THE LEGISLATIVE COUNCIL SESSIONAL COMMITTEE, GOVERNMENT ADMINISTRATION A SUB-COMMITTEE INQUIRY INTO RURAL HEALTH SERVICES IN TASMANIA MET IN THE CRADLE COAST AUTHORITY FUNCTION ROOM, CRADLE COAST AUTHORITY, BURNIE ON WEDNESDAY 3 NOVEMBER 2021

CHAIR - Thanks Fiona for appearing before the committee and thank you for your submission.

So you are aware of proceedings, this is a public hearing. People may come in, particularly the next witnesses. Anything you say here is protected by parliamentary privilege; that may not extend when you leave the meeting. It is part of our public hearing and will form part of our public record, with the transcript made available and published on the website, and will inform our committee's deliberations.

Before we start, do you have any questions about any of that? If there is anything that you want to say in a private session, you can make that request and the committee will consider it.

I will ask you to take the statutory declaration first, then introduce yourself and speak further to your submission. Members will then have questions for you.

Ms FIONA O'KEEFFE, OCCUPATIONAL THERAPY AUSTRALIA, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

Ms O'KEEFFE - Thanks very much for inviting me. I am Fiona O'Keeffe, the divisional chair of the Tasmanian division of Occupational Therapy Australia (OTA). We are a small group of occupational therapists (OTs) who volunteer to meet with the powers that be, who are based in Victoria to support their work in supporting the profession. We certainly welcome the opportunity to give evidence.

OTA is the peak representative body for occupational therapists in Australia. As of 30 September, there were approximately 25 300 registered OTs working across government, private and community sectors. More than 360 of those were in Tasmania.

Occupational therapists are allied health professionals whose role is to enable clients to participate in meaningful and productive activities. These can range from feeding and toileting independently, education, and returning to work or home after a disabling life event.

Our core focus across all areas is to enable participation in activities of everyday life, regardless of what these may be.

OTs provide services such as physical and mental health therapy, vocational rehabilitation, chronic disease management, assessments for assistive technology and home modifications, and key disability supports and services.

We support people across the life span, from early childhood - in fact, I work with premature babies - right through to end-of-life care.

OTs are already integral to supporting timely discharge-planning from hospitals to reduce readmissions. Timely access to OTs in the community can certainly reduce hospital admissions, with their expertise in preventive care. Their holistic approach is uniquely placed to ensure a sustainable and balanced mix of services is delivered across the whole health system, delivering the right care in the right place when it is needed.

We hope they can be afforded a prominent and strategic role in future policy planning and investment decisions, because we believe that this will reduce pressure on beds due to preventable admissions, such as those caused by falls.

Regrettably, at present there is a significant under-investment in OT services in rural Tasmania. According to all of the OT chiefs, there is certainly a shortfall in actual numbers, even when the positions are all filled.

Enhancing health outcomes and health delivery systems also requires greater recognition and support for quality-based education and training for the allied health professions. We welcome the postgraduate training planned by UTAS in the next few years, and we have been heavily involved in that.

While education and training are important elements of any workforce plan, it is important to understand there are other significant factors influencing recruitment. Particularly, these include - and this is information I have heard from members with my own ears - scope of practice, housing shortages, visa and sponsorship assistance. Comparable remuneration is a big issue, working conditions, relocation support and other recruitment incentives. These incentives could be particularly valuable in rural Tasmania's health system.

One of our big concerns is that when staffing levels become critically low, as they are now, therapists can only respond to crises, and their ability to work effectively using their full skill set just can't happen. This leads to low job satisfaction, and people exit the public health system to go into private practice, which is much more satisfying because you can control what you do.

Committee members need to be aware that there is a shortage of health professionals right across Australia, and of the many allied health professions, occupational therapy has one of the most acute workforce shortages. It is imperative, therefore, that in Tasmania we are able to compete for OTs graduating from mainland universities or moving from overseas. That's why we feel these problems could be addressed.

The written submission went into detail of these challenges facing OTs in rural Tasmania. I hope I might be able to answer some questions, or expand on some of the details that I've heard from my colleagues.

CHAIR - Thank you.

Dr SEIDEL - Great. Thank you very much, Fiona, for making this submission, which I thought was really comprehensive. I will start with a few questions, if you don't mind, and then other members will chip in as well.

You mentioned that there is a critical shortage of OTs in Tasmania. Even if you fill all the positions that are advertised, there would still be a shortage. Talk me through what it means

when we don't have OTs, and an older person is in hospital in Launceston or Burnie or Hobart and is waiting for an OT assessment before they can be discharged home - because if they don't have an OT assessment, they just stay in hospital, right? It costs a lot of money and nothing happens while they are in hospital; it leads to bed block. The limiting factor is the profession that can do the assessment to discharge the patient safely - and that's the OT.

What's happening there?

Ms O'KEEFFE - Sure, there are going be incidents where bed block is so bad that they get discharged anyway. One of the big risks then is readmission. They go home, they have another fall because they are unwell. We know that 10 per cent of people aged over 65 in hospital are in there because they've had a fall. If you break your hip, you have something like a 10 per cent chance of dying soon, and a 50 per cent chance of dying in the next three years, so we want to be able to prevent that if we possibly can.

The other thing, as you pointed out, is they are going to be languishing, hogging a hospital bed. If they can have a timely home assessment and get things sorted out at home to enable them to get home safely, the quicker that can happen, the quicker that hospital bed is freed up.

One of the other issues I'm hearing from colleagues - and because I work in paediatrics I was personally horrified to hear this - is that there is currently a nine-month waiting list for home assessments.

Dr SEIDEL - Nine months?

Ms O'KEEFFE - Nine months. Your mum or my mum is at home at risk of a fall, and you have to wait nine months just for an OT to come around. Then, when that OT comes, all they can basically do is just the bare minimum - okay, they need this; they need that; let's organise this; let's organise that. No ongoing support; no helping them with advice or some capacity building on how to look after their health in the future, et cetera. That's just catastrophic. A lot of those people must be having falls in the meantime.

Dr SEIDEL - So, what does it mean for the occupational therapist as a professional - when, as you said, it's really just crisis management - if you already know the person waited nine months for an assessment, and you will have only one occasion -

Ms O'KEEFFE - One chance.

Dr SEIDEL - Yes, one chance.

Ms O'KEEFFE - It's very hard to recruit people, and I'm advised that's one of the big reasons. It's very hard to recruit people. Just imagine: that particular OT is waiting nine months, she's getting there, she knows she should have been there nine months ago.

When I first graduated, I was living in country Victoria, and I'd be out there in a week. The district nurses would ring me up - Joe Blow's looking dodgy, can you go out? And you'd be there and it would all be sorted in a fortnight. Sadly, those days - of course that's decades ago - are long over, but it means the OT also gets no job satisfaction. They know they haven't done their job in a timely way, which is what was required. They're not able to follow up because they've got a huge list of other people and, really, they have to triage those and work

through them. You can't possibly be spending time doing what would be icing on the cake - health management or preventative care - when you've got another crisis waiting around the corner, so none of that ever happens.

That means those OTs can't work even close to their scope of practice. They can't use their skill set. They're just using the tip of the iceberg of what they're capable of, which just is depressing, really. A lot of those will then go into private practice and be working with very compliant patients who are paying you and being able to control their own life. It's really difficult for the people -

CHAIR - The attrition would be to private practice as opposed to getting right out of occupational therapy?

Ms O'KEEFFE - I don't know those figures. I wouldn't know. But a lot of people do go into private practice. The NDIS has been blamed, I think, probably incorrectly, for a loss of OTs. But I think it's more that the OTs probably in public health have stayed. There's more OTs working in Tasmania and they're mostly working in the NDIS.

There's still probably the similar positions in the public system, in primary health, but there's a lot more OTs. People have moved and there's other OTs that have come in. Because the national disability scheme is all about disability - OT and disability is our really core business.

Dr SEIDEL - You also mentioned you have more control in private practice.

Ms O'KEEFFE - Absolutely.

Ms LOVELL - Can I ask a question?

Dr SEIDEL - Sure.

Ms LOVELL - Fiona, just in terms of those long waits between referral and assessments, do you know if there's any data collected or any research that's been done around what's happening for people in that time? Is there any record of what adverse outcomes, if they have been assessed as at risk of falls, how many of them are having falls in that time?

Ms O'KEEFFE - I don't but I could ask and find out for you from the chief OTs and get back to you about that.

Ms LOVELL - I'm sure there are plenty of those types of incidents.

Ms O'KEEFFE - They've obviously got info on that - they've got info on the nine months so there must be something out there.

Ms LOVELL - Yes. Thank you.

CHAIR - It would be interesting to have that, and whether there has been any costing done, because if you're looking at trying to make an efficient and effective health service broadly, if you're spending three times the amount on the person who breaks their hip and ends up in hospital -

Ms LOVELL - Unavoidable incidents, yes.

CHAIR - - if they'd been seen within two weeks and a fall prevented - I mean, it's a whole lot of preventative health - then if there's not just any data around the number of incidents but any costing that might have been done?

Ms O'KEEFFE - There definitely has been somewhere and I think some of it might be in here. I'll have a look. Figures and costing. But, certainly, I know there has been evidence done around everywhere, in the big picture, and it certainly is cost-effective to get in there more quickly, as you can imagine. Just the days of people being in hospital with a fracture compared to not actually ending up admitted at all, or being seen by their GP and having their medication sorted or something.

Ms LOVELL - In relation to what you have mentioned in your submission, and you mentioned it a moment ago too, around the job dissatisfaction as a result of constricted scope of practice in the public sector. That really comes down to capacity constraints, is that -?

Ms O'KEEFFE - As I understand it, it's because people can't - there's too much workload so you always have to pick out what's the most important. OTs are really well trained in activity analysis and fatigue management, and a whole lot of other areas that they may be able to work in and, in the past, would have been working on with somebody who had rheumatoid arthritis or something like that. That would never happen now in the public system. You just wouldn't.

When they're in hospital, yes, you would see them and you would be talking through it. But that isn't happening in the community any more, as far as I understand. A community OT would just be going from one house to the next doing modifications and recommendations for equipment. I think there are issues - is it all right if I mention something else?

Ms LOVELL - Yes.

CHAIR - Yes.

Ms O'KEEFFE - I don't think it's in here but the chief OTs, when I was speaking to them, said that one of the issues too - and it's inevitable - if we can't do the job, someone else is going to and so other areas slip in. There have been a number of examples where the services that are perhaps the support services - sorry, I don't know the correct names for them - are then saying, 'Well, we will put in a rail' or 'We will do this' instead of getting an OT because it's too long a waiting list. That's a great idea in theory except there's loads of examples where the rail was actually behind them so they couldn't actually use it to get up off the toilet and just really basic things like that, even though it doesn't seem like rocket science.

Dr SEIDEL - I have followed up on this one because the Royal Flying Doctor Service talked about services they provide. They have health workers who work under the supervision of an exercise physiologist, for example, but their training is not four years as an exercise physiologist would have. It is only six weeks, very specific. They say it works really. It is the opposite to what professions do, which is becoming more professional. Do you think there is a risk that there is a trend, because we don't want to or can't employ professionals, we're having people do short courses and somehow making it work?

Ms O'KEEFFE - We are seeing that everywhere. If we're not available and people need a service, of course, they will find it. Exercise physiologists, I have to say, are a great profession. They're moving into a whole lot of areas and doing it pretty well, sadly for us. There's a real place for capacity building. We have to accept there is a shortage of staff. We can't pull 1000 OTs out of a hat tomorrow. We can use the OTs we have more effectively. We can use capacity building.

One of my jobs is with the Education Department. The place I work for has a contract with the Education Department to do capacity building with teachers of children with disabilities and additional needs. We don't actually work with the children, we work with the teachers to enable them to effectively manage the children's sensory and physical needs, et cetera, in the school. Exercise physiologists can train or supervise people. It's the timely supervision. If somebody is doing a program with somebody, as long as they can have good supervision with a health professional, maybe that's a solution. People might be cross with me for saying that, but I also think we have to be realistic.

CHAIR - It is about a team approach, it would seem.

With regard to the lack of satisfaction with the roles, when you are doing crisis management all the time, it must make it hard to attract people into the profession to start with. There is the postgraduate plan that's been looked at with UTAS. How do you think that can be made a viable, attractive option for school leavers going into university? Which campuses are they looking at putting it into?

Ms O'KEEFFE - Yes, I know a lot about it. It's a postgraduate course, so, unfortunately, it won't help school leavers and there are quite a few prerequisites. A lot of people want to do OT. I don't think we'll have any trouble attracting people. It's really popular. I've been working for nearly four years and it's a fabulous career.

CHAIR - A nurse or a teacher or someone who already has an undergraduate degree?

Ms O'KEEFFE - Yes, they need an undergraduate degree of some sort. It's a two-year master's degree they're proposing here.

CHAIR - When you say here -

Ms O'KEEFFE - They're going to run it across all the campuses, so people can do the study. Burnie students can do it here.

CHAIR - They've got a fantastic lab there now.

Ms O'KEEFFE - Absolutely.

CHAIR - It's better than the Launceston lab, which is pretty amazing.

Ms O'KEEFFE - I think they're planning to have a week every now and then where everybody comes together and does some intensive stuff. Most of the time, people will be living and working in their community. I'm doing a course in a couple of weeks about how they're going to manage the student placements, because they're going to have to think outside the square with that. They sound like they're doing a really good job.

CHAIR - Do you think that will help attract people?

Ms O'KEEFFE - Absolutely, yes.

CHAIR - You might pull some teachers out, then you'll have a teacher shortage, but -

Ms O'KEEFFE - I think it will. I think there will be people who've done something like exercise physiology. Maybe someone's done exercise physiology and thinks, I can see some of my colleagues are going into disability, they're doing all sorts of groovy things. OT covers such a broad area that there's pretty much something in it for everyone. If you do OT, you can work in almost any area.

Dr SEIDEL - I'll stay on the topic for a little bit longer. In medicine, there's a development in training rural generalists, so, doctors who can do a broader scope. The idea is to have the same for allied health - allied health rural generalists. Do you see that as a viable option for Tasmania or something interesting, considering that we might already have teachers who become OTs or people who have double or triple degrees?

Ms O'KEEFFE - I think in primary health, that is a reasonable model. It was OT Week last week, we had breakfast. You could see the hospital table was full of young ones. So, the young ones rotate through areas and they get experience in lots of areas. But one of the problems I think, which the hospital and the chief OTs are telling me too, you do still need people who have a higher level, you need leaders in particular areas. If you are working in acute rehab, you do need someone who has more experience in that area for those people that rotate through. So, there needs to be the opportunity for both, to a degree. I think out in the community it is a bit different. Mental health is another whole specialty where people tend to work in mental health and develop better skills. You can't use the Medicare mental health plan unless you have been endorsed as a mental health OT, so you have to get some accreditation in that area.

So, the generalist idea I think is reasonable but it needs to also include the ability for people to develop a higher-level skill area, otherwise all of the research and all of the stuff that people have been working on over the years is lost because nobody can work in oedema management, or burns, or perinatal or neonatal care, or anything else like that. Paediatrics, every hospital really needs a good paediatric department with an OT because that's huge.

CHAIR - To touch on some of the other matters you raised earlier about barriers to getting OTs in the first place, we talked about the scope of practice and that sort of thing. Access to housing, remuneration and relocations support were three things you mentioned. Access to housing is a problem for just about every profession, whether it's police on the west coast or health professionals, teachers, whatever. Can you just talk me through about the remuneration and how it varies? You talk about a lot of OTs going in to private practice. So how do we address these disincentives, if you like, and what is needed in that space?

Ms O'KEEFFE - I think pay parity is the main thing. The chief OT at Launceston was telling me she was very gleeful and happy that she had managed to recruit a senior person. And that is the big difficulty, getting senior people in. New grads need a job and they need to get into the thing, so they're relatively easy to get. But senior OTs with good experience and good high skill levels are hard to attract. This woman has taken a $15 000-a-year pay cut to move

to Tassie from Western Australia. The housing would probably be fairly similar. That is hard to attract and she doesn't get assistance to move her family.

CHAIR - There's no relocation assistance for her?

Ms O'KEEFFE - There is no assistance like that. Doctors move to a rural area and they get three months free housing and they get assistance to move but we do not get anything like that. I can understand that is a lot of money but maybe for the senior people, if you were trying to get a senior person to move to a rural area, which is really fantastic. I know when we moved up here, I got an offer, 'Would you like to be the chief OT at Burnie?' - an email from the hospital - 'tomorrow?' and I said, 'Sorry, I haven't got the skills set, no'.

Dr SEIDEL - If you don't have OTs, it is going to cost the health system, isn't it? If you don't have an OT, the patient stays another day in hospital. That is $2500 gone just for the day. Whatever it takes, it's penny wise and pound foolish, isn't it? There was an inquiry about the horizontal fiscal equalisation scheme designed to make sure we do have pay parity among states so we don't have the discussions. But it doesn't seem to exist, does it? It's crazy, isn't it?

Ms O'KEEFFE - Well, it happened years ago, decades ago. When I first moved here about 20 years ago, there was a big increase in pay. We all got this backpay, it was great and it brought it up. But I think since then it has slipped back again. That is one factor. I think things like the relocation cost, they would make as big a difference as anything because, 'We really want you here', supporting them when they first move, if you're able to provide them with a hospital house. Or there are people like me, I live up here, we have spare rooms. If the hospital contacted me and said 'Can you put up an OT for three months?', I could. Just thinking outside the square would make a difference. Pay parity is in the background there all the time, though.

CHAIR - On that point, has OT Australia had discussions with our state government - they are clearly having trouble filling these gaps - about those sorts of packages?

Ms O'KEEFFE - I think that would probably come through the union.

CHAIR - Rather than through professional bodies.

Ms O'KEEFFE - Yes, sorry, I don't know. To be honest, I don't know that.

CHAIR - Okay.

Ms O'KEEFFE - I think it would have been through this.

CHAIR - Who is the union? Is it HACSU or - ?

Ms O'KEEFFE - Allied Health Professionals - I'm obviously not in it. I think it's -

Dr SEIDEL - I think it's HACSU.

CHAIR - Which one, sorry?

Ms LOVELL - HACSU, I think.

CHAIR - Yes.

Ms O'KEEFFE - Sorry. I should know that.

CHAIR - That's all right. No, no. It's okay. Yes.

Ms O'KEEFFE - Yes, unlike nursing, where the union and the peak body are the same organisation, we're quite separate, so the professional body - it's not compulsory membership. Tassie has the highest membership, just out of curiosity, of OT Australia but not everybody is a member, which is unfortunate. And the union is separate.

Dr SEIDEL - Are you currently engaging with the Government when it comes to workforce planning?

Ms O'KEEFFE - I don't know. I would imagine so. Certainly, I've got a range of documents. Yes, I would have to check with them. Certainly, there was a big workforce submission - I've got a copy there in my bag - that went in this March, it might have been February. There certainly was a workforce planning thing I can send you, if you like.

CHAIR - That would be helpful in terms of - do you know off the top of your head the average age?

Ms O'KEEFFE - No. I will see if there is anything in there.

CHAIR - The average age is one thing but you also need - if the average age is, say, 30 but 99 per cent of people are under the age of 25 or 30 because they're new grads and that doesn't really deal with the senior positions that you need.

Ms O'KEEFFE - No. Where is it? Maybe I didn't bring it, I beg your pardon.

CHAIR - We can -

Ms O'KEEFFE - I may not have brought it but I can get it for you, the workforce one.

CHAIR - Yes.

Ms O'KEEFFE - I don't particularly think that we're overloaded with young ones but I don't know.

CHAIR - Okay. Yes. Would that document outline the more senior practitioners as opposed to the juniors as well, or is that just a more broad -

Ms O'KEEFFE - I don't think it does that but I can ask and see if OT Australia might be able to find that data.

CHAIR - Yes, because if all your senior practitioners are getting close to retirement age, then the problem is different from if it's dispersed right across.

Ms O'KEEFFE - I can find out. Will I send any answers to any questions to Jenny?

CHAIR - Yes, that's fine, but she will be in touch with you.

Dr SEIDEL - Fiona, you made an interesting comment in the last part of your submission about government's initiative to encourage people to move from the city into regional and rural areas, and they're national initiatives. Just today, the Premier was in the paper actually being quite proud that more and more people want to move to Tasmania and move to regional Tasmanian areas as well. But you said in your submission that there are genuine concerns that increased demand for services in those areas will result in even poorer health outcomes because we just don't have the providers there.

Can you elaborate a little bit on that - in particular, when you speak to your OT colleagues and your health service colleagues - what would it mean if all of a sudden more people are moving into regional areas where we already don't have any OT and people expect the same level of service they probably would have got in Sydney or Brisbane?

Ms O'KEEFFE - It just puts more pressure on the system. Certainly, we do see that when people have come from an area where they have had timely and a really high level of service, Western Australia, for instance. People might come. There seems to be more staff over there and they're really horrified when they have to wait or there isn't a service. I think it will just end up with more pressure, people feeling worse about the fact that they can't do the job. But a lot of those people won't engage with OTs because they won't be there.

It's not us that are going to bear the brunt; it's just more pressure on the government and everything else. Admittedly, I know that OT Australia did include that in there but personally I think we will get a mix of people in, we should get more OTs in as well. The sort of people who, hopefully, will want to move to Tasmania are going to be riding their mountain bikes all over the place and be quite fit and healthy.

CHAIR - There's a very diverse group that actually come to Tasmania and some of them don't fit that category.

Ms O'KEEFFE - No, no. I am sure you are all aware how the north west is meant to be the sickest and oldest and the poorest health outcomes. So here, in a way, we always have the best staffing in the areas that need it the least, and areas like this that need the highest staffing.

Dr SEIDEL - Are you aware whether OT Australia, as one of the peak bodies, was consulted when it came to the campaign encouraging people to move to regional Australia or Tasmania?

Ms O'KEEFFE - I'm not aware of that, sorry.

Dr SEIDEL - Because there probably isn't much health service planning going ahead, and needs analysis going ahead, when we start encouraging people to move.

Ms O'KEEFFE - I don't think so, no, but I don't know. My position is tricky, because I'm an OT, just working here. OT Australia is an organisation with professional staff who are fed information from us on the ground, to the best of our ability. I am not all over -

Dr SEIDEL - There is only so much you can do as well.

CHAIR - You're busy looking after people. If you had to put together three priorities for the Government regarding supporting OTs, not just the profession but to make sure there are adequate services in our community, what would they be?

Ms O'KEEFFE - Increasing the work force would be the number one. The other things will all feed into that, which would probably be pay parity and support with getting people here. Things like supporting relocation costs, rent assistance for the first three months, those sorts of things will be practical ways of trying to get OTs who are not currently working in Tasmania here. The number one would be increasing the number of positions because it's -

CHAIR - Even though they can't fill the positions they have?

Ms O'KEEFFE - Yes, but I think if there are more positions, that critical mass where you go over a cliff - you all know this, I am sure, when things, particularly in health, get worse, you go down this spiral and nobody wants to work there. That's what happens in a lot of the regions. The health services become poor and people say, 'I don't want to work there, it's terrible, you're working your guts out, you can't do anything decent', even though this area has so much to offer.

I think I mentioned this, Bastian may have heard this before, I think the Tasmanian Government has an opportunity across all health areas to run a decent advertising program. Get a really professional video up and running that can be wheeled out at all of our conferences: OT, physio, speech therapy, medical, all the specialty medicines, so they have it in their face, people mountain-biking, people looking at Boat Harbour beach, the lifestyle. You never meet anyone who says, 'I moved to Tassie, I really hated it and I moved away'. That doesn't happen. We all move here and we love it. It is a beautiful place to live and work.

We just need to get enough of a workforce here that is functional. We are in a position where the workforce is so low, it's a little bit like a woven blanket. The weave has become so loose that things are falling through all the holes and it's not keeping you warm any more. It doesn't have to be dead tight but it needs to be tighter than it is for it to be effective. That is my take on it, and everything that's been written by OTA supports the view that people can't work to their full capacity, it's not effective intervention.

CHAIR - I am trying to think how you would promote that. If you say we need 50 OTs in northern Tasmania and we advertise for 50 OTs, people think there must be a real burden there. How do you then get the message across that if we get 50 OTs, you'll be able to work across your full scope of practice, you'll have much higher job satisfaction and you'll make a real difference to the lives of the people you're caring for?

Ms O'KEEFFE - Do you mean, get that across to the potential OTs?

CHAIR - Yes.

Ms O'KEEFFE - You won't need to. They'll get that straight away.

CHAIR - They won't think, 'Oh my god, they need 50', they'll think -

Ms O'KEEFFE - Particularly if there's an explanatory note here, we recognise that we've been under-staffed and we're really injecting some action into it, everyone will be saying, 'Oh, that's going to be a great place to work'. I really do think that. People will understand that.

Dr SEIDEL - It's interesting, the pay parity thing and a housing package will signal that we want you, we value you as a person and professional, we want you to work in Tasmania, of all places. The Government spends a lot of money on promotional stuff, like 'Come down for air', which is lovely, but not really specific. Again the campaign could be specifically targeted for health practitioners, because that's the largest group that's being employed anyway.

CHAIR - That's right.

Dr SEIDEL - It's not that there are only a few; it's a huge group.

Ms O'KEEFFE - Absolutely. There was an interesting comment at an OT breakfast in Burnie. There were 21 of us at a breakfast just celebrating being OTs from across all sectors, and one of the young ones said, offhand, 'even though hardly anyone knows what we do', which was really interesting. At the coalface, she's obviously still experiencing other colleagues and also people in the community not knowing what OTs actually do.

CHAIR - That's a fair comment. If I walked down the street and asked people what OTs do, they wouldn't even know what 'OT' stood for. When I ask, what do occupational therapists do - 'Oh, something to do with work'.

Ms O'KEEFFE - Yes, that's right.

CHAIR - Maybe there needs to be greater awareness-raising in our community of their value and the scope, which starts from prem babies, right through to the dying person needing support and assistance and assessment.

Ms O'KEEFFE - Yes, and that is an ongoing thing that OTs work on. Those of us working on the ground aren't so concerned with it because we're all run off our feet.

When you work in disability, paediatrics, aged care - but, as you say, the average person on the street probably doesn't know what an OT is until they need one.

I agree we need to continue working on letting people know what we're there for.

CHAIR - Maybe that's something for the professional body to focus on.

Ms O'KEEFFE - It's an ongoing thing that they do work on.

CHAIR - When I was the president of the Australian College of Midwives in Tassie, that was one of my key focuses, because a lot of people back then still didn't know what midwives did. They just thought we were nurses. So, it is about understanding what you do and promoting what you do, even though you know.

Ms O'KEEFFE - That's true. Unfortunately, Occupational Therapy Australia does not have an office here. Our manager is combined with Victoria, so we're a bit of an offshoot.

There are only five of us in the division. We're just a little group of volunteers doing what we can. However, we can probably do better.

Dr SEIDEL - You don't receive peak body funding from the state government?

Ms O'KEEFFE - Not that I know of. The people on the committee don't receive any funding of any description at all.

CHAIR - Does the peak body of Occupational Therapy Australia get funding?

Ms O'KEEFFE - Not that I know of.

CHAIR - Does the membership fund it?

Ms O'KEEFE - No, we pay the membership.

CHAIR - Yes, I mean the members pay, and that's the only funding you get?

Ms O'KEEFFE - As far as I know. I will find out about that.

CHAIR - Most governments are reluctant to fund bodies that are going to advocate for more.

Mr GAFFNEY - It's an interesting point you made about people not being aware. As part of our inquiry, we have heard from a number of groups who are saying similar things. There are parts of the allied health profession that people understand, but as a committee that's something we will think about: what can we recommend or suggest to the Government for how they can address that - which is actually health literacy, trying to get it out there, and therefore showing the importance of those different areas, that aren't so much highlighted by the media on a Saturday morning, or whatever.

Ms O'KEEFFE - Which would be relatively easy, wouldn't it? Just invite yourself onto a talkback show or something.

Certainly, we're very reliant on GPs for community stuff. If a GP doesn't know anything about occupational therapy, or hasn't used a therapist before, then they're not going to be referring to the local OTs. The community OTs will be getting their referrals through the community nurses, primarily, which is what often happens - whereas hopefully most of the hospital specialists are pretty au fait.

CHAIR - It's a bit like the vaccine rollout. We didn't have a really whiz-bang campaign promoting vaccinations, because we didn't have the vaccines to give out. If you go out promoting 'This is what OTs do - everyone needs to see their OT', and you can't get one, well that's not so good either. It's a chicken and egg there. You have to make sure you have the capacity.

Ms O'KEEFFE - Absolutely. Certainly in paediatrics and in the NDIS space, which I know is nothing to do with you guys, but people have funding for the first time - far more funding than they can use - and they can't get therapists, and they're really cross and angry with us.

Mr GAFFNEY - It's interesting. It's the GP level that needs to know what the OTs can do and where they're available. They're the ones that talk most of all to the individual.

Ms O'KEEFFE - Absolutely.

CHAIR - And refer them.

Ms O'KEEFFE - They're the ones that can prevent -

Mr GAFFNEY - Yes. They're the ones that can actually - and if the GP knows that there's no OT in this area, they're not going to suggest that. But once there is, yes, it's that sort of thing.

Ms O'KEEFFE - That's exactly right. I think the core thing for Tas Health is to be able to prevent admissions - shorten admissions and prevent admissions. That's the key thing that can save money and, hopefully, pay our way.

CHAIR - Anything you wanted to say in closing then, Fiona?

Ms O'KEEFFE - Thanks very much for having us and for having me on behalf of OT Australia. I hope I've -

CHAIR - No, it has been very helpful. Thank you.

Ms LOVELL - It has been. Thank you.

Dr SEIDEL - It was great. Thank you.

CHAIR - It was a very comprehensive submission, so we appreciate that too.

Ms O'KEEFFE - Thank you. Jenny, were you going to send me those questions? Beautiful. That's really great. Thanks very much.

THE WITNESS WITHDREW.

Ms BERNADETTE SMITH, TASMANIAN DIRECTOR, AUSTRALIAN PAIN SOCIETY, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Welcome, Bernadette. Lovely to see you. For your benefit and information, this is a public hearing. Everything you say here is covered by parliamentary privilege. That may not extend beyond this hearing. It will form part of the evidence taken by the committee and published on our website when the *Hansard* is transcribed and inform our deliberations.

If there is anything you wanted to talk about you think is of a confidential nature, you can make that request to the committee and we would consider it; otherwise, it's all public. Do you have any questions before we start?

Ms SMITH - No, thanks.

CHAIR - If you wouldn't mind introducing yourself. Thank you for your submission that has been provided. I look forward to hearing from you.

Ms SMITH - I'm the incoming Tasmanian director of the Australian Pain Society. I'm also a registered psychologist working on the north-west coast and for the last eight years have co-facilitated the OPAL chronic pain management program, which is Commonwealth funded.

The Australian Pain Society would like to thank the committee for the opportunity and the invitation to the hearing today and welcomes the opportunity to talk about our passion which is pain management and access to pain management, appropriate pain management services.

The submission before you was submitted by the former Tasmanian director, Dinah Spratt. The Australian Pain Society's perspective is a multidisciplinary association and our mission is to advance pain prevention, management and clinical practice.

The membership is diverse. We have medical practitioners, GPs, dentists, psychologists, OTs, which explains the importance of interdisciplinary care when we're talking about appropriate pain management services.

The vision is that all people have optimal access to pain management, and pain prevention throughout their life. We view that as a fundamental right.

I think the Australian Pain Society, as a national organisation, is best placed to discuss the burden of the disease and overarching recommendations in terms of strategies and management, and from a rural perspective as well. I am sure there are other service providers who are perhaps a little bit better situated to comment more locally on some of the rural issues, although I can comment locally from the perspective of co-facilitating a pain management program.

Dinah certainly highlighted the secondary issue that we also have - which is really an extension of the problem we have with pain management, and access to appropriate pain management services - which is with the workers compensation system.

If we are looking at the burden of the disease, it is consistently evident from a health economics perspective that back pain was the leading cause of pain disability in 2017. When

we look at things from a rural perspective, we actually see that our rural clientele - rural people in rural communities outside the major cities - are about 23 per cent more likely to suffer the burden of the disease, and 30 per cent if you are aged between 50 and 64. So, from a rural perspective, it is already a huge burden and an economic cost. And when we look rurally, we already have an even bigger burden on top of that.

The other thing is that Tasmania has no paediatric pain service, yet we see that 25-35 per cent of children and adolescents experience chronic pain.

A second important problem with chronic pain - which is why it's so pleasing to see it was on this inquiry - is comorbidity, which is incredibly common among people with chronic pain. Approximately 75 per cent of people will understandably suffer other mental health conditions, and then what we see is that the comorbidity actually worsens the burden - so, for example, major depression in patients with chronic pain associated with reduced functioning, increased disability, more lost time from the workplace, and of course increased healthcare costs. Sadly, it is the leading cost of economic and social exclusions. So, we have this huge burden.

I do not think I need to convince you of the economic cost associated with chronic pain; you've been listening to this for a while, I'd say. But it is the third most costly health condition. It is bigger than cardiovascular disease, diabetes and cancer combined. It costs Australia about $140 billion a year, and on top of that, it is a cost to the general population, because they are paying about $2.7 billion a year in out-of-pocket expenses just getting the services they believe that they require.

On the issue of access to appropriate services, approximately 0.2 per cent of patients with chronic pain will actually be seen by a tertiary pain service, and 80 per cent will not actually receive appropriate treatment. The tricky part here is that this Australia-wide problem is actually very similar in Tasmania. In Tasmania, our only tertiary pain service, the Persistent Pain Service, is in Hobart. I think they have 1.4 full-time equivalents of medical consultants, 1.4 full-time equivalents for physiotherapy, and 1.4 for psychology. They recently lost their accreditation by the Faculty of Pain Medicine as a training organisation. So, no doubt that means less funding for them as well.

Dr SEIDEL - We asked at Estimates, but the minister at the time said he was not aware that any accreditation was lost, of any unit of the Royal Hobart Hospital.

Ms SMITH - I spoke with them Monday, so, I don't -

CHAIR - When was it lost?

Ms SMITH - It must have been very recently. I was speaking with -

Dr SEIDEL - Before Estimates.

CHAIR - Just after Estimates, probably.

Ms SMITH - Okay. Yes, I was only speaking with Hilton and Megan [names TBC] on Monday. I take their word as, just what I'm saying.

Ms LOVELL - Do you know why it was lost, Bernadette?

Ms SMITH - My brief understanding of it is that there was a mass exodus of medical staff and it's a little service, it's overwhelmed. They're no doubt doing the very best they can with what they have. They certainly, of late, have been trying to address some of the issues that we will highlight a bit today.

The interesting thing, too, is when we have a look at the ePPOC data - ePPOC is the national collection of persistent pain outcome data. Only PPS in Hobart contributes to that data because it's actually very expensive for services, so our service and the Launceston service don't contribute to that because it's very expensive to pay for that privilege, unfortunately.

But what we see, from the ePPOC data, the only little bit that I've seen, provided by Hobart, is that the clientele they are seeing in Hobart are about 20 per cent above the national average in terms of their socioeconomic disadvantage. They do service our clientele as well. However, it's predominantly southern-based. Here we have a service that is servicing already disadvantaged clients and that is without looking directly at those regional and rural areas from the north, the north west and west coast.

The first part of the problem, although it's outside the scope of this inquiry, is that the issue of capacity from a regional perspective then has this flow-on effect rurally. There's no doubt that the problem has been highlighted for many years. I think the 2015 white paper highlighted the issue of pain services and access to pain services. The 2016 coronial inquiry into the accidental opioid death of, I think they may have been a regional Hobart client, very much highlighted the problem of access to services but also, importantly, low awareness of pain and low awareness of appropriate pain management among health practitioners generally. This is a problem we see even more so rurally, and an over-reliance on biomedical interventions and on medications. I think in 2016, I can't remember the date, we were about 34 per cent above the national average in opioid prescribing. Again, this is because patients are getting treated where they can be treated. So, I guess, that represents -

CHAIR - Not by a pain specialist?

Ms SMITH - Yes, that's right. More recently, there's been quite a lot of work, in 2019, on the Tasmanian pain management strategy and I understand the clinical advisory group have endorsed, I think it might have been the musculoskeletal pain plan, I am not sure if I have the wording of that right; recommended and endorsed but not funded.

Dr SEIDEL - I am sorry to interrupt, isn't it bizarre? You just said that we have a Persistent Pain Service in Hobart with a handful of people there who just lost accreditation for whatever reason, yet we probably spend more time doing plans and submissions and strategies than actually funding the expert clinician on the ground. This is just a charade, isn't it? You said, initially, your goal is optimal access to pain management - optimal. I would imagine it would be your professional view that you are not going to discriminate against somebody who lives in Queenstown or Deloraine, or Launceston or Burnie, for that matter. What we have is not even a service, right? It's just tokenistic.

Ms SMITH - It is.

Dr SEIDEL - If you're in chronic pain and you live in Queenstown, are you expected to drive all the way down in your private -

CHAIR - Yes, you are.

Ms SMITH - You are.

Dr SEIDEL - That's contributing to the pain, isn't it?

Ms SMITH - Absolutely.

CHAIR - By the time they get back, they're worse off.

Ms SMITH - Yes.

Dr SEIDEL - I don't want to put words in your mouth but isn't it frustrating that we have report over report, and consultants and God knows what contributing to this, but we're still not going to fund any form of, at least, a hub-and-spoke model of persistent pain in Tasmania, whereas we all know what the burden is. We know how much it's going to cost. We know it's going to take people out of the workforce.

CHAIR - I take it this is all a statement. Get off your box now, and back to Bernadette.

Dr SEIDEL - It doesn't make sense, does it? 'No, no', the witness said. She encourages me to continue, Madam Chair.

Ms SMITH - Absolutely, you took the words out of my mouth. I will definitely have to agree with you. But you're right, as a private practitioner, time is so valuable. Even as a private practitioner or within my role here, going to meetings, which I just simply don't do. There's so much talk, we know the problem. But the issue is, it's not as simple as just throwing more money at it. And I think there are some economically viable options we have to look at. What else, from a grassroots level up, can we do as well?

Obviously, no one is surprised here that, when we look regionally and rurally - regional being Hobart, of course - but when we have a look realistically, the problem is simply amplified here. If we have a look at what we have from a regional perspective, there's fragmentation and there's fragmentation in terms of funding. So, in the northern region, THO -

CHAIR - THS now.

Ms SMITH - THS has an allied health-funded program, OPAL, in Launceston, which runs some programs. I'm not 100 per cent certain of all of the deal with that. On the north west coast, we have the Commonwealth-funded group education program, through TAZREACH. But again, while they're little services, they're not integrated and they're fragmented. They are services that are funded to service, they are not services that are funded to go out and give talks to GPs, allied health professionals, hospitals or physiotherapy departments who are servicing this clientele, so that they know the service even exists, even though the service has a 12-month wait. We see that amplification of it.

The other thing that's really important is that while we have this fragmentation, like you said, the hub-and-spoke model, we already know what the problem is. Perhaps, the issue is that, while we might all agree on a hub-and-spoke model, the difficulty of funding and accessing appropriate levels of funding, because what we're talking about is interdisciplinary care. What we do know is that it's not as simple as just accessing more allied health professionals, that what is really important is interdisciplinary care.

When we have a look at the International Association of Pain, interdisciplinary care is really about this very flat structure where there's collective communication and collaboration between allied health and medical professionals in a patient-centred care model. That's quite expensive to do.

Interestingly, there has been some work on some new Medicare item numbers that goes a little way towards addressing the importance of interdisciplinary care but by no means is the whole answer to this enormous problem we have. So, is the answer, often when I look at the things that are recommended for rural areas, throwing more money at allied health and medical professionals?

I can see that the AMA, the Royal Australian College of General Practitioners and Arthritis Tasmania have highlighted access, pain management as being issues. I certainly concur with their submissions. But the answer, I think, is a little bit more complex because we already know from the health workforce data that there's not a lot of access to allied health professionals. So, we have lack of capacity at the top level; we have difficulty with access to appropriate health professionals, whether they be medical or allied health, on the ground in the north west and west, western region and northern regions. We also know that those health professionals and GPs are not necessarily adequately trained in pain or what constitutes appropriate pain management. Here's where we see the problem of the overuse of medications, and what we call the serial referral method. They go from one referral to another specialist, to another specialist, to another specialist, until they’re spat out and end up in Hobart.

Training and educating health professionals, whether they be allied health, GPs, medical professionals or in the acute setting, about what appropriate pain management looks like is important, as is educating the community. If the community knows what is appropriate care for pain then that's really helpful, because then we have a grassroots approach where we're educating consumers.

Two years ago, the Pain Revolution came to Tasmania with the support of Tasmanian government funding. That is a grassroots community, building up capacity within the community. It is a not-for-profit organisation educating people about what appropriate pain management looks like, especially for persistent pain. I wish it was as simple as just throwing more money at it and adding more health professionals. Educating health professionals, educating consumers about what appropriate care looks like is also incredibly important.

Telehealth goes some of the way. The difficulty being that patients with persistent pain conditions require a physical assessment. At best, it can aid and help access appropriate treatment from something like a pain medicine specialist or from an appropriately trained team, but it doesn't go all the way there.

My final summary would have to be that the health economics, the burden of the disease is really simple, as is the answer, but when we look at things regionally it's a much more

complex problem. It's multi-level. I wish I had a simple answer but I don't really have a simple answer.

CHAIR - You hope it would be fixed if it was simple but, anyway.

Ms SMITH - Yes.

Mr GAFFNEY - I think the Australian Pain Society's conference is in Hobart in April?

Ms SMITH - Hobart. Everyone is very excited about a face-to-face.

CHAIR - It was cancelled last year, yes.

Mr GAFFNEY - Yes. I think there's an opportunity there for members who attend that to tour Parliament House, which will be good. Do you know the membership base in Tasmania of professionals who may be with the Pain Society?

Ms SMITH - Yes. The numbers nationally in the Australian Pain Society are quite small number. There are only 350 pain medicine specialists in Australia and there are 35 Australian Pain Society members in Tasmania. The largest is New South Wales with about 375.

Mr GAFFNEY - Are people in the profession connected to the Pain Society? What advantages are there? Does UTAS provide any information for medical professionals who are learning the trade? What relationships are there to say, 'This is what we're trying to do'?

Ms SMITH - At a national level there's the Australian Pain Society. Our advocacy arm is Pain Australia. We're linked in with the Faculty of Pain Medicine, AMA, RACGP. OT, I think, might receive communication. They are the collaborative among all the committees but were considered multi-disciplinary.

Because we represent all groups, most people who are part of the Australian Pain Society are also members of their own professional body. So, they might be part of the Psychological Society or the Faculty of Pain Medicine or the RACGP, but when they have a special interest in persistent pain, they will often become a member of the Australian Pain Society.

Mr GAFFNEY - It was interesting. You touched briefly, I think it was a national reform, about some Medicare items being - and I noticed that was a strategy. Could you expand on how and what they are doing to try to get more?

Ms SMITH - Medicare have recognised the importance of interdisciplinary care when we are talking about subacute and chronic pain and those more complex cases, and so they have introduced item numbers. I have only read the brief on it. I do not even know the item numbers. It is about allowing GPs and allied health professionals to be able to case-conference, to be collaborative and work in an interdisciplinary way, which is the gold standard - as outlined in the National Pain Strategy, using this biopsychosocial model of care, where you address the physical, phycological and environmental contributors to their pain.

So, the Medicare number allows the psychologist, the OT, the GP and other specialists to work collaboratively. My understanding, if I have this right, is that person does not have to be our client; they might be looking for input into the case. There is a recognition

interdisciplinary care is important, and Medicare currently doesn't allow that to be accessed, and so they are addressing that. It is step in the right direction.

CHAIR - Anne Burke, who is the [past] president, made the point that Medicare item number reforms may ease the situation longer term. You just said there has been some change, but you believe there needs to be more change in that Medicare scheduling. I know it is a federal government matter, but I am interested in what needs to change there.

Ms SMITH - It's a start. It's likely that the patient is still going to have an out-of-pocket cost. What I am not sure of is how many sessions are allowed to be funded. But it is a step in recognising the importance of interdisciplinary care.

CHAIR - So it is like an interdisciplinary plan of care, a bit like a mental health plan?

Ms SMITH - I think a bit like the ones with complex health conditions. There is a care plan that recognises that, but this is more about actually collaborating and having time to be able to speak to the GPs. It is a really important step. No doubt it will be a step in the right direction, and hopefully it will be enough that a patient does not incur yet another cost.

Dr SEIDEL - You also talked about optimum management. Often, costs are a barrier to optimum management, and I would imagine in particular in regional areas, where even if there was a pain educator available, or an OT or a psychologist who is trained in pain revolution modules, there would also be out-of-pocket costs. Even if a GP or [inaudible] nurse would recommend it, a patient might decide, well, I cannot actually afford it, because I am in pain. I don't have any income because I am in pain and cannot work. So, rather than go to the physiotherapist, and optimal care, can I get a script to go to the chemist?

Is that an issue you experience or have heard of in Tasmania?

Ms SMITH - I can speak from the perspective of the north-west, and being involved in the delivery of OPAL pain management programs. What we have seen over the last eight years - because we collect the same e-POP data - is that about 50 per cent of the patients are referred to the pain program on OPAL, predominantly from GPs. Eight years ago, they were on enormous amounts of opioid medications. You would see really high-dose prescribing; 50 per cent of our patients would be on more than 100 milligrams of opioids daily. Now, eight years down the track and with the reforms, federally and also rolled out within the state, we've seen that the prescribing has really reduced, which is so pleasing to see. It is all coming in line, the training and support for the GPs on what is appropriate when we are talking about persistent pain. That's been a really pleasing move.

The difficulty is, though, that they're still left with very biomedical interventions, unless they end up at either Hobart, where it will be recommended that they come back up and do a group program here. We only see a very small number of people. We assess about 100 people locally a year. The latent referral base is likely to be about 300.

We see a lot of GPs with their hands tied, if they know there's a service we see a bit of a scatter gun approach happening. They will refer to Hobart. If they know there's the federally funded program they'll refer to that or they'll refer to the physio. There's no integration so it tends to be the same GPs who know about a service who refer, or the ones who are interested in persistent pain. Otherwise, we see a lot of biomedical interventions.

Looking at the workers compensation system, we see far more medication, biomedical interventions. That's endorsed by the workers compensation system because they don't endorse the biopsychosocial model of care.

CHAIR - That's a shame, isn't it?

Mr GAFFNEY - I wasn't aware of the Australian Pain Society until the work on the VAD bill and getting that in there. It's not something that's an everyday discussion. You use the words chronic, persistent, sub-acute. I don't have a health background. If I stub my toe, there's pain, if I have gout and that comes on in my toe every now and again, that is a persistent pain until it goes away through medication. Would that be considered a chronic pain, if you have gout but the pain's not there all the time? I am not sure of the levels.

Ms SMITH - Thank you for asking the question. I work with pain all the time, so I think that's a really good question to ask. You're right. Acute pain is the pain we accept as being quite normal. It tends to be related to tissue damage, break your arm, stub your toe and off you go. We also have things like sub-acute pain. Someone might be recovering from knee replacement or hip surgery and it might take a little bit longer, so we call that sub-acute. It's understandable but there's a prolonged recovery.

Chronic or persistent pain, there are a couple of things in between those. Persistent pain - I tend to use chronic because everybody uses chronic, even though we are supposed to use the word 'persistent' now - means pain that persists for longer than approximately three months. It really means pain that persists long after the tissue damage has healed. It's more about protection and less about damage.

Then we have complex things, where there are disease processes: MS, gout, rheumatoid arthritis. These are still considered chronic pain conditions because they have a really profound impact on distress and disability. That is why the national pain strategy really endorses what is called the biopsychosocial model. It's not just about the medicine to deal with the gout. What happens if your pain still bothers you and starts interfering with work, it can affect our mental health, so we have to deal with the psychological, then we might have environmental problems with your workplace really not being happy about this. There are those other contributors as well.

CHAIR - Apparently your diet fits into that with gout, for example.

Ms SMITH - Yes, exactly. We have to look at the whole person. Even in acute pain it's very important. The WISE study, which is a workplace study the workers compensation system in New South Wales looked at. It is about early intervention and identifying people who are at risk of developing chronic pain. Give them the right services early and prevent lots of very expensive, costly health-related treatments down the track.

Mr GAFFNEY - The question that could be asked, because Dinah's submission focuses a lot on workers compensation. Regarding pain in general, what would be the three things that your organisation think would be beneficial for the inquiry?

Ms SMITH - I will keep it to three. I guess the first thing is really looking at capacity. As you said, that has already been addressed in multiple papers on capacity and what is optimal care.

Then, tapping further down on that, we have not just access to appropriately trained allied health professionals and medical professionals, but training and support of those on the ground - especially in rural and regional areas - as to what appropriate pain management looks like. Also, community education, so education would be my number two, looking at health professionals, medical professionals and the consumer.

Perhaps the third thing would be - given the uniqueness of Tasmania, these answers are probably not going to be replicating what we have in a large city. We can see why these things fall over, because they are really expensive when you try to replicate them.

Tasmania is quite unique in that the people who are involved in working with persistent pain are a pretty passionate bunch. No doubt they are a passionate bunch in all sorts of areas, but it's a very small multidisciplinary team of health professionals. I think the answer is flexible funding, from no doubt flexible models, but how to appropriately integrate what is already there.

We know there's no magic bucket of funds, but I'm trying to think from a more flexible perspective. I have a unique experience in that we are federally funded private practitioners, but we integrate ourselves happily into the public system. While we're not funded to do education, when I'm talking about the OPAL pain program you can see that thinking flexibly - but perhaps having a rural health policy that allows for this integration of different buckets of funds, and a seamlessness there already exists, because that would have to be our biggest frustration. There are things there, but it's not integrated, and therefore it is fragmented, and that means patient care is fragmented.

I think that might have been more than three points.

Mr GAFFNEY - Thank you. That was good.

CHAIR - You were expanding on the third.

Mr GAFFNEY - And Bastian might help you out. Bastian, do you have anything to add?

Dr SEIDEL - I was about to, but I withdraw.

Mr GAFFNEY - We have another comment/question.

CHAIR - I want to raise something that was raised in the media. I was contacted about it, because I've been advocating for chronic pain services in the north of the state forever, and all to no avail. The new co-location of the Launceston General Hospital with - is it St Lukes?

Mr GAFFNEY - Calvary.

CHAIR - Calvary, sorry, is an opportunity - at least in Launceston. There are still challenges for people on the west coast; it is not quite as far for people in the north-east. In

terms of the pain management challenges, particularly having to get in a car to travel - and as you said, back pain is a major factor in that - do you have any insight into what noise we should or could make, and how else could it be raised? It doesn't seem to be being considered publicly at the moment. This really should be one of the services integrated into this new facility.

Ms SMITH - Noise? Just expand for me.

CHAIR - If you were sitting across the table from the minister, what would you be saying to him about this? To say that, 'here's an opportunity to actually implement a more integrated service model for chronic pain' that actually meets the needs of his constituents, I might add.

Ms SMITH - Exactly that. I think the tricky part is replicating something that might work in a regional area doesn't necessarily work in a rural area, so being able to explore the reality of interdisciplinary care. If that means flexibility in terms of joint public/private, if you're talking about that as a method of being able to provide interdisciplinary care because it means it's accessible, then it speaks for itself.

CHAIR - You talked previously about the Medicare item numbers, that there have been new item numbers made -

Ms SMITH - Yes, new Medicare item numbers.

CHAIR - Obviously, the state doesn't control that but the state does make decisions as contracted through the Tasmanian Health Service service plan. Is that somewhere where we should see this? And whether it is some sort of collaboration with the private sector or whether it should be entirely public, do you have a view on that?

We talk about interdisciplinary care, which is really important in this space, but there's always a few concerns about public/private sort of models in these because sometimes it ends up being those who can afford it, can get it -

Ms SMITH - Yes.

CHAIR - And those that can't, don't - don't now and won't then. How do we overcome that?

Ms SMITH - I think one of the trickiest things is actually - the good thing about persistent pain services, is it doesn't need to be attached to a hospital. So, taking things outside of a hospital setting, hopefully, at least reduces some of the costs.

Flattening the structure so that you don't just replicate something in the north west that you can in the north, so that you're sharing and integrating - they've already been trying for so many years to replicate something in Hobart that can't stand up by itself. The reality is that trying to replicate something that has struggled to keep accreditation and now has lost accreditation in a regional setting, where we have good access, the best that we have, then it's like, 'Really?'. We have to think differently.

I think the federal funding often offers potential and I do wonder - I'm no strategist by any means, but is this perhaps where rural health policy comes in that somehow provides the scaffolding for public/private integrated funding? You're talking about LGH/Calvary. That if

there is perhaps rural health policy around this that helps to navigate whatever are the issues that often crop up and no doubt are well documented by others, in terms of bridging this problem, that sometimes happens with public/private integration? I don't know.

CHAIR - Let's talk for a moment about what such a service would look like in Burnie. We have, one could argue, an ideal opportunity with the North West Maternity Services Review that, in my view, is doing recommendations that are all in the right direction. The minister and secretary have said quite clearly that they don't want the private hospital to fall over and we don't either because we rely on it for a whole range of things. But there's maybe an opportunity there in terms of working together for a system that doesn't need to be an acute service in terms of access to acute beds but it could be a model that could be collaborated there. Talk me through how that might look.

Ms SMITH - The hub-and-spoke model that you were mentioning before, where you've got a central hub and, obviously, if capacity is built for Hobart or it's somehow supported - your one and only tertiary pain service - then you are able to support flatter structures that are flexibly funded and integrated. The key here is that they are integrated, that there is a central place that your referrers know how to refer a patient, so we don't get the scattergun approach, because that scattergun approach leads to PHN doing something over here, someone else funding something else over there. In that way, you're keeping things integrated and you're also keeping your specialist team here.

In reality, by the time they're referred to a persistent pain service, they have been assessed by their GP or multiple GPs, probably a specialist, they've probably had physical therapy of some sort, probably not psychology, so the likelihood of red flags is fairly limited. The likelihood that you're going to pick up something that the neurosurgical team needs to deal with is pretty slim. They've already been through what would be coined 'reasonable medical care'.

That then means that what is on the ground from a rural perspective is much flatter and cheaper from an allied health perspective. It can be supported by a GP with a special interest in persistent pain - if you need that - who can then, when you have your centre of excellence in Hobart or Launceston, or wherever that may be, it's much easier. The same for Launceston. Again, you've got somewhere where, in reality, the likelihood of picking up someone who really needed urgent assessment or intervention is pretty slim because they've already had that reasonable medical care.

CHAIR - From your experience working in the north west, particularly in this area, do you believe there would be enough work for a specialist team in the north west? That is part of the trouble of attracting staff. They're not working across their full scope, they're not seeing enough patients to make their practice worthwhile, if that's what their predominant focus is.

Ms SMITH - What I do know is that north west and the north, the pain medicine specialists who fly into the state are all from Melbourne. They predominantly deal with compensable patients and private patients. The interventions are dominated by medicine and interventional medicine, things like spinal cord stimulators, injections and so on and so forth. It's not really for the public. It's more along the lines of interventional sorts of medicine.

The reality, to attract pain medicine specialists locally to the north west region, highly unlikely. My understanding is that there used to be a position that was funded at the North West Regional that can't attract someone up here. You can accept that and you can use the

model they use in Victoria. I think it's in Shepparton, the Royal Melbourne support them and they have either a persistent pain-trained nurse, along with their allied health professionals or, similarly, you could use a GP. There's flexibility.

It doesn't have to be a pain medicine - of course, in an ideal world - but we're talking about fairly unique characteristics and it can look a little different. If they're struggling in Hobart, the reality is it's unlikely. Perhaps in Launceston, there might be more capacity.

CHAIR - You could still have Hobart or Launceston as the specialist centre and have the interdisciplinary care team based regionally.

Ms SMITH - Yes. It can look different. I think it is that, really, being a bit more flexible in thinking and flattening that structure, and cost-effective.

CHAIR - Thanks, Bernadette, you've done a fabulous job. It has been very helpful.

Ms SMITH - Thank you very much for your time.

The witness withdrew.

Mr DENNIS SMITH, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Thank you for coming and for your submission and presenting to the committee. This is a public hearing. Everything you say will be covered by parliamentary privilege, although that does not necessarily extend when you leave the room. It is public evidence so it will be transcribed by Hansard and will be published on our website and form part of the committees' deliberations.

If there's anything you wanted to discuss with the committee that you felt was confidential or of a more sensitive nature you could make that request to the committee and the committee would consider that, otherwise it is public evidence.

Mr SMITH - There is nothing sensitive in my statements.

CHAIR - You got the information about appearing before the committee? Do you have any questions before we start?

Mr SMITH - No.

CHAIR - I will ask you to introduce yourself. It is a brief submission so I would invite you to speak more about your personal experience and perhaps one of the reasons why you moved from Strahan to Devonport.

Mr SMITH - Before I begin, there is one comment I would like to make about what I heard the last person talking about.

Concerning the doctor's initial diagnosis for a patient and then passing information on to further doctors or specialists. One of the problems, in Strahan in particular, is that there is no permanent doctor. There are only locums and they are generally only on for four days per week. It seems to be on a rolling locum situation. So it is not possible to get other than computer records of a patient's history. That, to my way of thinking, causes a big problem from the patient's point of view.

CHAIR - By having to retell your story?

Mr SMITH - Constantly, and getting asked the same questions over and over again and not seeing any better result from having seen two, three sometimes four different doctors so that I think is one of the things that should, if it's possible, be addressed.

CHAIR - In terms of that point itself, Dennis, I know Strahan has struggled at times to get permanent doctors there. Because of the seasonable nature of the population, pre-COVID-19 particularly, the population would triple or quadruple during the summer period. In the winter it's a lot less, so the workload for a GP who is permanently located there would be less. Having no GP is probably worse than having locums but do you see a solution to that in terms of having more continuity of care from GPs in that area?

Mr SMITH - The other position that seems to be missing now in Strahan - although of late it has been partially, if not fully addressed - is the absence of a full-time nurse. A nurse

used to be available full-time and she generally used to handle a lot of the simpler problems that occurred on a day-by-day basis.

I am not quite sure at this point whether a nurse is now present full-time but I know that on occasions in the recent past, for myself, I have had to either travel to Queenstown which you may or may not know is a bit of a drive -

CHAIR - Ninety-nine bends.

Mr SMITH - Yes, or to Zeehan or Rosebery. Sometimes, that's very difficult to do, particularly if you're not well.

Ms LOVELL - Dennis, did the nurse work with the GPs in the past?

Mr SMITH - Generally speaking, I think yes, but also acted independently when the need was a simple patient problem, that is, did not require the full expertise of a doctor.

Dr SEIDEL - Is there now a community nurse present or is there no community nurse there at Strahan?

Mr SMITH - I don't know about full-time currently but in the fairly recent past there was no full-time nurse there at all.

Dr SEIDEL - So, the only health practitioner in Strahan would be a locum GP, that's four days a week if you're lucky, and it's only one person and that's it?

Mr SMITH - Yes, exactly.

Dr SEIDEL - And a receptionist?

Mr SMITH - And a receptionist, yes.

CHAIR - And they often work across other parts of the west coast too, covering Zeehan -

Mr SMITH - Zeehan and Rosebery. Queenstown has, the time I was there, I think there were three doctors on duty, but that was only on one day. I don't know what their normal hours are there.

CHAIR - Queenstown is operated by Ochre Health.

Mr SMITH - And so is Strahan.

CHAIR - That's right. Dennis Pashen is the GP there who is getting closer to retirement.

Dr SEIDEL - He isn't.

CHAIR - He isn't?

Dr SEIDEL - He has been close to retirement for the last 20 years or so. I can put this on the record.

CHAIR - One day it is going to happen. But he is supported by locums, mostly, on short-term contracts.

Mr SMITH - Okay, if I can move on to my own medical experiences, some good, some bad.

It started about three years ago. On the 5 August 2018 I suffered a stroke. I was in Strahan at the time. I was attended to by the local paramedics. They thought it wise, obviously, to take me to Burnie, a 2.5-hour drive, not exactly the most pleasant experience when your head is spinning

CHAIR - They took you by road?

Mr SMITH - Yes, that was by road. I was diagnosed with a partial blockage of my carotid artery and - this is a key point from my point of view - placed into a mixed shared ward in the North West Regional Hospital in Burnie. There were three men, including myself, and one woman. I have heard a number of doctors say that this practice should not be allowed to continue. I don't think it's nice for the woman, in particular, but that's up to women and other men to voice their opinions. It's my opinion it should not be allowed. I was placed in that ward pending transfer to a specialist hospital in Hobart. That transfer, I was told later, could not go ahead because of timing issues primarily with the hospital in Hobart, so I was sent home to Strahan.

Dr SEIDEL - They asked you to have specialist care in Hobart and because they couldn't do it, they sent you back home rather than keeping you in Burnie?

Mr SMITH - They couldn't do it in Burnie. I had St Luke's Private Health at this point. They wouldn't move me into a private ward prior to sending me down to Hobart. They said to me that the private system in Burnie does not have the appropriate monitoring equipment.

CHAIR - That's true.

Mr SMITH - As it was, the piece of monitoring equipment, which was really only a heart monitor -

Dr SEIDEL - [Inaudible 11.36.53]

Mr SMITH - was broken anyway.

CHAIR - At the public?

Mr SMITH - At the public. I actually fixed it myself, being an electronics engineer in the past. I did get it working. I probably shouldn't have done, but anyway.

The hospital transfer did not occur, they said because of timing issues with Hobart, so I was sent home. Approximately two weeks later I did get an appointment to see a specialist in Hobart and travelled down there with my own transport, although my wife had to drive me. I couldn't drive at that time, having just had the stroke.

I was admitted the following day to Hobart Private where I had surgery on my neck to clear the blockage. I subsequently spent close to three weeks in Calvary St John's for rehab.

CHAIR - Can I go back to when you were in the Burnie hospital when they couldn't transfer you to Hobart. Were they going to transfer you to the Royal or to the private hospital?

Mr SMITH - They wanted to put me into the private section in Burnie initially but because the private section wasn't available -

CHAIR - Monitoring wasn't available, yes.

Mr SMITH - then they were going to transfer me directly down to Hobart Private Hospital.

CHAIR - That's where you ended up?

Mr SMITH - That's where I ended up but they were going to transfer me directly via ambulance.

CHAIR - What was the reason they didn't, sorry? I don't quite understand that.

Mr SMITH - Because it was a matter of getting onto a specialist and he wasn't available. This was on Friday.

CHAIR - To receive you.

Mr SMITH - He wasn't available to receive me and, rather than have me stay and basically wait in Hobart Private, they just sent me home.

CHAIR - The alternative would have been to keep you in Burnie monitored and then send you to Hobart when the specialist was able to receive you.

Mr SMITH - That would have been an alternative, yes. That didn't occur.

That's it for that particular episode. The next one is on 10 September last year. I was diagnosed with an inguinal hernia, placed on a level 2 surgery list which, I am sure you are aware, is meant to be done within three months. Just prior to the three-month point, still no surgery booked.

I telephoned the hospital to inquire as to when I could expect surgery and I was told by a woman who was quite rude, quote, 'There are other people ahead of you, you know.' That, I thought, was unreasonable at the time. I couldn't get any further answer out of her. I was telephoned a total of nine months after my initial diagnosis. That surgery was booked for 25 May, and I went about a week prior to that for a pre-admittance interview. I was seen by three healthcare professionals, who all asked me nothing more than the same bunch of questions three times - not very efficient, from my point of view.

On the day the surgery was supposed to have occurred, I was living in Devonport. I was travelling from Devonport to Burnie and got a phone call to say, sorry, no beds available, your surgery has been cancelled. Obviously, I turned around and went home. Surgery was

rescheduled for 16 June. It was scheduled as a 7 a.m. admittance. I didn't want to drive from Devonport to Burnie to get there by 7 a.m., so I arranged accommodation in Burnie to stay overnight.

I got down to admission, went through the actual interview for admission - and then, shortly after completing the interview, I was told, no beds, go home, for the second time. I got about halfway home and received a phone call to say that if I am prepared to forgo an overnight stay in the hospital, surgery could go ahead.

CHAIR - Have your surgery and go home the same day?

Mr SMITH - Yes. They did ask if I had someone who could look after me at home, and my wife was prepared and capable of doing that. We agreed to go ahead with the surgery. The alternative would have been, when do I get in, and is the same result going to occur - no beds?

CHAIR - On that point, did you still have private health cover at that time?

Mr SMITH - At this time, no. This was purely public. I dropped it. I have since taken it back up again with my experience from the hernia.

Dr SEIDEL - You lived in Devonport at the time. Were you ever offered surgery at the Mersey Hospital?

Mr SMITH - No. I did see the specialist initially at Mersey, but the surgery was scheduled for Burnie.

Dr SEIDEL - So, it was never an option, noting that even now, looking at the Department of Health website, there's a department of surgery, functional operating theatres, a 25-bed surgical unit, and they specifically say they do hernia repairs there as well.

Mr SMITH - Whether they did that at the time, I don't know. As I say, the surgeon I saw initially was in Mersey, but the surgery was in Burnie.

Dr SEIDEL - It was never considered to be done there, or never offered?

Mr SMITH - Never offered.

Dr SEIDEL - The surgeon was there for an outpatient appointment, for the assessment.

Mr SMITH - Whether Dr Hoffman, who was the surgeon I saw at Mersey and who subsequently did the operation, works out of Mersey for surgery, I don't know.

Ms LOVELL - That was earlier this year, is that right?

Mr SMITH - Yes.

Dr SEIDEL - You paid for the accommodation yourself?

Mr SMITH - Yes. I was offered no compensation but, as it happened, the surgery did go ahead that day anyway, although I had to go home the same day.

CHAIR - You could have eaten breakfast, and you would've been ineligible to have it, so there you go.

Mr SMITH - The surgery did go ahead and it's been successful. For that I am grateful.

The next incident is not my own, it is that of my wife. Obviously I had to endure her pain, shall we say, as she went through the problem. This occurred on 2 July of this year. My wife collapsed one morning, just fell.

CHAIR - In Devonport?

Mr SMITH - In Devonport, fortunately. The paramedics didn't know what the problem was but all of her symptoms seemed to be that she'd had a stroke. She was taken to Burnie, placed into the Acute Medical Unit (AMU) and she was there for about a week. Tests were all run, all inconclusive. Following a week in the AMU she was moved to, once again, a mixed shared ward. She said that the conditions were absolutely disgusting. There was a smell of urine in the ward; she was woken at approximately 2 a.m. for blood to be taken by a doctor. She was asleep at the time and didn't know what was going on. She asked why blood was being taken at such an odd hour. A nurse came running over saying: 'No doctor, it's bed 57, not bed 55'. The doctor got the wrong patient. The doctor left without further comment or explanation to my wife.

The following morning, Marilyn checked herself out of the hospital, she was that upset and disgusted with the treatment that she got there. She was in a hell of a state by the time I picked her up. She was ushered out of the ward only able to walk with a walking aid. She said that they were rude, unhelpful and all they wanted to do was sign the release and get her out of the ward. No help was given to her whatsoever. They didn't even ask her why she was so upset.

We were back on the private system so we got her to see a specialist in Hobart, Mr Hunn, who is a spinal specialist. At this time she couldn't walk without the aid of a walker. A stroke had been ruled out as it did not show up on any scans. No tests that were performed indicated a stroke. They thought that it was spinal so we went to see the spinal specialist, Mr Andrew Hunn. He had her admitted to Calvary hospital.

Once again, numerous tests were run; they couldn't find anything so she was moved across to Calvary St John for physio. She can at least now walk but there is no explanation as to what the cause of this was. That's basically it.

CHAIR - What do you think could have been done to improve both your experiences? Having been a former health professional I know that communication is the key. That's one thing, but what do you think needs to change in order for people like you and your wife to have a much more favourable experience with the health system?

Mr SMITH - My perception is that doctors and healthcare professionals in general treat the symptom of a problem, not the cause. If you have a headache, take an aspirin. What is causing the headache? Could be anything. Prior to this stroke, I suffered migraines for many years and was only given painkillers. It turned out the migraine was caused by a blocked carotid artery. Of course, that wasn't picked up until I had the stroke.

CHAIR - Living in an isolated community, which Strahan is, and having access to just a rolling number of GPs, and perhaps a practice nurse at times, or a nurse supporting the GPs, what service do think would better serve the community? They may not have picked up the blocked carotid artery without that more extensive testing, which you are not going to get in Strahan.

Mr SMITH - Simple. Ultrasound picked it up.

CHAIR - Are they doing ultrasounds in Queenstown?

Mr SMITH - At Burnie.

CHAIR - I am just trying to understand, in terms of picking up conditions earlier. Obviously, what we don't want is for people to end up in hospital, ideally, because it is very costly and not a pleasant experience for some, as you have articulated very thoroughly. So, it is about trying to keep people well, and out of hospitals.

From your perspective, what do you think could have helped you in keeping out of hospital? You cannot do much about your hernia. I accept that those things happen, particularly with men who have done a lot of physical work.

Mr SMITH - I think more diagnostic capabilities. Doctors train better on diagnosing the cause of a problem, not just trying to treat the symptoms of the problem.

From the west coast point of view, I think if the hospital in Queenstown was better equipped, that could possibly be a big help.

CHAIR - You also need staff trained to use any equipment that the hospital has, and functioning equipment that does not need a patient to correct.

Mr SMITH - Yes, that would help. The other thing I see, as far as hospitals are concerned, is mixed wards. From my point of view, that is a big problem. There does not seem to be anyone in the hospital in each ward perhaps, or group of wards, that is actually responsible for the ongoing care and accountability of the staff. There used to be the matron.

CHAIR - There still is. They are called the director of nursing now.

Mr SMITH - The CNC?

CHAIR - No. That is another level down.

Mr SMITH - Well I've seen no evidence of anyone who performs the function of a matron, not even in private. Okay, maybe I am not supposed to see her, as a patient.

CHAIR - Back to the old days.

Mr SMITH - At least there was someone wielding a stick. If some of the nurses weren't performing properly, she was there to pick that up. It does not appear to be anything like that. Just in the difference Marilyn saw between the staff in the AMU and the normal ward, there is

a tremendously wide gap in the quality of care, and just the attitude of the nurses. In the AMU they were fabulous.

CHAIR - So, what made them fabulous? I am just trying to understand what it is that was different.

Mr SMITH - Their attitude, their willingness to help seemed to be totally lacking in the ward, whereas in the AMU, even while I was there as a visitor, they would come around and ask if there was anything you would like. Can I get you a cup of tea or coffee? That did not happen once while Marilyn was in the ward.

CHAIR - So, could that be a staffing issue, do you think, the number of staff?

Mr SMITH - Not the number of staff, but the quality of staff. I'll give you another example of when Marilyn was in the ward. She was admitted into this ward around midday. Dinner was served around 5 o'clock; I am not sure of the exact time. There was no hello, how are you, here's your dinner, like there was in AMU. Marilyn thought it was a nurse who actually placed the tray on her mobile table and left, no word at all. Marilyn looked at the meal and thought, this is not something that I would order, and called the nurse.

At this point, she couldn't tell exactly what she'd been given, so she prodded it with her fork. She didn't taste it, but did at least prod this piece of what turned out to be meat with her fork, and left her fork resting on this piece of meat. She called the nurse, who came around, and Marilyn explained it doesn't appear to be her meal. The nurse checked the order sheet against what was there, and said this isn't yours. She took the meal, as is, across to another bed, and just put it in front of the patient there.

If it was Marilyn, she wouldn't have touched the meal that had come from someone else, not knowing whether it had been touched or not. To my way of thinking, the nurse should not have done that. It should have been a replacement meal once it had been in the hands of one patient.

Dr SEIDEL - You mentioned that one of the reasons you left Strahan was the medical care you couldn't access there.

Mr SMITH - Yes.

Dr SEIDEL - How difficult was it to make a decision to leave your home, where you have lived for a few years I would imagine, finding a new place, which was Devonport? You probably would have stayed in Strahan if you had felt the care would have been of a decent standard - probably not world's best high-tech stuff, but continuity of care, same doctor and nurse, something very basic.

Mr SMITH - You've obviously never had a stroke.

Dr SEIDEL - No.

Mr SMITH - It's a scary thing. For me, it was a relatively mild one that has left me with a slight slur to my speech, and a little difficulty walking, but that's it. I was very fortunate. Even so, the effect it can have on you is quite significant. Basically, it scared the hell out of

me. There used to be the air ambulance, which we'd hear all the time in Strahan. Over the last couple of years, I think, it's rarely heard, so I don't think the air ambulance is operating on a regular basis unless it's for extreme cases. I would have felt safer if I'd have been taken to the hospital quickly. It was a two or two-and-a-half hour drive - during which, I might add, the ambulance hit a kangaroo on the way.

Dr SEIDEL - Realistically, when it's a stroke or heart attack, time is the most important thing, isn't it? The sooner you access specialist care, hospital care, the better it is. There is almost the expectation that we are not going to go on a two-and-a-half hour road trip, but get the chopper out and be retrieved.

Following up on this, your wife in Devonport had a suspected stroke, and is not taken to the Mersey hospital but to Burnie - which again delays the contact with an emergency environment.

Mr SMITH - Ten minutes, as opposed to half an hour or 35 minutes to Burnie, yes.

Dr SEIDEL - At the time, were you disappointed? You had moved to Devonport to be close to a hospital, and you need care that is time-critical and that's not available in the Mersey so they sent you somewhere else.

Mr SMITH - The difference between half-an-hour's drive and two-and-a-half hours just makes the difference of 10 minutes in half an hour seem insignificant at the time.

CHAIR - Can they do a thrombolysis at the Mersey?

Dr SEIDEL - No, they can't.

CHAIR - They can do it Burnie?

Dr SEIDEL - I don't know.

CHAIR - They can, with support from Victoria.

Dr SEIDEL - Yes.

CHAIR - Yes. That would have been why they took her to Burnie, I would imagine, in case she needed thrombolysis.

Mr SMITH - The paramedics, both for myself and for Marilyn, were brilliant. There's no way I could fault them. The care in the hospital was a different matter.

CHAIR - I'm sorry to hear you've had those experiences. No one deserves those sorts of experiences or expects them. You hear very good stories coming out of hospitals and you hear some really sad ones that should definitively have been handled better. Thank you for sharing your personal experience, as difficult as it must have been for you to relive it all. It wouldn't have been pleasant, so thank you for doing that. It does help to understand the personal perspective and where those problems are and what solutions there may be.

Mr SMITH - Thank you for the opportunity.

CHAIR - Is there anything else you wanted to add before we finish?

Mr SMITH - We know that nursing staff are overworked and under-resourced. The cost of private health cover is way too high. There are emails going around currently concerning the way specialised equipment is costed and used to increase the cost of private health insurance. Private health insurance doesn't cover all the costs.

CHAIR - No.

Mr SMITH - It can be a very expensive exercise.

Ms LOVELL - Dennis, can I ask a question? You don't have to answer this if you don't want to. How much are you paying in premiums for yourself and your wife for private health cover?

Mr SMITH - For both of us, $310 a month.

Ms LOVELL - What impact is that having for you?

Mr SMITH - If I'd had private health when I had the hernia, I think I would have been done immediately. Because we had only just got back into private health, there was a waiting period and we had a fight with St Luke's because they felt that with Marilyn it was a pre-existing condition.

We had gone over the two-month waiting period but were still into the pre-existing waiting period. We had a hell of a fight with St Luke's, which was later resolved in our favour. Private health insurance is not, shall we say, for the faint-hearted.

CHAIR - It is also not affordable for everybody.

Ms LOVELL - No, that's right.

Mr SMITH - No, it's not.

CHAIR - And you have to make sacrifices - what you were alluding to.

Ms LOVELL - I'm assuming that you'd had public health and cancelled it and now you've taken it back up?

Mr SMITH - We took up private health insurance in 2000, after getting back from an extended stay in Europe. We were paying a hell of a loading at that point. We were at the stage where we were just free of that loading, so the price did come down but not tremendously. When we had the experience with my hernia and made the decision to go back on to private health again, it's still expensive.

Ms LOVELL - It's not a choice you should have to make.

Mr SMITH - No. A comment by the previous person here was that merging private and public medical systems would be a good idea. I think that as well, if it can be arranged.

Obviously, the people running the private hospitals are not doing it out of the good of their heart. They must be making money out of it. If that is the case, why can that money not go into the public system?

CHAIR - I think the shareholders probably have a view on that.

Mr SMITH - For the people putting the money up, yes, but if they can run a private hospital as a profitable business, why can't the Government run a public hospital, not as a profitable business obviously, but at least one that covers its own costs and not have the money come out of the taxpayers' funds?

CHAIR - If you don't have universal access it means you turn up and get treated for nothing. That requires government funding, which is what we have in Australia. A full universal access system.

Mr SMITH - But if everyone paid out of their wages into a health fund, it could be cheaper than what private health is currently. I think it could be available for every taxpayer.

Ms LOVELL - That's getting into tax reform territory. I don't disagree with you but it's another whole conversation.

Mr SMITH - The money wouldn't then come from the taxpayer, it would come out of the separate health funding. I believe it is the way it happens in England currently.

Ms LOVELL - Thank you, Dennis.

CHAIR - Thank you very much.

THE WITNESS WITHDREW.

Ms JUDI WALKER, CENTRAL CONNECT, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Thank you for appearing before the committee, and we appreciate your submission. This is a public hearing. The evidence you give will be transcribed by a Hansard recorder and will form part of our public record on the website and inform the deliberations of the committee. Everything you say in front of the committee is covered by parliamentary privilege. That may not extend once you leave the hearing. If you did want to discuss anything of a confidential nature, you could make that request and the committee would consider it. You are welcome to make comment on your submission or provide an opening statement, then we will go to questions.

Ms WALKER - I am here today in my capacity as Central Connect's program lead of the Chronic Health Action Group. I am also the governance consultant to Central Connect. Central Connect is a sustainable community governance model. It has a community leadership round table providing inclusive representation of central coast consumer groups, service providers and advocates across the board. The role of the leadership round table is to develop and oversee strategic direction to create those health and wellbeing outcomes the community desires. This is an initiative which arose directly out of the Tasmanian Anticipatory Care Project, which I was privileged to lead, and also the Collective ed. Project, which you may be familiar with. I won't go into why all of that was done but I was lucky enough to be asked to develop the governance model and to implement it. We're just coming to the end of the yearly cycle of doing that now. Hopefully, things will go from strength to strength after that.

The round table has action groups for doing things; the chronic health one put this submission together. You will see that it's more solutions-focused than outcomes-focused. I guess the key message I want to get across is the importance to the inquiry for government and any other interested bodies to consult directly with rural and regional communities about health outcomes, and access to community health and hospital services. This is very much taking a local approach. We have based it on the LGA for fairly obvious reasons. We feel that around Tasmania now - for example, Bastian, in Huonville - the way in which community organisations have formed to actually represent the voice of people in their communities for better health and wellbeing outcomes, that's really what it's all about. That's around stating the obvious that each local community has very different needs and perspectives, and we really feel that grassroots action to drive change locally within rural and regional communities must be matched by changes in health services. The way health services are arranged at the moment doesn't exactly provide an avenue for local communities' voices to be heard. That's the gist of the message.

From a systems perspective, if we're really serious about thinking and doing rural health and social care in the right place at the right time, then we need to think about it in the way that is what's not needed, to get rid of stuff, as well as putting new systems in place. You just can't pile stuff on top.

You have seen the submission. We tried to give a little bit of the health and wellbeing profile and I did want to draw to your attention the fact that we've done a lot more work on that since we've put the submission in because it was quite a long time ago, in March.

We believe very strongly that the voice must be matched by evidence and you know how difficult it is to get evidence at the local level. To really drill down and get good statistical data

at the local level is really hard. We've actually created a data repository so that we feel confident we can provide evidence to support what the community is saying, which is really important.

Another thing I need to draw your attention to - the big piece of work this year - has been to develop a community wellbeing framework based on evidence and community advice. We've been running a community advice survey which, predictably, while it's had a good response, hasn't really reached those people who we feel we'd really like to hear from. So, we have supplemented the community voice survey, which is an online survey. We have been going to groups and doing it face to face, but we have also been running focus groups through Neighbourhood House, the No. 34 Aboriginal Health Service, the Salvation Army, Bridge Program and things like that, to really try to hear the voices of people who should be heard.

The framework is a draft at the moment. It is out for consultation. I am not going to table this, because there will be a beautiful graphically designed version in November, but this is my working copy of it. It is a framework on a page. It is really a high-level strategy type document, to be of use to council, and to those groups and organisations who sit around the table and others - it could be the school, Simplot, Patrick Street Clinic. When they are developing their strategic plans or annual work plans, they can actually dip into this and be assured that this is what the community is saying at the moment about health - but not only health, thinking of the social determinants of health more widely, particularly education, and that really tricky one to define, which is connection.

The things that are in the submission are not really telling us anything vastly new. I think that is a good thing, because it is actually reinforcing what people are telling us.

For example, I am sure you can come up with what people are saying about health in regional and rural communities. It's local access to doctors, to specialists, to mental health and health promotion. I am so pleased to see the terms of the inquiry have been widened to include mental health and health promotion. In our community, as in most other rural and regional communities, that is a big problem.

We have the data to support that now. The idea is that if everybody can work together - very idealistic I know - but if we have a roundtable where the key leaders meet, we are beginning to develop that connection. The central coast is absolutely amazing as a community, as are other rural communities. So much is happening. What people are telling us - and this is what is in here - is that the community actually wants to have access to that information.

We did a very quick and not terribly scientific count, for example, of the specialists who actually hire rooms in Ulverstone and deliver services - it could be from the GP clinic or the community health centre or the No. 34 Aboriginal Health Service, but people don't know about it. Those are the sorts of things regional and rural communities really have to grapple with. Transport obviously is a big issue getting to places.

We did some incredible things in the Anticipatory Care Project. I'm not sure if you are familiar with that, but there was a site in the northern suburbs of Launceston and they actually got Metro to change their bus times so that your bus could connect with another bus, because they didn't before. So, there are things that can be done if we get that information and if we can support that information.

So, has this given you a bit of an idea?

CHAIR - Yes. Just an explanation. The reason we didn't have mental health wellbeing in our initial terms of reference is because the way our committee is structured, we would have different ministers. Now the same minister has both, so we brought it together after the election.

Ms LOVELL - Thank you, Judi, for your submission. It is very sobering reading. There is some distressing stuff in there. I have some questions about the submission, but before we go into that, you've mentioned a couple of times that Central Connect provides a voice for the local community. Can you elaborate on your view about why, particularly for rural and regional communities, that is so important?

Ms WALKER - Yes, at two levels. From the grassroots community level we look to local governments and local governments provide the voice. If you go strictly by the Local Government Act, that's not what local government is there to do. We have the mayor on the community round table, which is very helpful, and a number of council officers on action groups. Council has a very important role to play but it's not the voice of the community.

It gets back to this lack of connection and confusion. Local communities need a voice because they need to be heard. That voice is not always heard because there is too much disconnect, turf wars and people all competing with each other. On the central coast we have two really active Rotary clubs, which is terrific, but when you think of how much could be achieved if they were perhaps working closer together, along with all the other multitude of service clubs that are in the community.

The reason why is because, traditionally, rural communities are not listened to. It's very hard, it's very tricky and I think it's up to the local community to take on that responsibility and provide the voice. Hence, a community-driven governance model like this.

Ms LOVELL - Looking at your submission and how the central coast connecting care program is working and what's happening with that, you mention health and wellbeing connectors in the local community. Can you talk us through what they do and how that works?

Ms WALKER - Yes. This is what we feel must happen. Sorry, I didn't declare a potential conflict of interest at the beginning which I should have done. I happen to be the chair of Health Consumers Tasmania as well. As I'm sure you're aware, the current Government, as part of its election commitments, agreed to Health Consumers Tasmania's suggestion to try out in three rural communities what we call community health and wellbeing hubs but the Government is calling them networks and that's fine. One for Huonville, one for Scottsdale and one for Ulverstone.

It's based very much on the evidence that we have gained through the Anticipatory Care Project and other projects that having a local health and wellbeing connector and trained connectors in the community is one way of helping to solve that tricky health literacy, health navigation problem. With the anticipatory care project, we used the right-place model which, as you know, started off in the Huon Valley and has now spread to a number of other local government authorities, including Central Coast.

We used that model of training frontline people in the community - the hairdresser, the newsagent, the receptionist at the GP clinic, council people - as connectors. They're people who talk to other people or other people talk to them and have questions. It's about knowing where to go to find the answers.

As part of that we developed, as other communities have done, an online community directory, deliberately very local and parochial. There are lots of statewide and national directories, but you don't get the local information. You don't get information about the walking club or cooking classes, which are the sorts of things you might need if you have type 1 or type 2 diabetes. We are really moving towards a social prescribing type of model.

What is missing is somebody to coordinate all of that and to bring it all together. That's what the community health and wellbeing networks are going to try out in those three different places. We believe that we have developed that model on the central coast - not to the extent that Huonville has, but we have done it in the central coast way to fit the community, which provides a good base on which to build.

In the literature, as I'm sure you know, there's a whole heap of different ways of doing this, but what seems to fit our community is this idea of local connectors. Being absolutely realistic, it's very difficult to have something totally community driven. It really does need the paid help to bring it all together and to coordinate it. That's really what the model is.

Ms LOVELL - Thank you. You mentioned transport earlier, and I know you've spoken of a few examples in your submission about the Patient Travel Assistance Scheme. I think we all know it's unrealistic to offer every service in every single community, but we need to support people to access those services when they need to travel. Can you talk to us about how the PTAS is working for your local community?

Ms WALKER - It's very difficult to find information. I'm speaking now as a person living with cancer, who has had to find out the hard way as to what you do and how you access things. I think I do have a bit of authenticity about that.

One of those examples was actually me accessing a neurosurgeon, which is not the easiest of things to do at any time, but during COVID-19 it was very difficult, particularly when the decision was made by the two neurosurgeons in Hobart that they weren't going to visit any other places, and that they weren't using telehealth either. I had to drive down for a 30-minute appointment and drive back again. I actually can afford to do that, but I wasn't offered that. The PTAS form is quite difficult for people; it doesn't come automatically.

Elsewhere in the submission we talked about how the behaviour, attitudes and language have to change, both at the health-worker level, but also at the consumer level. We're very good at being led. We don't really, all of us, want to take the initiative and find things out; we expect they will be there for us. Quite a bit of behaviour change needs to happen there. That's what we've been trying to do in the community health literacy program that we've been running.

It's at the health-worker level as well and, usually, at the receptionist level, the people who provide the PTAS forms. It's not that things aren't there. They are there, but trying to find out about them is really tricky if people don't offer that information and advice. That is from my experience.

CHAIR - It's also retrospective. You still have to fund it upfront yourself, and then be reimbursed.

Ms WALKER - Exactly, it's fairly clunky.

CHAIR - It's difficult for people who may not have the money upfront.

Ms WALKER - Or the literacy skills to be able to deal with that. Again, that's where the coordinator type role comes into it.

Ms LOVELL - If it's not being offered to you, you might not know to ask the question, because you might not know that it's even an option.

Ms WALKER - Exactly. That's why training frontline workers has been so important, if they know that's what we should be doing.

Ms LOVELL - Again, on transport, in the submission, on page 5, it says that:

> Transport needs must be identified at the local level. Leaving the local region for crisis care has to be integrated and supported across the journey to return to community. Local community intelligence at the LGA level should inform transport planning.

Is that something that's not happening now?

Ms WALKER - It does happen but it doesn't happen consistently. I'm sure you've heard all the stories about going to the Launceston regional hospital, particularly during COVID-19, into the Emergency Department. You get there okay but at 2 o'clock in the morning when you're discharged, you can't get home again because there's no transport. We've heard that over and over again. Again, it's lack of coordination.

CHAIR - And communication.

Ms WALKER - Yes.

Mr GAFFNEY - When did Central Connect get up and running?

Ms WALKER - It morphed from the round table we had for the Tasmanian Anticipatory Care Project. The Collective ed. program wanted to do a similar thing. We thought this is really a little bit not sensible to have two community round tables in a small community, we just can't support that. So that's why we came together because to me, education and health are the two ingredients of wellbeing, amongst others. The first meeting of the community leadership round table of what we called Central, or what they called Central Connect, was in December last year so it's just coming to the end of its first year. The backbone support which is so integral to this has disappeared. I won't go into that because it involves another organisation and I'd have to request in camera. But in a way that's probably quite a good thing because it means the people on the leadership round table actually have to take ownership of it, which is what we've been building over the year so it's not run by me as a paid person to do those sorts of things.

You do need coordination but there are ways in which you can do this. Organisations involved can provide it; there are all sorts of different things. This round table has been up and running for just a year. We are looking at business models at the moment. We have a business model action group, which is busy doing things, and we've decided on the type of incorporation we're going to go for. So, it's all ready to stand on its own two feet.

We thought we would have backbone support up until the end of this year but it hasn't worked that way. As I was saying, the benefit of hindsight is a good thing because the leadership round table has to stand on its own feet if they really want to do this in the community. If the model is the right model to enable them to do it, then it will work. If not, there are many things that have been done that have fallen apart.

Mr GAFFNEY - That's part of the past five - there was seed funding made available. Where did that come from and how does that work?

Ms WALKER - The Anticipatory Care Project funding finished this time last year but it provided an incredibly good base. I was the program lead for that. It was run through Patrick Street General Practice. I was employed there. We were all determined that we were not going to have yet another short-term funded project which didn't have some initiatives in place to keep it going in some form or another. So that's where it came from.

Collective ed. funding was supposed to finish at the end of this year. It has actually finished a little bit earlier. That has provided the backbone support to keep the round table able to meet once a month, which is a pretty big ask for busy people in the community but it has worked. We've just done a pretty thorough reflections evaluation of the round table, again so that we can learn how to keep it going. Does that make sense to you, Mike?

Mr GAFFNEY - It does. Specifically, I want to know who initiated the funding and how much funding there was. You said in your submission this is a sustainable model. At the moment, the sustainability is based on seed funding to do some stuff and you're working towards that. If, at a certain point in time, it becomes the Connect for central coast, is there an expectation that Central Coast Council, or whatever form there is, will have to provide some of the funding or are you going to go back to the Government? I want to know how that works.

Ms WALKER - This is what the business model action group is looking at and have come up with a number of scenarios. We're realistic enough to know that you do need some money for these sorts of things. Not vast amounts of money. And there's enough good will around the table to keep things going on a temporary basis if it has to. But one of the things we've found difficult, we have applied for some grants and we've been successful with a couple of them, but we've had to get council or Health Consumers Tasmania to auspice them. While that's lovely, it is awfully hard to do. That's one of the reasons why an incorporated model is an attractive one, which is what will happen.

It's really the community trying to rise above this ridiculous thing where we have short-term funded projects, there are good things there and then they just fold. And probably because there were people in Collective ed. and also in the Tasmanian Anticipatory Care Project who are so stubborn that we will make it work.

Mr GAFFNEY - During this process, is there a case to go back to whoever it might be and say, look, this is what we have put in place, this is what's happening, this is where we're

moving, it's good for our community? And, therefore, for sustainability, you need somebody driving it or, at least, there's continuity of the process, I suppose.

Ms WALKER - Yes, although the community leadership round table needs to drive it, but it's all the little bits underneath that which help to sustain it. You're absolutely right. It's the question of looking around at what's available. We've had full and frank talks with council and we do not believe it's the responsibility of council to fund something like this and that it should be as self-sustaining as possible.

There are opportunities, for example, the health and wellbeing network for the region. I would not like to make any assumptions whatsoever because I think that's irresponsible to do. But there's one group in the community now that has a proven track record which could be considered for that role. But, Mike, that's only two years' funding. You can't just keep hopping around from funding to funding. This is why we want it to be driven as much from within the community.

Wynyard, Waratah, there are similar things happening, as I'm sure you're aware. If we look closely at rural communities, there's usually that spark in them. It just needs igniting and it does require people who have passion to be able to bring all of this together. I have to admit, if you had not had, for example, me as a governor's consultant who has perhaps a few skills in that area, who believes in the whole thing, that can help put something on the right path, but you can't rely on somebody like me forever. It has to be driven from within the community. It is being recognised by governments that rural and regional communities do exist and they have a lot to offer.

We were very happy to read Our Healthcare Future because it was about our hospital care and it did have some really good ideas about community-driven health. That's the way things are going, but communities do need to take that responsibility. It's not the responsibility of local government. Local government support is really crucial, such as the mayor's support around our community leadership round table. In the mayor's monthly message she promotes, probably every third month, things that are happening, promotes the Community Voice Survey. So you are getting support from council in that way.

I lead an action group on community information and resources. The Anticipatory Care Project gifted the online community directory to council and it was merged with council's. They had a terribly out of date community directory. This was the right idea but there was nothing to back it up and do it. We designed an automated system for our online directory which automatically goes out and gets the information updated. It wasn't hard to do.

This action group has overseen the transfer of the community directory to council and will continue to provide that oversight. Council is quite happy with that. There are ways and means of doing it. I just wanted to demonstrate to you that our communities - and it's not just ours - are doing stuff that government needs to be tapping into. We know, for example, that communities like to look to places like the little community health centre in Ulverstone, which was the old hospital, and they are so poorly resourced.

I believe that's where the visiting specialist should go to so in its own right that becomes the hub that people turn to. My husband needs specialist medications and we have this lovely complicated system where Mersey actually fills the prescription and I used to trot along and pick it up and it has to be kept at a certain temperature. Then somebody told me because they

knew I needed the information that they have the right fridge at the community health centre and that the Mersey could deliver the medications there. Stuff like that. I think I'm a reasonably intelligent person and I should be able to find these things out but it's really hard.

Mr GAFFNEY - Thank you.

CHAIR - I have a couple of more specific ones, perhaps. Judi, I'm hearing you say that with deep community engagement the Government would perhaps better consider not a one-size-fits-all approach but community-driven.

That's fine as long as you can engage deeply with the community. We know that family and child centres engaging with the families who need it most is the most difficult task. Is the group able to do that? You talked about groups such as Neighbourhood House, the Salvos and the No. 34 Aboriginal Health Service.

Ms WALKER - They were all on the community leadership roundtable, yes.

CHAIR - The people who sit at the table on behalf of those organisations, not the people down here who struggle to get out of bed, struggle to get their kids to school, don't attend antenatal care regularly, and are likely to be subject to a child safety consideration and those kinds of things. How do you get these people to understand what their needs really are? Often, these are the ones we just don't get to. The services may well fit middle-class people who are relatively educated, but these are the ones who really need it. How do we do that? Because that is the challenge for every community in every area.

Ms WALKER - As you know, in Ulverstone, a Child and Family Centre is being developed at the moment. The plans have just gone through council. People were saying we're just duplicating what is going on with all of this. We said no, that is not the point - we are there to provide connection. So, I am actually talking with the principal of West Ulverstone Primary School, Angela McAuliffe, about how that development links in.

CHAIR - Where is it being built?

Ms WALKER - At West Ulverstone Primary School. At the school itself. We have the Neighbourhood House, Richmond Fellowship and the school there, so that is what we are discussing at the moment. We had a discussion this morning in Devonport at the Clinical Senate forum about how everybody says so glibly, we must have the heart to reach around the table. Life isn't like that.

CHAIR - They don't turn up to those things, no.

Ms WALKER - And why should they? We don't provide the support for not dealing with health literacy. We are beginning to make, I think, some long-term gains by working in schools and trying to improve school health issues.

Central Connect has a lovely little project going with Ulverstone Secondary College, which is all about that. I managed to get a grant from the Consumers Health Forum - the national body - to employ two young people from Ulverstone Secondary School. The idea was for them to work on the community directory and create a youth portal, so it would be something meaningful. That is happening, but the gain is that we have managed to get this as

part of the curriculum, so these year 9 students are being assessed on it. They have been to the community health literacy training that I have been doing as part of Central Connect and THS North West Health Promotions, with Michelle Towle.

So, they have been to all those training sessions, and presented at those training sessions with what they are doing. That is an example of young people getting involved, and I happen to know that one of them comes from a family that we were probably just describing then.

Those are long-term ways of doing it. I just think it is never easy - there is never a magical solution, but if we can get all these initiatives to connect together, the Child and Family youth centre mustn't work in isolation in West Ulverstone. Yes, it has a really important job to do there, but we need to make sure we're not going to duplicate what they're doing somewhere else. That is the reason for the community leadership roundtable, to provide a means for that connection.

CHAIR - Do you have a foot in the door with antenatal connections with women who are pregnant? You have a chance there to make a difference.

Ms WALKER - There is a chance there. The only way we are connecting at the moment is through GP clinics and the community health centre, but it is not a specific thing that is being targeted, because it has not come up as a major issue from the community voice survey. Probably because the wrong people have been asked.

CHAIR - That's my point.

Ms WALKER - Yes, exactly.

CHAIR - The points where you can make the biggest difference -

Ms WALKER - But you've got to start somewhere.

CHAIR - Yes, I'm not disputing that, I'm thinking, how do we get to those, where you can make -

Ms WALKER - Teen pregnancy, as you know -

CHAIR - If you can intervene in a positive way in the antenatal period, maybe you can avoid an acquired brain injury through fetal alcohol spectrum disorder and flow-on effects.

Ms WALKER - Yes.

CHAIR - The strategy document that is in draft, when do you expect that to be completed?

Ms WALKER - We're going to launch it to the leadership round table on 19 November. It's nearly there.

CHAIR - I wonder if you could provide a copy to us.

Ms WALKER - Yes, no problem. It has been terribly difficult to reduce that into one page. It has been a nightmare.

Mr DUIGAN - I was interested in your health connectors. Are these employed people or is it voluntary?

Ms WALKER - We haven't had any money or a grant to take that further. We tried it out.

Mr DUIGAN - Anecdotally, how is it going?

Ms WALKER - It was part of the evaluation the University of Tasmania did, the Institute for Social Change, as being a good model. It has to be something flexible enough to meet the needs of different communities and I think that's what's going to come out of the Health Consumers Tasmania-auspiced community health and wellbeing networks model. Certainly, the Ulverstone one will want to promote this whole health connector philosophy, if you like, and have funds to be able to drive that, because it won't work otherwise.

The volunteers, Ulverstone has so many volunteers, it's beautiful, but it's all over the place. When we did that project, we started to tap into the different volunteer groups to train them as volunteer connectors. At that level, the community is very willing to work on a voluntary basis but you do actually need the model I described in here, which is a form of social prescribing, needs to be working as part of the GP and allied health services. And referrals need to be made to whatever you call that particular person. And that person needs to have some sort of professional training to be able to manage that. We have to be realistic about it. The actual connectors on the ground, the people who are either volunteering or doing their jobs, If they are receptionists at council, the council is paying them. The newsagents are brilliant. I had no idea newsagents talked to so many people. The same with hairdressers.

CHAIR - Hairdressers are a social entity, and they were opened up before anything else with COVID-19 because of that mental health aspect.

Ms WALKER - In TAFE courses for hairdressing, when it's done on an apprentice model, I don't think we actually include that. It would be brilliant, wouldn't it?

CHAIR - You don't go to the hairdresser for a chat, do you?

Dr SEIDEL - My hairdresser actually has a diploma in counselling for that particular reason. We have talked about this. Their barber shop initiatives are actually very good when it comes to men's health, in particular.

Judi, I know you are representing Central Connect but you are also an international expert in rural health, so we are very lucky to have you here in Tasmania, if I may say that. In your introduction you said: 'Communities always want the same - local access to doctors and local access to mental health services.' Why do you think it's still so difficult? It hasn't changed over decades, has it? Why is it not working? Is it that there is no market for it, so what the consumer wants and needs is just not being met? Is the price signalling all wrong? Does the Government not get it right?

What is lacking there? It is a very basic need and one could argue it is something very simple to achieve.

Ms WALKER - It's a combination of things. We know how complex it is, particularly when you get federal and state things colliding.

I have to choose my words carefully, but general practice as a business model is perhaps not best suited to be stuck in a Medicare system. It is quite difficult to change. Some GP practices have managed it but not all. We are looking at bulk-billing and other aspects for access to GPs and to medical specialists. There are other things you can do. I talked earlier on about the fact that many of us in the community have attitudes and beliefs about health care which don't help. We believe that it's our right to certain things. It goes back to what you learn in school. We have quite a bit of attitude-changing to do at the community level, the consumer level as well as at the health worker level.

It's a combination of things. I've been in this game for many years. When we started the University Department of Rural Health and the Rural Clinical Schools programs in 1996 or 1997, can we say hand on heart that we have made a change? Not really, not enormously. We are taking young people from rural areas to train as doctors and nurses and midwives and other health professionals but we somehow are still not meeting the community's needs of having some permanency of doctors. We are not staying in communities.

My belief was always to not try so hard to get young health professionals to stay and work in communities but try to have the philosophy that a rural community is one of the places you will be working in and that you have the skills to be able to transfer to different environments. If every health professional was able to work in a rural area, and the same with teachers, for periods of time then I think we would have better outcomes. As you know, Bastian, when you look at the GP reg numbers it's not good. The old doctors are disappearing now and it's a different model. We have to think differently about that. Communities have to think differently as well.

CHAIR - The training's not the problem?

Ms WALKER - The training has been a huge problem but I think we have done a lot of change there.

CHAIR - Talking about having permanent GPs, Bastian was saying having access to GPs close to home and having health services close to home, if you're training them and they are having that rural experience but they're choosing not to stay, is the training the problem or is it the conditions and other things in the workplace?

Ms WALKER - It's six of one and half a dozen of the other, and there are other opportunities. We haven't nailed it yet. I talk to young doctors, graduates from the Rural Clinical School. I am back there working now doing community-based research with the final year medical students, which is such a joy. They will come and work, and they are planning to, but other things will come up. It means that they won't necessarily stay in the rural area. I think our expectations have to change and the consumer expectations need to be helped along as well, so that we're not always thinking we've got to have a GP at our fingertips, and we have to get in at half an hour's notice, and that we have to have the specialist within cooee.

There is quite a lot of work to do there. I think, again, if we can get these community models in place, that starts to change that and we start to work in the schools with the kids. But it's a long-term thing. It has just been easier to set up - not easy but relatively easy - to throw lots of money into rural clinical schools, and it is lots and lots and lots and lots of money, and great things have come out of it. But you can't expect one initiative to solve all the problems.

CHAIR - There's more than one point of pressure.

Ms WALKER - I wish I knew the answer. The mental health one is interesting. Again, we did a snap survey: everyone's saying 'can't get into a psychologist. Headspace haven't got any spare' - all those sorts of things. I found a couple of psychologists that weren't terribly busy who are housed in other organisations, sometimes in a GP practice or in a health service, and people just don't know. And, dare I say it, my GP colleagues aren't always well-informed to be able to refer, so there's something somewhere that's not clicking.

CHAIR - Lack of connection.

Ms WALKER - Lack of connection and you can solve a lot of that -

CHAIR - And communication.

Ms WALKER - just by having a GP leader on your community round table. It's surprising how quickly the word gets around then among other people. But change is happening. We mustn't get too depressed about it.

CHAIR - Don't be too negative. All right. I think we're out of time.

Ms WALKER - I don't know how this is going to come out in *Hansard*, I'm sorry.

CHAIR - Is there anything you wanted to add before we wrap up, Judi, or have you covered what you need to?

Ms WALKER- You've asked some super questions. Thank you very much. You clearly understand what this is about. This is a tough gig you've got with this inquiry but it's an important one. And looking at the outcomes of the similar inquiries in other states, if we don't keep probing away at it, it's just going to get worse. I truly believe that if the government of the day does have the faith and trust to be able to consult with local communities, and if those local communities have got responsible and trusted governance in place, they can respond and provide information on behalf of their communities which is authentic. Then we will get gains from that.

All of the things which you would have seen over and over again, if we used our health infrastructure perhaps in different ways, if we resourced things differently, all the things we know - more money for prevention - then we will get there. But let's keep talking and let's try and shift some of those really stubborn attitudes that exist in communities.

Ms LOVELL - Thank you, Judi.

CHAIR - Yes, wise advice.

Ms LOVELL - Very helpful.

Ms WALKER - Okay. Thank you.

CHAIR - Thank you very much for making the time.

Ms WALKER - Am I the last on your list today?

CHAIR - Yes, for today. Yes.

Ms WALKER - Good.

Ms WALKER - When are you reporting?

CHAIR - We had to cancel some of our hearings because they were scheduled when the lockdown down south happened and we weren't sure whether we were going to be able to hold them or not and whether people could come in and all that sort of stuff.

Ms WALKER - Of course. Yes.

CHAIR - They rescheduled later in the month so as soon as we can.

Ms WALKER - Yes. Good luck. I'm sure some good things will come and at least it's continuing to put the spotlight on regional and rural.

CHAIR - Yes.

Ms WALKER - If we don't do that then things get forgotten.

The witness withdrew.

The Committee adjourned at 1.24 p.m.