as health practitioners. At the moment, they are restricted to working at ambulance services. I believe it would take a small legislation change for them to be allowed to be generally employed into the health sector. That would also satisfy the mental health inquiry about paramedics and burnout and PTSD, in terms of ultimately providing career paths for paramedics, which is something we desperately need.

We need to amend legislation in Tasmania - for example, take out 'medical practitioners' in the Poisons Act, and replace it with 'health practitioner'. We would like you guys to champion us on a national level to be able to change or update MBS and billing parameters for nurse practitioners and allow paramedic practitioners to access those as well.

We want you to advocate for us in the community. I have seen Mike Gaffney doing some work there. I was doing some work with Mirza and his new GP Clinic and he told me that you have mentioned nurse practitioners to him. That is very useful, because he was open to me

coming on board in that practice. Just one word from people like yourselves really goes a long way to help us get some credibility in that sector.

We need to be asking questions at a policy level, and that is where you guys come in. What are we trying to achieve with a locum workforce? Is this the way we need to sustain our health future, with the ongoing slug of locum doctors? I ask you to accept the evidence, as I have reiterated in my paper. I am passionate about this. The opinion of the medical fraternity around alternative models of care is that we are going to bring demise to our patients. The evidence totally contradicts that - twenty years of high scrutiny in the USA.

CHAIR - Can you repeat what you just said about the doctors' concerns, because we lost you for a moment.

Ms SPICER - The doctors' positions that we have heard are that nurse practitioners or alternative models of care would provide a second tier service, and that by letting us have full prescribing rights or full access to billing and prescribing, we will somehow endanger our patients.

The evidence is completely contradictory to that. The evidence over 25 years out of the USA, New Zealand, people who work in those sectors and the patients, is that nurse practitioners are safe, affordable and are effective solutions to health care. In fact, in the USA, you will not see a GP, you will see a nurse practitioner in a family practice clinic. They actually have taken the place of GPs in the USA. New Zealand is very similar. We had the opportunity to speak to the Chief Nurse in New Zealand last week, or a few weeks ago, and she attested to the success of nurse practitioners in GP roles in the regional communities. Again, the evidence is contradictory to what the doctors are telling you.

You also heard that at the start of COVID-19, when politicians wanted pharmacies to be able to administer vaccinations, the RACGP and the AMA protested, saying that would not be safe for patients either, and would cause a lot of problems. Well, in fact, that has been a roaring success and pharmacists have cemented their place in the management of vaccinations forever. We need to give our alternative models of care the same opportunity.

CHAIR - Following up on that; I will take you back in a minute to the barriers to entry to nurse practitioner training and what might be the barriers there.

You have talked about New Zealand, and certainly, in the USA, as I understand it, there are completely nurse-led clinics and nurse practitioner staffed clinics. Because the hesitancy remains with some of the medical practitioners, would a transitional staged approach be better in that nurse practitioners become complementary to those practices so you do not have the revolving door of locum GPs, say, rather than trying to establish, initially at least, standalone nurse practitioner clinics?

Ms SPICER - Yes. We acknowledge that people are inherently change resistant and rather than enforce complete change we agree that that would be an appropriate way forward. In Canberra I have just found out recently they have four nurse practitioner-led walk-in clinics in the ACT. They are completely nurse practitioner-led centres and they will refer their complex care back to GPs and that is very successful and they are looking at opening up another four as we speak.

I agree, in Tasmania we would concede that to work in a collaborative model, as we do anyway, but physically in the presence of GPs would be a way forward. We would love to see some funding for that.

At the moment, GPs have funding availability up to about $25 000 to employ a nurse but that doesn't lay over to employing a nurse practitioner so there's no incentive for GPs to employ nurse practitioners in their clinic. They can't bill like they can. We only have four billing numbers that we can bill to and none of them include procedures or examinations so we're not a financial viability for GPs at the moment.

CHAIR - So, in order to address that there need to be a few things that will need to happen. There needs to be changes to the Medicare scheduling to enable nurse practitioners to be able to charge.

Ms SPICER - Correct.

CHAIR - That way, GPs don't have to directly fund them from their practice.

Ms SPICER - You could do it two ways. You could fund nurse practitioners to work into the GP clinics so provide half a salary or whatever and then if we couldn't get the Medicare Benefits Schedule (MBS) changed in the short term. Ultimately the MBS hasn't been updated since its inception in Australia. We have had four numbers for 10 years and that hasn't changed, largely due to the opposition of medicine.

CHAIR - How should it be funded? Should it be the feds who fund that money or should it be the state, ideally?

Ms SPICER - Federally, we need to get the MBS billing numbers expanded and state governments should fund trainee positions in Tasmania.

Leahanna, do you agree?

Ms STEVENS - Yes. It is definitely a federal issue and there are different ways of approaching training and transitioning for sure but there would have to be some statewide buy-in to support that, absolutely.

CHAIR - Is training currently available in Tasmania for nurse practitioners to undertake a role that, once completed, would see them in a position to participate in a nurse practitioner-led clinic, for example?

Ms SPICER - No, there's nothing. UTAS don't have a course and there are only three candidates. Nurse training roles are called 'nurse practitioner candidates', so that you are actually employed to train to become a nurse practitioner - they're candidate positions. They're inherently unicorns within the health sector and there are three in Tasmania. They are all within the THS - two in the Royal and one at the Launceston General Hospital.

CHAIR - How do we increase that? They wouldn't even recover the attrition rate that would exist so what needs to happen there?

If you were the Health minister, what would you do to fix this?

Ms SPICER - My opinion is that we need to follow the suit of New Zealand. If you look at comparative population and demographics, Tasmania should have around 15 training positions per year. UTAS should put on a course to provide that. They should be under scholarship.

I am currently studying under a federal scholarship through the University of Queensland but that requires me to go out of state so it would be good if UTAS could have the same support. We would have 15 candidates per year, producing 15 nurse practitioners every two years. Meanwhile, the federal government could provide the appropriate billing and prescribing changes that we need, so that would see that filter out into private practice. Nurses will tend to stay and work in rural and regional areas longer and are usually quite happy there, becoming ingrained in the community. That is what I would like to see happen. My model would be an urgent care centre that has funded training positions and that would also take over those Ochre roles and provide a 'hub and spoke' model to the regional areas. Leahanna might have some thoughts about training and education. She is well-versed in that.

Ms STEVENS - Yes. I think there is a two-pronged approach. There is the private model and there is the supported state model. It depends on which way - there is the incentive that it would be good to have a GP with nurse practitioner model. There should be those incentives there for GPs to train and grow a nurse practitioner within their service. However, they do not have those incentives. I think that needs to be looked at on its own as well.

In terms of training through universities, nurse practitioners have a whole year internship where they need their clinical hours met. That could be flexible to be done anywhere, but they are usually done within the stream of where they are working and specialising. Take emergency departments, for example, what we know of very well, there aren't any funded positions for that. The strategic planning, unfortunately, sometimes it just does not seem to be happening as much as we would like to, to strategically know where those positions should be and where they would be.

I think there is a loss of communication across a lot of multidisciplinary areas about what services the community get. So having a look at what the issues are within that specific community and what kind of specialities do they look for, like chronic health, physiotherapy allied health, nurse practitioners and how we can all work together. An urgent care model could be publicly funded, it could be co-funded, that is what is in my submission, that maybe a mixed model might work a bit easier for everyone.

Nurses and doctors do work really well together. It is a more cost-efficient model as well, long term, looking at the price of locums. Why not invest in nurses to train them alongside with the (indistinct) and the GPs to set up an urgent care model?. That is sustainable, where the student nurse practitioner from UTAS can go and spend those hours in that clinic, governed by an existing - we just need to recruit some nurse practitioners. I know mainland nurse practitioners who would like to come down to Tasmania but without those positions we have not been able to bring anybody down. Setting up those models first needs to be planned.

Ms LOVELL - Leahanna, thank you. Just to follow up on that, I know there are lots of different models and ways that this happens around the country. Is there anywhere that you would point to as the gold standard, best practice or where it is working really well? Are you aware of some of those different models?

Ms STEVENS - Yes. As Ali said, Canberra's walk-in clinics have been quite successful. It depends on what you are doing, if you are looking at a walk-in clinic where you want to offload some of the easier presentations, fractures, simple cuts and wounds and very simple things, that can be managed quite easily. That takes that bulk of work from the emergency departments into a separate area and that leaves emergency departments for the more complex and acute issues, which is what an emergency department should be mainly dealing with. I think that can work really well.

We need after-hours services, there is a lot of that, there are no after-hours services. That really helps offload emergency departments as well as also gaining access to the GPs. Like the north-west, we cannot get into a GP for three to four weeks and new people moving here cannot access a GP as a lot of GPs have closed their books completely. They need somewhere to go for those very quick and easy things. I think that urgent care model works really well. It could work better when there are more nurse practitioners who can manage those quick and easy things and be able to easily consult with their GP or a (indistinct) or even the model within what I have written up, is consultation with the Emergency Department and you offload and share patients to where they need to be. Trying to have the right person in the right place is really important, instead of wasting a lot of time for somebody who will have to be moved and then wait for five hours for a removal.

Those urgent care centres work really well. Those sorts of things offload GP waiting lists and offloads emergency departments. ACT did that, and some other states have had a look at doing that as well.

Mr DUIGAN - Is there a regulatory barrier for that to happen in Tasmania? Could we be doing it?

Ms STEVENS - No, I do not believe so.

Ms SPICER - My submission talks about the THS feasibility study for a nurse practitioner-led model in Invermay, Launceston, and they did all the planning of the opex and capex studies for that, but they ultimately went with the GP-led centre. I think they have 22 GPs working there. It has not made an impact because there is a billing, or a levy, of $150 to walk in the door, unless you've got a health care card. Anecdotally, that has not really made any impact.

But the modelling for a nurse practitioner centre has been done and it could easily be implemented in Tasmania without any encumbrances.

Mr DUIGAN - Given you have four Medicare lines, how do you go about charging for that service? Is it just simply fee for service or is there another way of charging patients in a nurse practitioner-led clinic setting?

Ms STEVENS - That would be up to the business owners and how they want to run that. With the current four Medicare items it is not financially feasible to work like a nurse practitioner. It is not worth it. It is really difficult to run a business and full-time income on that form of allowance.

For example, if it has been half-an-hour suturing a wound - and that takes a lot of time - we cannot bill for that procedure, whereas a GP can bill for suturing,. We are really hamstrung by the MBS items and that is a national problem. But you can set it up a private fee, and then a Medicare rebate can be paid back to the patient as well. They will out of pocket. It depends how the model is set up, and if there is partial funding and again, how you work with the GPs and the medical team within that unit.

Ms SPICER - We would need to be funded to get success in the short term.

CHAIR - We know there are nurse practitioners working in more narrow areas and they have limited prescribing rights, and limited investigative powers, or roles. Can you talk about the scope of the training program that you are talking about, and how broad it would be?

Ms STEVEN - Do you mean the training?

Ms CHAIR - Yes, the training that UTAS would need to do.

Ms STEVENS - It is up to the individual student, depending on which specialty they are focusing on. They gain their own clinical time. At the moment, it is on their own back to seek those hours, unless you have a scholarship and the workplace supports those hours.

CHAIR - If you wanted to train someone up to work in a nurse-led urgent care centre, what would that look like?

Ms STEVENS - It would be suitable for them to gain some hours through an emergency department or even in a GP clinic. If the centre was up and running, then they would work as a student through that centre and be supported by the nurse practitioners and the GP that was working there, for sure. Just like any intern would. It is just gaining those required clinical hours.

Ms SPICER - The nurse practitioner course at UTAS is generalised. All nurse practitioners study, for instance, judicious use of medicine. We do three or four pharmacology courses. Sometimes they are out of medical degrees as well so the same course is taught to nurse practitioners. All nurse practitioners, no matter what your speciality is, will do the generic course and then your independent practice hours, which for me, as Leahanna alluded to, is a whole year or 400 hours of independent practice, and my speciality is in ED so that has to be within an ED or an acute care setting to qualify or for me to get endorsement at the end. So, we do a generic two-year masters. It is clinical, it is not 'fluffy', it is very clinical and a lot of it is taken out of medicine and then we apply our own independent practice hours in our specialty to get that endorsement at the end. That would mean, if we wanted an urgent care centre, those trainees would have to be in ED or primary care GP clinics. As Leahanna said, we would actually train them in an urgent care centre to do what we do there.

CHAIR - Thanks for describing that.

Mr DUIGAN - My question is whether becoming a nurse practitioner is something which is widely aspired to in the nursing fraternity or because the role is somewhat hamstrung, to use your words, do people want to be nurse practitioners? Because there is a bit of work that goes into it?

Ms STEVENS - We have many nurses who would love to be nurse practitioners, but they don't enlist and they don't enrol because of where we are at the moment, that it is expensive for them to do it; they have to do a lot of those hours in their own time when they are already working full-time or they are already working quite significant hours to try to add that on top of what they are doing. These are experienced nurses, and by that time to gain that experience they have already had a family, they might have young families, so there are a lot of those issues as well. Unfortunately at the moment, it is not very attractive to try to go and train because a lot of it is off your own back and it is very expensive. So, if that was assisted somehow or supported, because there is often no confirmation of a job afterwards. Even if you studied as a nurse practitioner, there is no job for you at the end. So, it is a very big risk for a nurse to take two years of training and expense and then not to gain a job in that qualification.

I have trained nurse practitioners on the north-west who have left and gone elsewhere because we did not have any positions for them, and that is the risk you take with training at the moment. We spend a lot of time on nurses and then they go elsewhere and that can happen anywhere, but unfortunately the jobs are just not there at the moment and the incentives to do it. If there were, we could have some fantastic nurses, they live here, they love Tasmania, they have family here, they are grounded in Tasmania and will stay and that continuity of care is really important for patients that I think gets missed. It is a shame because we want to see the same doctor, we want to see the same nurses because they know our history and that is really important for patient safety as well. So, if we had more continuity of health care service that is really important and nurses can do that.

CHAIR - So we need to get critical mass, don't we?

Ms SPICER - I think there is some light in the end of the tunnel. I was recently in Queensland for university, to do my residentials, and while we were there the University of Queensland has been asked to provide 40 places at university next year and 30 new practitioners to start in the second year up there because Queensland nurse practitioners have taken off. There have been some changes in Queensland legislation that has allowed a little bit more freedom within the sector for nurse practitioners and they currently have nearly 600 nurse practitioners in Queensland and they are anticipating to have 10,000 up there by 2030. So, it is really booming up there. Nurses aspire to be nurse practitioners, that is the clinical peak of our nursing career, that is as far as we can go clinically within nursing, and people want to be at that level, but without positions or providing paid training it is just out of reach for a lot of people.

Mr DUIGAN - What did they do in Queensland?

MS SPICER - Nurse practitioners have a seat at the table up there so because they have so many. They have their own union and the executive director of nursing of Metro North is a nurse practitioner and she is very 'clouty' and she has decided that nurse practitioners can fill the voids in regional areas. They are in the Royal Flying Doctor Service (RFDS) too. They are doing air clinics, flying into remote regions and running clinics there. It's really taken off in a big way up there because they've got a seat at the table and they have some political clout.

Mr GAFFNEY - I have separate question following on from that. You said that there were 600 NPs in Queensland. What are the current numbers practising in Tasmania? People listening to this would be interested to know.

Ms SPICER - There are around 40, Mike. That's it; about 37 FTE and about 40 nurse practitioners.

Mr GAFFNEY - Ali you alluded to this, and Leahanna, one of the things that we have trouble with in Tasmania are emergency department overload and ambulances arriving at our major hospitals. You gave me an incident some time ago. If a paramedic practitioner or a nurse practitioner had been able to assess at the time, what percentage of those people wouldn't then have to go on to the emergency department or to a major hospital?

Are there any stats around that situation?

Ms SPICER - Yes. I can talk to the north-west because I've pulled the stats and I work there. In ambulance primary care jobs, at least 60 to 70 per cent of our work; so, 70 per cent of people ostensibly could be managed either at home or in primary care situations.

In the Emergency Department at Mersey General Hospital, I know 50 per cent of patients don't reach an in-patient bed; so, if you take out the complex patients you are still talking around 30 per cent of patients who come to the ED who could be managed in primary care or with a nurse practitioner.

If we had paramedic practitioners in Ambulance Tasmania, a lot of those patients wouldn't even need to be transported. They could be treated and managed at home.

Mr GAFFNEY - Do you have a voice to the THS or to the Government here that you have been able to put this forward, or do you have a union or a group that are trying to further the cause?

Ms STEVENS - Nationally, there is the Australian College of Nurse Practitioners (ACNP) and then we all have our state chapters. Tasmania has a chapter, which most of our 30 to 40 nurse practitioners are members of. The ACNP Tasmanian chapter collaborates with the office of the chief nursing office.

Sometimes, we feel there's a lack of invitation to certain meetings that would be useful for us to be involved in, but other than that it is difficult to say.

Ali, do you have any thoughts about that?

Ms SPICER - Yes, we don't get a seat at the table is ostensibly the answer there. We don't have the numbers to form any weight. We're not really involved in workforce planning. We've had conversations with clinical leaders and executive around the usefulness of nurse practitioners and paramedic practitioners.

Obviously, whilst there are no jobs and there are legislative encumbrances, it's hard to get momentum or any weight behind that, so we're continuing to be vocal but really not making any ground.

We need people who believe in the cause in policy making or we need a seat at the table, and that hasn't happened to date.

Mr GAFFNEY - I know that we're getting towards the end of your time. Is there any question or any area that we haven't touched on, that you want to highlight to the committee? We have your submission, but sometimes it's helpful if you can voice anything else that you might want to imprint onto the committee.

Do you want to go first, Ali and then Leahanna?

Ms SPICER - I'd just reiterate that this is a viable solution and something that we should all get behind. Nurse practitioners are going to happen. We can either be left at the train station or we can get on board and really start having an innovative and healthy state.

New Zealand also had opposition from the doctors but they just pressed the 'override' button and said, we appreciate all your protests but we're going to try this because we don't have any other options.

We've continued to sink money into locum GPs for 25 years and we are still 120 GPs short in Tasmania. That's not going to change. We have to look for something different. It's not really even innovative - it's tested and tried. Let's move on.

I reiterate - look at the evidence and contemplate what we're trying to achieve in the long term.

Mr GAFFNEY - I thank Ali and Leahanna.

Ms STEVENS - Thank you. I agree - for nurse practitioners to definitely be considered as an option for healthcare services. We can prescribe; we can order investigations; we can formulate a plan; we can refer to specialists. We can do everything that our medical counterparts can do and we most definitely don't want to replace GPs and our medical guys. We want to work with them. In terms of budget, we're a much cheaper option versus a locum who's going to come and go. I am very patient focussed, and what's best for our patients and our community should be number one. Nurses have a good grasp of what people need and that work complements medicine well. We can work together to formulate good, holistic care to people.

Supporting the funding of nurse practitioners is still going to be cheaper in the long run and can achieve so much as well ,which is fantastic.

We need to be invited more into health planning and health strategic planning for our communities we need to be on those tables and conversations with committees and not just have medical representation. Nurses or nurse practitioners should be there. From a federal level, we need Medicare and MBS sorted out as soon as possible. Thank you.

Mr DUIGAN - My question is along similar lines. As you look at the legislative and regulatory framework, if there was one change you would make that would advance your cause, what would that be?

Ms STEVENS - It would have to be the MBS. I already work in private practice. I am forced to charge a private fee, but I'd be happy not to do that. I don't want to do that. I want to help people but I can't. I would like to do that, and that would incentivise other nurses and the practitioners to set up their own businesses because in that way we can move forward; but

we are quite stuck with that. Again, we want to work with the GPs and doctors, because it works really well. I have done it for 25 years. I like working with doctors. There need to be more of those opportunities out there, not just being medically led everywhere we go.

Mr DUIGAN - For you Ali, that's the number one change - the MBS?

Ms SPICER - Yes, on a federal level. On a state level, I would like to see an injection of funds into nurse practitioner sustainable roles. At the moment, nurse practitioners, once they filter off or move, we don't replace them and we don't create any candidate positions, so our numbers never grow. I would like to some statewide investment into nurse practitioners. Ultimately, if we had one thing to do it would be to update and allow nurse practitioners to be able to be financial in private practice, and that is done through the MBS.

Mr GAFFNEY - In New Zealand, when they presented to us, there were several pieces of legislation that they had to address. If there was goodwill here from the Government, we could address some of those pieces of legislation. I know the federal thing is here, and that's fine too; but at the state level, for example, is it workplace safety where you guys can't sign off on the form even though you've given the person the stitch?

Ms STEVENS - WorkCover Tasmania. The ACNP Tasmanian Chapter put forward to the WorkCover Board to have nurse practitioners in, say, in the emergency department. If you suture a wound that was sustained at work, we were unable to write the initial WorkCover certificates. That creates extra work. We have to get a doctor to come to see the patient and get work on the whole episode of care. Not requiring a doctor, we can manage that on our own quite easily. We submitted to WorkCover to have that legislation changed in Tasmania. At the moment, we are waiting on a formal response back from that. I believe there has been some negotiation and there has been some movement with that. I am not exactly clear what that is; emergency department nurse practitioners may be able to have access to that. That was another thing that WorkCover was not supporting nurse practitioners as writing up the initial medical certificates for those.

CHAIR - Would that need legislative change to formalise that? I imagine it would, wouldn't it?

Ms STEVENS - Yes, it did.

Mr GAFFNEY - Do you know if there was any other support there from other people within the medical fraternity for that to occur, or was there some pushback?

Ms STEVENS - There was some mixed feedback, definitely. Yes.

Ms SPICER - The stakeholders at that meeting were predominantly medical and insurance providers and the consensus was that even nurse practitioners in private practice - and I will bring forward Kerry who does this for a living. She would see these patients in primary care for a living and she has been precluded. So, they have agreed that emergency nurse practitioners can have sign-off rights for WorkCover but nurse practitioners in private practice could not.

I might add that in other states, nurse practitioners are able to do that and we also have some restrictions involving immunisations in Tasmania that other states do not have. There is

some discretionary stuff entrenched in legalisation in Tasmania that just has not caught up with other states so there is not a lot of clarity and that also encumbers nurse practitioners coming into Tasmania because they cannot do as much in Tasmania as they could in Queensland for instance.

Ms LOVELL - Alison, could I just ask a question about that? In terms of the nurse practitioners in emergency departments versus private practice, was there any reason given for why? Is it a supervision thing or is it - I do not understand why they would say in this environment, yes, but in this environment, no?

CHAIR - Just on that, is it not the case that not all GPs can do it either? You have got to actually be accredited to sign off on work -

Ms SPICER - There is no training course for GPs to do it but there will be a training course for nurse practitioners.

Ms LOVELL - There was no reason given for why?

Ms SPICER - No, there was not any reason but similarly, we suspect it is about the supervision in the ED.

CHAIR - Alison, you mentioned earlier about paramedic practitioners and how people could be cared for in their home if you had a paramedic practitioner attending. As I understand it, if the paramedics who attend a patient at home and the patient is very dehydrated, maybe if they had gastro or whatever it is and they need intravenous fluids, if they put up IV fluids they would have to transport. But if a paramedic practitioner was there they would be able to treat them at home, administer the IV fluids, monitor and then leave and leave the patient at home? That should be another staple, yes? It just prevents that unnecessary transfer.

Ms SPICER - Correct. Also, they can prescribe antibiotics. A paramedic practitioner has the same prescribing rights as a nurse practitioner so whatever is within your scope of expertise you are able to access. Especially, on the north-west and I have taken this up with the executive of the ambulance as well, the role for the paramedic practitioner would just change lives up here. There is poor public transport, we are spread right across the north-west in really remote areas and to have someone that can actually provide really good quality care in the home would just be fantastic.

CHAIR - We are out of time, thank you for giving a bit of extra time and thank you for your appearance and your submission. We really appreciate that.

Ms SPICER - Thank you very much for the opportunity to present and I look forward to hearing the findings later in the year.

Ms STEVENS - Thank you for the invitation, that is fantastic.

THE WITNESSES WITHDREW.

Dr DENIS LENNOX, EXECUTIVE DIRECTOR, RURAL AND REMOTE MEDICAL SERVICES (RETIRED) APPEARED VIA WEBEX

CHAIR - I am Ruth Forrest, Chair of the committee. Opposite me is Nick Duigan then Mike Gaffney and Sarah Lovell behind me and our secretary and Hansard at the back of the room.

The information and evidence you give to the committee today will be recorded and will form part of our public record. Because you are not in our state you are not technically covered by parliamentary privilege so if you have any concerns about anything that you have said and you would like to review the transcript before we publish it please let Jenny know. Otherwise it will be published and form part of our public record and inform the committee's deliberations.

Dr LENNOX - Thank you for that. I am sure it is not likely to be the case.

CHAIR - Thank you for appearing before the committee and I invite you to introduce yourself and talk about your experience. I know you were the executive director of Rural and Remote Medical Services so I am sure you have a lot of stories to tell about rural Australia. I don't know if you have any experience of Tasmania, as such, so it would be good to hear about that.

Dr LENNOX - I did visit Tasmania and was involved with some colleagues focusing on Tasmania's rural health services on a couple of occasions. To back up, I occupied that role under various titles for the last 18 years of my career. There are many ways in which I realise now that I had been prepared on the pathway I was tracking to lead to that point, not least of which was having executive roles at the Toowoomba hospital.

I came here in the early 1980s to Toowoomba to lead a reform of the Toowoomba hospital services and before I progressed on that I did my groundwork to understand the directions that these services needed to track. Critically, I realised it was an important hub for a large rural community. It was a referral centre and so an important part of the reform we embarked upon was to relink this regional health service back to the referral communities. That began a pathway, not least of which was establishing the first rural doctors' training program in Australia, and the world for that matter, way back in the late 1980s.

For the last 18 years of my career I was working at a departmental level in an advisory capacity and the focus of our work at that stage was recruiting doctors through rural Queensland. I should say I am retired now since 2017. As I listen to news articles the subject of failing rural medical services fairly frequently reaches national publication and it saddens me enormously to find that decades later, after decades of the same plaintive cry about lack of doctors, lack of service, lack of access, we don't seem to have changed all that much.

My focus in the very first instance was the only thing we believed that we could do at that time which was to recruit international medical graduates and as I was doing that I increasingly came to understand that it was a rather perverse strategy. Here we were recruiting the least prepared doctors to work in the most challenging practice locations in our communities. I remember reporting, informally in the first instance but then formally at one stage, that this was a major disaster about to unfold.

I became substantially involved in the huge problems in Queensland in the early 2000s relating to Jayant Patel in Bundaberg. It was my report which had been refused by the minister at the time and the director-general which became the subject of a great deal of public discussion by Hedley Thomas, a *Courier Mail* journalist at that time, referred to as the Lennox Report. It probably was my first attempt to try to redress the problems that were occurring and in the first instance, the focus at that stage was to better manage recruitment, training and placement of international graduates if we were going to rely upon that.

As a consequence of the political responses at that time, I could no longer continue in that work. I suddenly found myself completely disabled in terms of any work in the international medical graduate front. With the little spare time I had at that point I reviewed all of the things I knew about rural health services and the systems we had in place to supply them with doctors and concluded that we were not doing the right thing. We needed a systematic transformation of the system to recruit doctors to rural communities.

What I would like to do very briefly is to go to the back end of that whole consideration: it took me a good part of 15 years or so to finally formulate in my mind the essential problems. Let me just summarise them this way and I am willing to explore any of the issues that you would like to in any detail. When you use the phrase 'rural health services' or 'rural medical services', certainly within the health system the majority of people will think about something that is broken and not functioning well; it is not providing good access to the needs of rural communities; it is lacking doctors or it is lacking nurses; or it is lacking capacity in some form.

We have come to accept over decades that rural health services are failing and there has been a perverse resignation to that status. The serious question is why? Why is this so? I have come to see that the critical characteristic of rural services which makes them so prone to failure is their small size, small capacity. Now, this does not necessarily mean that a small service could not flourish, but you have to manage that risk and in any other circumstance if a corporation or a government body or whatever it might be recognises that there is an inherent risk in an operation that you are carrying out, then you put in place appropriate risk management strategies. We have rarely done this for rural health.

I have concluded that we are plagued by a syndrome that affects every part of our society from executive government to rural communities themselves and I refer to it as the 'frontier syndrome,' this sense that because a small community is remote and distant from major centres then you simply cannot expect to have a good health service. In fact, that has been presented to me on numerous occasions. They'll name a particular location, 'Denis, this is … don't you realise...' and implied in that statement is 'we can't expect a good service'. I think this is a sad resignation to a reality that we have poorly risk-managed rural health services in Australia for a very long period of time and it has become accepted that that is the way it is.

We have made many attempts at government level, particularly federal and state levels, to redress it, but most of those have simply been a band-aid to the problem and from the federal point of view there was a series of band-aids, particularly related to medical workforce, not least of which were the actions to recruit and make it possible for international graduates to practise in rural locations for periods of times. But none of those redressed the core problem, the core problem being small size.

Now, if you think about small size of service it has critical flow-on effects for both the community and for management and recruitment of services. The very first thing is that if you

have a small sized community - when I say small, I mean small in head count or professionals who are providing that service - then you risk accessibility issues. In other words, unless each of those small number of professionals - let's talk about doctors which is my particular area of expertise - unless those doctors have a full range of competence in practice then the community lacks access to service. For example, if a community has two doctors and both of those doctors are male, then a significant number of the elderly female patients in that community will probably not access services or gynaecological problems as they might otherwise do.

CHAIR - And some younger ones too

Dr LENNOX - And some younger ones too, absolutely. Access becomes fraught and then capacity becomes fraught. If that community has an expectation, for example, that there is a 24/7 medical service at the hospital, then you have to consider the full time equivalent of doctors that are required to provide a 24/7 service, and not just a headcount. We traditionally considered that if we have a doctor in the town, that is adequate. In decades past, in an era of the veterans and even some of the baby boomers, being in a rural community and providing service on a 24/7 call has been the way that things are done. Many have done that with great grace and extraordinary capacity. Some have become rather crusty and cynical, and I know that syndrome quite well, having engaged many rural doctors in conversation. But I can say, the next generations will not do that. They will not contemplate working in that way, and neither should they.

There is a critical issue then about capacity, and finally, there is a critical issue about financial viability, or business viability. You can imagine that if there is anything that fractures parts of the service in terms of the scope of practice, the availability of the workforce to perform all functions, and the integration of the service in a financial sense, all of those simply add to the greater fragility of the service. In fact, those are what contribute to the chronic failure of these services.

The traditional response to that is, firstly, the frontier symptom that I mentioned. Why would we expect to be any different? This is just the nature of living in small rural communities. The second response has been, well, the service is not up to scratch. There is a risk to women in providing birthing services here, there are not enough women being birthed every year to sustain a service. Traditionally, the response by health service managers and health service executives has been to close service down. That has been the fear of rural communities for decades now - that someone will move in and close down the service.

The reality is, that scenario is not necessary. If we redress the reality that rural services are inherently fragile, that does not necessarily mean they can't close. With appropriate active management, not passive resignation to the circumstance, but active management at each of the elements at its core - we've seen here in Queensland that where a service was on the brink of failure, and the loss of the community was going to be enormous - that could be turned around.

Many colleagues have argued at different times that it is not justified to have the number of doctors that I have often advocated for in rural communities, but the work we have done is been very objective. We worked with data which demonstrates the number of doctors that you would expect in a community based not only upon the population, but upon the demographics; upon the relationship between demographics and demand for medical services; the relationship between morbidity and mortality and the demand for medical services. In fact, in some

instances, when you apply those measures, when you adjust the population with those characteristics, particularly in Indigenous communities, you will actually double the number of doctors warranted on that community beyond what might be in a larger, high socio-economic status centre.

When you track through that pathway and then develop the business model, it becomes evident in many circumstances that rural services can sustain a much larger health service. And once you begin to build capacity, the range of service options available to the community increases, there's greater access to services, there's greater satisfaction by the rural community, and the business model improves. It's crucial to that business model to ensure that the firewall between Commonwealth funded services - that is, general practice services - and state funded services - hospitals - is closed. That represents one of the greatest risks to the fragility of the rural medical service.

Through somewhere from the period about 2010 or 2011-12 we progressed some substantial work here in Longreach, where medical services were on the brink of collapse because private practice had become completely unsustainable. The existing workforce was about to depart, leaving those substantial communities and the small communities around them - Winton, Aramac, Blackall, Barcaldine - without medical services.

At the time, there was a head count of five doctors serving that community. When I retired in mid-2017, we had increased the number of doctors serving those communities to - a very viable practice. It was thoroughly integrated - general practice and hospital practice. There was a single point to oversee medical service in both general practice and hospital-based practice and because of that capacity, there was greater access to services by all parts of the community. General practice was integrated across all of those communities, so that if you were a female patient at Winton, for example, and there happened to be a male doctor there at the time and you preferred to access the female service, you could go to Longreach. You would have to drive to Longreach, of course, but your records were there because it was the same practice.

CHAIR - How far is that drive?

Dr LENNOX - Two hours.

Ms LOVELL - Denis, how big was the area that covered?

Dr LENNOX - I can't tell you in square kilometres but it's fairly large. Let me tell you in distance travelled. From the southernmost point, the communities are spaced about an hour in between. From Tambo to Blackall it was an hour. From Blackall to Barcaldine is an hour. From Barcaldine to Longreach is an hour. Longreach is the centre so the radius of the community served is probably up to four hours' travelling time.

Ms LOVELL - Thank you. That explains it well.

Mr DUIGAN - What about in terms of population, Denis? How many heads?

Dr LENNOX - You're testing me now. I might need to take it on notice and get back to you, but I think it was between 4-5000.

CHAIR - Total?

Dr LENNOX - Total.

CHAIR - And you had 25 doctors.

Dr LENNOX - Yes, 25 doctors.

CHAIR - What about allied health staff?

Dr LENNOX - Allied health flourished. Once we got the medical workforce in place, even private allied health practice returned to town and was flourishing, the last I saw.

As a consequence of this development, there was a complete change in hospital practice. I remember talking to the director of nursing about this; they were rather worried about it at one point. The number of hospital admissions to Longreach plummeted.

When we examined the causes for this, we discovered that chronic disease was being far better managed. The hospital couldn't remember the last time they had admitted a patient with asthma or with severe diabetes and as a consequence of that, the hospital redirected its services to increasing surgical options.

Ms LOVELL - On the number of doctors, Denis; I know there's no ideal formula but we've been told one GP to 1000 is roughly where it meets the needs of the community so that is a high ratio. Is that because you disagree with that ratio? Is it because it was integrated with the hospital? Obviously, it worked really well.

Dr LENNOX - Can I tell you that for years I had overseen the district workforce shortage and areas of need of assistance in Queensland and it frustrated me no end. The Commonwealth had a medical workforce advisory committee process at that stage that used to set the population ratios - how many doctors to patient ratio - and that was a useful tool at aggregate level. If you were looking at Commonwealth level in terms of workforce supply of doctors or even state level it was useful.

When you drilled that down to a local level I found it absolutely useless and it frustrated me no end which led to the development of a tool we called Medically Underserved Communities of Queensland and that was a tableau form I developed with the assistance of a couple of statisticians and an epidemiologist within Queensland Health. We first determined those known relationships between need for medical service and socio-economic status and the need for medical service related to morbidity and mortality in the community.

We took the whole of the Queensland population then, based upon the Census data, and broke that down to local community level and I adjusted the population for those known relationships. This is the other major issue about rural medical services. Not only was the issue of sending international graduates, most poorly trained, into the most challenging medical practice circumstances, the issue was that rural communities have a greater need. Rural communities carry the greater burden of morbidity/mortality. When you consider that into the need for medical services it dramatically increases the numbers of doctors warranted in the community. I don't recommend using a standard simple headcount of population per doctor number. It is not useful in a rural community.

Ms LOVELL - Thank you. On the growth that you were able to facilitate in that workforce, a challenge we are hearing a lot here is attracting and retaining doctors, particularly to rural communities. What was it that was so successful for you in this program, do you think?

Dr LENNOX - That is a nice segue to invite me to address the other key elements. I have started at the back end in our discussion now to talk about what we referred to as a fragile but flourishing, in other words you can turn things around. It is about service and workforce redesign in rural communities. Before I leave that can I say that it is crucial for communities to be actively involved.

The traditional approach is that rural communities wait for doctors, nurses and allied health services like rain from heaven. They have been emasculated in terms of any ability to be involved in a process of recruiting, building and sustaining rural service and we found here in Queensland that can be turned around. It takes a fair bit of work because there are decades of cultural approach to the whole idea that services in our community have broken and 'why doesn't the government send a doctor', to the things that they can do to be involved in the process. Of course, it necessarily links with [inaudible] at the federal level as well, but certainly communities can be turned from becoming passive recipients of failed services to active participants in building flourishing services and we have seen that happen in Queensland.

Then back to address what to do about the workforce. That was the issue that occupied my mind back in 2002 when I could do nothing further about international medical graduates. I began work at that stage built upon the experience that we had, to systematically redesign at state level a medical workforce supply and the key elements of that - there are three key pillars, in fact. One was recognition of practice. This is crucial and to an extent this has now reached national level. The issue is that doctors in a rural community must have a broad scope of practice.

Many of us have grandparents - or even parents - who will remember and will tell stories of going to see their GP to have their tonsils removed. Or a GP being the doctor who removed their mother's gallbladder. General practitioners in the early decades of the 20th century or even the mid-20th century were generous in the truest sense. They admitted patients to hospitals; they had anaesthetic lists; they operated; they delivered babies.

In the second part of the 20th century, general practice contracted into a specialised, office-based primary care practice in the community. Particularly, fee for service, that is a significant part of general practice. If you take somebody who is trained in that practice now and place in them in a real community, there is only a limited amount of work they can do in that context.

The pathway to general practice has changed somewhat in my career time as well. When I first graduated, most doctors spent four, five, six years in hospital-based practice before they went into general practice. There was no specific training in general practice at that stage so the training they got for themselves was training in a hospital context and then they moved into general practice.

The family medicine training program was first established about the time I graduated in the early-to-mid 1970s and then it became formalised into the training program for general practice. As a result of failure to maintain an adequate supply of doctors in Australia over

decades, we finally reached the situation particularly in the early 2000s with a huge medical shortage in Australia.

At that stage, general practice trainees could do only one year as an intern at the hospital to be formally registered and then move into general practice training. General practice training consisted of three years of training in office-based practice in the community. If you took that candidate then, that young fellow, and placed them in a real community, they are not able to do what is required of them.

In that 2002 year, with other colleagues, I devised a form of medical practice which was a direct response to the needs of the community. That is, someone who was fully competent in primary care practice, including the broad elements of public healthcare as well because doctors in the rural community are often involved in public health issues, not only individual practice issues. They needed to have full competence in secondary level service, in other words, in hospitals. They needed to be able to cope with emergencies, in-patient care of patients in a hospital level.

They needed to have a capability at a specialist level and at least one discipline that we nominated at that stage, related particularly to a need in rural Queensland. So, obstetrics was high on our list, anaesthetics was high on our list. Since about the time that I retired, probably 2016-17, we were largely filling the quota of doctors with obstetrics and anaesthetic skills in rural Queensland. We had rebuilt birthing services in Queensland and at that stage we needed to temper the number who were wanting to do anaesthetics or obstetrics.

That gave us an opportunity to push further in the other disciplines, which we had anticipated would surely be required in the future. That includes mental health, adult medicine, emergency medicine et cetera.

There is a full range of specialist level, practice capability that this doctor needs. It is the same capability that general practitioners had in the mid-20th century but have now lost. It is a process of restoring that. We gave to this doctor a new title the 'rural generalist' recognising the difference from the general concept of the general practitioner and the outcome of the training programs for general practitioners to say we needed to devise an entirely different category of doctor or discipline of medical practice and that was accepted in 2005 by the Government of Queensland.

The next thing we needed to do was to ensure that this recognised practice was valued for its true worth. So, in a landmark industrial case in 2005 we attained specialist equivalent salary status for rural generalists in Queensland. That made a huge impact. When I went first to recruit into the training pathway that I'll talk about in a moment, when I was able to tell medical students that there was a prescribed discipline, well-established, well-recognised and that it was going to be remunerated in our state at specialist status, the reaction wasn't so much about money, the reaction was about recognition and value. They said to me, over and over again, 'wow, this is a worthwhile pathway for us to travel in Queensland' and that has certainly proven to be the case.

So, they were two central planks; recognition of practice and value of practice. I'll just touch on this very briefly. The recognition of practice process became a very sophisticated complex task. Beyond the simple means of just recording and having formal recognition of that discipline in Queensland, we then needed to consider the status of all the doctors in rural

Queensland who were practising in the field and whether they measured up to those new criteria or not. Obviously, it's not going to be acceptable to have a number of them simply not recognised because they haven't tracked the formal training pathway or haven't obtained the qualifications, and not reward them for the work they were doing that they had done their own way to that pathway.

So, we established a fairly sophiscated process of assessment of all rural doctors who were practising currently and then, with the College of Rural and Remote Medicine, developing pathways for them to attain the status within a period of five years and the government established a contract with those doctors that would remunerate them at the new specialist level providing they progressed their qualifications within the period of five years.

CHAIR - At the front end you're talking about?

DR LENNOX - At the front end. So, if they were in service they were paid the new salary level up front, accepting a contract they would complete the necessary formal training pathway within a period of five years. We didn't grandfather anyone. We provided a formal tracked pathway and assisted and guided them.

CHAIR - But you did pay them. So essentially, it's a form of grandfathering them with a commitment to that assessment.

DR LENNOX - Yes.

CHAIR - Oh, that's good. Anyway, go on.

DR LENNOX - They were remunerated but they were required to obtain the qualifications. That was a huge task, but it was completed and only with a few difficulties in the end, but it was completed. This occurred over other disciplines as well, I won't go into detail on those at the time in Queensland. We were addressing addiction medicine and some other unrecognised disciplines in Queensland. I think there was a total of about 120-odd doctors who were in this circumstance, so it was a relatively large task.

So, then we established a pathway of training and what became evident in this process was up until that point, a few Australian graduates who were tracking to rural practice found their own way there. They developed their own pathways, if you like, to obtain that outcome. We recognised that we needed to establish a pathway that made a very clear, supported, tracked, highway in effect, to practise as rural generalists in Queensland. Career navigation was crucial and we began that process at medical school, becoming enrolled with medical skills to develop the interest of medical students.

James Cook University probably rose to the occasion on this more than any of the universities in Queensland, but Griffith University picked it up subsequently as well, and it makes enormous sense that we are active in recruiting a potential rural generalist workforce at medical school level. So, the interest and passion are developed at that level and medical schools provide the opportunity for the students to begin experiencing exposure and training in those rural generalist contexts.

The career navigation process continued on. Rather than just allowing the medical students and graduates just to stumble along on their own way, we provided each of them who

committed to this pathway with colleagues who would oversee and guide them up, it was a one-to-one engagement. We had a number of support medical staff, career advisers and mentors that each of the trainees from medical school was attached to, who followed them right through with the development of their career. Because, of course, these are the years in which they are navigating significant other challenges which might impede or help them towards the end goal of winding up in rural practice. Partnering, children, children with health issues which turned out to be a very common problem - we discovered that when we actively managed that situation, some people who were passionate about finding themselves in rural practice, who seemed to be encountering absolute opposite things to that pathway, we managed to get there anyway.

One classic example. I remember a young lady with enormous passion to do this whose husband was a policeman, found she was headed off at the pass because her husband contracted cancer. This required him for a period to be in a larger centre for accessing radiological and other cancer treatments. So, we modified the pathway for this lady, and we stayed with her on the course of her husband's treatment and recovery from cancer. The pathway was purposely designed for her around her family circumstances. In that period of time, I think three children arrived as well. So, there were delays to her progress. Eventually, she completed, he recovered, and she went on to a flourishing career in Kingaroy. In fact, she became a leader in rural generalist services in that context. Building general practice, et cetera. So, career navigation is crucial.

The second part of it is that we have promised to the graduates that they will get further, faster. We copped some criticism for this, that we had developed an elite pathway. Within the medical profession, within student ranks, there was concern that why should rural generalists get favour out of the others? We said, 'well, you might see it that way, but my perspective is that we are giving rural communities particular consideration, because they have long suffered due to the lack of doctors. They have long suffered by the medical pathway not delivering the workforce.' So, in my view, it is entirely justifiable to provide an elite pathway for rural generalists.

So, we established positions in hospitals that were dedicated in the early postgraduate years to rural generalists, in which hospitals are committed to give a range of terms to them in advance of others in the junior workforce. They were given privileged access to training opportunities in the pathway, and crucially, at the other end, I developed a pathway on the basis that if we received five years of valuable service at the peak of their career from each of our rural generalist graduates, I would be satisfied. In other words, we didn't expect that they would necessarily remain for the whole of their career in a rural location and that's become a crucial part of the whole concept.

If a young medical student thinks that we're drawing them down a pathway which has become a dead end and if they get themselves here they've got no options and they can go nowhere else, then that becomes a huge impediment to actually going there in the first instance. So we have a significant number of rural generalists now who have provided valuable service as rural generalists for five, six, seven or so years and at that point have chosen to move into specialist training in the discipline of their specialist training interest and are now practising as respiratory physicians, addiction physicians, emergency physicians, anaesthetists and obstetricians.

In other words, we have tracked them down a pathway where they've provided valuable service to us and then when their family circumstances mean they can no longer remain in a rural location, they have options. Their success in tracking into specialist training has been remarkable. That's been an important part of the offering so the development of that pathway has been absolutely crucial.

That's been formalised to some degree. I don't think the national rural generalist pathway is quite as sophisticated yet probably as the Queensland pathway but nevertheless, there is recognition of that at a national level, a national rural generalist pathway in place.

The National Rural Health Commissioner has responsibility for oversight of that and I think they are working with the College of Rural and Remote Medicine and the College of General Practitioners at the moment to progress the special-funded pathway to rural generalist practice through the Commonwealth.

CHAIR - Can I just come back to a couple of points you made, Denis? You talked about the risk management that you need to undertake in a smaller or fragile service in a rural area. You touched on some of them. I wonder whether there are other risk mitigation measures that are important?

The other important thing is the funding model for this. If you have 25 doctors servicing a population of, say, 5000 people, or whatever it is, then clearly the private practice model is not going to work because you're not going to make money, or all of them, potentially.

In that circumstance, who steps up? Is it the feds that pay for the funded general practice aspect of that? Is it the state? I am interested in the funding when we are talking about the funding of the training. If you could go to those two points first.

Dr LENNOX - They are very pertinent questions and they took a lot of work. What became apparent is that the Commonwealth is a funder of general practice. It is not a manager of general practice. It is not even a manager of general practice service although I notice that there are some reforms they are contemplating on that front at the moment.

The crucial issue from the Commonwealth was whether they would accept a reform which involved integrating a general practice with hospital-based practice and that it could occur in such a way that would not be in breach of the Medicare act. So it required state initiative and I think that's probably still the case but it became evident in the process that the Commonwealth supported us in the process but it required substantial work on the state to make some changes.

Queensland has long had and I think all states - I'm pretty sure Tasmania has the same - an arrangement for specialist staff employed in hospitals to have granted private practice. This has been a longstanding arrangement. It is not in breach of the national health insurance legislation. There's a special provision that provides for this to occur.

We tracked very carefully that whole process in Queensland in relation to general practice. It required a good deal of, and sometimes fairly challenging negotiation with stakeholders, but eventually we arrived at the situation that we would actually implement the provisions of the Queensland industrial relations, the agreement for medical staff in Queensland, to enable rural generalists to practise privately as well. They are granted private

practice. What we did though was to ensure that in a rural location that this was all thoroughly joined up so there was an existing private practice and there have been various models we had embarked upon over the time. My colleagues in Queensland country practice who are continuing this work would probably be able to give more detail about this. I can give you their contacts later.

The very first model we developed in Longreach, for example. There was an existing private practice in the community at risk of closing. We established a contract with that practice. It was a contract between the Health Service Board and the practice.

CHAIR - For the state you are talking about?

Dr LENNOX - The state brokered it but the contract was between the local health service board and the practice. We drew up the contract for them so it was in state authorised form by which the practice would receive workforce supplied by the hospital so all the doctors in that community were employed by the hospital as salaried medical officers.

CHAIR - Paid for by the state, the Queensland government?

Dr LENNOX - They are salaried by the hospital. Their salary arrangements provide them a grant of private practice. By agreement they can practise privately and the hospital in effect contracted with the private practice to provide the private practice option for them. In other words, the practice had a guaranteed supply of general practitioners into the practice and what that did, of course, resulted in a major shift from hospital-based services to general practice services. There was a massive increase in chronic disease management, flourishing allied health services but a thoroughly integrated system.

Mr DUIGAN - Sorry to interrupt you there. That seems to be the circuit-breaker where everything blows up, this juxtaposition between state funding and federal funding. What was the particular circumstance in Longreach that allowed that to happen? Is the fact that it has a high Indigenous population, was that something that you brought to the table? How were you able to do that deal? It is not a deal that anyone else is doing. We are not doing it here in Tasmania.

Dr LENNOX - We were able to bring it to the table because all of the necessary requirements are already legislated so it is possible through the National Health Insurance Scheme. The state simply needs to have an appropriate grant of private practice to its salaried medical staff. That needs to operate with integrity and then if there is an independent private practice there needs to be a transparent contract between the hospital service and the private practice. The Commonwealth has no difficulties with that. There was nothing new required, Nick, in that process.

Mr DUIGAN - No, it is then for the state to pay the bill, essentially.

CHAIR - The bill for the services provided in hospital?

Mr DUIGAN - Yes, which is paid by the state.

CHAIR - That is right.

Dr LENNOX - Yes, but then what happens…

CHAIR - When these salaried medical staff worked in the private practice they were funded through the Medicare scheme, I assume?

Dr LENNOX - Yes.

Mr DUIGAN - On account of the very low population count that would be a pretty low number.

CHAIR - Yes.

Mr DUIGAN - So it is the state that has acquiesced and says we will pay.

Dr LENNOX - Yes, but this is the key issue, particularly relating to chronic disease and the burden of morbidity in rural communities. Currently, the burden of responsibility of that is not being borne by the Commonwealth through Medicare. If you have a deficit of doctors in rural communities then you are just not getting the services and we demonstrated that in Longreach. The Medicare service level increased enormously as a consequence. What happens in the contract is that the practice has an agreed level of administrative fee, which the practice took out of the earnings. Then the rest of the earnings were paid back to the health service, to supplement the salary of the medical staff. That is how it worked. Then, we assisted that practice to take over the practice of each of the communities around Longreach. For Winton, Barcaldine, Tambo, Blackall, there is a one medical practice, one general practice for all of those communities. The head office is in Longreach, with branches in each of those other locations. You can imagine what that did for the efficiency of the operating of the practice - one single medical record and access. That proved to be tricky - and I am not technically an expert here - but they managed to set up an arrangement that, if a patient presented to any of the hospitals, in those communities, the doctor who attended that patient in the hospital, if he was a GP in the practice, could immediately access the practice records. That was an enormous facilitation of service. In fact, I concluded -

CHAIR - Before you move on, Denis. You said that allied health also flourished under that. Were they also employed by the state?

Dr LENNOX - No. They were private. Entirely private. I have long argued this as well that - and I don't defend the medical profession, I am prepared to critique it pretty soundly at times. I have never found myself in that position, I don't think it is appropriate. I have quietly argued for quite some time that, until you get a good medical service, a good medical practice workforce in the community, all other parts of the health care system will suffer. Nursing, allied health will actually follow upon a good medical service being established and that certainly has proven to be the case in Longreach.

CHAIR - Do they have nurse practitioners in those centres?

Dr LENNOX - Yes. Now you are testing my memory. I am pretty sure some of the smaller and remote places have nurse practitioners in practice. That was the first model we developed. Until 2005, rural medical services in Queensland, as are far as general practice was concerned, apart from losing workforce, the practices themselves were fairly stable. But from 2005 a flourishing medical practice in Cunnamalla in south-west Queensland collapsed. Over

the years, like a disease pervading western Queensland, I tracked private general practice after private general practice collapsing. When I retired, in the whole of western Queensland, I think there were only two or three remaining general practices, and they were questionable in terms of their sustainability. There is a serious issue here about the applicability of the standard fee-for-service, privately operated and owned general practice within rural communities. It took a fair bit work with key stakeholders to steer away from ideological responses to this and simply say, we have to find something that will work in these communities.

Another major development occurred in Cunnamulla, after years and years of a failed service in that community, that had enormous needs, particularly with a substantial Indigenous population. In the last years before I retired, my office had a business unit which could provide on-the-ground services for general practice for rural communities. We were contracted by the south-west health service and local government, as well as engaged with Indigenous communities to rebuild general practice in that community. We brokered an arrangement where the local community-controlled Aboriginal health service and the hospital health services entered into a partnership - similar, but somewhat different from the model in Longreach, to provide medical services in which the hospital health service supplied the doctors into the Aboriginal health service in return for a number of other things. In fact, the whole primary care service in that community was being managed out of the Aboriginal medical service.

Since then, another service - in Millmerran, not far from Toowoomba - completely collapsed. There was no buyer, so the practice completely folded and shut up. In that situation, the Queensland country practice has been contracted by the Darling Downs Health Service Board to rebuild that practice and re-establish it. The practice has now been given to the Darling Downs Toowoomba Hospital Foundation to operate.

This is a situation where the state is finding various legitimate means to reform and rebuild general practice - that is, Medicare billing general practice in rural Queensland. If the state doesn't take that initiative, then the Commonwealth hasn't - and won't, I believe. It's not been their remit. They have simply funded general practice services, they haven't managed them. The Commonwealth has taken no responsibility for the opening or closing of general practice services anywhere.

As they collapse throughout rural Australia, of course the Commonwealth has been without means of doing anything about it. They are not providers of services. In this situation, where communities are suffering as a result of the collapse of the general practice model in rural locations, I'd argue very strongly that it is reasonable for states to step up and find a way of retrieving the situation, without it necessarily becoming a major expense to the state. In those situations, the state acts to ensure that an appropriate level of Medicare billing is occurring in those communities so the burden is not shifted to state-based hospital services.

CHAIR - As was demonstrated in Longreach?

Dr LENNOX - Yes.

CHAIR - We're just about out of time. Would it be helpful for the committee to have a copy of your report? Or is that really history now?

Dr LENNOX - The initial report way back? That was simply a report into the status of overseas trained doctors. There is more recent documentation. Can I take that on notice because, of course, I'm not there now, I've retired so I don't have ownership of that documentation. My Queensland country practice colleagues, led by Dr Dilip Dhupelia and Jenny who is the Business Manager, would have documentation they may be willing to provide to you.

CHAIR - If you wouldn't mind doing that and checking with them and if they are happy to provide to the Committee you can forward on Jenny's details. It might be helpful to have a bit more detail around the model and how it works.

Mr DUIGAN - Certainly; if there's a write up of where those agreements occurred.

Dr LENNOX - They might need to obtain agreement from the Hospital Health Service with whom they worked, because Queensland Country Practice acts as a broker, a facilitator. The ownership of the service rests with the local health service, of course.

So they mainly obtain (inaudible) from the health service provider (inaudible) sample report, for example.

CHAIR - We'd appreciate it if you could just ask them if they have anything that might be helpful to the committee.

Dr LENNOX - I can do that through Jenny? Yes, I can do that.

CHAIR - Thank you.

Dr LENNOX - Will do.

CHAIR - Thank you for your time. It's been really helpful.

Ms LOVELL - One last thing, Denis. I noticed from your email that you're celebrating a special anniversary tomorrow.

Dr LENNOX - Yes, I am.

Ms LOVELL - Congratulations, and I hope you have a lovely 44th anniversary celebration with your wife.

Dr LENNOX - That's very kind of you, Sarah. Thank you very much.

Ms LOVELL - Thank you. It was really helpful, Dennis.

Dr LENNOX - It was a great honour to talk to you today. I hope it's been helpful.

THE WITNESS WITHDREW.

PROFESSOR ANDREW WILSON, CO-DIRECTOR MENZIES CENTRE FOR HEALTH POLICY AND ECONOMICS, UNIVERSITY OF SYDNEY, TOOK THE STATUTORY DECLARATION, APPEARED VIA WEBEX

CHAIR - Welcome Professor Wilson. We are pleased that you could join us. The proceedings today are being recorded and transcribed for the purposes of *Hansard* and that will be published in due course once it is available. Because you are not in the state you are not covered by parliamentary privilege so if you have any concerns about anything that you have said during the hearing that you wanted to review the transcript before we put it up please let our secretary, Jenny, know. Otherwise it is part of the public hearing.

We are also streaming at the moment as well so there may be media watching or perhaps members of our own Health department, hopefully. If you would like to introduce yourself to the committee. You have seen our terms of reference and you have seen the information in relation to giving evidence to a committee. You have probably done it before in other places. If you have any questions feel free, otherwise if you would like to introduce yourself and then speak to our terms of reference and your experience.

Sorry, I didn't introduce the members. This is Nick Duigan over here, Mike Gaffney, Sarah Lovell and our secretariat and Hansard down the back of the room.

Prof. WILSON - Thank you, Chair, and thank you for the privilege to contribute to your work. I thought I would do a little introduction of myself and then I would make a few general comments and then be happy to answer any questions that I can on any issue you want to raise in relation to this.

I have a number of hats but I am the co-director of the Menzies Centre for Health Policy and Economics and in fact I do work with the Menzies Centre down in Tasmania as well. My background is that I have spent about half my career in senior roles in two state health departments, in Queensland and here in New South Wales, and the other half as a research academic with expertise in epidemiology, health systems and health policy research.

I want to be clear that I don't claim to be an expert in rural health specifically, although in my roles in government I have had direct responsibility for issues of health workforce, including rural health. That included, for example, when I was in Queensland I was responsible for the rural districts which covered all of western Queensland, the Cape and Torres Strait islands, as well as a number of the regional centres in that regard.

Health care is a human services industry. It is one of the largest employers and it employs a diverse range of workforce and includes a high dependency on a highly-skilled workforce. That is important for what we are talking about today because of the long training periods that go into the training of professionals.

I have also been a member of the board of Health Workforce Australia while it existed. I am currently involved in the evaluation of a number of virtual care services, including the Western New South Wales Virtual Rural Generalist model and I have also been a dean of a school of health and deputy dean at the University of Queensland and dean of health at Queensland University of Technology so I have also seen it from that side.

My work, particularly in relation to the virtual care, the evaluation of the virtual rural general program has reignited my interest in the complex issue of access to good quality health care for people in rural and regional Australia. While I am a city dweller, I am impacted by this issue regularly as much of my family lives in regional or rural settings in Queensland.

Professionally, while acting director-general in one of the states, one of the lowest points in my career was having to tell a small rural community that the government had decided to close their hospital. I have had to front families who have had family members die as a result of a breakdown in the links between rural and other services and, as I have indicated, I have been long involved in the health workforce and I am currently the chair of the accreditation committee of the Australian Health Professional Registration Authority.

I would like to make a couple of observations on rural health if you would give me the time to set the scene.

Firstly, our health system has an obligation to provide safe services, especially primary health care to all Australians, including those in rural and remote areas. The challenges we face in doing this are shared by similar countries. I was amused recently to see concerns being expressed on what they described as rural health and access to medical workforce for a community about 100 kilometres from London.

My assessment is that the international experience shows that there is no one fix for the issues that we see in access to health care in rural and regional areas. Generating more nurses and doctors or other health professionals alone will not fix all the problems of access. It's important but it's not the sole answer.

Secondly, every community location has special features that account for the health care access issues in that locale. This may be issues of remoteness, history of medical services as they existed in that service, specific needs of those communities - for example, with our Aboriginal and Torres Strait Islander communities. So in finding solutions, you need to take, what I call a place-based initiative. You actually have to look at each of those individual sites and think about the issues that are generated in that site.

This was really brought home to me recently, as part of the evaluation of the Virtual Rural Generalist Service here in Western New South Wales where I was shown the rostering records for a range of communities in that area. In that roster it showed the local health care arrangements and it showed where the Virtual Rural Generalist scheme was being used. You could just see this diversity of arrangements across just that one local health district in terms of what was going on. As we talked about it, those local issues just evolved and came out. It really reinforced in me the need to think about this, both from a systems point of view - how we support that - but also from a local point of view.

The nature of health care continually changes. What is considered acceptable care for a particular patient and condition, even 10 years ago, may not be so now. Our systems need to be able to flex to achieve that.

Multidisciplinary care is the norm for most chronic and complex conditions. We have to think creatively about how we achieve that in rural and remote settings and I think this is one of the roles that virtual services can help in supporting our on-ground services.

Developing a professional workforce for rural and remote services has to start at the beginning of the training pipeline. Yes, it is important we facilitate suitable students from rural and regional cities into our medical, nursing and other health (inaudible) but there's a limit to which that is going to address workforce issues.

The reality is that given the population distribution, most students will come from metropolitan homes so we need to find a way to make rural practice interesting and attractive for all students from the start.

When we were developing a rural workforce strategy in Queensland, we were very focused on this. We had to look at all aspects in the pipeline from talking to students before they entered a professional program, very early engaging with students in their programs - in their undergraduate programs - getting them involved in things like clubs that were focused on rural workforce, offering opportunities for them to go early - even before they got into their clinical training to rural settings to see what was happening, all the way through that pipeline through to their specialist training.

The next comment I want to make is that lifestyle and family are important to everyone and that includes people who work in rural and remote health services. We cannot expect nurses, doctors, paramedics and Indigenous health workers to work 365 a year, 24 hours a day. They need a guarantee of relief. They need night cover. They need weekends off. They need holiday periods. They need maternity leave. They need leave for professional development.

A key part of what we did when we were in Queensland was to ensure to embed that and to create a situation where there were attractive working conditions for people under that system. Our system has to be built to support this, regardless of whether people are public or private practitioners because we are a system which has a mix of public/private providers and we have to think about that in terms of what that happens. Actually, working in private practice can be a very lonely situation, where you're the only practitioner in that setting. It is also about safe services, that tired people make mistakes and we can't afford that in health care. Again, I believe there's a place for virtual services in the support and supportive roles in relation to this.

Just because we work as a health professional in a rural setting, does not mean you want to practise old-fashioned medicine. People who work in rural practices want to be able to provide appropriate, modern care for their patients. Facilities need to be available to enable this - adequate, contemporary - and they need to have usable diagnostic technologies.

In saying this, I'm not suggesting that we are going to be able to provide high services such as MRI in every small town but many of the technologies we talk about, such as ultrasound, are things which are amenable to a much more flexible and much more amenable use by practitioners who are not necessarily specialist radiologists or ultra-sonographers.

Also, we need to think about other ways that we can get those services to rural people. You can have mobile imaging services, for example. There are examples of mobile radiation therapy services available for delivering those services into rural communities.

A key issue for me is the issue of easy backup. Our system will continue to depend on overseas-trained staff for many years. In the 2000s, when I was in Queensland, we were registering over 2000 doctors from overseas each year, most of those on one to two-year visas.

They would frequently find themselves in rural remote settings, working in a health system about which they knew little. They hadn't grown up in it. They didn't have the sorts of connections that you develop when you train in the system. For example, even simple things like knowing the names of specialists that they could refer people to.

A critical element of the rural program that we have developed was developing an appropriate orientation program for people who are coming into it and providing a 24-hour a day support line, which could provide them with immediate support and help them find specialists and link them to a referral hospital, without them having to know which was the most relevant one for them to do, to make it easy.

I mentioned earlier the issue of lifestyle and family. An issue in relation to this that is sometimes forgotten is that this applies to the specialist workforce in as much as it does to the general practice workforce. In regional centres you can have solo or very limited specialist practice, particularly people who are willing to provide services in the public sector. It is just not viable to provide 24-hour procedural cover for things such as trauma surgery or in this day and age, stroke therapy, with only one specialist in town. We have to staff in recognition of this and this too makes for long-term sustainability. I well remember one regional centre in Queensland which had a regular turnover of orthopaedic surgeons and continual problems of supply in the public hospital, until such a time as we recruited three people into that role so that they could actually support each other. It meant that they could each develop a viable private practice while continuing to provide services into the public hospital and particularly, after hours in relation to that.

Rural and remote medicine may not be a lifetime career. We need to accept that. In Queensland, with the rural generalist program we accepted from the start that if we got a doctor to stay five years in a rural area, it was a success. If they stayed 10 years, it was a great success and anything beyond that was a real bonus. That is realistic, given the nature of today's graduates, their expectations about work, their expectations about lifestyle and their family commitments. We should recognise and reward that appropriately.

And then my last comment, and I know I've gone on a bit, there is a place for fly-in fly-out health professionals. Possibly there are going to be other ways of going in and out for much of Tasmania, but the same principles apply. This will be a reality for some places so the question becomes how to structure this in a way that provides safe and continuous care and building the systems around that -the information systems, the virtual care systems - to enable that to be safe.

I have had great respect for the rural remote nurses in Queensland, many of whom had been providing long-term care to remote communities in the Cape and Torres Strait, Mornington Island and those areas for years, on a fly-in fly-out basis, being based there for weeks at a time before interchanging. I have GP friends who provide similar services to rural communities. They have a real commitment to those communities but they do it on the basis of a longer-term fly-in fly-out arrangements, and similar arrangements within Aboriginal communities.

This is just one of the other realities that is part of finding solutions to access to good safe health care for rural, regional and remote communities. Thank you for this opportunity to express my views and I am happy to take any questions on this or any other aspect that you may want to ask.

CHAIR - Thank you. I will start off by talking about the rural generalist. We have a fledgling process here in Tasmania based at the Mersey Hospital. Our previous witness, Dr Denis Lennox, was talking about establishing their system in Longreach. He talked about the transition for those who have been working in rural areas for a long time, and paying them at the outset and then giving them certification or accreditation or whatever was required to register them as rural generalists.

Do you think that paying rural generalists as a specialist in their own right, once they are trained - not the ones you are bringing into the system - is making a difference? I would like to explore that a bit further in terms of how that then applies to GPs who haven't trained as rural generalists. We have a lot of them in Tasmania that have been practicing for a long time. They would probably be able to undertake a similar process as what happened at Longreach or more generally in Queensland.

Prof WILSON - I will make a few comments around that because it's important to see the fuller context for this, not just seeing the award in isolation. Yes, we need to remunerate people appropriately and yes, we need to recognise that these people have developed a mix of skills which in some cases are certainly difficult to reproduce these days. There is a role for doing that.

In Queensland, as Denis probably explained, we had an interim sort of award which sat between our awards which were for hospital-employed doctors and the specialists' awards. There was a range of reasons for that which we can go on to, but it increased the remuneration in a big way. However, the most critical parts of it weren't how much they were paid, because most of these doctors are reasonably well paid. The biggest part of the award and, in my view, the most important part of the award, was the fact that we guaranteed them that leave. We guaranteed them the weekends off a month, we guaranteed them the annual leave and we guaranteed them their professional development leave. That was so attractive that we were inundated with people who wanted to switch over once that program was attached.

In fact, had there not been a change of government it is my belief there would have been a substantially greater number of practices in Queensland where people would have moved over to a model which wasn't where they would all become staff specialists, but one where there would be a much more mixed relationship in relation to that.

Queensland has this model which allows people in those sorts of settings to have a mix of payments. They get a salary from Government, but they also got a proportion of the earnings that they had through MBS billing, through private practice billing as part of that, and it also made it very attractive.

There needs to be some creativity in the way we start to think about funding this. It has certainly moved a long way, from when I had similar sorts of responsibilities here in New South Wales in the late 1990s and early 2000s. There was a situation in far western New South Wales where there was a small number of doctors - I can't remember the exact number, but we are talking fewer than 20 doctors - who worked in that area. When you looked at the MBS billings and what they were getting, and special payment arrangements and what they were getting from the state government, a large amount of money was being paid into those areas. There is no doubt in my mind, that if we had been able to find a way to bring the Commonwealth and the states together to fund those positions - if we found some way to get that shared funding arrangement - that we could create very attractive remuneration for people to work in those rural areas. Not necessarily aiming for people to be there forever, but building packages which

incentivise them to stay for periods like five or ten years. The could be a remuneration which may have a bonus, for example, at the end of that time. Not a $20 000 bonus but a $100 000 or $200 000 bonus - the sort of thing that will attract the sorts of graduates we see today, who may well be carrying substantial debt when they graduate from medical school.

CHAIR - Just on that model, that has been used in various forms to say well, a certain population should have a certain number of GPs. It is one GP to 1000 people, as a ballpark. We heard from Dr Lennox that does not work in a rural environment; it actually can have a perverse outcome. Would you like to talk more about that?

Prof WILSON - I won't say those sorts of ratios are plucked from the air; but we compare health systems and we look at the number of doctors that people have in one place compared to another and it is a sort of community average of what might be expected. It doesn't necessarily bear any relationship to access to health care for people. If you don't have any bulk billing service within a rural community, then it doesn't really matter how many doctors you have there, there is a group of people who are going to be disadvantaged and unable to access that service because they can't pay the co-payments. You have to think about it in terms of access.

The other thing is that we need to be flexible and we need to think more broadly about how we utilise the available health staff. At the moment, our system is built around doctor billing. If your system, if your town, is staffed by a private practitioner then basically most of his or her income has to come from billing arrangements. If you have other competent primary health care practitioners in that town, how do they get paid? Who is going to pay them? We need more flexible arrangements for remuneration which allow for other people to provide those services in conjunction with whatever medical staff are there.

Mr DUIGAN - Thank you, Andrew. My question is on that particular issue. State Governments tend to spend their health budgets in the big city hospitals but when a general practice falls over in a small rural or regional town, everybody looks to the state Government, what are you going to do about that? Are you going to stand that service up? Is there a direct correlation between the state spending some money in that space, whether it be in conjunction with its multipurpose centre in the town or whatever it is? Is there a direct, evidenced benefit to a pay off at the other end?

Prof WILSON - Under our system, in essence, the states become the default provider when other systems fail. Inevitably, state governments end up having to staff different services and that's an ongoing problem here in New South Wales, in Queensland, whatever, where the state government has to step in.

If I am interpreting your question correctly though, I think what you're asking is - if you proactively invest before the system's failed, what's the return on that investment? I am not sure that there is a lot of evidence to go with this, but I think it would certainly fit in with the other comments that I make that if you don't build those other things around your medical services that are there, you're almost setting them up to fail. You have to have those other elements around it in this day and age to provide a proper service so, yes, I think there is a return on investment from some up-front expenditure. Whether that comes from state or commonwealth coffers, my view is that for most rural communities it should be a shared responsibility to make this happen.

Denis probably spoke a bit about the Longreach arrangements where they have a third party which has become an administrator of those pool funding arrangements. That is a model which has been advocated also by a number of the rural health organisations in Australia, of having this regional or local consortia that become holders for funds from the different sources and provide and make that proactive investment which is broader than just the medical service.

Mr DUIGAN - How difficult or otherwise is that to achieve in a policy or regulatory setting where we are at the moment? How much has to change in order for that happen easily?

Prof WILSON - I don't think it's a regulatory issue. It's a policy issue that governments can address. Governments can agree that's the way they're going to do things. There already are exemptions, for example, that allow different billing arrangements for small communities within the Commonwealth legislation so there are ways that can be achieved if there's a will to do it. We have seen that in some of the smaller communities.

There are challenges in this, particularly if there is a hospital involved. If there is a hospital involved and it is staffed by a state health authority, then there's a whole separate set of awards. There are industrial issues that become part of what's there so that becomes a trickier situation to negotiate as to where that boundary sits but remember, for many rural communities, it's their primary health care services and their emergency services which are the key thing that they're looking for security around.

Mr DUIGAN - Are there are other jurisdictions that you're aware of that fund health like Australia funds health - other countries, other places?

Prof WILSON - There are no direct examples. Interestingly, when you drill down into the United States, you find places which look more like us. What are the attributes that make us different? We have a public/private system. We have a fee-for-service system. We have split funding between Commonwealth, states, and private health insurers. We couldn't make it more complex if we had set out to do it from that perspective, so while some of those elements are reflected in other settings, not all of them are, but there are some jurisdictions in the US where you can see similar sorts of things happening and exactly the same sorts of problems playing out in terms of services to rural remote communities.

Mr DUIGAN - Is there anywhere that has done a good job of overcoming some of those issues?

Prof WILSON - Whenever anybody asks that sort of question, I always start by saying that any country's health service has a uniqueness about it. They grow from a social, cultural and economic perspective, so people may say: 'why don't we just do what they do there?' But when you actually try to fit that in to the Australian setting and all those other things we were just talking about, whether you can actually do it and whether you get the same return is unlikely.

You are asking about some of the specifics. I know there are examples around the world where people have found base solutions to these sorts of things, but I'm going to avoid answering questions because I don't think I can provide you the detail that you are looking for. There are other people who would be better placed to do that. I think I did suggest that the secretariat could contact the New South Wales Health Department because I know they have

just done three papers for their upper House review, which summarises a lot of those things and in a lot more detail than what I can describe to you today.

CHAIR - They have provided those papers to the committee. We are hoping to speak to someone from the department and get them released so they can speak to us. Following on from Nick's question, is there any comparable example in New Zealand at all?

Prof. WILSON - I don't know. I frankly don't know it well enough to be able to answer that question.

CHAIR - We're having a witness appear before the committee tomorrow from Buurtzorg, which is a Netherlands organisation which has quite a flat structure delivering services predominantly in patients' homes. They've recently, and it's only very recently, commenced operations in Australia, in West Australia and Queensland. Are you familiar with their work in Queensland?

Prof. WILSON - No I'm not, but that's very interesting. I mean there are some interesting models which have come out of the Netherlands particularly in the primary health care space. Both in terms of service delivery but also in terms of primary health care research they have been real leaders in this field. I will go away and have a read about it after this.

CHAIR - Tune in tomorrow at 12 o'clock our time, a bit earlier in the day over there, for him. I came across the model reading a book called *Human Kind,* a very good book, I would recommend it to you and got in touch with them because it is quite an interesting model to contemplate whether it is adaptable to Australia. Like you said, you can't just pick up a model and drop it in, but I do note from talking to the gentleman who is speaking to us tomorrow that they provide services in the small rural community about, from memory, 200km east from Perth. We're really keen to hear what he has to say about that and whether there might be more adaptable models. Not so much on a medical model, I think it's focused more around nursing care and that sort of thing in peoples' homes. Anyway, watch this space.

Mr GAFFNEY - I'm interested in what you said about doctors going there for five years and then perhaps getting a bonus at the end of that time to offset some of their expenses. Is one of the issues that young graduate doctors who are going to the remote and rural are a bit concerned that's it going to be a limited range of experiences, there's no critical mass and they might miss out on opportunities to have more focused expertise around them? Do many of them say, 'Look I wouldn't mind going for a couple of years, but then I'd like to go back to city for six months or a sabbatical or something to experience a greater inflow or input?' I'm interested in what stops the individual doctor from opting for remote and rural Tasmania, especially in their early years. Are there any studies or anything you can provide us with?

Prof. WILSON - I think this is a really important issue. There is some research around this and one of the concerns that early career doctors have is that they are going to be shut out of other opportunities. You have to remember to be a medical graduate these days for over 50 per cent of courses in Australia, you do an undergraduate degree, you probably have to do an honours or four-year degree, and then you'll do a four-year medical degree, so you are already at eight years, and then you have your internship on top of that. In that period of time, naturally enough, many people would have developed long-term relationships in that period of time. So they're not necessarily free agents to choose to do what they want to do and even if they do think there may be advantages of either financial or just experiential from doing it, they

are going to have a mind to their long-term aspirations in relation to this. Clearly, that is an issue that people feel like they may be locked out of future opportunities.

One of the things that - I know don't whether Dr Lennox - spoke about this but one of the things we observed with the rural generalist programs was that these people have no trouble getting themselves jobs back in the city after they've been in this. They are so well experienced and they have a mix of skills, of generalist skills, that most people who work in even outer metropolitan areas or in regional centres, don't have. They had no problems about moving around a system and moving back into it. But if your aspiration is to become a surgeon, then that becomes more problematic.

It's going back a bit but it's worthwhile just thinking about - one of the things that we tried to do in the Queensland setting was not send a message that in going into the rural generalist program, you were doing something which was second best or that we were sending people who were under trained to these areas. People talk about mandating periods of time for people in rural areas as part of what's going on, or if not mandating it, having requirements around this. In the appropriate setting, that's okay but we don't want to put people who are inadequately trained into settings where they can't provide safe care. That's not going to be good for their communities and certainly, potentially, it's going to be bad for them, in terms of things that might happen to them in relation to it.

On the other hand, I think there is a role - I think one of the things that has been a really good development in the Australian setting is the development of - trying to increase the opportunities for people with specialist training in regional centres. That, I think, has been a really good development. Good to see that the Commonwealth has recommitted funding to that program and it certainly has led to a growth. It's still not enormous but certainly a growth in registrar-type positions in regional communities. It doesn't solve your small community problem but it certainly helps in those regional centres and that's an important part of the whole picture. If those regional communities are able to provide good or better local specialist support then that actually has a flow-on benefit to the smaller communities that surround them, in terms of people being prepared to work there. But it also means that you're sending a message that people aren't necessarily going to be stuck, just because they do some rural medicine.

Mr GAFFNEY - It was interesting when they had studentships many years ago, with the teaching profession. They used to say to people, if you chose a rural or isolated area for your first posting, then you would be sort of guaranteed where you would want to end up after that. That actually meant that a lot of people went to the isolated areas, enjoyed it and stayed.

CHAIR - A lot of them didn't because a lot of them weren't really the most suitable people to have in those isolated areas.

Mr GAFFNEY - Are you talking teaching?

CHAIR - Yes.

Mr GAFFNEY - That's a difference of opinion.

CHAIR - If they're not well suited for the position.

Prof. WILSON - It can be quite a shocking experience to do it. It can also be very exhilarating - people never forget it. This is going back a long way and I'm not for a moment advocating it but when I first graduated, when I first went into medicine, it was in Queensland. It was an expectation that you had spent a period working in a rural community before you could get onto a specialist training program.

Now, the unfortunate part about that was that I think it was abused in a way in that people were sent to settings where they really were not able to provide a safe service, but there were many other settings where you could do that. I think it was a very good signal about it. Whether you could actually do that this day and age, and do it in a way which met the safety standards that we apply - the safety and quality standards that we apply to our health care today - would need to be worked through. I think there are system issues there but it could be done.

CHAIR - You may not have any thoughts that you want to share with the committee on these matters but the potential, and in some cases actual nurse practitioner-led clinics to supplement other medical services in the regional area. Do you have any comments around building the allied health workforce? We heard from Dr Lennox that when you have enough GPs and rural health practitioners, that they will come because they will have referrals. Do you have any comments on that and the value?

Prof WILSON - Yes, I confess I spent something like six years when I was in New South Wales Health when I was the chief health officer, on a committee getting the first nurse practitioner program up and recognition in New South Wales. So I am big supporter of nurse practitioner in that regard. The bulk of nurse practitioners don't work in primary care. They work hospital-based settings at the present time but there is a substantial cohort who do work in primary healthcare settings as well.

I think this is what I was referring to before that we need to look at the whole workforce, not just the medical part of it because if you get those complementary services - and they should be working together in those smaller communities - then you can provide support for each other in that setting. It also means that you can provide a mix of services that you may not be able to achieve. I am thinking for example of women's health issues where there is only a male doctor in town. You may have nurse practitioner as female or vice versa as the case may be and you offer a better and more diverse sort of service to that rural community. People can be appropriately covered, particularly if you have virtual services that also support those services in those places.

Yes, there is a place for nurse-led services and as I was saying before, there are some places now where they are the foundation of the services which are proposed. In many remote communities it is the nurses who are providing an extraordinary level of care within those areas. Rural remote nurses who are not necessarily nurse practitioners, provide an extraordinary level of service in some of these communities.

CHAIR - The skill level of some of those remote area nurses, if you could do something like you did for the rural generalist, for those nurses and effectively grandfather them in a way that you assess their skills, is that something we perhaps should look at for some of these nurses? They are terribly skilled in the Aboriginal nursing workforce.

Prof WILSON - You have reminded me of another point I meant to make earlier and that is we have to think about the whole workforce. You can't just think about the doctors or

the nurses. These things go together. We have hospitals here in New South Wales - a hospital I am thinking of - where they can't get nursing staff to staff that hospital. It doesn't matter if you have a doctor there; the hospital can't operate because they don't have adequate nursing staff to operate. In the same way as we think about that pipeline for medical graduates, we also have to think about a pipeline and the incentives for nursing and allied health staff to work in rural settings as well. There are industrial and award issues that would need to be addressed in relation to that and that would need to be a part of the solution.

CHAIR - I don't know if there is anywhere that you are aware of that may be funding the training of nurse practitioners in the way similar to the funding that enabled the rural generalist to be funded or paid at that specialist level while they completed their assessment accreditation or whatever it was called. Are you aware of any models?

Prof WILSON - I am not aware of anywhere that is doing it. It wouldn't surprise me if there were. I'm just not aware of them.

The other really important point that you were making is about recognition of prior practice as part of this.

Again, we did that successfully with the medical profession recognising that so we have vocationally registered and non-vocationally registered general practitioners. But we recognise that even those who are not vocationally registered, that is, do not have a specialist qualification in general practice or rural medicine, are still providing a high level of service in those sorts of settings.

It is an important area for us to look at and flexibility in terms of how we recognise training skills and do that. It's relatively easy to do that within award systems. It's harder to do that within the formal accreditation systems, although I think we will be moving there.

CHAIR - Which is a matter for the accreditation bodies, isn't it?

Prof WILSON - Yes. As I said, I wear many hats. One of them is as the chair of the Accreditation Committee for the Regulator. It is one of the issues on the agenda.

The Accreditation Committee was given a series of priorities by Australian governments - the Australian Health Ministers' Advisory Council (AHMAC) at the time. One of those areas is looking at regulation and recognition of those services, because they saw having more flexibility in relation to that as a high priority. That is one of the areas on the agenda.

CHAIR - Across the board, not just medical practitioners.

Prof WILSON - The committee I chair sits above all the accreditation bodies, so it sits above things like the AMC, and whatever. They are all independent agencies which are approved by the national regulator. Our role is to think about the policy issues that underpin those, and that then might inform what the regulator requires of those different accreditation bodies.

CHAIR - Is there a time frame for that work to be completed?

Prof WILSON - There is, but it's relatively new. We've only had two meetings so far, and we're still working through the work plan. It is also really important that we do not disrupt the systems that are in place. One of the challenges of doing things in health care is that you don't want to disrupt what you've got. You want to be able to improve it and move on. Similarly, the accreditation models work for a large part of what we do. We have very highly qualified and well-recognised health professionals in Australia and that's largely due to the accreditation programs that we have in place. But it creates some problems for us. It creates a degree of rigidity in the workforce that we'd like to try and move on from. In doing so, we don't want to lose the benefits that we've gained from that accreditation process.

CHAIR - Are there any other questions?

Is there anything further you want to share with the committee before we finish up?

Prof WILSON - Going back to my opening comment - I believe you need two ways of thinking about this. You need to think about what the system issues are, or the things above, and they are things like your overall workforce, your proactive investment to create the right sorts of environments. You also have to look at it from a local situation, because you're not going to be able to provide everything everywhere and you have to bring the community with you in understanding what can be delivered at that community level. I believe communities can be engaged in that process at a local level and can understand what these issues are, but you have to put the effort into doing it.

CHAIR - On that point, we have seen quite an amazing community engagement piece some years ago in Burnie on the north-west coast, where we had patients travelling for cancer treatment for at least two to three hours, sometimes four hours, depending on where they came from, from the north-west to Launceston for radiation therapy and other treatments. One of our high wealth individuals funded some linear accelerators and the radiation centre and he also funded a number of scholarships for radiologists or radiation therapists it might have been. We had public meetings about the need for this for a number of years and he stepped in and almost forced the Government's hand, if you like, to get them to act. It is very well utilised. It had a connection with the Peter MacCallum clinic initially; now it links with Launceston General Hospital.

Prof WILSON - One of my other hats is that I am a co-director of the Australian Prevention Partnership Centre and the Tasmanian ministry of Health has been one of our partners for almost seven years now. We have been working with them quite a lot over those years and we did a beautiful piece of work that was facilitated in Tasmania around local consultation on prevention issues that we have written up. It was such a nice example. There is capacity locally, I know, to do this well, having seen it happen.

CHAIR - Can you provide a copy of the paper that was written up on that matter?

Prof WILSON - Yes.

CHAIR - That would be great, if you could provide that through to Jenny that would be really helpful.

Prof WILSON - Yes and I will send you the links to all of that.

CHAIR - Thank you very much for your time, we appreciate it.

Prof WILSON - You are welcome. Thank you for the privilege of talking with you.

THE WITNESS WITHDREW.

Ms JANE HAYBITTLE, NORTH WEST EYE SURGEONS AND DEVONPORT EYE HOSPITAL, APPEARED BY WEBEX AND TOOK THE STATUTORY DECLARATION

CHAIR - Welcome, Jane, to our public hearing for the Rural Health Inquiry. This is a public hearing and it is being broadcast and it will be recorded and transcribed as part of our evidence before the committee. I will get you to take the statutory declaration in a moment.

All information you provide to the committee is covered by parliamentary privilege and if there is anything you wanted to discuss that was confidential in nature you can make that request to the committee and we would consider that and if it was in confidence it wouldn't be published. All other information you provide is part of the public hearing and will be published on our website and inform our report.

Do you have any questions before we start?

Ms HAYBITTEL - No. What I will do is I will give you an outline. If you want more information about accident and emergency and the services we provide, and the details of that which I would like to make you aware of should be private because they involve patients, but I don't need to go there if this isn't the right time to do so.

CHAIR - I will get you to take the statutory declaration and then invite you to introduce yourself. I know you have sent us an email with an outline of the areas you would like to cover. If you could then speak to that and then the committee will have questions for you.

Ms HAYBITTEL - I would like to introduce myself as practice manager for North West Eye Surgeons and director of North West Eye Surgeons. I have run the practice since 1995 and it has evolved enormously. Thank you to the committee, Jenny Mannering, Michael Gaffney and to the Chair, Ruth Forrest, for inviting me to present today. I am now going read my opening statement which will take five to six minutes and will make the statement available to the public record. I look forward to this meeting so as to collaborate and to make the Health Department and the Tasmanian State Government aware of the efficient, effective model for rural eye care North West Eye Surgeons has created over the course of 27 years.

North West Eye Surgeons has achieved great outcomes relating to eyecare for the people on the north-west coast, together with the federal government, Jeremy Rockliff, the Department of Health, Senator Jacqui Lambie, Michael Gaffney, Ruth Forrest, Nitin Verma, president of the College of Ophthalmology. We have learnt valuable lessons. There is more work to be done and that is what I would like to talk to you about today.

My request today is for the Tasmanian Government to recognise the major contribution North West Eye Surgeons provides to the people of the north-west coast and with continued support and collaboration the model we have created can be sustainable into the future. The model can be replicated across Australia as it treats accident and emergency and provides a specialised diagnostic process to determine the causes and urgency of surgical medical intervention or urgent referral to a neurosurgeon or neurologist or cardiologist and much more. These emergencies come from accident and emergency, doctors, optometrists and work sites.

Where we were a few years ago, the public waiting list for cataract surgery, glaucoma, ocular plastics, vitreoretinal, strabismus surgery in both adults and children, corneal graft surgery, was four years. Prior to Devonport Eye Hospital receiving the public contract for all

ophthalmic public surgery on the north-west coast, the waiting list was down to 17 months. The waiting list since we received the contract in January 2021 is now down to six to eight months. The reason being that the Commonwealth Government has funded a final year fellow registrar who is able to perform surgery so the registrar, - be it a 'he' or 'she' - is fully trained and is able to operate on their own with one of our surgeons being in the building. So we brought the public waiting list down to six to eight months.

There is no limitation on how many surgeries we do and this is as instructed by the Commonwealth. Previously, with the public list we would be given x number of patients and the public system would release so many cataracts and so many of this and so many of that. Only category 1s were monitored. Now, we have a waiting list and we try to service this waiting list as effectively, as efficiently and as quickly as possible. The waiting list down from four years to 17 months and now down to six to eight months is a great achievement and affects the figures for the entire Tasmanian elective surgery waiting list numbers.

North West Eye Surgeons received Commonwealth funding as the first ever, as I understand, in Australia for public outpatient ophthalmology.

As I understand, the Commonwealth Government is able to look at Medicare statistics. The state Government - and this is how I understand or perceive the system to be - that the state Government and the Commonwealth Government do not marry as far as looking at the figures through Medicare. I am not sure how the state Government, where they get their figures. Some funding for public outpatients (inaudible). We didn't get this and for many years we have bulk billed public patients which is not sustainable in a private ophthalmology practice.

After the Commonwealth was alerted, the Commonwealth looked at the bulk billing rates. No ophthalmology practice private in Australia or anywhere in the world would be bulk billing patients because it's not sustainable. It's not profitable. In fact, it's not at all viable.

After servicing patients for 27 years, the option was to close our door because the money did not equate with the expenses and fortunately the Commonwealth looked at our bulk billing rates which were way above and not even equitable to any other specialist practice, especially ophthalmology which is very cost driven because of all the equipment that we have and the trainees operating this equipment. This was given to us last year. The bulk billing rate, for example, is $76.80 for a first patient consult and if this requires multiple tests, we can bulk bill for one or two other things but most of the bulk billing is that figure. The follow-up fee is $38.60 and as I said, this is not sustainable for all the diagnostic equipment required in an ophthalmic practice. North West Eye Surgeons have always bulk billed laser surgery and when I say laser surgery none of this is cosmetic laser surgery. We have five different lasers, and for these lasers the rebate from Medicare is approximately $400 per laser. We have never ever billed a private or a public patient and we will continue to do that.

However, the Commonwealth has recognised that before you have any of these lasers - and we have five different lasers - the only laser that is not rebateable from Medicare is one laser that we have which is for floaters in the eye, where they vaporise the floater. It's called laser vitreolysis. It's regarded as cosmetic surgery.

Ms LOVELL - Sorry to interrupt, can I just clarify when you say the laser surgery that you bulk bill, it's not cosmetic. Is cosmetic laser, would that be corrective eye sight?

Ms. HAYBITTEL - So there are two lasers that they regard as cosmetic. One is the lasik for corrective laser surgery, and the other one is if you get a floater that's a vitreous detachment, we can laser that, and it vaporises. You might need two or three treatments but it vaporises the floater. There are risks, but it saves somebody having a vitrectomy. This laser is regarded as a cosmetic laser, it's not in New Zealand but it is in Australia and patients have to pay for that. So, those two they need to pay, but we have five other lasers and if you want to ask me about that at a later stage I can tell you about them.

The Commonwealth government is now providing funding for all patients and recognising that if one has a laser you need multiple diagnostic tests before the laser is performed. These lasers are invasive and they require a lot of diagnostic tests. So, the Commonwealth has funded us for a consult. The consult fee is approximately $260 and then they will also pay us a procedure fee for any of the lasers, which would equate to the Medicare rebate fee of $380. For a public patient we are now receiving approximately equitable with a private patient as long as we don't do more than one laser or even if we do a procedure in the rooms, which is very common, the Commonwealth will pay for the consult and the laser or procedure.

The north-west coast has been acknowledged by the Commonwealth as an ophthalmic area of need, which I have been trying to highlight for many years, not for financial benefit, but for continuity, and from the cases that we see on the north-west coast from newborn babies to patients over 100 is absolute essential service. The Commonwealth looked at the bulk billing numbers and have given us the recognition and asked us to present our case to the College of Ophthalmology, which we haven't had time to do because we've grown so much.

We're training a lot of new staff. With the new registrar who's fully funded we have to employ more staff and provide more technical support for this registrar. These registrars will be rotating through the practice. We also have other registrars and we also train all the medical students that come through the rural clinical school. We provide them with training in ophthalmology and lectures on a continuous basis.

An example of category one care provided in-house is intravitreal injections. Now, to many practices in the city, and even in Hobart as I understand, I am not sure about Launceston, if you need an intravitreal injection - this could be for diabetic retinopathy but continuous, you might require injections plus laser (inaudible)

CHAIR - I have just lost you there, Jane.

Ms HAYBITTEL - (inaudible) Our internet has been shocking in Burnie today, so just alert me to the fact if it goes off. The intravitreal injections - and I just took that because some practices think it is a money-making business but it actually requires lots of technicians to make a diagnosis - I do not know if any of you are medical sitting in the room or aware of the rules of ophthalmology. If you need an intravitreal injection, for example your vision suddenly goes and you have a vein occlusion, which is a clot in the vessel, or you have macular degeneration and you are going to require ongoing Eylea or Lucentis injections into the eye, this is heavily funded by the Commonwealth government. We have to prove to the Commonwealth, by doing multiple tests to show that the patient has a problem with the macular. We have to do all the tests before the injection is done.

Now, I have every figure that you possibly want, if you do want them. We just looked at 2021, and in 2021 we performed over 1300 injections in-house. Most of these patients range in age, we have young diabetics who are 14 or younger, we also have patients who are over 100. Many of them would choose not to travel to have the treatment and effectively they would lose their vision because if you do not have the injection - and you have macular degeneration - on a regular basis, your vision will drop back and that vision cannot be retrieved. Those are all the patients, diabetic retinopathy, macular degeneration and central vein occlusion, all of those were untreatable a few years ago.

Training is a very important part of our program and I think a very valuable one. We provide an in-house ophthalmic technician's training course which is intensive, extensive, educational, medical and scientific. The courses we offer in-house provide jobs for school leavers and provide sustainable careers for these disadvantaged youth, mainly from an educational point of view. There are many of our staff working across Australia who have come through our program and they are highly trained and highly regarded. Usually in any medical ophthalmic practice you would have orthoptists working. We do not have orthoptists living here. We train the technicians and the technicians perform all the tests, which enables the doctors to see so many patients. These technicians know the anatomy of the eye, they are highly skilled and we have managed to get them jobs across Australia. The College of Ophthalmology is looking at us accrediting our program as the only model for ophthalmic technicians across Australia. Currently they are only in America and India. We have been running this program for 27 years and put many disadvantaged youths through this program. North West Eye Surgeons will seek to register this model across Australia.

The reason for the urgency of this meeting is to ensure that the State and the Commonwealth Governments continue to provide funding for patients' consulting which saves many lives and enables patients to be treated as a matter of urgency in their own backyard. If the Commonwealth funding is withdrawn, the public service will cease to exist. I urge you to consider the effects this would have on the health and wellbeing of north-west coast patients - approximately 150 000 patients - ranging in age from neonates who are born prematurely in Hobart and then referred to us to follow up on the north-west coast so that they can come home, and neonates born in Burnie or Devonport with their eyelids still closed, with tumours, with cataracts, many sensational cases. If this consulting was not funded by the Commonwealth Government, no other private surgeon will do what we have done for the last 27 years.

I am not seeking funding. I am asking you all to make sure that this service that is available at the highest possible level for public and private patients is sustainable into the future. As I said, our patients range from newborn to over 100 years of age. We are fortunate to have received the public operating contract and this enabled one of the companies from New South Wales, Presmed, to partner with us and provide continuous care for patients into the future. Presmed has not previously bought or had any interest in Tasmania. However, they have 100 ophthalmologists across all specialties and would be able to continue the very professional care we have provided in all specialties.

As I said, currently in Devonport we do vitreoretinal surgery, retinal detachments, all trauma surgery, glaucoma surgery, cataract surgery, large oculoplastic surgery and we are also in the process of bringing in the latest method of corneal graft surgery. We use the Burnie Private Hospital a lot. We work with them to do all our pediatric cases under general anesthetic. Any patient requiring general anesthetic we would work on in the Burnie theatre, because there

is an ICU here and we can provide a safe environment. Our training not only involves ophthalmic registrars, but anaesthetic registrars in ophthalmology as well.

That is what I had to say and I am open to any questions you might have.

CHAIR - Jane, to clarify, all the surgery you do, including public and private patients, is conducted at the North West Private Hospital and the public patients are under contract from the public hospital system. Is that right?

Ms HAYBITTEL - No. It has changed. It was becoming more and more dysfunctional. We had surgery out of Mersey, surgery out of Burnie and private surgery out of the Devonport Eye Hospital. Ophthalmology is such a highly specialist operating environment. There is no margin for error and you need specialised nurses and specialised equipment. We did start doing vitreoretinal in Burnie but it became unsafe, because Burnie became a mainly obstetrics, joints and emergency surgery service. Often, the nurses who were qualified in ophthalmology had worked right through the night. Our surgeons would come in and they would be very unhappy because they didn't have a nurse who knew anything about ophthalmology and when they were asked to pass certain instruments, the nurse didn't know what to pass.

CHAIR - In the public or the private hospital?

Ms HAYBITTEL - The private hospital.

CHAIR - All at the private.

Ms HAYBITTEL -Yes. It got to the stage at the Mersey General Hospital when the doctors would walk in the door and feel unsafe operating there.

Burnie has evolved enormously. They have bought a new cataract machine. We have stopped doing the vitreoretinal surgery due to all the trauma surgery or all the emergencies they have, like obstetrics coming in there which, obviously, take precedence over even our category 1 cases. We fully understand that; however, it wasn't a safe environment because the nurses might have worked right through the night and then they either couldn't work or we would get a new nurse, the equipment wasn't in the right position, the instruments weren't correct and we were working under circumstances that were unsafe. Since we have got the contract for the Devonport Eye Hospital, the Mersey Community Hospital has closed after 45 years of eye surgery, we are performing all the public surgeries as well as the private surgeries at the Devonport Eye Hospital, and we are also operating in Burnie - public cataracts and general anaesthetics for strabismus surgery, and oculoplastic surgery we are doing in both locations, to enable us to service the numbers.

CHAIR - Is that still at the private hospital in Burnie?

Ms HAYBITTEL - Yes.

CHAIR - There isn't any equipment at the public hospital, is there - it's all at the private?

Ms HAYBITTEL -Yes. We have done that for 27 years, which makes sense because it is a very expensive set up and it also requires dedicated, trained ophthalmic nurses.

CHAIR - You raised the point in the notes that you sent through about you could also possibly build ENT services which is Ear, Nose and Throat?

Ms HAYBITTEL - Yes.

CHAIR - Has that been discussed at all, and do you think that's an option that should be live and considered?

Ms HAYBITTEL - Presmed Australia have nine theatres across New South Wales. They asked about ENT. They have ENT and they find that ENT and ophthalmology in theatres are a good combination. They said they might build an ENT theatre in Devonport. The long-term aim - and this is the first time they have been into Tasmania, so they are obviously a bit nervous about everything - they are looking to grow the eye theatre at 62 Oldaker Street, where it can become multiple theatres for eye surgery, ENT and possibly any other surgeries that might be needed. Across the road there are three properties that we own. These back onto Coles and Kmart and we already have approval from the Council for a medical centre there.

Presmed Australia is very worried about coming into Tasmania. Mike and I don't want to see any financial benefit, as we have done as much work as we possibly want to do. We are very happy to see that through, and possibly Devonport could be the hub for private and public ophthalmology, ENT and other specialities.

CHAIR - How many ophthalmologists have you working there now, across the three settings?

Ms HAYBITTEL - We have our Commonwealth-funded registrar which will be a continuous arrangement. That is one. We have Rob McKay who is the vitreoretinal, Andrew Traill who is based in Hobart but comes every week. He has been coming since 2013 for two days a week performing the vitreoretinal surgery, all the retinal detachments, all the ruptured globes and we have Michael Haybittel. We have Rob, Andrew, Mike, Ryan, another registrar, Robin Abell, who is a corneal specialist visiting from Hobart and he sees the corneas and he will also be introducing soon into our theatre corneal graft surgery. Now Mike does corneal graft surgery which is long and tedious and complicated but the new corneal surgery is much simpler and more effective.

CHAIR - As in grafts?

Ms HAYBITTEL - Yes, but the technology has changed. They use a DSEK (Descemet's Stripping Endothelial Keratoplasty) and it is amazing. It takes half an hour.

Mr GAFFNEY - What would be your greatest fear with the Presmed changeover? What are the things that you are most concerned about looking to the future?

Ms HAYBITTEL - I am not at all concerned about Presmed because the fact is that they are able to provide the ophthalmic care - because my husband is 66. Dr McKay is an ornithologist. He can't wait to go to South America and study ornithology on a full-time basis and we have all worked so hard. Dr Traill, Dr Abell, our registrars, will continue the service that we would. I am excited about Presmed because most big companies like Nexus and Cura and Ramsay Health would only buy the hospital side but Presmed only ever buy 60 per cent and the doctors on the ground earn the other 40 per cent and keep the management. So we

would keep the management and we are in the process of training our young staff to take our jobs which we can't wait to hand over might I add.

Mr GAFFNEY - My other questions then, the relationship between the service you provide and the state Government, how could that be improved or are there areas that you think could be improved? We are writing recommendations and findings so is there something there that you could talk to us about?

Ms HAYBITTEL - With the state Government we have support on the ground. Currently, I will tell you what our issues are and this could help with the state Government. If a patient presents at Accident & Emergency, we have signed a contract to service every patient who presents at Accident & Emergency and are then referred to our room. We had two patients last week - and this is on a daily basis - where they are seen at Accident & Emergency. They are triaged, they have been sent to us.

We will provide all the testing and say, this patient has a brain tumour and a haemorrhage. They need to be referred urgently to Hobart and we will send them for an urgent MRI. Now when we phone at 5 p.m. because we are regarded not as a state provider, we are regarded as an independent organisation, we can't get a result. The patient who is now about to die and needs urgent treatment, has to go back via Accident & Emergency to be able to get a report.

On Friday they were sent for an MRI urgent at 3 o'clock after consulting with our surgeon who can diagnose the problem from a physical point of view, with the third nerve palsy and do all the tests and look at the swelling of the brain and diagnosed a brain tumour with a possible haemorrhage. This patient we got the report on Monday because you cannot refer to a neurosurgeon before you've got a confirmed result.

So I-Med are doing an excellent job. They are working long hours; however, I-Med regards us as not being part of Accident & Emergency despite that patient being referred to us from Accident & Emergency in order to get an urgent result. If it's after 5 o'clock there are no radiologists at the Royal who report back to us. That patient has to go and sit in Accident & Emergency.

We had another patient from Mersey, same thing happened.

CHAIR - So to address that do you need an MOU or something like that with I-Med? What needs to happen in that circumstance?

Ms. HAYBITTEL -Well I think what we do need is for I-Med, because we have fought this for many years and I know previously we had no MRIs so we are very lucky to have MRI here. But I-Med needs to realise that on the north-west coast there is no neurologist, there is no neurosurgeon, so ophthalmology sees all the neurosurgery cases and all the neurology cases that are pretty urgent by the time we see them.

So, we need I-Med to realise - if the state Government could voice that to I-Med that the patient does not have to go back to Accident & Emergency where they've been for seven, eight, or nine hours, we have referred them on for an urgent MRI. You can only have an urgent MRI after 5 o'clock in Burnie, not in Devonport, which is fine. As far as the reporting goes, the reporting stops at 5 o'clock for us, not for Accident & Emergency. So if I think if the state Government could highlight that to I-Med and say, 'if North West Eye Surgeons phone and ask

for an urgent result you need to call out one of your radiologists', because we wouldn't call them out unless it was urgent.

CHAIR - From what I am hearing, it requires the state Government to issue a directive under their arrangements with I-Med to create on MOU or something like that, but to say we consider the eye hospital as part of our public health system in these circumstances.

Ms. HAYBITTEL - Yes. That would help us enormously because on this particular Friday I think we worked until 8 p.m. or 9 p.m., which is most nights. Our surgeons feel very helpless when at 8 o'clock at night they know that somebody has this dire medical problem and they cannot get an MRI result.

CHAIR - Sure, so there was another point you made about bulk billing of public patients not being viable or sustainable. We've heard that in regard to GP practices too, that it doesn't cover the costs of providing the service at times.

Ms. HAYBITTEL -You can't compare ophthalmology with GPs.

CHAIR - Oh, I'm not, I'm just trying to say we have heard this is an issue and obviously it's a different issue for you because of the costs of providing your service are much greater.

Ms. HAYBITTEL - We have Commonwealth funding for that now. What I am saying to you is that no other private specialist across Australia, be it Presmed or any other visiting specialist would provide this care at the bulk billing rate. Currently, we have that funding from the Commonwealth which covers the consult fee and the intervention fee like a laser, an OCT, so before you do a vitreoretinal injection, you need to do an OCT, an ocular coherent tomography. With the software, with the technology, those machines cost $150 000. We have technicians working them, then we still need to perform laser or injection. Very often if someone needs an injection, they also need laser combined. The bulk billing rates, no one else will provide this, so it's a non-negotiable.

What I am saying is, I am not here to ask for funding, because I am about to bow out. I have trained my staff well, we have provided a very good service but if the Commonwealth funding is removed you will not have a public service, no ophthalmologist will bulk bill where they can work across Australia and earn and see a tenth of the number of patients we are seeing. There are 18 ophthalmologists in Hobart and the reason being, if you ask Andrew Traill, who works for us and Robin Abel, they want lifestyle. They do not want to be seeing thousands of patients a day. The bulk billing rate is not even a negotiable in a specialist practice. Currently in Hobart, if you needed an injection, if you needed urgent intervention, you would go to the Royal Hobart and that would be provided. So, the bulk billing rate, fortunately the Commonwealth has provided that. But it is not an option, if that gets removed and that is what I am highlighting now, the training of all the technicians, the public waiting list and Presmed would be unable to serve the public patients.

CHAIR - Yes, I understand what you are saying, Jane. The Commonwealth have a commitment to fund those public patients, which is unusual in many respects because normally they do not fund that sort of -

Ms HAYBITTEL - It's not unusual when you look at our model, Ruth. They looked at bulk billing numbers and, I haven't been very vocal in this, but we equate to an area of need

equivalent of far Northern Territory and far Northern Queensland remote areas where there is no access and that is an unacceptable situation. It is an area that the Commonwealth was shocked by when they looked at the bulk billing figures because no other practices in the whole of Australia bulk bill. Where they have models in Broome, for example, I know the person running that, they have an enormous amount of funding from Twiggy Forest and from private entity groups. The bulk billing is not even a debatable issue going into the future.

CHAIR - I just want to clarify, though, that the federal government are funding this and they are intending to continue to fund it, from what you were saying -

Ms HAYBITTEL - I want you to make sure that is continued. I won't be here to make sure it is continued and I certainly would not stay on the north-west coast if there was no ophthalmologist because if you lose your vision, you want an ophthalmologist.

CHAIR - I just want to get to the nub of what we can do here. We can make recommendations around the state government's responsibilities, we can note some of the federal government's responsibilities, we cannot actually recommend they do certain things. I accept what you are saying and that the important thing is that federal recognition and funding continues. Prior to that, the State never saw any inclination to step in and fund that because it is a Medicare item. I am just understanding why -

Ms HAYBITTEL - No, the state government. I presented my case multiple times. Our option two years ago was to close the door for the treatment for 150 000 patients. That was the recommendation from Michael Haybittel, Rod Mackay and all our other specialists working for us. We were working so hard and it is not about the remuneration, it is about obviously who is going to see thousands of patients, working, some days now we see 200 patients in a day through our practice. These patients are critically ill requiring immediate intervention. My worry and my concern is that if the Commonwealth withdraws this funding, why should Presmed or any other ophthalmologist work on the north-west coast when they can see a tenth of the number of patients and earn a living? No one will work here, and registrars need to be supervised.

CHAIR - What I'm trying to get to here and I just want you to clarify this so it's clear, is that if those public patients were being treated at the Royal because they were in Hobart, then the state would be paying for that?

Ms HAYBITTEL - Yes.

CHAIR - But because they're public patients being referred to the Devonport Eye Hospital and it's not a state facility, the state is not paying for it, so the Commonwealth has stepped in and it relies on the Commonwealth continuing to fund that, otherwise it will fall over?

Ms HAYBITTEL - Yes but we've always provided a free service for public patients, a bulk billing service. In fact, what I did put to the state government and to Tas Outreach was that we were seeing 150 paediatric patients a month in our paediatric clinics and our reimbursement for those patients was $300. Now, the Commonwealth has stepped in and the state should have done something long ago about that because I have reinforced that, reinforced that, reinforced that. The Commonwealth - and our cases for paediatric very often with neonates born in Hobart prematurely, they get retinopathy at prematurity, they cannot be

discharged from Hobart unless we follow them up. Most of them don't even have Medicare cards.

The person who sees them in Hobart is paid a salary but we are obliged - a fax will be sent to us - it's our obligation to follow up that patient with no remuneration prior to this Commonwealth funding. It was an unacceptable situation and totally disregarded by the state government. Undervalued, disregarded by the state government. I think when the Commonwealth looked at the numbers - Medicare have been to see us over the years and said, 'My Goodness, how do you bulk bill so many patients?' We also, through the Commonwealth government, as I understand, because I'm not privy to these figures, see more brain tumours, more aneurisms than any other ophthalmic practice across Australia because if you've got a brain tumour, if you've got an aneurism in Hobart, you would go to the neurosurgeon or you would go to a neurologist. We see more MS patients presenting here, end-stage MS.

We've saved many, many lives, where patients would have otherwise died and it's a non-negotiable. There never has been an outpatient clinic on the north-west coast. Michael and Rob were paid salaries, which really was a minimum amount, and we bulk-billed the patients in-house. So when we looked at possible sustainability for the service and to attract other surgeons here, it was totally unattractive because the costs outweighed the benefits of moving here and earning what they were earning. If the bulk billing rate stops, the cataract surgery list would stop from here because we can't triage patients. Normally by the time someone has a cataract, they have three or four appointments because we have to look at the macula, we have to see that there are no other issues - like amblyopia - we have to measure for lenses, discuss what visual outcome the patient wants and provide a lens for that. We've been doing that for 27 years in-house. There has never been public outpatient consulting across the north-west coast. There is no other option for patients, but this has never been recognised by the state government as the provider of essential care. If you speak to any Accident & Emergency doctor, or any optometrist, or any GP they would say without North-West Eye Surgeons we probably wouldn't be here because we at least have the option of passing over to you when somebody suddenly loses vision. We had a young girl who went to her GP last week. She phoned to say I have a fixed dilated pupil and I have been told to come straight down to you and it took us three hours to try and save that eye and to save the other.

If you were working in Sydney, you could say I am a glaucoma specialist, my hours are from 8 a.m. till 4 p.m. and you can go to the public hospital after hours. If you present here at a public hospital, one of our surgeons is on call seven days a week. You will come back to our rooms, and our equipment will be used to make a diagnosis and to treat you.

CHAIR - As a public patient.

Ms HAYBITTEL - As a public patient.

CHAIR - Thanks Jane. We are out of time. Is there anything else you want to say that you haven't mentioned?

Ms HAYBITTEL - No. As I said, my only fear is that the Commonwealth withdraws that funding and then you wouldn't have a public system on the north-west coast. Whether you would have a private system, I don't know. We employ over 45 people. It is an important issue. Thank you for inviting me to your meeting. I appreciate you hearing what I had to say.

There is no financial benefit for us, but I hope that into the future this highly sophisticated model that we have set up is continued. Thank you for that.

CHAIR - Thanks Jane and give my regards to Mike.

THE WITNESS WITHDREW.