PUBLIC

THE PARLIAMENTARY JOINT SELECT COMMITTEE ON PREVENTATIVE HEALTH CARE MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART, ON WEDNESDAY 13 MAY 2015.

PREVENTATIVE HEALTH CARE INQUIRY

Ms VANESSA IRELAND AND **Ms CLAIRE SCHURINGA**, DHHS PODIATRY, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Ms Forrest) - Welcome to the committee. Everything is being recorded on *Hansard* today. While you are speaking everything is covered by parliamentary privilege but if you speak to the media or someone else outside these proceedings you are not covered. It is a public hearing and the media may be present. Your evidence will be part of the public record and will be on our website once it is transcribed and will form part of our report. Should you wish to discuss anything in confidence you can ask the committee for that opportunity. We have received and read your submission so I will now ask you to speak to your submission or add any further comments.

Ms IRELAND - I have been a podiatrist for 20 years, 10 of which have been at the Royal Hobart Hospital. I wanted to make a submission to this inquiry on behalf of my patients, my profession and my current workplace, the podiatry department at the Royal. I feel well placed to be able to say our patient type or demographic has become more challenging over the years, and preventative podiatry has never been more important. The chronic medical conditions we're seeing, such as diabetes mellitus, are becoming more complex and challenging to treat, and the complications of those conditions such as peripheral vascular disease and peripheral neuropathy are becoming more complicated.

A large part of our work is preventative in nature. If we take an example of a diabetic patient who might come through the door for a diabetic foot screening to assess their risk of ulceration, we would then put a management plan in place to prevent ulceration. That may include self-care and advice. It may go on to include things like hyperkeratosis or hard skin, and off-loading of pressure areas with orthotics or specialist footwear. Then we get into the other side of things when they unfortunately may have as foot ulcer. We are trying to prevent deterioration, infection, gangrene, hospital admissions for amputations, partial foot amputations or lower limb amputations. I think the social demographics of health which I wrote about in my part of the submission, specifically access to health in the social services systems, poverty and transport, are barriers to effectively delivering those preventative health services. That is why I wanted to highlight that in my submission.

Ms SCHURINGA - I have been a podiatrist for 11 years, five years here at the Royal and I have worked in Queensland and the UK. Vanessa has worked in the UK as well. I have been the coordinator of the High Risk Foot Clinic for three years. One of the major clinics that we run at the hospital is the podiatry department, but it is a collaborative clinic with eight different disciplines involved. It is a really exciting clinic because it is one of the best in Australia in terms of the disciplines that are actually involved in the clinic and who were keen to be involved.

We are looking at that next tier of prevention, so for people who are diabetic and have complications with their feet already we are looking at preventing amputation and further complications because of that.

I have done a short audit on the clinic, and in 2012 to 2013 we saw over 200 patients with over 900 episodes of care within those two periods. We had 15 direct admissions to hospital from the clinic and most of those were for amputation. Even though it is in literature to prevent amputation, it obviously is dealing with clients that are at chronic stage of their disease.

Mr VALENTINE - How many amputations?

Ms SCHURINGA - I do not have that data with me but it is quite a lot.

Ms O'CONNOR - Is that a consequence of diabetes or smoking? How do people get to that point?

Ms SCHURINGA - In the High Risk Foot Clinic, because it is underneath the endocrinology team it is only diabetics that are usually seen in that clinic, so it is diabetes-related. Diabetes can lead to a lack of circulation in the feet, a lack of feeling in the feet. To give you an example of how it happens, we have two cases at the moment of patients who are diabetic who have walked on nails and they have gone through their shoes. They did not feel them because they have no sensation in their feet. They kept walking for several days. They do not put any antiseptic or anything on them because they do not feel that it has happened. They do not have circulation to heal that problem. Our job is really about educating people to be checking their feet, checking their shoes, to prevent those injuries to a foot that is at risk. Then infection gets in and amputation is usually the only option once infection is in place.

Mr BARNETT - As a person with type 1 diabetes and involved very much in the diabetes community over a long period of time, the last time I was advised of amputations per year in Tasmania directly as a result of diabetes type 1 or 2 it was 70.

Ms O'CONNOR - In a year?

Mr BARNETT - In a year in Tasmania, on the knee or below.

Ms SCHURINGA - I would say that is probably accurate.

Mr BARNETT - It would be of interest to me and I think the committee if there is any way of checking those statistics. This was many years ago but it was about that figure each year. If it has gone up or down it would be very interesting to find out what those figures are, because it is alarming. It alarmed me at the time and I am sure it alarms members of the committee.

CHAIR - What would be useful to have is figures from 20-30 years ago to now, if you can, because these interventions that you are talking about in the clinic are fairly new, I understand. How long have these sort of clinics been operating?

Ms SCHURINGA - The High Risk Foot Clinic has been operating for 15 years. It is best practice for at least 15 years.

CHAIR - The other issue then is access. Are you saying it is okay if people live in Hobart but anyone outside of Hobart may as well forget it?

Ms IRELAND - They can travel in, but that is often a major barrier and patients would prefer to be seen for certain treatments in their locality, but then we don't have the medical team that is involved in a high risk foot clinic.

Ms SCHURINGA - It is mostly the vascular surgery team that do the amputations for diabetics, and there are only three in the state.

CHAIR - In terms of the access to podiatry services in the region, the north-west and even the north, you have identified they are quite lacking, what services are there outside of Hobart for anyone who is a diabetic that does fall into the high-risk category? In the case that there is an issue they are dealing with, not just preventative, but dealing with preventing amputation, what services do they have? Do they have to come south?

Ms SCHURINGA - Vascular services is probably a restricting factor on that, rather than podiatry. As a podiatrist we don't do any amputations. There is in the north-west a diabetes specialist podiatrist. They come underneath the diabetes funding and they run a lot of the high-risk services in the north-west. Again, they don't have a lot of the specialist input that we have access to here in the south. They don't get the endocrinology and vascular teams.

CHAIR - That could be done over the internet.

Ms SCHURINGA - It could be if it was available.

CHAIR - You could stick your foot in front of a computer screen and take a photo. It's not that hard.

Ms SCHURINGA - It isn't, and as a podiatrist I'm not able to say how vascular people are able to do that. In the north in Launceston there is a high risk foot clinic. Again, vascular services are limited, but they do have an on-call endocrinologist when they are available.

Mr BARNETT - Is that part of the diabetes centre or is that a separate one?

Ms SCHURINGA - No, the podiatry department is running that.

Mr BARNETT - The diabetes centre has a number of podiatrists [inaudible].

Ms SCHURINGA - Yes.

Mr VALENTINE - Do you know what sort of percentage of those 200 patients, 900 episodes, would be from rural or remote areas? Do you have any feel for that?

Ms SCHURINGA - Most of them are from the south. We have very few who travel - a couple from Launceston in probably a year. I don't have an exact figure on it, but just anecdotally I could say that a majority of them are rural from out of Hobart.

Mr VALENTINE - If transport is an issue for even those people who might not be that far from Hobart, but they're still disadvantaged and they cannot get transport, is this a case for mobile services of some sort? Or the joined-up services needed aren't going to be there if you provide that.

Ms SCHURINGA - The way that the High Risk Foot Clinic runs at the moment is very much based on relationships that the disciplines have with each other, so the specialists walk across the road from the hospital and give their time to this clinic in the afternoon. I think if it was rural then there would need to be additional specific allocation of funding for the clinic.

CHAIR - Is there capacity then to do the video link-ups and things like that for consults?

Ms SCHURINGA - We've thought about doing that, particularly to trial doing something in Clarence because we have a large podiatry clinic in the Clarence Integrated Care Centre. We thought about doing that, but at the moment we're probably at capacity in the Hobart clinic, so ideally we're seeing 12 patients if we have the staff for that. The time would have to increase.

Ms O'CONNOR - Vanessa, you spoke at the HACSU briefing the other night on allied health professionals, and it was great. I'm interested in the level of staffing at the clinic at the Royal because there have been, as you know, cuts to the health budget at a state level. Has that impacted on the clinic?

Ms IRELAND - Yes, it has impacted on a number of different clinics actually, not just ours. We were working out earlier that we probably have at the moment 8.6 full-time equivalents, but we believe from a document we saw that we should have about 12.94 full-time equivalents.

CHAIR - That's just in the south?

Ms IRELAND - Yes. Unfortunately that has led to a number of our community clinics essentially being decimated. Sorell and Kingston are all basically a skeleton of what they previously were. We had a brokered service in Nubeena that does not exist anymore. We cannot service that. We have had the offer of different services. The brokered services that we could provide, say through TAC at Geeveston, we cannot service that as there is nobody to do that job. That would be fantastic because there is a large Aboriginal population in Geeveston. It is an area of disadvantage and it would be fantastic to be able to service that but we physically do not have the staff to do that.

Ms O'CONNOR - At its optimum capacity the clinic at the Royal would have 12.9 FTEs?

Ms SCHURINGA - The High Risk Foot Clinic?

Ms O'CONNOR - Yes.

Ms SCHURINGA - It runs once a week. For full capacity in seeing 12 clients, we need five podiatrists to do that. So if we reduce staff we cannot see as many people.

Ms O'CONNOR - I am trying to be really clear about the numbers. So the podiatry clinic at the Royal has 8.6 full-time equivalents?

Ms IRELAND - It covers a lot of different clinics. We run things like mechanical clinics, general treatment clinics, diabetic assessment clinics, nail surgery, a whole gamut of different things. Our scope of practice is quite wide.

Ms O'CONNOR - There are 8.6 podiatrists?

Ms SCHURINGA - For the whole of southern Tasmania, yes.

Ms O'CONNOR - At the Royal for the whole of the south?

Ms SCHURINGA - Yes, for the whole of the south, and from the Royal we go out to different community clinics.

Ms O'CONNOR - There are also podiatrists located at Sorell and at Kingston.

Ms IRELAND - They are our staff, though.

Ms SCHURINGA - I go to Sorell once a month from the Royal.

Ms O'CONNOR - How long is the waiting list for podiatry treatment?

Ms IRELAND - It depends what you are referred for. If it is low risk it could well be for five months until you get your initial appointment. Currently we are not able to appoint low-risk patients.

Ms O'CONNOR - So you have had to stop accepting those patients?

Ms IRELAND - We accept them but they stay on hold. We have never had that before.

Ms O'CONNOR - How many podiatrists from the southern region do you think have been lost?

Ms IRELAND - From the numbers it would appear to be close to four.

Ms O'CONNOR - The impact of that on people who are either high risk, or considered medium to low risk is what?

Ms SCHURINGA - Delayed access.

Ms O'CONNOR - Does that mean for their conditions?

Ms SCHURINGA - Basically their quality of life would not be anywhere near as good. Once patients are receiving treatment they often feel significantly better if they their actual condition stays the same for a while. The feeling they are in the system.

Anecdotally, patients say, 'Thank goodness we have seen you. We are really worried about this but now I am feeling a lot better.' We hear that all the time. Certainly in the community we try to be as flexible as possible. I work at the Huon Community Health Centre. I did an audit a couple of years ago because there were significant numbers of patients requiring appointments at short notice who we were really not able to appoint, but we were slotting them in left, right and centre because they could not travel. The thing is if we could not actually see those patients their quality of life, their health, would seriously deteriorate. Those who cannot travel or for whatever reason won't access the hospital or High Risk Foot Clinic or other clinics in the community, we do see them as inpatients. The next minute we are getting referrals that they have been admitted.

CHAIR - You say the low risk people who have either been referred or seeking to make appointments themselves would do that -

Ms IRELAND - It would have to be through a health professional. A low-risk person is somebody who has low medical need and usually low podiatric needs. They might have diabetes but have no complications.

CHAIR - Yet.

Ms IRELAND - Yet. Once we have assessed them, if they have been referred in through a foot screening, we can identify what level they are and whether they are at low risk or high risk.

CHAIR - Those people who are low risk and who do not have a complication yet, and prevention is, of course, the key to this, are you saying you cannot even screen them to check them or do you screen them and then you cannot allocate them?

Ms IRELAND - We would screen them and if we needed to see them for an appointment we can do that, but sometimes a low-risk patient does not actually need any follow-up appointment. It is really if they are in that medium to high risk that they would often need ongoing treatment. High risk does not necessarily mean they have a wound; it means that they could develop one. Immediately they have a wound they are already in the highest risk category.

Ms WHITE - We talked about THO South, FTE numbers. With the move to THS, are you familiar with what the structure will be for podiatry under that? Has there been any consultation with Allied Health around what that will look like?

Ms IRELAND - Not at our level.

Mr JAENSCH - Thank you very much. You would be aware that podiatry and other Allied Health services are provided in the private sector and by other organisations? Including Diabetes Tasmania?

Ms IRELAND - Yes.

Mr JAENSCH - In terms of podiatry services in other parts of Tasmania, including Hobart, you would be aware that if you have diabetes and your GP provides an enhanced primary health care plan, then you can access podiatry services on that plan?

We would not want the committee to think this is the only option for people to obtain podiatry services, albeit a very good option and an option that would provide excellent service.

Ms IRELAND - It is true, but some of our clients are requiring weekly or second weekly treatment so they would be out of the five that they would be eligible for.

Mr JAENSCH - No worries. Picking up on Rob Valentine's question earlier in terms of rural and regional areas, and getting your thoughts and views on how best to care for Tasmanians in those areas. Any suggestions you might have that you could share with the committee on a better way to care for them?

Obviously, visiting Hobart in your centre, or the diabetes centre in Launceston, or in Burnie, for services, is one way, but do you have a view in terms of telehealth? Community transport is another option, but do you have some views that you could share with the committee on better ways to deal with it?

When telehealth, for example, is being used in other places where you have a diabetes nurse educator or just a nurse in front of a screen, and you beam back to you and your experts at the centre and provide advice that way. You can do the touch and feel checks and so on. Do you have views on that?

Ms IRELAND - A lot of the work is hands on so I am not sure we could really be out of the equation for that. We could certainly advise patients on a teleconference or to a nurse who has a patient and has said to us, 'Yes, that really looks like something we need to see urgently'.

As far as being able to do what our core business is, which is dividing unviable tissue from a wound, or dividing half a keratose as a hard skin from pressure areas, manufacturing, grinding orthotics, and that sort of thing, we physically have to be there.

Ms SCHURINGA - I think we already do a form of telehealth. A lot of nurses send us photographs of patients that they have seen or might have been worried or concerned about, to get appointments quicker through our system.

We have not extended to full-on telehealth. Getting the infrastructure- - you need good wi-fi - in place to be able to perform.,

Mr JAENSCH - Do you have that at the moment or do you think it would be useful to have improved infrastructure arrangements?

Ms SCHURINGA -It would be useful to have improved infrastructure arrangements.

CHAIR - It has to be at both ends, doesn't it. It is okay to have it at one end but you have to have it at both ends.

Ms SCHURINGA -Yes, we have one iPad for our department and we use that for patient education and things like that. I think you need everyone to be on the same technology for it to be able to work.

Mr JAENSCH - Sure. Finally, in terms of your communication with other parts of the state so that we have a state-wide picture, you are picking up the south and the southern end, do you have much communication with your colleagues up north and north-west and elsewhere? If so, how does that work and how do you work together on issues that might pop up or challenges you face?

Ms SCHURINGA - As far as I know, there is a manager meeting that takes place over the telephone at least once a month with the north, north-west and south. I went to uni with some of the people who work in the north-west, so I have a connection with them and communicate with them. We do that as departments, so all of us try to get together at least two to three times a year. We did that recently via telecommunication rather than travelling to each other. We are aware of sharing information, we communicate as a podiatry team as a whole in the public sector.

Privately, we have a Tasmanian association for podiatry and that is where the private sector comes into communicating but publicly and privately, communication could probably be improved.

Mr BARNETT - Do you know how many there are in the private sector?

Ms SCHURINGA - No.

Mr BARNETT - Proportion wise?

Ms IRELAND - I really don't know.

CHAIR - On the north-west coast I have people trying and it is very difficult in the private sector - public is even harder, I think - unless you have an urgent need. It is really difficult.

Mr BARNETT - Do you know how many podiatrists we have in Tasmania?

Ms SCHURINGA - No. I would say they are more prevalent in the higher population centres, I would say Hobart has the majority of private practitioners.

Mr BARNETT - Thank you.

Mr VALENTINE - I was reading in your submission, page 40, you say there is a dramatic increase over a four-year period in the number of patients in the wound care ward, foot ulcers, and a large increasing number of people with diabetes. What four-year period was that and do you have any handle on why this increase has occurred?

Ms IRELAND - This is an audit I undertook at the Huon community health centre, it was a low risks ethics approved study. I had started to see this increase in patients needing those sorts of emergency appointments, such as ringing to say, ' I have a sore toe that is pussy and bleeding', or those who are finding it hard to come up to the Royal Hobart Hospital and wanting to be seen locally.

There was a large increase in those patients and I was thinking, is it just me, why is this happening. I did a study and worked out how many people with diabetes had been there in 2008 and how many had been there in 2011. I got advice on the type of study methodology by a professor at Menzies and we worked out the best way of doing that. We worked out that there had been a 40 per cent increase in those patients with diabetes across those four years and also a large increase in the number of people presenting with foot ulcers over the four-year period. I don't know why that was.

Mr VALENTINE - Which four years are we talking about?

Ms IRELAND - It was 2008-2011. It took me about two years to do the data collection because I was doing it off the side of my desk because of time. Nevertheless, the stats are still there. There are a number of reasons - you could say we were getting better referrals, patients became more aware they could access that service. It could literally be because patients' health had deteriorated.

We know that places like Bourke and Huon and other rural and remote areas have higher rates of poor health, poor literacy and access to services are not as good, so their health generally is not as good and their ability to care for themselves is not as good. We know that things like diabetes and foot ulceration increases a person's risk of depression by a quite significant amount and therefore your ability to self-care is less. Maybe there has been a whole shift but I have not got to the bottom of why there was a large increase.

Mr VALENTINE - You have not got any correlation with the overall occurrence of the diabetes type 1, for instance, being increasing?

CHAIR - Type 2 is the one that is increasing.

Mr VALENTINE - I know type 2 is but maybe -

Mr JAENSCH - They are both increasing but type 2 at a higher rate.

Mr VALENTINE - Type 2 would not have the same level of foot problem would they, as type 1?

Ms IRELAND - Yes, type 2 has.

Mr VALENTINE - Okay. That leads to the other question in terms of the demographic, especially regional rural people that are not able to access the services. Have you any real understanding of the unmet need? When you go to Sorell Clinic is there a backlog?

Ms SCHURINGA - There are a few referrals waiting at the moment because they only go once a month. They wait for several months because of the availability of an appointment. Most of those waiting we try to make sure they are not high risk and we would ask them to come into the Royal Hobart Hospital to be seen in a faster clinic or to Clarence to be seen faster. We try to prioritise where the needs are but most of the time people will have to travel if they want to be seen in a faster way.

Mr VALENTINE - Have you noticed an increase in people wanting to access the service over that period?

Ms SCHURINGA - It is hard to say because we have also had reductions in staffing. There is an increase but is that because there are more or because we have less staff to provide that service.

Mr VALENTINE - Knowing the work activity of those people, what their background is and whether it is coming from a certain section of the demographic that you are treating, I do not know. Is it farmers? Is there a trend there?

CHAIR - Or is it politicians?

Ms IRELAND - It is across the board and various ages.

Ms SCHURINGA -Diabetes is one of those chronic conditions that unfortunately affects a large range.

Ms IRELAND - Or age group for those who are even at the most catastrophic end. They can be in their early twenties right up until 90. That is very depressing.

Mr VALENTINE - Thanks.

Mr JAENSCH - Thank you both for your contribution and for the work you do. I understand from the submission that over half of your patients have type 2 diabetes and the majority of patients have other health complaints that tend to travel together, such as cardiovascular, renal, obesity et cetera. Your role is to prevent existing conditions from escalating into disastrous ones. Those conditions are associated with these pre-conditions.

Ms IRELAND - That is right.

Mr JAENSCH - What more could be done, in an ideal world, to put you out of business? What could GPs be doing? What could a health system do to better catch the earlier stages so they never get to meet you, which would be tragic because your are lovely?

Laughter.

CHAIR - In the ideal world, what would be the perfect integrated health care system that meant that if people did have diabetes, and some people have no choice about how many diseases they get, but how do you provide for them.

Mr JAENSCH - The picture painted at the bottom of the first page is of a suite of avoidable, chronic, lifestyle-related diseases in large part. It seems to be a cohort of maladies that travel together that we know about and we understand. Is there a proactive, early intervention that would pick them up? Do you know of somewhere that is doing that well? Do you have ideas about who should be doing what, when to divert them?

Ms SCHURINGA - My only opinion on that would be get in when they are early, go to schools and education. Education can take many different forms and whether people take that advice is another matter. Empowering people to take their own health onboard

from an early age is important. It would help with a lot of the chronic conditions, particularly from lifestyle factors.

In terms of other systems that are doing it well, I am not sure. I know a little about Scandinavian systems and the way they do health care. I know, for a communist nation, Cuba has a really great health care system.

CHAIR - One of the best in the world.

Ms SCHURINGA - Yes. Everyone has a GP that is lined up to that person.

Ms O'CONNOR - One of the best in the world.

Ms SCHURINGA - Yes. Everyone has a GP who is lined up to that person.

Mr JAENSCH - They would go back to work in the factories making cigars.

Ms SCHURINGA - Whether that would work in the culture of Australia and its health system is hard to say.

CHAIR - Are you promoting communism perhaps?

Laughter.

Mr JAENSCH - As a person who lives outside the health system - and will stay there if I can - by the time our system is able to prescribe and refer the person is already sick. Can we make prescriptions for prevention earlier on? You talked about information but I am not entirely convinced that is enough. When a doctor tells you to do something you do it, when a doctor gives you a pamphlet you are interested but you take it or leave it.

Ms SCHURINGA - It's also getting people to go to the doctor at that stage. If you're not sick you're not going to the doctor so how are you going to get that health information?

Mr JAENSCH - What if you go to a doctor with a cut or a graze or the flu and they note you are obese and ask some questions about your smoking et cetera. Is that an opportunity to be picking those things up and diverting people early, even if that's not the case they are presenting?

Ms IRELAND - We get a lot of referrals for those types of patients for a diabetic foot screen with some of those factors. They don't have to be seen by podiatry for a diabetic foot screen, they could be seen by the GP themselves or the practice nurse. We pick up a lot of those types of clients at those early stages when they're not very ill at all. They just come in for a routine check. We would then be able to give them some early intervention with advice on footwear; maybe prescribe orthotics if they needed something like that. We see a lot of patients at that early stage before they've even become ill.

CHAIR - What Roger is alluding to is that there's possibly an avenue - and this is again a resourcing and funding issue and probably a Federal Government responsibility in many ways - where everyone should have a well person check every year or two years.

Everyone is funded to go to their GP or the practice nurse - nurse practitioners could adequately fill this role - and do blood pressure, foot checks, smoking cessation information, cholesterol, fasting blood sugar et cetera. Those who are identified through that process need to be put onto a care plan. Those who are perfectly normal could be put down for a check in three years. Is that the sort of thing you're talking about, Roger?

Mr JAENSCH - Yes, definitely.

CHAIR - Do you think that could work?

Ms SCHURINGA - There is opportunity for that. Our service at the moment is very reactive because we are treating the need that has arisen because of the chronic condition. Everyone has a part to play. The media reports on certain research that has happened, the Paleo diet and things like that, that are incorrectly promoted. There is a lot of education but you can't force people to go and see someone when they're not sick.

CHAIR - It's about somebody else. An education program is about somebody else, not about me.

Ms SCHURINGA - A lot of the health promotion we've tried has been trying to go out to where people are. We do a few stalls. October is foot health month so we try to do a bit of promotion during that month. You capture a different clientele if you're going out somewhere to see them rather than expecting or inviting people in.

CHAIR - If such a model was put in place - every year, two or three years - where everyone had a full check and there are times in women's lives, particularly with Pap smears and you can link it directly to that potentially. Is there any idea of what the saving could be from picking up people early? I go for my pap smear but I have found I have a high blood sugar level. I would not have gone to the doctor. The education around pap smears has been fairly effective, even though we all love having them don't we? Not.

Ms O'CONNOR - My mother has never had one. Refuses. There you go, sorry.

CHAIR - As a midwife I think I should at least front up for a pap smear, seriously.

Ms IRELAND - That is a good idea, linking them with something else that people are already going for.

CHAIR - There has already been a good education campaign out there.

Ms IRELAND - They have that culture around going for those checks.

CHAIR - Cervical cancer is hidden, the same as ovarian cancer, which is even more difficult. Diabetes is essentially hidden, though you do get more warnings about diabetes if you are alert to it, than you do for ovarian cancer.

Ms O'CONNOR - I am curious to know whether you would regard podiatry as a front-line health service because there is this peculiar discussion about what is a front-line health or community service and the more I listen to you the more it sounds like podiatry is part of the front-line of preventative medicine. I do not want to ask you a question that makes

you feel uncomfortable to answer so feel free not to answer it. Podiatry is a really essential preventative health service isn't it?

Ms IRELAND - I would say 'yes' because there are no other professionals that do what we do. That is the bottom line. Our scope of practice is large and we can do interventions that other professionals do not do.

Ms O'CONNOR - You talked about that period from 2008-11 where there was a spike in high risk cases and a spike in the work load. What have you noticed from 2011 on? Has that level of increased demand, and I take on board what you said Claire, about not knowing how the numbers fall, but has the level of increased demand sustained?

Ms IRELAND - It has. One of the things that was put in place as a result of that spike was an additional clinic once a month which added to the Huon community health centres because that is where the study was done. We assumed it would be pretty much replicated everywhere. That has made an enormous difference to the ability to get patients in quickly for those high risk general treatments for things like dividing and so forth without ulceration and then also if they do need an ulcer treatment in the local area rather than travelling to Hobart, that has made an enormous difference. I have these patients, it would be great if there was a spot there can you come on Thursday?

Ms O'CONNOR - So the Huon clinic is run a bit like Sorell and Kingston where you outreach once a month?

Ms IRELAND - No, it is run every week in the community health centre. In fact a lot of our health centres are run every week a lot further down. We have Huonville once a week and then once a month there is an additional clinic. Cygnet is once a month. Dover is once a month. Kingston is now once a month, but it was every week. Sorell was every week or every fortnight.

Ms SCHURINGA - It was every week and now it is once a month. We go to Triabunna once every month or every seven weeks.

Ms IRELAND - There is Glenorchy which is about two or three times a week.

Ms SCHURINGA - Clarence, we go several times. Brighton is once a week. New Norfolk is twice a month now. That has been reduced. Bothwell and Ouse, half a day at each every two months.

Ms O'CONNOR - If, for example, you go to Bothwell for half a day, that whole half a day is full isn't it of people you need to see?

Ms SCHURINGA - It is. I make sure it is full.

Ms O'CONNOR - It sounds like a great outreach service.

Ms SCHURINGA - It is.

Ms O'CONNOR - You would like there to be more of it I know, but it is really an extensive outreach.

Ms IRELAND - Yes. I think that is one of the things that I would like to see more of is the ability for us to see more of those high risk general treatments. These people haven't ulcerated or they previously ulcerated and now healed and to try and prevent them from getting another ulcer. That is where the community health centres are brilliant for that. We can provide an excellent, flexible service but only if we are properly resourced.

Ms SCHURINGA - Because our service is both acute, sub-acute, and community, we have that integration between seeing clients that are in hospital and they're admitted for high risk need for their foot, perhaps an infection in their foot ulcer, we can put them through the high-risk foot clinic and then see them back out in the community when they are all cleared up. We have that connection of people who should be moved throughout the health system from community to hospital and back the other way because we have a relationship with physicians who are able to admit, we're able to put people into hospital.

Mr VALENTINE - I am wondering whether you have any statistics or understanding as to whether these people are single people who live on their own? Are they the people who have more problems and issues chronically?

Ms IRELAND - In the study I did there was more men than women accessing the service, so 53 per cent men, 47 per cent women. I think we know anecdotally that single males don't do as well if they have a chronic foot ulcer or chronic medical condition.

CHAIR - Is that because they present later in the illness though?

Ms IRELAND - Possibly, but also because of the care factor and someone else being around to bully them into arriving at appointments or saying, 'Come on, your ulcer is stinking let's change the dressing,' and those type of things that your wife, husband, partner, might nag you to do.

Mr VALENTINE - Living on their own as opposed to just single, is that what your feeling is?

Ms IRELAND - Yes.

CHAIR - We have run out of time, but thank you for that, it is been great and we appreciate you coming in.

Ms O'CONNOR - I have a pure appreciation of the work you do.

Mr JAENSCH - Will there be a commitment to get some of those figures on the amputations?

Ms SCHURINGA - I can give you amputations for the Royal, but for Tasmania I'm not sure whether that might be better through the vascular surgery team because they're a statewide team.

CHAIR - We may need to ask the department later today.

Mr JAENSCH - We might do that.

CHAIR - If you're happy to provide what you have, but for the statewide we'll probably need to ask the department. It would all be done in hospital.

Mr VALENTINE - One would hope so.

Laughter.

CHAIR - Thanks for your time.

THE WITNESSES WITHDREW

Mr PHIL EDMONDSON, CEO, AND **Ms SUSAN POWELL**, DIRECTOR POPULATION HEALTH PROGRAMS, MEDICARE LOCAL, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Thank you. The evidence that you are giving is being recorded by *Hansard*. It is a public hearing so once it is transcribed it is put up on our website and becomes part of the public record. You are covered by Parliamentary privilege while you are before the committee, but if you spoke to the media or someone afterwards then you're not, so keep that in mind. If you wanted to give the committee any information in confidence then you can make that request, otherwise it is all public. I know Phil is a seasoned campaigner at these things, but do you have any questions before we start?

Mr EDMONDSON - No.

CHAIR - The other thing too is the evidence from the last committee in 2013 including the submission from TML has been taken into evidence for this committee as well as your most recent submission. We have all read those and invite you now to speak to your most recent submission as things have changed a little since the last one and then the committee will have questions.

Mr EDMONDSON - Thanks for the opportunity to take a second bite at the cherry. I guess I should characterise my evidence in relation to the changing nature of the organisation. We are in the current throes of becoming something different in comparison to the base under which the submission was written and presented this year. We are on the way to becoming the Tasmanian Primary Health Network as opposed to Tasmania Medicare Local, which is the title under which the submission was presented. We see no difference in the evidence we will give on the basis of that organisational change.

First and foremost we see a strong, vibrant, flexible and adaptive preventative health care system as being housed with general practice and community care central to its success and its core. If we are going to meet Tasmania's ambition to become the healthiest state by 2025 it is not only central it is critical.

So much of our system resourcing is thrown at tertiary treatment and high end care of what might be termed the reactive end of the spectrum. Put simply when our focus and attention is almost exclusively on what happens in hospitals there is a tendency to prioritise investment of limited health resources on easily countable and measurable outcomes like waiting lists, the number of hips, the number of knees, people in beds et cetera.

We want to present to you today the more difficult end of the spectrum to count, measure and monitor. The responses required are clearly different. They are responses that need to be intergenerational in nature and have long-term commitment from government funds and providers.

It is important for a contemporary health system to be able to have the skill systems and resources to deal with tertiary needs. In the context of our evidence we do not hold that we should be taking away from a safe, efficient, effective and vibrant hospital sector. The health system needs also to be able to recognise the need or we will determine the

obligation it has to do its utmost to provide the services and support required to people well in the community and out of hospitals. As a colleague of mine always says, who happens to be a GP, people die in hospitals and we need to keep them out of there. It is not good enough for us to simply say we are providing the backstop to health service. We need to be looking at what happens at the front end.

Achieving optimal health outcomes for the Tasmanian community will effectively require a re-orientation of focus on prevention and community based intervention. The term varies in different jurisdictions, anticipatory care is one of the emerging terms for it if it is to succeed.

The methodology needs to go one step further and extend beyond the reaches of traditional health service into community and social care. Our health system in its current move is breaking the geographical shackles and it is great to see we are starting to try and work towards removing some of those. If we are to break those shackles that traditionally bound us we need to recognise and accommodate, as well as address, the social environmental influences, what I commonly term the social determinates that so strongly provide health outcome, health equity and health status in the states, particularly like Tasmania.

Government is committing itself to establishing a one health system and, again, this is something over a long period of time we have held is a fundamental problem. It is a fundamental barrier in our way of funding and managing our own resources. This necessarily means that we will have to take account of and work hand in hand with health services, GPs and providers outside of the hospital and tertiary sector. Building and operating a single health system will need all to work collaboratively. This will only provide genuine outcomes for Tasmanians if the health system also recognises and accommodates the environment in which it operates.

TML as it now moves towards its newly secured role of Tasmanian Primary Health Network from 1 July has worked hard. We have constantly made claims to embed and drive the message as both the Medicare Local and prior to that, as divisions of general practice, that primary care is the solution to many of the problems that face our current health system. Our message hasn't changed and our resolve across the sector is extremely strong.

Government has a strong role in setting the framework. Whole of government has to be lockstep behind this. This is not simply a Health department issue, obligation or response. It is a whole of government requirement for this to happen.

We need policy settings that enable single system planning, mechanisms to demand that resource allocative decisions take account of and respond to social and economic circumstances of populations as well as address the challenges of our built and lived environment. This is the context in which both our private and public health services are provided. Our health system needs to be enabled and required to act within and respond to that environment.

The health-in-all-policies approach needs to be adopted across all governments, federal, state and local. The well documented and authoritative work of previous committees should not be forgotten or lost. Groups like the Health and Wellbeing Advisory Group

took some of these things to a significant extent. It would be a real loss if the work that has been done that was lost or ignored in this process. It needs to inform the decisions we take from here on.

We now have a near perfect storm in terms of state health reform, federal health reform, the long overdue move to a single THS, confirmation of a single primary health care network, continuing access, hopefully for another 12 months, to some of the major federal investment through the Tasmanian Health Assistance Package. I was disturbingly unable to find any evidence of that in the budget papers last night.

Ms O'CONNOR - Only because there wasn't.

Mr EDMONDSON - I think they have renamed it and some of the appropriations may have been internal rather than external. We have to wait and see what happens. There was some reference in the fiscal paper side of it to the elements that relate to palliative care et cetera for Tasmania, but it was not in the health papers perse.

Ms WHITE - There is some money there for the redesign works still.

Mr EDMONDSON - That is correct.

CHAIR - What was that?

Ms WHITE - There is $9 million for redesign

Mr EDMONDSON - Cradle Coast, Connect to Care money. There was money for mental health service. There is a range of things in there but there was a remarkable absence of detail. Getting to the bottom of that is a critical issue for the time being.

We have this once in a lifetime opportunity, with a common establishment point for many of the structures and processes, to get some alignment of process and policy and to remove some of the entrenched barriers that we have traditionally had to come up against in moving towards single system planning, single system thinking and single system resource allocation. We have a huge opportunity that we will be utterly remiss if we were not to act on.

Tasmania has a progressive and highly capable and committed primary and community sector that understands and relishes the opportunity to work in partnership with government and lead the way with respect to developing and involving what could be the most progressive, most integrated and most responsive wellness oriented system in the country.

We need a government that shares the vision of the primary and community sectors and that is prepared to invest in the fundamental elements that underpin such a vision. When I use the term, investment, I don't necessarily mean in dollar terms, I also mean in terms of commitment and long-term policy.

Ms O'CONNOR - Phil, when you talk about investment, could you give a little bit more detail on where you think that investment needs to focus?

Mr EDMONDSON - Initially the focus is clearly and necessarily in the policy area. We need to drive a different way of doing business within government that recognises responsibility for health is a whole of community, whole of government responsibility. That is the first domino that has to fall. Without that, we will get this iterative, piecemeal approach that traditionally they like doing. We will get the continued favouring of infrastructure style investment in health care - big buildings, nice, flashy premises that make little difference to health outcomes. But they are easy to build and cut ribbons on and it makes people look as though they are doing something. We have to move out of that paradigm and into a paradigm that says that setting a policy and long-term direction needs to be adhered to and agreed and accepted by all sides. When we change, as we frequently do, from red to blue or green, whatever the case may be, that we have an environment that allows us to actually continue rather than go through this continuous stop/start approach.

Ms O'CONNOR - So we need to have tripartisan approach to health, and that is just the political side of it. There is the community and system side as well, but ideally to have all three political parties commit to a vision for health, take the politics out of it and that the vision is a long-term vision.

Mr EDMONDSON - Yes. Easy to say but the reality of that is very difficult to achieve in our current way of doing business, in government in particular. People do not like to effectively trade away the right to make decisions around such bit chunks of GDP as health commands.

I think the biggest failing in relation to the federal response to National Health and Hospital Reform Commission Report was the decision very early on to shelve the idea of having a national health commission. A national health commission was proposing to do exactly what you are saying. That was, take the principal decision-making responsibility for long-term health policy setting outside of government and to hold successive government to a long-term, 20-year path. That would have solved many of the problems that we are talking about today in one fell swoop.

Mr VALENTINE - So the government becomes facilitators rather than -

Mr EDMONDSON - Absolutely, and effectively I believe that is the obligation they have, but unfortunately it gets all too often caught up in the business of politics. Tasmania has the opportunity to create that ourselves if we want to. That is a choice that only government can make.

Ms O'CONNOR - To be fair, I think we are having a go at it with the reforms at the moment.

Mr EDMONDSON - I agree. Sitting here at a table like this is fantastic. As I said last time, I absolutely commend this committee for tackling this particular issue. It is something that is all too often shelved, all too often is ignored, and the challenge is before us all. From a primary care perspective, you have a primary care sector that is willing and able and almost demanding the right to work with you in actually implementing that. Everybody in the health sector, across primary and tertiary, are sick and tired of this cyclical rubbish that we go through every three, four, five years. The problems we are dealing with now are 20-year-old problems. We failed to deal with them then, and we

failed to deal with them multiple times since, and they are sitting before us again. The challenge I guess is there for all of us.

To finish off there, the elements from our point of view include shared vision, a boldness and courage to challenge the traditional top-end investment demands. A high profile coronary episode is a very attractive thing to respond to. Far more difficult to respond to the many years of challenges and issues in terms of lifestyle and preventative services that are required to actually stop someone getting to that point.

The willingness to work in genuine partnership, a focus on and intend to apply the whole-of-government, whole-of-system, response, to firstly recognise and secondly develop responses to the social determinants of health. We have to grab this term and we have to give it a really good shake. It gets thrown around and bandied about very liberally, but understanding the implications of social determination in health outcome and indeed outcome across a range of areas, is something that we seriously have to grapple.

The work of the joint committee in setting a progressive and genuinely ground-breaking challenge to the health system is clear, and I would strongly encourage the committee to see its role as driving, setting a future agenda, rather than dealing with a current problem.

Our submission, coming towards the end of your process is probably strongly reflective of many of the things you have heard from a range of other people. We make six principle recommendations, I won't go into those, and it strongly alludes to many others that other presenters would have referenced also.

CHAIR - Cassy made the point that there is health reform going on at the moment. I attended only one of the public meetings because we were down here with committee hearings at the time. It seems there is still predominantly a focus on the acute health setting, even with that. I guess this comes down to part of the dual-funding model we have that is still quite a confusing mess in many ways. It's money from here and there all feeding into one pot that then goes in several directions. My first question is around the funding and how we can make this more transparent and more targeted in doing that. That's the underlying issue here, or one of them. The other thing is this whole-of-government approach and the Health in all Policies approach. How do you see that working? I think we understand what we're talking about, but to apply it in a practical sense that doesn't take money out of the Health budget directly for either primary or acute health care and then fits into that. I agree with you that we need to have a shared long-term vision that can't be fiddled with every election. The same with education. How would you structure and see that work, this whole-of-government Health in all Policies approach?

Mr EDMONDSON - From our point of view it's quite clear we have basically a two-tier funding system in the sense it is partly contributed by federal and partly contributed by states, with the community as a significant additional contributor in that space also. I believe we are stuck with that, so the challenge for us is not to look at simply banging our heads against a brick wall and saying it has to change because the likelihood is it is not going to. The challenge for us is to find ways of either pooling resources, where that is an option and a possibility, and the funding limitations permit that or - and I think this is probably the most realistic mechanism - implementing a resource allocation process that brings system partners together and considers needs, gaps and priorities as a

collective group, with the consequent allocation of resources then being done in such a way as to recognise the shared responsibility of all to ensure we have a single functioning system, because if something is not going well in primary care, it will inevitably result in a flow to the front door of the hospital. You have to make sure all the parts are working. You have to make sure the railway tracks, unlike the Indian railway system, are the same gauge all the way through and then when something is happening it is known and understood that that occurs in that environment by people at the other end of the system, so we are not duplicating and repeating things. Having a single pathway of care for a range of conditions into and more importantly back out of hospital into the community is absolutely foundational to getting that smooth and safe transition of care, which is absolutely essential to prevent readmissions and avoidable harm.

Ms O'CONNOR - What's the structure to achieve that, though?

Mr EDMONDSON - One of the key structures is the work that is currently going on both in our environment and with the Health Services Innovation Tasmania crowd through the university in conjunction with the THOs. That's the clinical redesign pathway process within the hospital sector that accommodates and matches to the health pathways program we're running outside in the community. We now have 150 pathways of care across a whole range of conditions that have been developed. Those are taken into account when planning hospital pathways. It's known what has happened at the point at which somebody comes to a door. If somebody comes to the front door of the hospital and haven't had their work-up, the opportunity exists for the hospital to say, 'You're not ready for admission. We shouldn't be putting you on a waiting list yet. You need to go back to your primary care provider and ensure these other steps are acted on'. That then is the mechanism for change in clinical behaviour and process, but ensures you have a smooth flow through a system and people are in the right place at the right time.

CHAIR - And everybody knows; their GP knows when they've been admitted and when they leave.

Mr EDMONDSON - That's exactly right. I said this to the committee last time. The New Zealanders in Canterbury do this really well. Yes, they have a single system funder, they have a single government but they do this 'into and back out of hospital' stuff extremely well and the key there is a pathways process that is honoured and recognised by all players in the system. People sing to their hymn sheet tune. They do not step outside those barriers and when the requirement comes to pass or transfer a patient a through, there is clear understanding about what needs to go with that patients in terms of information and there is clear understanding about the options that are available for that particular person at that time. That is the mechanism to get a smooth transfer across the system.

In terms of the funding, the environment is such that it requires a collaborative approach to priority setting and investment that can only occur with good will and/or a policy setting that requires that that be the case.

CHAIR - When we are still seeing the cost shifting that goes on. If I am going in for a hip replacement, if I get all my work-up done as an outpatient or with the GP, the Commonwealth pays for that. If I have it done in the hospital, the state pays.

Mr EDMONDSON - I am not an apologist for the major flaws in the system in relation to that sort of cost shift and top opportunity and it has been a game that has been played ever since time immemorial between systems. I think we are moving into an environment now where people are accepting that you can only take a planning process so far if your focus is on where the money is coming from. We have to take the focus back to what should be happening to a particular person in a particular location. Forget where the money comes from. Focus on what is required and what should be provided to that particular person at that time. That is when you will start getting some honesty back in the process. Cost shifting is always going to happen as long as we have two tier funding.

CHAIR - In that sort of case don't we need to consider incentivising the process so when someone turns up at the hospital door for the hip replacement, they are fit and ready to go?

Mr EDMONDSON - That is absolutely what we are talking about in terms of the pathway. This should not be something that a primary care practitioner has to say - that there is a 15 month waiting list for hips. Even though this person does not need one at the moment I will put them on a wait list now because that might get them their hip when it is about ready to fall to pieces.

Those sorts of games happen at the moment and it is the system characteristics that drive that type of thinking. I am not naive enough to pretend that that is never going to exist but if we encourage and support clinicians to follow pathways and those pathways become the determination of best practice. Clinicians are driven by evidence and practice. They are scientists essentially. They are driven by evidence and practice. They do not want to do things that are not safe, that are not effective, that are not right. Pathways talk language that clinicians understand and can respond to. If we engage primary and tertiary care clinicians in determining the points for transition of care we have an opportunity to get a much greater level of honesty into the system that to an extent is countered by some of the game-play that goes on in relation to funding.

Ms O'CONNOR - Where is the oversight of that necessary system? Through the clinical redesign process and the pathways. How do you have oversight so that the pathway of a single patient from primary care through to whatever the end of the journey is, is followed up?

Mr EDMONDSON - That is a good question. Health systems are good at self-monitoring and self-managing and to an extent there is almost a taboo around non-clinicians making judgements about where the clinicians are doing the right thing.

It would be broadly agreed in clinical circles that the strongest motivator for compliance is the perception of, 'am I being seen by my peers as doing the right thing?'. That is a very, very strong driver in clinical thinking. Clinicians do not like not keeping up with the Joneses. I do not mean that negatively. It is a very powerful quality limiter. Safety and quality systems can only go so far in terms of looking at process, but so much of what a clinician does is down to their competence and capability and it is the outcome that is achieved that broadly becomes the measure of whether the process has worked.

Ms O'CONNOR - Agreed. In the disability sector there are local area co-ordinators, so the individual's journey is discussed quite broadly amongst professionals who have a stake in that individual's wellbeing. Should the oversight of a system like that be a bureaucratic structure, like the Department of Health and Human Services, or should it belong to THS? I'm not sure the peer model will always make sure that there is a discipline there.

Mr EDMONDSON - I think one of the problems we have is that we have dis-invested in strong clinical leadership over a long period of time. We have tended to defer to non-clinical leadership in the health system too far. As a non-clinical leader in the primary care sector I have to be careful what I say. The reality is the balance needs to be right. Funding should have measurable outcomes attached to it and the measure for those outcomes should be shared by both administrative and clinical structures. They need to be working hand-in-hand. You cannot have a system that is administered solely by clinicians. Likewise, you cannot have a health system that has no clinicians in it.

The reality is the performance indicators need to be set properly to get the measures you need to be able to determine whether the outcomes you are getting are safe, effective, cost efficient and in the interests of the patient.

Ms O'CONNOR - Ultimately, aren't you saying that it's the THS that set those performance measures?

Mr EDMONDSON - To an extent the THS will set some performance measures. It will set performance measures for the areas of responsibility that it has. Pathways are guidance mechanisms to encourage clinician adherence. There's no hard and fast rule that says you have to, but if there's one thing I have seen works very strongly with clinicians is they don't like to do things that are not considered by peers to be unsafe. Clinicians are very good at making those judgments, they are trained to make those judgments and ultimately they are the ones left facing the patient if things go wrong. I don't think you can remove the fact that there is a very strong and powerful performance limitation there that isn't necessarily somebody standing over you telling you what you have to do. It is true, government needs to set performance indicators through the system and as its principal delivery mechanism, a THS would be inherently a major contributor to assessing that delivery against those indicators.

CHAIR - I want to go back to how you set the 'health in all policies' framework. I have a couple of questions waiting.

Mr EDMONDSON - I'm not a policy expert and I'm not an expert in structuring and managing government policy. The 'health in all policies' approach is simple to say, but more complex to implement. I think the responsibility for overseeing the implementation against a 'health in all policies' approach needs to sit within the highest office in government. It needs to sit as part of the Premier's responsibility to hold his or her departments accountable. Ultimately, that's the only way you are going to get a genuine approach to 'health in all policies' that has a chance of succeeding. 'Health in all policies', by its nature, requires a collaborative focus at the highest level of executive government. I'm no expert in that field, but I'm firmly of the belief that that's where that oversight and responsibility should sit.

CHAIR - It's easy to say that DPAC should be responsible for it and to require education policies being developed, that the health lens is put across it, infrastructure projects and the whole bit. There is a concern in some corners that that could be a slowing down mechanism?

Mr EDMONDSON - A barrier typically put up by people who don't want to implement it.

CHAIR - Yes, or a tick and flick approach. We have put the health lens over it, yes, that's right, done that, tick.

Mr EDMONDSON - I would share your concern if that's all it was. There is a very well worked set of success indicators for an approach such as this. Again, this is not an area of my expertise, but I'm firmly of the belief that there is evidence that provides a guideline as to how that should work.

CHAIR - Where is that evidence Phil?

Mr EDMONDSON - It is not tick and flick. It has been implemented in a range of different environments. It has been tested in several international environments. This is probably a Graeme Lynch type environment of expertise given the work they have been doing in that sort of space. We firmly believe that foundation stone needs to be there.

CHAIR - I am interested if you have somewhere you can direct us so we can look at a model that has been implemented and works in a way that does not add to the cost, does not become totally bureaucratic and delivers outcomes not just measuring health numbers.

Mr EDMONDSON - The Health and Wellbeing Advisory Committee did quite a bit of work on this and the health and all policies collaboration that is chaired by Graeme Lynch, is the source of the most up-to-date information. He would know far more about that than I would. I can ask him to send you information because I have no doubt that he did the work.

Mr JAENSCH - Phil, thank you very much and I agree with everything you have had to say but I want to challenge and exercise a couple of shopper things. We are hearing a lot from people in the sector about the social determinates of health and the unpacking of that, which is good. I would prefer to look at a socially enablers of health which sounds to me a little bit more -

Mr EDMONDSON - More of a positive thing.

Mr JAENSCH - Yes. The health-in-all-policies approach that is being advocated sounds like people in the health system talking about how someone at the other end of the government, the highest possible office, should take responsibility for coordination of all these other things so we can get on with being health people. It proposes an elaborate architecture for achieving that. In my experience, working in areas of prevention around health, some primary health practitioners, GPs, are loath to refer people to anything other than some other sort of doctor. They are not prescribing food. They do not trust flaky community led do more exercise stuff. They are very keen to refer people to other qualified folk and they could refer people into other streams of healthiness. Primary health organisations and structures like yours could be proactively making submissions

to the people who already are funded to provide public transport, housing, education and literacy programs. The things we refer to in social determinates are already being provided by governments. We already have a budget for that.

CHAIR - Can you get to the question, Roger?

Mr EDMONDSON - Can primary health practitioners do more to refer people to preventative measures that are not to do with medicine? Can primary health organisations participate more in the planning and delivery of these services and infrastructure that will contribute to prevention as health enablers in our community?

Mr EDMONDSON - The very simple answer to both of those questions is absolutely. The reality is a health system is a very complex thing. Knowledge about what is out there, what services are there, who is there to refer to, is one of the key drivers as to who, in a health practitioner sense, I might refer somebody to and for what purpose.

I will go back to the comment I made initially. We have a tendency in anything outside of the core component aspects of health, and probably if you look at those as being the major funded elements of the PBS, MBS and the hospital funding, to be short termist in the way in which we invest. You have a problem with drug use and you chuck some money at it. There is a real absence of long term, structured investment that gives the knowledge and confidence to referring practitioners about who is out there in many cases. It is a case of trying to keeping on top of that information about what services died this month because governments disinvested, or what services cropped up over here because they have invested in something else. One of the hardest challenges we have is ensuring referrers are aware of services that are there and available to support them. That is probably the biggest challenge in encouraging people to use the full breadth of services available to them.

We and many of the services do the best they can to educate and inform referring providers about what they are there for and what they can do. Often if you are faced, in a general practitioner sense, with a quick decision when you have a waiting room full of people and you an hour behind, you do so. Often there is not the time to research and find out what is out there. A lot of it is habit.

Mr JAENSCH - Is that where we need to be making the investment? We readily talk about the need for more joined up policy and services at the point of origin rather than at the point of delivery.

Mr EDMONDSON - There is dual responsibility here. Longer term commitment to the things you are talking about will equal the capacity to drive much better and much more structured utilisation. I would concur with your view but it needs to be a partnership. If we, as practitioners running around trying to find out who is there this week versus who is not, it becomes a self defeating game.

Ms POWELL - It is not just about the functions people might provide or services that might be delivered, it is the agreed way of working. If you look at someone with an injured knee, the doctor may look at the injured knee and look at what the issues are. The local government might be looking at what the setting are in which the people have the opportunity to exercise which might prevent people having knee injuries or provide

opportunity for rehab style exercise. Workplaces, with their workplace, health and safety officers, often focus on the safety side and the legislative requirements of workplace, health and safety, looking at employee health and wellbeing in a truer sense of the words. It may then make an employee more mobile, less prone to injury and less likely to get that knee injury. It is not just about what other specific function I do, or the specific health issue the person ends up at the GP with, because people often only go to a GP once they are ill. What are all the roles the different organisations can play in first preventing that knee injury, or delaying the onset of that type of injury with wear and tear that comes with time, versus waiting until the knee injury is there and then dealing with it at the point of needing orthopaedic surgery. It is about a way of working and having an agreed approach.

CHAIR - We did talk with the last witnesses about people often only turn up to the GP when they have something wrong with them. If there was an opportunity for once every one, two or three years well person check and you can link it to women, particularly to their pap smear every two years. Not everyone has pap smears but you capture a lot of people that way. Do you think that is something that should be considered? How we structure this into this whole shared vision and approach?

Ms POWELL - That is one way of doing it. We focus on the importance of health literacy as part of our submission and in order to have people engaged in those processes, people need to understand what it means for them and motivate them to make that a priority in amongst all the other priorities or issues they may be confronted with. We need to look at how we build it into systems but it is also about looking at the GP and pathways to the GP and beyond. It is also about how we work with the other assets we have in our community, the aged care sector, the neighbourhood house, community shared, local government, who also have that shared understanding and that consistency of message about the important things for health and wellbeing or early intervention.

Mr VALENTINE - Removing some of the physical barriers to access as well, such as community transport and making sure it is available.

Ms POWELL - Yes, access to healthy foods and all those sorts of complex issues. It's so multi-layered.

Ms WHITE - Phil, you talked about GPs not having enough time often to sit with a patient and talk about all those other things. Do you think there's a role potentially for social workers to be imbedded in GP clinics so that if a GP has a meeting with a patient and you think, 'There's a lot more going on here. I'll just refer you to talk to my social worker after I've dealt with this'? The social worker will hopefully have knowledge of all those other support structures that could help that patient; do you think that could work? How would that be funded?

Mr EDMONDSON - Ultimately the solution to a lot of what we're talking about is integration of care. It's less focus on isolation of individual people in individual settings and more about how we structure a collaborative response utilising the skills available across the health care sector, and the social care sector in many respects, to respond to the needs of individuals. I have no doubt that for many people the benefit and value of engaging with a social worker would be tremendously beneficial. Likewise the opportunity to have a nurse educator engage with that patient on other aspects of their

health care would also be inordinately valuable. I guess the extent to which that applies is the stuff of the funding question we were dealing with before. Ultimately these resources exist in communities and the challenge has to be how we better engage them in the interests of the individual, not in the interests of the practitioners themselves, that should be driving the models we set up to respond to particular needs in particular areas. That is ultimately, I think, probably the only way I can answer that question.

There are arguments that a dozen different types of health or social care providers should be much better engaged with general practice and their patients in order to get a more rounded outcome that attends to some of the social determinant elements we've been talking about. For me this is not about how much more we should invest. It's about how we can make better use of the huge investment we already make in these services across our communities. We all have a role to bring together that integrated plan for service delivery.

Ms WHITE - Yes, and it's integrated in a place, from what I can tell. A lot of people, even if you referred them to another support service, wouldn't go because they have only ever presented at the point when they are sick anyway.

Mr EDMONDSON - And that comes back to the health literacy question around understanding that advice is given for you to benefit from. It's not there simply because you want to give it. As to compliance and that issue of people taking advice seriously and acting on it, we have to acknowledge and accommodate the choices individuals make in that space as well.

CHAIR - You have to deal with the fear, too. People are sometimes worried about having some screening test in case they find something.

Ms POWELL - It's also about how we, through the funding resources we have, encourage that integration. Some of the work we're doing at the moment, even with our rural health services, is part of planning annually. Those providers are asked to demonstrate who they are collaborating with, how they are doing that and for what purpose. Is it for information sharing, is it around joint projects, is it about subcontracting services for delivery in more appropriate areas? We are starting to try to build in how we ask and expect of those providers to be demonstrating how they're collaborating with others. That is with local health providers, but it is also with the schools and local government to look at what the connections are outside an immediate service area. I think there are opportunities to build it into how you resource, not just the level of resourcing but how we ask for that resourcing to be used.

Ms O'CONNOR - How is that driven and guided?

Ms POWELL - For us at the moment it is through funding agreements we have. That is an expectation of how that service performs and what we ask it to perform.

Ms WHITE - You said before about measuring outcomes. The Government used the progress report which measures activity every quarter. Do you think there's room in that report to put more focus on the preventative health space? We talked in previous hearings about measuring things such as preventable illness, communicable diseases, tobacco, drug and alcohol related diseases, avoidable deaths, avoidable hospitalisations.

Measuring against those things which are identifying how we are addressing these more preventable elements of the health spectrum, and if Government is held accountable against those measures you could rest assured that they would invest in those things because they are transparent. Do you think there is room in the progress reports which are released quarterly to include that sort of data?

Mr EDMONDSON - I think it is essential that it is. Effectively the National Health Performance Authority sets and accesses this information from states, from national databases and reports it back through My Hospitals and My Communities websites; the information is already there. The question really is to what extent are we taking it seriously and how are we using that in successive decisions around resource allocation and priority setting. For me, it is as much about how we use the information as opposed to what is it actually telling us. Unfortunately the game play that goes on with data is to what extent can we manipulate it to make it look better than it really is, or what spin can we put on it to explain away why we are crap at something and somebody else is much better than we are.

Ms O'CONNOR - Or the other one is how do we cover this data void. Because there are plenty of them. Huge gaps in data and understanding.

Mr EDMONDSON - There are. There are also a massive amount of data that we collect that we do not use. It is about giving access to the right people to it to assist in making the right decisions. The corollary to that is the fact that if you collect and you report on things you inherently make yourself accountable against them, and that is the reluctance often. Again, the other component that needs to be taken account of there is - is the bit of data that is being reported on telling us what we need to know in terms of getting a quality outcome or not. We tend to use these de facto measures that often are not reflective at all of the outcome we are trying to get or the work that we are trying to do. The measure has to have a strong relativity to what it is you are trying to improve or fix.

Ms POWELL - Measuring prevention is much more challenging than measuring once the incident has happened. Long term and a clear understanding that it is going to be generational before you start to see that change if you are looking at progress.

CHAIR - But if we don't start collecting this information on outcomes then we are never going to be able to demonstrate that there are cost savings or benefits in terms of money if we are focused on the health budget, if you must. That is the bottom line for Government in establishing funding for these things.

Mr EDMONDSON - Hips and knees and things are easy to count but what are the outcomes for people who are getting them?

CHAIR - How many people become mobile again and don't go to hospital?

Mr EDMONDSON - Exactly. The rehabilitation time and so on.

Ms POWELL - Or how many hips and knees have we prevented by having improved [inaudible].

CHAIR - How much weight reduction campaigns could save knee replacements being needed in the first place.

Thank you very much for your evidence. We appreciate your time.

THE WITNESSES WITHDREW.

PUBLIC

Mr DAVID GARDINER, ACTING CEO, AND **Mr STUART SMITH**, PRESIDENT, EXECUTIVE OFFICER, PATHWAYS TASMANIA, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Thank you for coming along. This is a public hearing everything is being recorded on *Hansard* and will be transcribed and put on our website as part of the public record. You are covered by Parliamentary privilege while you are before the committee, but if you do speak to the media afterwards you wouldn't be, so just keep that in mind. If there is some evidence you wanted to give to the committee that was confidential you could make that request and the committee would consider that, otherwise it is all public and will inform our report. We have your submission, which you gave before and the submission from last time, too, is also taken into evidence of this committee as well and they're transferred from last time. There has been a couple of years between them and we appreciate you updating the submission. I think it is an area that has had a bit more attention of late in the general public, so we're very keen to hear your submission.

Mr SMITH - I'm the president of the ATDC and that is why I'm here today.

Mr GARDINER - I'm the policy and research officer at the Alcohol, Tobacco and Other Drugs Council and at present I'm acting in the role of CEO of the organisation. The ATDC is the peak body for the Alcohol, Tobacco and Other Drugs sector, so we represent the organisations working in the alcohol and other drugs space. We also represent consumers and their interests in this area. We work closely with government in terms of trying to influence service provision in this area. It is one of those areas where we are continually trying to seek additional funding and an increased understanding of the particular needs of services and the service users.

Some of the things that we highlighted in our submission are the benefits that can be realised by investment in prevention. Things like the needle and syringe exchange program have been in place for many years. They do mitigate other sorts of illnesses, diseases, conditions being realised by the fact that people are able to access services for that type of equipment to enable them to safely inject substances. It is the sort of thing that for some people might be unpalatable, but enables safe injecting equipment to be available.

For people who use drugs it can be a tortured pathway that may have lead them to that particular lifestyle. When you talk to people who use or have used drugs, it's not like many people have chosen to become an addict. Some of the stigma or discrimination that they experience on a day-to-day basis when accessing services, be they services provided by a health practitioner or in terms of accessing housing, etcetera, it can be a grim experience for some people, not for everybody. The services that are available are the key.

What we do know from the work that we've been attempting to do more recently in the promotion, prevention and early intervention space is that many of our services tell us that they would like to be able to spend a lot more time working in prevention and early intervention, but they are continually diverted as per their funding agreements and requirements to work at that more acute individual client end of things. As much as they

would like to work in more of the early intervention area, time and resource constraints simply don't enable them to.

Ms O'CONNOR - What sort of organisations are you talking about here? Can you name some of the community sector organisations that fit within that space?

Mr GARDINER - We're talking about residential rehabilitation services, organisations like the Salvation Army, the Bridge Program, and Stuart's organisation.

Mr SMITH - When we talk about residential services, we provided some money that has come out recently, but it is about creating access to those services, understanding what the needs are and creating access to those services, and what is sustainable in those services, ensuring that we have a broad range. When I saw Cassy this morning, I am thinking of the Housing Connect model that has been implemented. With the health model there needs to be something very similar. It is about creating access to all Tasmanians, from the north-west coast to Launceston. The majority of our population is in Hobart, so it is about creating access to those services and making the current system accessible and sustainable and then building from that.

What we see as an organisation, because access is so diverse, you put a lot a money in to keep the organisation sustainable, and that actually undermines your ability to provide the product you are trying to provide. It is all of these things.

When we talk about determinants of health, whether it be drug and alcohol issues or other issues, it is not just in that one space. It is in multiple spaces, and as David said, it is about understanding the journey that people go on to get to the place that they are in and learning not to discriminate against that person and really support that person's journey. Working with youth myself, you see many young people who, as a young person, face trauma, and understanding what that leads to and being able to put things in place. The earlier we can put interventions in place, as the previous speaker talked about, you cannot measure those things sometimes, but they are vital in the terms of being financially effective, but they are vital in terms of the person's life and the effect on the individual's life, the families, the community and the effect on the justice system. The earlier we can put those interventions in place and help the person deal with those health issues, the better we will be.

Mr GARDINER - It is important for us to take a focus on preventative health and to better understand and work within the social determinants of health framework because whilst we do not necessarily want alcohol and other drug issues to be seen purely within a medical model, it is a complex journey that can take people to a place of alcohol and other drug misuse. While some people can see it and understand it as a disease, there are many factors that influence where and how someone ends up in a place that makes them basically misuse substances and require the different services to support their life or lifestyle and require different services to basically live better and try and integrate back into the community.

It might be a mix of services that requires someone to basically live life to the maximum and they might bounce back and forwards from services. They might, because of the nature of their substance misuse, find themselves relapsing also.

CHAIR - The comment you made in your submission said that despite the desire to coordinate or integrate services for clients, there are often structural systemic barriers in place which prevent cohesive a client-focussed service delivery. These barriers include competitive tendering processes as well as the silo funding arrangements affecting many community service providers which see them funded to deliver only specific discreet areas. You have touched on that . I would like you to give a bit more detail around that. When you look at activity-based funding models as opposed to population-based funding models, we can focus on that first. There is a huge issue with ice at the moment, and now the Prime Minister has acknowledged it as a problem. Obviously there is a lot of focus on that. Do we lose sight of all this other preventive stuff by trying to fix an urgent problem. If you talk about these barriers first and how that can impact. Also, those red flags that fly and how that impacts on delivering that preventative approach.

Mr GARDINER - We are all well aware of the vagaries of funding of services at different Commonwealth and state government levels and the different programs and the reasons for those in terms of trialling or piloting different service models. The fact that something might funded for a year or two years or three years and might basically than be phased out or incorporated into ongoing recurrent funding, one organisation might be successful for that sort of funding and others not.

Other organisations are funding on a recurrent basis to deliver different sorts of programs at a Commonwealth or state level. There are a whole host of different sources of funding and organisations based on their strong desire to be sustainable will try to attract whatever funds they can to continue to provide their services. They might be creative in terms of the way that they fund different services.

That is the sort of thing that we are alluding to in that statement within our submission. In increasing focus on processes like competitive tendering there can be a shift away from cooperation and collaboration between services because it is becoming more ruthless.

Mr VALENTINE - Competitive.

Mr GARDINER - Yes, that is the word. There is the nature of larger organisations and that competitive advantage that they can have. They might have efficiencies in terms of how they approach service provision and a stronger infrastructure and administrative base for how they are organised. That is not to say that some of the smaller services that provide unique services aren't necessarily needed by particular population centres within the state.

Different funding sources also bring with them different reporting obligations and reporting frequencies and that can place a burden on organisations. Some contracts require quarterly reporting obligations at different points in a contract. Others, as we are seeing with the State Government at the moment, there is a good shift to an outcomes based approach. There is still this balance between needing to report on activities and services that are delivered at the same time as trying to, in a better way, understand the outcomes that are achieved for clients and the community and the population at a larger level.

Not all services are equally placed in terms of their data information systems to be able to yield that information. There are multiple factors that place some organisations in a better position, or a more competitive position, when it comes to accessing new sources or funding to deliver their services into the future.

CHAIR - How do you deal with the red flags as they go up in this whole framework?

Mr GARDINER - By advocating to government in terms of being aware of some of these issues around sector reform and to be conscious of some of the potentially perverse outcomes of shifts to an outcomes based funding framework. To work with, not just our sector, around an outcomes based framework but to consider the way in which the entire community sector is supported around enabling data information to be better gathered. There are different components of the overall community sector that are better placed in terms of their data information systems.

Broadly there is a dearth of information in the alcohol and other drugs sector around outcomes that are achieved for clients. That can be because of the way in which consumers use the service system. Once people have had a particular experience within the service system, and perhaps that journey has come to an end, it is not as neat as someone having a successful presentation in a hospital and a surgical procedure. Basically they do not get an infection so they off back into the world.

Mr VALENTINE - It frustrates the decision making process doesn't it?

CHAIR - One of the things on your radar must be the ice issue in the community. There are some views in the community that they are people who are unemployed, they are this, they are that, they are everything else but other evidence would suggest it is right across the board. In terms of looking at the social determinants of the health impact on areas you are dealing with do you have data around that and it is an area we really need to be focussing on?

Mr GARDINER - We do not think we have adequate information to justify the current focus on amphetamines. That is not to say that it is not a current social and community issue. We are concerned with the media focus on the issue that it is an overrepresentation and potential glamorisation and dramatisation of it being an epidemic.

Mr VALENTINE - Distorted view you are saying?

Mr GARDINER - Absolutely. Again, the absence of data makes it very difficult to make a statement one way or the other. At a forum I attended late last year some of the information that there is data around has told us the drugs of greatest concern in the community are around alcohol and cannabis. They are not necessarily the messages, I do not want to politicise this, some of the more conservative sides of the community want to hear. Alcohol is an amazing revenue raiser for government. In terms of addressing things like social determinates of health we know the work at a legislative and regulatory level around tobacco yields amazing results in terms of health outcomes. The same could be achieved potentially around things like changes to the way in which alcohol is promoted and is so readily available. That is not quite as palatable to our society at the moment. An illicit substance such as methamphetamine and talking about that as an

epidemic and how it is destroying families, breaking down the fabric of our society that is -

CHAIR - A bit of diversion are you suggesting?

Mr GARDINER - Perhaps your group -

Ms O'CONNOR - We must be careful here because the people who are working in the community sector at the frontline and families of addicts say it is incredible destructive, it has destroyed my family.

Mr GARDINER - Absolutely.

Ms O'CONNOR - We are seeing incidents of code blacks at the Royal Hobart Hospital. It is when the duress alarm is pressed and it has increased significantly over 18 months. Domestic violence rates in the north are up by 10 per cent. I understand what you are saying. Then we have the Australian Crime Commission describing it as an epidemic.

Mr GARDINER - I don't doubt that at all, Cassy. I am saying it concerns me the issue is potentially being looked at in a police and law enforcement sense rather than in a greater whole of system approach with a health and wellbeing focus. I do not know the link is necessarily there with a direct cause or link between methamphetamine and some of what you talked about in terms of domestic violence and health presentations. Substances like methamphetamine, and indeed lots of other substances or drugs, tend not to be used in isolation. There is often a poly drug use history side.

Ms O'CONNOR - That is right.

Mr GARDINER - To focus on one substance, we believe, is erroneous. We have no problem with the Government's investment of nearly $5 million over five years in terms of increasing access to residential rehabilitation beds and hopefully that will be done in a considered way. We would never want to see a strategy that is about investment of funding only in beds or services for a particular drug. We would rather see services available to respond to alcohol and drug needs. It looks like that will be the response of this Government at the moment. We want to see a response to the issues associated with alcohol and drug use.

Ms O'CONNOR - When you look at alcohol and illicit drug use, for example, something has manifestly failed. We are dealing with very similar numbers of people coming through who present with addictions to various substances, whether they be legal or illegal, so where's the point of failure in the system? For all the money that is being invested in rehabilitation, all the money that's going to fund peak bodies such as yourself, all the money that's going into the Department of Health and Human Services, the Alcohol and Drug Section, something isn't working? We are not seeing any significant change to the statistics.

Mr SMITH - That comes back to the same issue around getting the appropriate data. That was one of the pleasing things in the Health minister's release about getting the appropriate data. I agree it's clear to people there is more ice use happening, but are we seeing new drug users or people just changing drugs? It comes back to the same issue of

creating a system that creates access throughout the state, taking into account Tasmania's broad and diverse population, and creating access and a system that is sustainable and funded effectively and is based on good data and outcomes measures.

Ms O'CONNOR - Data is very important, and I agree with that. We have some data around the use of ice: for example, the Australian Household Drug Survey and the illicit drug reporting system. What you're saying about people switching drugs, there is some evidence that points to people moving to ice over other drugs, including cannabis and other forms of methamphetamine. There is some data there but isn't the missing component, whether we're talking about alcohol, cannabis or ice, that there is very little work going into systemic early intervention and education? So we're not stopping people before they take on various drugs, we're not educating them or building resilience into individuals and targeting at-risk communities.

Mr GARDINER - We would agree, absolutely.

CHAIR - Doesn't that then go back to this focus on an epidemic rather than focusing on the prevention and identifying the risk factors and social determinants that result in those risk factors being prevalent? Do we have the data that identifies risky drug use and behaviours with social determinants? Is it across the board? It doesn't matter where you are from or what your socioeconomic background is, what your education level is - does it make no difference? You could take a different approach if that's the case.

Mr GARDINER - Not necessarily. Unfortunately, it's not as cut and dried as that. There are different paradigms of understanding of substance misuse in that you can take a more biological or medical model in neuroscience and how that understands addiction or you can take a much more social determinants approach and consider the entire environment in which someone lives and how that can influence some of their risk-taking behaviours and the influence on violence, family breakdown and so forth. It's not as cut and dried as saying that if you're subject to these environmental influences then this is likely to happen. We can't say it will only affect these areas or it will be across the state, but there are certain areas where you would focus in early investment and prevention type programs because of the environmental influences and what they can result in.

Mr JAENSCH - The social determinants thing is a wheel, it seems to me, because depending on who we speak to everything is a social determinant of all the other things and vice versa. I can see in this context that alcohol, tobacco and other drug use can be a determinant of health and itself is a product of other determinants. I am interested in these discussions about where we can find points of intervention. Where do we have people who are sufferers of, users of, creators of these problems and where can we nip them in the bud? I am interested in your comments, if you have any, on where alcohol, tobacco and particularly other drug use, intersects with the justice system. Do you have views or statistics on the number of people who are in our prison system who are using drugs and who are in jail as a result of drugs and the programs we have in place within our prison system to treat and prevent drug use. Can you comment on those?

Mr SMITH - I don't have the statistics in front of me but I suspect they would be high. The first place of intervention that crosses is with the education system and one of the statements in our report is about having the ability to fund projects from multiple departments, people taking joint responsibility, especially when we talk about

prevention. We have seen a younger and younger cohort accessing and using illicit substances at unhealthy levels - it is always unhealthy at that age. It is being able to start at a very early age through the education system and youth justice.

From my own service perspective, greater than 70 per cent of people would come in with some legal issue combined with their substitution factor. I would say it is probably even higher. When you think of the older clients, when you have family, legal issues and other issues, it is nearly 100 per cent of people. You don't get a client rock up with one issue, it is normally to sustain their things -

Mr VALENTINE - Associated with their habit.

Mr SMITH - Absolutely.

Mr JAENSCH - It we have someone who enters the justice system as a result of drug related crime and we have put them in jail, do we routinely address their addiction?

Mr SMITH - I think there are some programs that are in the process of starting. Historically, no.

Mr JAENSCH - We put them back out into the world with the same driver of behaviour that put them in jail?

Mr SMITH - Yes, and still current to a large degree. I know there is some work happening in that area.

Mr VALENTINE - It probably increases their access or the desire to get further into drugs, in some cases, when incarcerated?

Mr SMITH - Potentially, and that is the great issue of the criminalisation of drug use and our social understanding of it.

Mr JAENSCH - We have heard commentary on the radio about the tobacco ban in prison here. Can you comment on that? Will that work? Is that something which then could extend to other forms of substance use?

CHAIR - Are you talking about legal versus illegal drugs in prison?

Mr JAENSCH - If we have people who are coming in and they are using a range of substances, legal and illegal, where it sounds like there has been a policy adopted of removing tobacco from those environments and working with people on curing those addictions, is that a precursor of us doing more for other addictions while they are in there?

Mr SMITH - I couldn't comment because I would not suggest they are supporting other addictions while they are in there.

Mr GARDINER - It looks like an example of a project that has been well handled by the Justice department in the way in which substitution therapy is being made available to inmates and the way they have tried to deal with the fact that some inmates have tried to

get around it. It has been a volatile issue in terms of people considering it from a human rights issue with, at present, tobacco is a licit substance. The department has tackled it from a workplace, health and safety issue and has made a judgement about that. For all intents and purposes, it looks like it has been a well-handled initiative in the way it has been rolled out across the department.

CHAIR - We are dealing with the illicit drugs, so there should be some expectation that you will not be using illicit drugs in prison.

Mr GARDINER - We know it does go on.

CHAIR - We know that, yes.

Mr GARDINER - To be perfectly frank, in a very ambitious sense in our budget priority statement last year we would love to see the consideration of something akin to a needle and syringe program within a prison setting, in recognition of the fact that it does go on. In jurisdictions where similar programs have been introduced internationally, it hasn't presented safety issues and it does address the issues associated with chronic conditions.

Ms WHITE - I wanted to ask about the court mandated diversion program. I understand from representations made to me by constituents that there is a real problem in the north of the state, particularly for people needing placement in that program. Are you familiar with the challenges that presents for people who should be supported through the court mandated diversion program but who aren't getting that support?

Mr GARDINER - I'm not aware of all the issues, but I do know there have been some in terms of program access because of resource constraints. That's a joint initiative, partially funded by the Commonwealth and the state, I think.

Ms WHITE - I'm not sure.

Mr GARDINER - I don't know enough of the detail around the funding levels, but I have heard of access issues around the program.

Mr SMITH - An effectively funded CMD program is again a good initiative. Through our program we have a number of guys who work with CMD who enter our program as an alternative to a longer prison sentence or to a prison sentence in total, and to be able to give people an opportunity to, yes, pay for their crime, but do it in a way that is restorative, is vital. Things like the CMD program, when we talk about health determinants and putting interventions in place that are likely to decrease ongoing offending, are vital. Even though we get the bad stories from people who misuse that program, for the vast percentage it does work and it gives them an opportunity to work through it. It is my understanding, especially in the north, that there have been issues. Some of those issues are going to be around residential services and other intervention programs. CMD and being able to provide other services in conjunction with their CMD program.

Ms WHITE - It is interesting to hear you say that because I thought it would be a good strategy to help people with a restorative approach to their drug use to hopefully stop

using drugs, but if there aren't places then how are we supporting those people? We're not supporting them really.

Mr SMITH - No, we're not. Understanding that drug addiction is much more than just the physical part. If you keep people physically off drugs and put them in jail for a year, we know that's not enough because they go out and use again. We need a whole lot more. Again, it's the systematic approach that helps the person being able to cope. The person has to do their penance for what they have done, but restoring the person so they're not going to go through that again is vital. That's where a CMD program, where it's appropriate, is going to be much more effective than a term of imprisonment.

Ms O'CONNOR - One of the issues that is expressed to me about the current rehabilitation system is that it is under-resourced and there are not enough rehabilitation and detox facilities in the state. Do you share the concern? It goes back a little bit to Rebecca's questions as well. If a person is lucky enough - and I use the word with caution - to secure a rehabilitation or a detox bed, and in this instance we are talking about crystal methamphetamine use, and they have a two-week stay in Serenity House in Burnie, at the end of the two weeks they're put back out into the community and they go back into the same world that they came out of before. Almost inevitably they get back into the same scene, back into the same problems and back into this cycle. How do we make rehabilitation more effective? Is it case management? Is it follow-up? What is part of the solution to making sure that the rehabilitation dollars we spend are a good investment and not just making government feel better? Yes, we're providing beds, but then there's no change to the individual behaviours because they're straight back into the problem zone.

Mr SMITH - I think that's a real concern. Again, not having seen the tender that is going to come out calling for those beds and how that's all going to work. My organisation, City Mission and Salvation Army are in the process of putting together an MOU to be able to work together to be able to try address some of those issues. You are right; the issue is much more than having the person in a residential service for a period of time. The challenge is back into the community. As an organisation we are at the moment exploring a model and looking at perhaps an alternative model that does it within the community to be able to bridge those gaps, because that is a concern. I think the answer again comes back to resources and making sure that we build appropriate relationships. It is about not just waiting for someone to be at Missiondale and finish their program, then make a referral to the Bridge program in Hobart. There has to be some overlap. It is good for the Government to be able to provide the funding but it is also good for us as a sector - and this is where the ATDC try to advocate and support - that we work collaboratively. It is vital in Tasmania if we want to provide diversity of services and give people choices of different services. That is great, but also then those services need to overlap with each other. I think we are growing, until we come to having to fund probably from the same bucket of money.

Ms O'CONNOR - Is part of the solution something like a Housing Connect model where we locked the providers into a room with Alison Jacob and said, rather than have you all compete for the pool of money, given your expertise you need to come up with a model that works and is fair. I think that was quite novel in collaborative terms at getting traditionally competing organisations to see that they all had an equal stake in making it work.

Mr SMITH - Yes. Also having services in the housing market I saw that process and thought that was very creative and positive. We are now just starting to see some strong outcomes around them. I am a top-three service so our initial impact was less than us.

Access is the key issue. We talk about detox. Our detox is in Hobart. I really believe that, when you are in that heightened drug use, to ask somebody in Burnie to go to Hobart with no support, I think that is a real issue. When you are talking about, yes, I have been through detox and I am in a better place to think, to ask somebody to go to Hobart to the Salvos or to Launceston Mission, to us that is more realistic.

Mr VALENTINE - Taking them away from their networks and all those sorts of things.

Mr SMITH - Yes. You are going to detox, you are going to have the emotions, you are going to go through psychosis, you have all that stuff, and you are asking them to go to Hobart, away from all their family. A lot of families cannot drive to Hobart to visit. I believe that first stage is vital to be able to provide a better service in Launceston and the north-west coast, whether that is funding a service like Serenity House to be able to get into more of a medical model or medical support. I believe that first stage is where it is more vital for something to happen in the person's own environment, because it is hard enough making that first step, let alone asking them to travel 400 kilometres and be by themselves. Historically, access to detox in Hobart has been a huge issue.

Mr GARDINER - Cassy, that approach of enforced collaboration could work, but we also need to remember that it would need to be collaboration compelled between both the public and community sectors and that in some ways the public sector has an advantage in terms of both funding the community sector but in terms of also being gate keeper for some services that it provides itself. For some of the services that it provides itself it determines the policy framework within which those services are provided and the access criteria, and so some clients are not permitted until they are considered to be stable, or somebody may not be permitted to detox if they are perceived to have an underlying mental health condition. We see issues around people being denied access to pharmacotherapy or takeaways under pharmacotherapy if they do not fit a particular set of clinical criteria. We would need to make sure that there is a level playing field around some of those things too and that the criteria are more equitably determined.

Ms O'CONNOR - You talked about access to detox in Hobart being a huge issue. Is the only detox facility in the state in Hobart?

Mr SMITH - Yes, and at different times there has been recruitment and retention issues around staffing of doctors, which has meant that their operational level has been low.

Ms O'CONNOR - What is the capacity of it?

Mr SMITH -I don't know the numbers, but I know it has been reported as being only 40 per cent or 50 per cent occupancy.

CHAIR - That is the staffing levels?

Mr SMITH - Sometimes around staffing, sometimes around access from the north and north-west.

Ms O'CONNOR - Is this at the Royal?

Mr SMITH - St Johns Park.

CHAIR - Thank you very much for your submission and your evidence.

THE WITNESSES WITHDREW.

PUBLIC

Ms MIRIAM HERZFELD AND **Ms MORVEN ANDREWS**, SOCIAL DETERMINANTS OF HEALTH ADVOCACY NETWORK, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Welcome ladies to the committee. I think both of you have given evidence to the committee before.

Ms ANDREWS - I haven't.

CHAIR - Sorry, Morven. It is a public hearing. Everything you say is recorded on *Hansard*, it will form part of the public record and be published on our website. You are covered by parliamentary privilege while you are before the committee but if you spoke to the media afterwards, or other people, you are not at that point. If there was evidence you wanted to give in confidence to the committee you could make that request and the committee would consider that otherwise it is all public.

We received and read your submission and the submission from the previous committee as well has also been taken into the evidence of this committee even though there are a couple of years in between. We have received your updated submission. We invite you to give your background, your roles and then speak to your submissions. Members will then have questions.

Mr HERZFELD - We do have an opening statement but to clarify for those who do not know I am one of the co-convenors of the Social Determinants of Health Advocacy Network. We were set up in 2012. We have 230 members across the state and we are a voluntary network of people who are interested in social determinants of health. Morven is a co-convenor along with myself. I also work as a public health consultant.

Ms ANDREWS - I am a co-convenor of the network. I am semi-retired now. For many years I worked in the government sector in health and human services and also in education. I have also worked in the community sector in Tasmania.

CHAIR - Thank you.

Mr HERZFELD - I would like to read an opening statement. Thank you very much for giving us the opportunity to make representation to this committee. We are really pleased to be here again.

We would also like to highlight while we are in a position to be able to make the representation today there are many people, including those who we recognise as being first in the queue to be harmed, who are not able to raise their voices in a forum like this. We really want to urge you, in addition to gathering evidence through this formal process, to talk to the people who can tell us what it is really like to live with poor health as a result of societal conditions in which they live. Their voices matter as much, if not more, as those of us who are able to be here today.

As I said the Social Determinants Advocacy Network was established in 2012 to bring together people to promote action on social determinants of health so as to improve health and wellbeing outcomes for all Tasmanians. We believe that the opportunity for

everyone to achieve their highest attainable standard of health is a human right. We recognise the prerequisites for health that are outlined in the Ottawa Charter for Health Promotion, developed in 1986. They are things like shelter, education, peace, food, income, a stable ecosystem, sustainable resources and equity.

We don't support the notion that health is simply a lifestyle choice. Is it a choice to have asthma that has been exasperated by mould growth in a cold, damp, poorly maintained rental property? Is it a choice to suffer from an unmanaged mental health condition with no treatment plan or support, no permanent address, no job or no hope? Was it my choice to lean on the health system for a mental health condition at a time when my employer chose to let me go because I wanted to continue to breastfeed my child, which would have been challenging in a statewide full-time role?

For all of us our health is affected by the society we live in and this is what we are advocating for. Did I bounce back? Yes, I did, but why? Because I had access to resources, skills and support. Many people do not.

Despite the commencement of some very promising initiatives at both the federal and state level in relation to preventative health and the social determinants of health, these have amounted to very little over the past years. In fact, the reverse is starting to occur. We have seen the demise of Population Health Services in the Department of Health and Human Services, the very unit that has gathered strong evidence to highlight inequities in health. Not only does this name no longer exist, the unit was reviewed in an appalling manner and significant resources have been depleted.

What does this tell us? That we will turn a blind eye to health inequities? These resource cuts are being felt in the community sector as well with programs like the Canteen Accreditation Program, the Family Food Patch Program at risk of further cuts. Programs like Move Well Eat Well in the Department of Health and Human Services are also at risk. We should be building not cutting these programs. I would argue that in addition to issues such as nutrition and physical activity a program like that should be expanded to also cover mental health.

We've seen the development of a Green Paper and a White Paper with very little emphasis on preventative health, which has recently been addressed by the establishment of a committee. However, we have no opportunity to have input into that process and we question how the outcomes of that committee will align with the findings of this inquiry. We haven't witnessed any strong leadership to progress the recommendations of the World Health Organisation report on social determinants of health either.

What we have at the moment is a patchwork of good initiatives with potential, but nothing that brings things together. We feel that the Tasmanian Government should show leadership on this. We need a long-term plan to reduce health inequities that brings all these things together. Importantly, this needs to filter down to local government and community level to ensure there is a voice for members of the public.

We need a plan that has cross party support and we would like to put forward the question to you: is this possible? Would you go to an election promising the same things as your colleagues from other parties?

Ms O'CONNOR - Depends how good it was.

Laughter.

Ms HERZFELD - We have resubmitted our earlier submission along with a cover letter and some ideas for action. We provide these ideas for action, not as a comprehensive plan but to provide some tangible suggestions for how we can get to work on the social determinants of health, particularly because many people find the concept too large to grasp. We wanted to show you there are ways we can begin to work towards creating a more equitable society.

Mr VALENTINE - I was interested in your submission, action 4 on the last page. You talk about needing to mandate training to health workers on social determinants of health and healthy literacy. Are you talking about a general awareness training or are there glaring gaps that you might point to as being needed?

Ms HERZFELD - I think there are glaring gaps and I am not wanting to put the fault on the workforce. It is a complex area and when you are under pressure in the health care system, the idea that you would recognise the underlying causes of a person's condition is going to be difficult for anybody. We must do that, otherwise what we end up doing - there is a saying and it goes something like, what's the point of treating people if we send them back to what made them sick in the first place.

There is a need to expand the workforce's thinking around social determinants of health. But that must be matched by the ability to refer people to services that can support and assist them.

Mr VALENTINE - Joined up services.

Ms HERZFELD - That is right. We are not saying that people who work in the emergency department need to start dealing with housing issues, for example. We need pathways that people can follow and they can be supported to have those things addressed. If you have, for example, a mental health condition, you have no housing, the chances are that you are going to re-present to emergency. We know that happens because you have these conditions you are living in that make it very hard for you to recover from your health condition. Within the health system there is a gap in the knowledge and the skills about how you can act on social determinants of health.

I would like to ask Morven to comment on the importance of health literacy because one of the things we are finding is that people often limit the meaning of the term health literacy to, does this person understand what I am telling them. It is not just about that. It is about providing the person with the skills and the resources so they can act on that and move on.

Ms ANDREWS - It is building their capacity so they can find their way through the health system and know what is out there and what the resources are, so they are not just being able to talk about the health condition but to be able to manoeuvre through the health system.

CHAIR - Is that particularly difficult for the people we are talking about here and, if so, for what reason? Why is it more difficult for people to negotiate? I come from a health background and I can negotiate the health system with my eyes closed but many people cannot.

Ms ANDREWS - I have tried to manoeuvre through the aged care system and even with a health background and knowing that system, it can be difficult for people who do not have that knowledge of what options are out there and their capacity to talk to people in their language. It can be extremely difficult.

CHAIR - How do you address that? Health literacy is such an important aspect. It is not just understanding that I will have to take two tablets three times a day, otherwise I will get sicker. What do we need to do that?

Ms ANDREWS - We need to educate health workers so they are speaking the language of the clients but it is also a matter of the clients having the language to be able to access information to be able to speak to health workers and not be belittled in any way so they are respected.

Mr VALENTINE - Quite often they might have mental health issues too. They may not be able to communicate as well as some might. So that is an issue too.

Ms ANDREWS -There is room for a lot of advocacy from health workers.

Ms O'CONNOR - Can you describe the 'ideal-world' system, a whole of government response that accepts that there are social determinants to health and wellbeing and accepts the need to invest in health living messages? Where might that sit in government, and what might it look like?

Ms HERZFELD - How it looks is that health is valued as much as economic growth and that there is a recognition that the two have a lot in common and that for a prosperous society we need that. We need economic opportunity and that is beneficial for health and wellbeing.

Ms ANDREWS - It has the reverse as well. Health and wellbeing is essential for economic growth.

Ms HERZFELD - Yes. It has to address the inequity in health. That is first and foremost. We have to close the gap between those who are experiencing poor health because of their social circumstances. Bringing everybody up to a more equal level, to have that opportunity to attain good health is fundamental. It is about fairness and equality.

We have that up in lights. We have that as our fundamental goal and we hang things off that, whether you work in Education, Department of State Growth or Health, we are working together and we are aspiring to that as our central goal.

It looks like a long-term plan - thirty plus years. Some of the issues around the social determinants we know are inter-generational, particularly things like education. We know they are things that we are not going to change overnight and that is why we talk

about the need for cross-party support, because unless we get that, we are not going to make real gains in that area.

In regard to your question about where that might sit, Morven and I have had lots of discussions about that and we can see the value in this kind of work sitting in the department of Premier and Cabinet for example, as being a whole of government driver, but we also have concerns about that because of what we have seen happen with initiatives in the past, such as the social inclusion strategy. We have seen a change in government and so that no longer exists. We would hate that to happen to something as important as this. We have talked about the idea of a standing committee. Whether that is something that can be looked at. We don't really know what the answers are.

What believe we have some excellent skills and expertise and what we are seeing is that expertise is being disregarded. I am talking about population health. There is a lot of data in that area. Whether it sits in DPAC or outside of government, there is such value in that unit and we should be making the most of that.

Dr Roscoe Taylor's *State of Public Health* report, for example, has loads of data that illustrates the social gradient in health outcomes. We need to base our decisions and our work in this area on that kind of evidence.

Ms O'CONNOR - Can we talk about population health? In the consequence of the last state and Federal budgets was a cut of about $6 million to population health. I am not sure whether my memory is failing me there.

Ms HERZFELD - The National Partnership agreement money?

Ms O'CONNOR - No, but there was a combination of cuts to population health that I think totalled about $6 million. How important is the role of population health, what is it now under this Government, and what are we at risk of losing in terms of our understanding of the epidemiological facts even of people's health? What is at risk here if we do not have a properly resourced population health division or an area of government that is focused on that?

Ms HERZFELD- To clarify before we get into that, I got this data from Roscoe before he left. The national partnership agreement money was $8.5 million. Just national partnership agreement money over four years so that does not include the State cuts.

Ms O'CONNOR - Can you talk about the role of population health in setting good public health policy. What is population health called now?

Ms HERZFELD - Public Health Services.

Ms ANDREWS - To my mind population health is quite different from public health. It certainly encompasses public health but it is a much broader concept. We are in danger of losing the strategic policy role that population health has taken in the past. While the epidemiological functions may remain getting that over all strategic government is in danger of being lost. That brings together information from right across the system and pulls it together, particularly around equity.

Ms O'CONNOR - The review was undertaken by the University into population health and I read the review report. Do you know who was consulted about the role of population health? My reading of the review was that it was a stitch up. What is your view on that?

Ms ANDREWS - Our understanding is that nobody was consulted. There was no real engagement at all either with stakeholders of population health service or population health itself.

Ms O'CONNOR - Or TasCOSS?

Ms ANDREWS - No.

Ms O'CONNOR - So the community sector, the wider health sector was not consulted about the future of population health?

Mr BARNETT - Chair, through you, point of order. Do you believe this is appropriate to the terms of reference or more appropriate to Budget Estimates? This line of questioning.

CHAIR - I am interested in the views of witnesses as to where they think the issues that need to be addressed around the social determinants of health.

Ms O'CONNOR - I think the questions are quite reasonable because in Budget Estimates we get to talk to the Health minister. Here is an opportunity to talk to stakeholders.

Mr BARNETT - This is the health prevention committee, isn't it? We have the minister coming this afternoon.

CHAIR - Yes, and this may inform the questions to the minister.

Mr BARNETT - It may do. Depends on the question. Anyway I put it to you. It is your call.

Ms O'CONNOR - Well we have seen the demise of a very important part of the Department of Human Services and it needs to be explored.

Ms ANDREWS - We just want to see somewhere, where you have got that strategic overview, that can really push the issues that we are concerned about in terms of social determinants.

Mr VALENTINE - I say it is not about the politics. It is about the data.

CHAIR - The question is whether the new public health services will have a strategic approach, and you believe it will not. Your evidence is that you believe there is a risk of losing that. That is what you have said?

Ms ANDREWS - I think we have probably already lost that. There are not the staff left to do that so where it is going to sit in Government and who can undertake those functions.

CHAIR - It is relevant to the terms of reference of this committee.

Mr VALENTINE - It is a question we can ask this afternoon.

CHAIR - That is what I am saying. It is a question that we can ask the minister. It is also something that can be brought up through health budget Estimates as well. A strategic focus is relevant to preventative health.

Ms O'CONNOR - That is right.

CHAIR - We will move on anyway.

Ms WHITE - I wanted to ask about one of your recommendations, which Rob touched on, around educating the health workforce.

Social determinants of health as a concept can be a little bit difficult for some people to grasp. I understand you are working on something at the moment around the language that is used to better explain what the social determinants of health mean. Are you able to provide an update to the committee on that work?

Ms HERZFELD - Basically we're undertaking a small research project, for which we have ethics approval, to talk to members of the public about the concept of the social determinants of health, particularly the language that often is used in that space. We all like to throw jargon around, such as health inequities - we've done a lot of that today. We wanted to find out from members of the public whether these concepts resonated with them. We are running focus groups and we have done a couple of those already. It's early days in the research but it is a very interesting process. Early indications are that language such as 'social determinants of health', 'health inequities', 'entrenched disadvantage', 'vulnerable communities', alienate us from the very people we need to be supporting to improve health and wellbeing. That may not be surprising but it is good for us to be able to recognise that is a finding in the Tasmanian context. The people who are living in most vulnerable circumstances - and we've talked to some of those - don't want to be known as 'our vulnerable Tasmanians'. They are people who have needs the same as everybody else. They have some extraordinary strengths in their community and we need to be building on those. They also have significant challenges and those are things around poverty and education. We need to be supporting people to move out from those conditions. It is a very important project because it teaches us about how we engage with our communities that are most at risk.

CHAIR - When you say 'we', who is 'we'?

Ms HERZFELD - All of us. I am doing the work along with my colleague, Michael Bentley. We are doing the research with the idea we are going to pull together something to publish and feed back to all of us who work in this space. We can then say 'This is what the research is telling us. This is how we need to be communicating these things'. These are the things that are important for people's health and wellbeing. From the focus groups we've run, when we say to people, 'What's important for your health and wellbeing?' they are not saying it is the hospital or the doctor. They're telling us about their home, community, social connections and opportunities in life. They are the things I believe are important but people are telling us they're the things that are important to them. We have five questions in our focus group research and the last question is: 'Our

government wants us to be the healthiest population by 2025, how do you think this can be achieved?' They are telling us they need action on social determinants of health, they're talking about their communities. We need to address education and housing - it's a critical issue for people and people are recognising that, even though they don't use the jargon terms. It is an important area and we want to share the findings.

I don't want to harp back to this, but as to how we consult and have this conversation, we don't see preventative health as being a secret issue; we want to be part of the dialogue and the discussion. We don't want to criticise the Health minister. We think there is some great stuff happening there but we still gaps and we will continue to raise our voices. We are concerned when people such as Dr Roscoe Taylor are not recognised in that space and we will say that. It's not out of criticism for anyone in particular, it's about understanding people have knowledge and expertise and they should be valued and we should be using that in our forward planning.

Ms WHITE - Do you think at this point from the focus groups you've held you have identified some common language you might be able to start using instead of the 'social determinants of health'?

Ms HERZFELD - Not really. It is a very difficult one. When I ask people who might be considered to be most disadvantaged they talk about struggling to get by, being a battler. I don't know if that's the kind of language we would be using in our policy documents or search. That's always going to be a tension. First and foremost we need to recognise these are people; they are human beings just like you and I. Whether they live at Sandy Bay or Gagebrook, they are people who want to live a good quality life. It is very easy for us to label people and put them into a box and say, 'Those people over there aren't making the right choices to be conducive to health and wellbeing. We are saying that that is actually not the case.

Ms WHITE - I have one final question and it goes to your earlier statement that public health is very different to population health. Could you explain what you see to be a definition of population health compared to public health?

Ms ANDREWS - I think public health is a much narrower definition, whereas population health encompasses health equity. Population health to me takes in social determinants very much, whereas public health is much more a functional definition.

Ms WHITE - More of a service delivery definition as opposed to understanding.

Ms HERZFELD - The formal definition from my university days was that it was an organised response by society into some sort of hazards or things that are detrimental to health. I think it has broadened out since then because you have this concept of the new public health which is broader than that. The thing with population health is that it looks at the whole of the population as well as cohorts within that. We often talk about as being proportionate universalism; we need to act across the population but with an intensity that addresses issues for those that are most disadvantaged. It is looking at specific cohorts and it is looking at the data and identifying how and where we need to put our energies and efforts. Public health traditionally is about a whole of population, vaccination, water quality, those things that go across the population.

CHAIR - I think we have a double-edged sword here in many ways, you only have to look at the reaction to SBS's *Struggle Street* the other day.

Ms HERZFELD - I was wondering if you were going to bring that up.

CHAIR - We have struggle street in Burnie or anywhere in Tasmania. You recommend that we talk to people who live with poor health in their societal conditions. I think that is a sensible idea, however to get some of those people in front of a committee like this would be very difficult for them. There is a huge power differential across the table regardless of any language we use or anything else. I think it makes it awkward in some respects to really hear from those people directly that like. With your research, when do you expect to have that available because that would inform and is the real people's voices I am hearing so when are we likely to be able to get it?

Ms HERZFELD - July. I was not suggesting that these people front here. I know what you are saying. Even with the focus groups it is hard to get people to come and talk to us in their own communities. Certainly organisations like TasCOSS represent the voices. I noticed from the list of people who are presenting that there are certain groups that are not presenting and I think that is a shame in a way.

CHAIR - There are not many that aren't.

Ms O'CONNOR - Who would you like to see here as well, because we are very open to suggestion.

Ms HERZFELD - I would like to see the aboriginal community represented here, for example, and groups from disability.

CHAIR - We have invited them.

Ms HERZFELD - Okay.

CHAIR - We can summons people but we wouldn't do that in this sort of circumstance.

Ms HERZFELD - What we do know is that there are certain cohorts who are more disadvantaged, who have more barriers, and if they won't come I am suggesting that you look at the evidence base around those people as well.

CHAIR - It would be helpful to have your research which is directly engaging with those people.

Ms O'CONNOR - What about refugee communities. Are they feeding into your research?

Ms HERZFELD - Yes, they are. We were contacted by the Red Cross. Their bicultural program works with communities and they were keen to be part of it.

Mr JAENSCH - Thank you for your contribution and for advocacy for people who aren't here for all sorts of reasons. Is the Social Determinants of Health Advocacy Network actively making submissions to those parts of government and the community sector who

are responsible for delivery of housing, public transport, community transport, education and literacy services in those other areas?

Ms HERZFELD - What do you mean?

Mr JAENSCH - This is a health system review and a lot of the submissions that we are taking and the witnesses are hearing from are talking about what the Health portfolio area should be focusing on in terms of a greater balance of preventative health and the rest. In our discussions about the social determinants we talk about a whole range of other services that government is providing as well and their need to be contributing to the solution. As an advocacy group, are you presenting this sort of information and these needs to the people who run the buses and housing or those other areas, or are we funnelling all of this inquiry through the health lens, not the determinants lens?

Ms ANDREWS - We're a fairly new network and we are also all volunteers, so we don't really have a huge capacity, but if there was an opportunity we would certainly take it.

Mr JAENSCH - Because they need to know.

Ms HERZFELD - We certainly do the whole-of-government stuff like pre-budget submissions. We've done things like that in the past, but as Morven said our capacity is pretty limited; we have no money. We're here as volunteers and so we do what we can in terms of speaking up about these issues. It is a really important point that you raise. We do know that a lot of issues that are pertinent to health and wellbeing outcomes are issues that are the core business of these other areas of our society. Transport is a classic and housing is another one.

Mr JAENSCH - Just on the topic that you raised about appropriate language, I tend to agree. I think so much of the language we are working with tends to reinforce the helplessness of the subjects and that in itself is perhaps disempowering in the dialogue. I've been trying to salt into the discussion throughout that if our social determinants can be social enablers of health as well, and therefore they're more prospective looking, that then is perhaps a narrative that we can take to other ministers and portfolios and say, 'You're area has been identified as something that can help make people healthier,' rather than, 'You're responsible for people being sick all the time.' I think there is a positive way in that.

Ms HERZFELD - I think partly it would be great if somebody other than the Health minister said this is what we need to be doing. That is almost like what we need. I've been asked to be involved in the Hot House on Education. At first I went, 'I'm not an education person,' but that's not what they're doing. They're bringing in an economist, a health person, an educator, bringing in all these people who are going these people are going to think about education. Wouldn't it be great if we had that around health? We need someone like MONA to say we are going to pull together a round table of experts from all walks of life to help resolve the health problem. Yet what is happening at the moment is that us healthies are here, but we need to engage with these other sectors and we need them to be part of the solution because they bring a different perspective to it, but with a common goal. I think that's fantastic.

CHAIR - Thank you very much.

Ms MORVEN ANDREWS WITHDREW.

Ms MIRIAM HERZFELD, HOBART WOMEN'S HEALTH CENTRE, WAS CALLED AND EXAMINED, AND **Ms GLYNIS FLOWER**, HOBART WOMEN'S HEALTH CENTRE WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Thanks, Glynis, for joining us. We received your submission, which was quite comprehensive and we appreciate that and invite you to make some opening remarks - the purpose of being here, your background, and then speak to your submission and anything you would like to add.

Ms FLOWER - On behalf of the Hobart Women's Health Centre I would like to thank the select committee for the invitation to attend today.

I am Glynis Flower, the executive officer of the centre. I am accompanied by Miriam who is a member of our board and she is the co-author with Morven Andrews of our submission.

Mr JAENSCH - There is a patter emerging here.

Ms FLOWER - I know it sounds a little incestuous but when you have board members with those skills you don't do it yourself. I was on leave and there were three health submissions to be done in February and we did all of them. One was the rethink and the other was for the sustainable clinical services white paper and this one, so we had a busy start to the year.

For those who do not know, the Women's Health Centre has been operating for 27 years, funded by the state Government and we are a health promotion charity recognised by the Australian Taxation Office. That is our core business. We operate from a centre in North Hobart, we offer a range of services to assist women to make healthy choices. We run a preventative women's clinic with a nurse practitioner. We offer services of a nurse, and allied and complementary health professionals. We provide space for support groups and these are about breast cancer, pregnancy, birth, grief after a loss, and a number of other things. We maintain up-to-date resources on health and we operate a statewide women's health information line. We share information through our Facebook and our website pages.

Our on-call programs operate in Hobart, Launceston and on the north-west coast and they are for women recovering from breast cancer. We conduct occasional forums, workshops and information sessions, in other parts of the state and we consult with women on policy and strategic direction.

We provide advice to government, especially around women's health and wellbeing and our presence here today is to provide information about our model of practice and our commitment to preventative health. It might sound like we are here to blow our own trumpet but we think we have a model that has some pertinent things to say about the way health prevention operates in Tasmania. We concentrate on women but we believe in a gendered approach to health including health promotion and prevention for both men and women. There is a lot of evidence now to show not only promotion but also diagnosis, research, care, and delivery of services, can benefit from a gendered lens.

That is what we aim to do with our service and we think it is something that needs to be looked at across the board.

We recognise sex and gender and they are two very different things. Sex is the biological side of you and your gender is the social conditioning or the way society looks at males and females. There is a very different meaning in those two things. There are risks and conditions in life stages which only affect women or men due to their biological makeup but there is also social conditioning of gender that can influence your ability to stay healthy.

For many years medical research was carried out largely on men and often on male medical students. So it is not surprising some of the research is not necessarily the best advice for women. Although there have been changes, there still needs to be more research that investigates health from that point of view.

Gender roles have changed over the years but there are still significant differences in the expectations, opportunities and roles in our society and health prevention cannot ignore sex in general in cases of health. Even the way men and women access health information is different. Women are much more likely to seek information for themselves and for their families. For those women sitting here, you would be familiar with the doors of public toilets in the airport, for instance, where often there is a message about prostate cancer because it is the women who collect the information and take it back to the family. My guess is that the reason the same ad in the gents as in the women's, it an indication these people know what they are doing and they know women are the great collectors of information. Not only are women good at getting information for themselves but they are also good at collecting it for their blokes.

Equity and education workplace opportunity income as you have already heard, is an important part of how people can respond to health issues. We are great supporters of the social determinants of health.

It is important to understand that health is not only the business of Health and this has come up before. If you think back to the nineteenth century, most of the important changes that improved people's health were about things like sewerage, engineering, reticulation of water, safety in the workplace, workplace laws about children being employed in factories. They were some of the things then and hopefully we did get over those things but it is still the case that if we are going to improve health for the whole of the population, we have to take into account things other than our health services.

Whatever the committee considers, it needs to consider it is not just about pouring money into the Health department and getting them to get on with building hospitals or whatever, it is also about improving things in other areas like education.

The reason we think our model is interesting is because we treat the whole woman and we use the word holistic, but we do not want to give the impression of some new age approach to the world. It is that we think bodies are not separate from minds and that because you have a sore toe, it does not mean you have lost your brain or any of those things. It is important that is how you treat people.

When women come to our centre they are all treated equally and on a par. If someone walks in the door, they may be coming to use the shower because they are homeless or they may be coming for a counselling session or they may be coming for Thai Chi, they might be having a cup of tea, they may be coming to a support group, they might be waiting for a bus or they come in to change the baby. There are all sorts of reasons why people come in the door. As far as we are concerned, they are all the same in the sense of being treated equally. They all different in the stages in their lives or the problems they face.

We have people who are employed by us who are called health workers. Unlike a lot of health workers, they might as easily be sitting down with a woman with a housing problem or a workplace problem or problems about understanding their prescription or their medication. They may have a problem with having nowhere to leave their swag if they are homeless. They might have to park their care in our car park because they have nowhere else to sleep tonight. There is a whole range of issues that come up with women who come to our centre. But because we are a universal service and nobody knows why you are coming through the door, it is a much more respectful approach and it also means there is no stigmatising of coming to our service. It is very important that our service works so well because of that. Anyone can walk in and they can be there for any reason. It gives me enormous pleasure sometimes because I have to walk through the reception area to get to the photocopier, to see women around the coffee table and you might have a woman who slept in her car last night, talking to a woman who may have come from a fairly affluent background but I know she is having problems because her husband has just died.

Women are there for all sorts of reasons and because the atmosphere of the place is set up to be welcoming and safe, those women get to talk to each other and they get time out from the world as well. Those things are what we value about our services and they are a very good way to look at health promotion in general.

The other things we do well is that we do training for other services around the social determinants of health and about approaches to health promotion. We also offer bulk-billed services and manageable, in terms of finances - barriers are broken down in order for people to get what they need.

We set the place up so that it looks more like a home than a clinic and it is not overly, sort of, clean if you know what I mean. It is not sort of white and shiny. It looks more like a home and people feel comfortable. There is a general culture that if you come through the door you are welcomed and not judged.

Those are some things that other services could learn from. I don't say that everybody has to become the Hobart Women's' Health Centre, but there are aspects to the way we work that others could learn from.

We are also a very good partner. We spend time with women and we listen to them and we try to fit them to a service if we cannot offer that service. We never say 'no, we cannot help you, go away'. That is why we can have a worker who spends half a day helping a woman who has run away from a violent situation and doesn't just need somewhere to stay, but also needs to know where to go for legal assistance, how to sort out their joint bank account and all those sorts of things at a one stop shop.

Obviously we have to refer people on and there are specialist services. More and more we are finding that women need more than a specialist service. They need someone who is going to spend time to go through and unload all those things, to know what happens.

As I say, some just come through the door and have a cuppa.

CHAIR - You appear to be talking about the challenges and benefits of the provision of integrated and collaborative preventative health care models. There are challenges in achieving that and you seem to be doing it fairly well. What are the keys to creating an integrated service that we have got?

We have health, education, justice and infrastructure. How do you establish a framework that picks up all those without people dropping between the gaps. We have heard from a number of people, transport can be difficult for people. They haven't got a car or they haven't got fuel.

How do you establish an integrated service that does this well?

Ms FLOWER - I guess we have been doing it for a long time, but we are a relatively small service. Most of our work is in the south. We are not funded enough to set up centres all over the place, which is a shame.

CHAIR - So how are you funded?

Ms FLOWER -We are funded through the State Government.

CHAIR - Entirely?

Ms FLOWER -Entirely, well we fish around like most community organisations for bits and pieces. We have an arrangement with the YWCA. They used to fund that through Avon, but now every year we look out for bits and pieces.

There are a number of programmes like that where additional funding is found.

No matter whether you are a small or large service, it is about knowing what is out there and making relationships between organisations.

Governments can structure that, but to some extent it is about the energy and the skills of people who are involved and their willingness to work openly with other services.

Sometimes the government services are set up in a way to almost compete with each other for money. That can be harmful to that collaboration. We try and keep abreast of everything that is happening that we can use. We are always excited to get more information about another service.

We visit them, we work with them in partnership. We do projects together. We plan together so that we know where we can refer women if we cannot help them.

CHAIR - We are a small state, what sort of over arching framework do we need and how could you see it happening? You have got your own little network down here. There has been a lot of other services that do not know you exist and could have links. In the north-west or the north, around the Launceston area.

How are you putting into place something that could achieve this without being over bureaucratic.

Ms FLOWER - I don't think there is one answer for that. We would be mad to think there is and it is not going to happen overnight. There has to be a shift in thinking and there has to be a plan to achieve certain things. It is not all government, and it is certainly not all state government.

Ms O'CONNOR - Glynis, can you describe the shift in thinking that we need to embark on?

Ms FLOWER - What was being said earlier is that health in government is often not about health, it's about sickness.

Mr VALENTINE - The department of the sick and ageing they used to suggest was the DHHS.

Ms FLOWER - It's true. It is unfortunate and every government struggles with that because there is this crisis thing happening. There are people who are very sick and need hospitals, but there has to be shift and it has to be a long-term thinking and across governments and political parties. We have to work together on these things. I can't think of anything more important than the health of a nation. I just don't understand why that wouldn't be something people would come together on.

You were suggesting that one great new bureaucracy wouldn't work but a shift in culture is very important around health and the social determinants of health. Already local governments have moved quite a long way in this direction. Local governments in Tasmania in particular are very stretched. Over the years they have had to take on this and this, but it is amazing how well some local governments have taken on health and healthy communities. Some of that is because there have been small buckets of money to get an officer in or whatever, but they have been able to shift their thinking. Years ago they used to talk about roads and rates and rubbish, and that's still the case. If you don't clear your rubbish and have safe roads you're not going to have a healthy community. There have been some fabulous things such as new infrastructure walking trails and programs, so local government has made the shift. There have been shifts in smoking which 20 years ago we would never have imagined. That has been due to a simple law in Tasmania. Tasmania was ahead of the game. I am English and I went back to England not long after it had come in here and I walked into a pub to have a meal and there was smoke everywhere. We don't realise how far we've come in a lot of these issues. It's not insurmountable. We have to stop thinking it is too hard. We have to open our minds to it being something more than the 'health' department. There needs to be a will - and I am not a politician so I can't get politicians to work together - to say what is more important than a healthy life for every Tasmanian.

Ms O'CONNOR - Glynis, we would all agree on that and we would all agree that the health of the citizens is a priority. Politically there are different sets of values that are applied to

public health and health prevention messages. Until you can get an agreed set of principles about what health and wellbeing is, and what we can agree on in the long term vision we are all committed to, you are going to have ideological differences between parties. That is a huge challenge.

Ms FLOWER - That is a challenge and thank goodness I am not a politician. There are surely some things that are true across the board. The health systems we have in Australia and most other western countries are not sustainable if we are only doing what we're doing now. Health promotion is the answer. It's about people taking responsibility for their health. It is also about recognising that some people have more capacity, or their situation allows them or has helped them look after themselves better. We have to have something that encourages people to participate in their own health. I work for a health centre but I don't have a perfect health life. I do not necessarily do the things I would like to do. I am sure if every day I do my 30 minutes of exercise. I do think it is time for us to stop messing around. I really applaud your having this committee and I think it is great. All we are offering is some of the things that we have done which we think are good, but there needs to be a plan and I am hoping what comes out of this committee this time is some plan that is not just about the Health department, and not just about state government, but it is about how you engage, you leverage, you partner with other parts of our community to get the health of Tasmanians up above that bottom rung.

Mr VALENTINE - You say you cannot get politicians to talk together, but in fact that is exactly what you are doing. You are presenting the problem. That is terrific.

CHAIR - Is there a model that you are aware around the world or around the country that has done this a bit better than Tasmania in terms of a model that has got a plan that is broader than health, is broader than education. We have heard about South Australia, which has a sort of thin approach which seems to be falling away again perhaps through budget issues. We heard about the Canterbury area in New Zealand as well. Are there areas that you are aware of?

Ms HERZFELD - Sweden.

CHAIR - What is the benefit of theirs?

Ms HERZFELD - A whole-of-government approach; recognition of inequalities in health across government, across portfolios; setting bench marks and goals that all sectors have a role to play in.

Mr BARNETT - I think you touched on it before. How do they do it in Sweden or elsewhere? Who provides the overarching leadership and how does that work?

Ms HERZFELD - I am not 100 per cent on the governance side of it, Guy, but I think it is with the central agency whatever that name that would be. It is not the health department as such. It is a whole-of-government approach, not just the health department. Addressing inequalities is overarching but the actual governance arrangements I am not sure about.

Mr BARNETT - Are you leaning more towards a DPAC-style governance overarching or a joint parliamentary committee, or one over the other? You don't have a fixed view?

Ms HERZFELD - I do not have a fixed view. I would like to see us look at the pros and cons of both. What I would not like to see is losing the expertise that we do have in the Health department, so tapping into those, whether the drivers for it come from DPAC. I think there is expertise there, as there is expertise in Justice and State Growth. I do believe in the notion of population health. I think that is fundamentally important.

Mr VALENTINE - I interested in work you are doing in rural areas.

Ms FLOWER - In the last year or two we have been doing a program called LEAP, which was in response to the changes at a federal level of women being asked to go back into the workforce when their children were a certain age. We were finding there were a lot of single mothers or teenage girls who had left school to have their baby, or had their baby at that stage, and so had no experience in the education area. They had no confidence in their own ability. The program is an adaption of a program we used to do that was about preparing them for work and study, but building their confidence, working on the strengths they had gained. After all, if you have seen a baby through to primary school you have learnt a few skills but you do not necessarily recognise it. It is a seven-week program. We have so far delivered it in New Norfolk, Triabunna, Kingston and we are about to apply for some funds to put it elsewhere.

We've also been doing some work around Mentors in Violence, which is a bystander program training people up to respond safely to a conflictual situation. The Encore program, of course. We also have done some work around menopause and midlife stuff in different communities. We partnered with Neighbourhood Houses, particularly in the south, but we've done some in the north. We've also done touring forums around things like health complaints. We're limited; my full team would add up to about 4.5 staff, but we do a lot with our money.

CHAIR - Thanks very much for your time and your submission today.

THE WITNESSES WITHDREW

PUBLIC

Mr GUY DOW SAINTER, CEO, AND **Ms FAY JOHNSTON**, ASTHMA TASMANIA WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Thank you. The evidence you are giving is being recorded on *Hansard*. It will be transcribed and become part of the public record. It is a public hearing. We've had some media here on and off. You are covered by Parliamentary privilege while you're before the committee but that doesn't extend once you leave the committee. If there is anything you wanted to say of a confidential nature you can make that request to the committee and we would consider that, otherwise it's all public.

We don't have a specific submission from you, but you are a signatory to the Health In All Policies group. They came last week.

Mr DOW SAINTER - Firstly, I thank the committee for inviting the Asthma Foundation of Tasmania here. Before we start in earnest I would like to give some context surrounding the foundation and our experience with asthma, and give you a reason why we didn't make an individual submission. I can assure you it wasn't from a lack of enthusiasm, but for reasons that will become evident in a few minutes.

The Asthma Foundation up until now has been a service delivery organisation. The reason I mention that is that we've been operating very much at the coalface. I'm a little bit concerned that perhaps we might not be able to provide the committee with the level of strategic advice or strategic comment that you are probably after. That was one of the reasons I invited Nick Cooling along, but unfortunately Nick couldn't make it because he has had a major personal blow today. He could talk about the health system more generally. .

CHAIR - He's based down here.

Mr DOW SAINTER - Yes. He is a lecturer at the uni and his special interest is in allergy, so he is somebody worth speaking to.

Having said that we're a coalface organisation, the foundation is now changing its focus. While retaining our current services we'll be concentrating on identifying ways in which we can help people with asthma on a systematic basis. We're about to develop a strategic plan for the foundation, which will begin almost as soon as I walk out the door. Our first task will be to begin a discussion with our numerous stakeholders. We're also contributing to the National Asthma Strategy which will be rolled out in 2016.

The reason for this change is that we have come to conclusion that if there are 58 000 people in Tasmania with asthma, we are simply not speaking to nearly enough of them and the preventative issues surrounding asthma are enormous. Asthma affects one in 10 Tasmanians and specifically one in six Tasmanian children. That is roughly five children with asthma in every single class. It is the number one chronic disease in causing emergency presentation amongst children and it is probably implicated in many more of those paediatric presentations.

One thing we need to make clear is asthma is not just a childhood disease. It causes major problems with productivity with nearly one in three people with asthma saying it

affects their careers and work performance. As with many chronic diseases, it disproportionately affects the poor.

Unfortunately, despite the fact that nearly 2 million Australians have a disease that prevents them from breathing properly, there is complacency in the community about asthma. This is probably one of the main reasons we have so many people with poorly controlled asthma.

We have come to figure by extrapolation, but I would absolutely stand by it, in Tasmania somewhere between 9 000 and 14 000 people exhibit symptoms of poorly controlled asthma. There are undoubtedly many more, while not poorly controlled, they are not nearly well controlled enough. Except for a small minority, whose asthma will not respond to medication, it illustrates the greatest tragedy of asthma. A large proportion of people who have the disease could be leading a far more active, full life. They are not, simply because they are not taking their medicine or not taking it properly.

Abiding by medication regimes is a major issue which we would like to tease out with you today, especially in the context of those with under privileged backgrounds. An issue that goes hand-in-glove with concordance is the issue of primary health care as adhering to national guidelines for asthma.

Another issue that has a huge impact on all Tasmanians, especially those with lung and heart conditions, is air quality and that is why Fay is here. She will be able to answer questions on the impact of air quality on all Tasmanians, not just those with asthma.

The foundation is in the process of drafting a strategic plan and it will be completed in the next three months. The comments we make here today are not necessarily the party line but are our considered opinion at this time. One vital thing that is missing, Fay is also on the Asthma Foundation of Tasmania's medical and scientific committee so she comes as part of the Asthma Foundation.

CHAIR - Fay, did you want to make some opening comments or do you want to address the matter of air quality?

Ms JOHNSTON - My background is that I am a GP clinical doctor and I work in public health. My substantive position is with Menzies where I research environmental causes of ill health. The main focus of my research has been poor air quality. I have worked very closely with public health and the Asthma Foundation, and agencies that burn land for various reasons, to address this issue. My views on this and then take question might be a way to go.

Tasmania has a big problem with poor air quality compared with other states. Many of our original towns do not come close to meeting national air quality advisory reporting standards for particle air pollution largely because of wood heaters. I did a study in Launceston where there was an intervention in the year 2000 and the air quality improved considerably. Launceston's air quality is not nearly as bad as it was. I evaluated the deaths in Launceston before and after this intervention and it showed they were reduced significantly, particularly deaths from heart and lung disease were reduced overall by about 10 per cent. It is hard to say an absolute number but it is probably 10 or 15 lives each year. Many things cause deaths from heart and respiratory disease. Air

pollution is a contributing factor but it is a really important one and there are many towns in Tasmania that are similar to what Launceston was. Even though Launceston has improved it and Hobart have room for further improvement. It is a direct dose response relationship so the more we can improve our air quality the greater the savings we will get. If we see a signal in deaths, even in our small population, that means there are huge other health effects going on. Deaths are really the tip of the iceberg with air pollution. There is a lot of exacerbation of asthma and ill health. There is lots of progression of heart disease. There are precipitating factors that along with all sorts of other factors can lead to worse heart disease or cardiac arrests, heart attacks and those sorts of outcomes. In Tasmania, particularly in relation to chronic diseases, health-in-all-policies socioeconomic disadvantage, compared to other states we are worse off. Air quality affects everyone equally but we are more at risk of the detrimental effects of air quality at all those levels. Risk from air pollution is greater for those who are socioeconomic disadvantaged, those who are smokers, those who have chronic heart or lung disease - all those factors.

Social and environmental determinants of health have a huge impact on our state's population. Air quality is a factor which can be addressed. We can do something about it fairly quickly. I definitely see it of importance, particularly the winter issues but also intermittent severe smoke episodes from bush fires and burn offs and things like that.

CHAIR - Tasmania has its clean, green image that we would like to portray. You are saying it is not quite as simple as that. In many European cities you have monitoring stations in public places, next to main roads. They have numbers on them - either green, red or yellow - indicating whether it is meeting a standard set. Is raising awareness the first step or is it more than that?

Ms JOHNSTON - I think it is part of what is needed. My team has a new research grant and we are working on that issue. We are setting up a real time sensor network across Tasmania for air quality, pollen and all sorts of things that affect health with the idea of having an application which delivers information to the health department, forestry, to people with asthma and hay fever. They will be able to get real time information and plan public policy, or individual care, accordingly. There is enough known about the harms and what might be effective to reduce the harms. It is not the only part of it.

The other issue with wood heaters is that education alone is close to useless. Wood heater standards are able to be overridden by poor practice in using a heater so they do not really protect the community that well. It is usually only a small proportion of users who put most of the air pollution into a valley or a town. People need to be responsible for their smoke. Councils are responsible for this but they are not really resourced, or they do not feel they are at this point, to enforce the legislation we have.

CHAIR - When the regulation came through with 10 feet of smoke from your chimney or whatever it is, how many of those people have been charged with offending? You probably do not know the answer to that?

Ms JOHNSTON - It is unusual.

Mr DOW SAINTER - Not very many.

To have a public education approach, as Fay says, is not going to work. There have been various public education approaches before. My background was previously in marketing and you have to have a multi-pronged approach or it is not going to work. It has to be a public policy issue.

CHAIR - You need legislative change?

Mr DOW SAINTER - Legislative change, the will to enforce -

Mr VALENTINE - And incentivisation.

Mr DOW SAINTER - Yes, all those sorts of things.

Ms JOHNSTON - Subsidising less polluting heaters is a great idea.

CHAIR - Like pellet heaters as opposed to wood heaters.

Ms JOHNSTON - Pellet heaters. You can't override before practice, they do very well.

CHAIR - Self regulating.

Mr DOW SAINTER - One of the things that we would say is that it is very important that the disenfranchised are not left out of the mix. With just about any chronic health condition you are going to see some poor Mrs Smith, whose son-in-law brings the wood to her from his property every couple of weeks. She is probably doing the wrong thing burning slightly green wood but if she does not have a decent source of heat then there are all sorts of other issues that she is going to have to cope with from a health point of view.

We have to be extremely circumspect but we have to also be very decisive in what we do.

Ms O'CONNOR - Do you want to say what you wanted to say Faye and then I will ask the question.

Ms JOHNSTON - Wood is often freely available and it is sensible for the disadvantaged to use. From the greenhouse perspective it is not perfect, it gives off methane, but it is probably better that some other options. Cold kills people too so I am not advocating banning wood stoves. A lot that can be done to reduce the emissions from wood stoves and where it is possible to have alternative sources of heating it should seriously be considered. It is a complex balance and I wanted to acknowledge that.

Ms O'CONNOR - I do want to ask a question about air quality standards and regulations. My understanding is that we regulate for PM 10 so we regulate for larger particles but there is a lot of evidence coming through about the impact of PM 2.5 particles on lung health. Do you think we need to be examining improved air quality regulations so that we are regulating the 2.5's that go into the atmosphere but also monitoring them? My understanding is that we do not have the monitoring system in place for the finer particles.

Ms JOHNSTON - Our standards are national and they are for PM 10, the bigger size particle. There is an advisory standard for PM 2.5 and there has been a strong recommendation that that will become the new standard. I think that will happen very soon. It is important to understand that meeting the standard does not mean there is a lot of ill health that can be avoided by improving on the standard. The standard does not mean you are safe if you are below it but it is a good first act to try and achieve the standards and we do not do that in many places in Tasmania.

Your final question was?

Ms O'CONNOR - It was about monitoring as well?

Ms JOHNSTON - Yes, Tasmania has one of the best monitoring networks in Australia for PM 2.5 and 10. Our EPA has done fantastic work and lead the way but there are lots of gaps in that. Part of one of my new projects is with the EPA as a core partner to expand that network.

Ms O'CONNOR - I have to ask you this question because I am a Green member of Parliament but the impact of burn offs including forestry. Every autumn we get emails and letters from constituents who are very concerned about their asthma and the exacerbation of it or their heart condition as a result of the burn offs. I understand the wood heater issue is a serious Tasmanian concern but the impact on the health of people with asthma and that associated range of chronic conditions from burn offs, whether they are from forestry or control burns, how do you minimise that?

Mr DOW SAINTER - I think the answer probably lies in the original submission that I made with the health and all the policies collaboration. Our tentative position, I have not had it ratified, is any human created burn, regardless of their reason and whether it be regeneration or fuel reduction, we would like them all to be viewed through our Health in all Policies framework. Using this approach we could review the need for and/or the level of burning required to see the healthiest outcomes for Tasmanians.

Ms O'CONNOR - I am reassured to hear that. In the past the Asthma Foundation has been a bit reluctant to engage in debate about burn-offs and where they come from because politically it is a very sensitive issue.

Mr DOW SAINTER - I am probably slightly more robust in my attitude.

Ms O'CONNOR - Will you be approaching government to have a look at the whole issue of burning on public and private land and the impact on public health? I don't believe it has been discussed enough or that it is dealt with as a public health issue.

Mr DOW SAINTER - I couldn't agree more. It has to be dealt with as a public health issue. Unbeknown to a lot of people we are our own worst enemies. We didn't really explain we were going behind the scenes and talking to a number of people. We had the philosophy that it's probably better to be inside the tent than outside. Unfortunately we got wedged for some of the comments that were made. We are completely agnostic as to where the burns come from. If it's causing a lack of health in the broader population that has to be seen and addressed. As to us being able to specifically address it, except as a lobbying group, that's a bit difficult because like the last mob we are 4.5 FTEs as well

from a resource point of view. We would certainly be backing anybody who wants to use the approach I've just talked about.

Mr JAENSCH - Is there a body of work that understands the difference in the nature of smoke generated from fuel reduction versus uncontrolled burns that might happen if there isn't fuel reduction?

Ms JOHNSTON - I lead a research program that is trying to address that very issue and there's not a lot of work that has been done on it. Biomass burns, whether it be grass, tobacco, leafy litter or high-intensity wood, the spectrum of pollutants that are generated are remarkably similar. It's a question of the relative proportions of the organic carbon content to the inorganic, but they will all produce carbon monoxide irritants, cancer causing PAHs, elemental carbon and things that promote inflammation similar to cigarette smoke and severe forest fires. We have measured it in community volunteers with simple blood tests and tests of lung function. They are more similar than they are different. The differences are probably subtle depending on the conditions of the burn.

Mr JAENSCH - I am not pushing a particular agenda, but we have a challenge as a country where we have fire in our ecology and we either work out how to manage it or we get rid of the ecology and replace it with one which is more attuned to our nostrils. To the extent that controlled planned burning can be of an understorey of fuel rather than the floor canopy and everything else, composition might not change but volume and being able to choose the day on which you do it should create some mitigating circumstances. Is your research assessing those things as well?

Ms JOHNSTON - Yes.

Mr JAENSCH - A bushfire is not a planned burn and it does whatever it wants when it wants and mostly burns everything. If we can avoid that, at least we can plan for the other.

Ms JOHNSTON - We are highly bushfire prone and we are going to have massive bushfires and they are going to get worse with climate change. They probably are already. Our choice is between managing or not managing. We can't have no fire; that is not an option. It doesn't fit with our ecology. It is not my direct area of expertise but I collaborate with a lot of fire ecologists. The limited evidence available would suggest that planned fuel reduction burning overall reduces severe bushfires. There are ratios of 3:1 and 7:1 of areas burnt. It is still rough but the best evidence we have is that it probably is beneficial, if it is close to a community that you are protecting. Burning 5 per cent of the south-west of Tassie will not help anyone from any perspective. If you want to protect a community you need to manage the fuel close to that community. That means your repeated planned burns are going to affect an awful lot of people, so the side effect, the public health cost, is quite high. From my perspective it is not a case of don't do it. I think we do not have an option but to address our fuel loads, but we need to put a lot more effort into addressing the side effect, the public health impacts. If we know we are going to burn, it is a plan someone knows, then everybody who has got a heart or lung condition should have the benefit of that knowledge in advance. They should not be waking up wheezing because of a planned burn.

Ms O'CONNOR - Which happens now.

Mr JAENSCH - There is your app.

Ms JOHNSTON - Yes, we have got a way to go.

Mr DOW-SAINTER - I might read this statement which is as close as we have come to a platform on fuel-reduction burns.

Ms O'CONNOR - Just fuel-reduction burns or forestry as well as fuel reduction?

Mr DOW-SAINTER - There are two statements I could make. Regarding all human created burns, regardless of their reason, the one that I said previously, I think we have got to put it in to a Health In All Policies framework, which seems like a bit of a copout but I do not see how on earth you are going to do it. For example, if we really seriously want to embrace the Health In All Policies issue then you have regen burns by Forestry, so maybe you withdraw resources from Forestry, but what are the knock-on effects of that on the health of the people as well from an economic point of view and privations that they may experience. If we are going to have a Health In All Policies approach then we have to have a health in all policies approach.

In terms of the increased fuel-reduction burns, I think it is really important that we do make it very clear what our position is. While the foundation completely understands the need to reduce fuel and the potentially fatal consequences of not doing so, the injurious and potentially fatal consequences of inhaling wood smoke needs to be considered as well. We are not suggesting that fuel-reduction burns should be reduced at the moment, however we do recommend that strategies are devised and continually refined that would decrease the impact of wood smoke on those whose health conditions are disproportionately affected by wood smoke. Ultimately, given that it is not only bushfires but also smoke from fuel reduction burns that endangers a population, we need to understand the optimal quantity and method of fuel reduction before the level of smoke mitigates any positive outcomes achieved by the burn-offs.

Ms O'CONNOR - Can I ask why Forestry burns were not included in that statement?

Mr DOW-SAINTER - Because I was simply addressing -

Ms O'CONNOR - It is not because it is a bit too political?

Mr JAENSCH - You had a separate statement on regen?

Ms O'CONNOR - You do?

Mr DOW-SAINTER - Would you like me to read it out?

Ms O'CONNOR - Not if it is exactly the same. You either have a planned burn or you have a bushfire, and I just thought that that was missing from the statement.

Mr DOW-SAINTER - No, I don't believe so, Cassy. I think with one we are talking about a really clear and present public health issue which we will see more and more of. In terms of regen burns, I am completely agnostic about them. It is just simply another man-made

burning. What we have to do is view it through the Health In All Policies. Essentially what I have said regarding fuel-reduction burns is included in all human-made burns.

CHAIR - In relation to air quality, is aerial spraying an issue and is that something that you measure?

Ms JOHNSTON - It's not routinely measured that I know of and I would need to find out and get back to you as I don't know a lot about that area. You are talking about crop spraying and insecticides?

CHAIR - Yes.

Ms JOHNSTON - I understand it's more an issue for contamination of waterways and foods more than inhaling.

Ms O'CONNOR - They've stopped monitoring through DPIPWE. There's clearly much less of the monitoring of water quality and chemical contamination, unfortunately.

CHAIR - If you take that back to the terms of reference, is a 'health in all policies' approach appropriate and how do you frame that, where does it sit, and what does it look like, I would like you to address your mind to that.

How does that look in terms of monitoring all aspects that can impact on air quality, but also water and land, which is probably not so much your areas? I'm interested in what your views are and how you subscribe to the 'health in all policies' approach? How do you see that working and what do you see it looking like?

Mr DOW SAINTER - It's not just the evidence that the EPA could give us in terms of levels of PM2.5s or PM10s or whatever. You also have to start factoring in other social issues. To be honest I'm not a social scientist so I really can't supply you with any more information.

CHAIR - How do you see the 'health in all policies' framework working, where does it sit and how do you incorporate this into the development of public policy? That's what we're talking about here.

Mr DOW SAINTER - I do not have the ability or the knowledge at the moment to be able to tell you. I would suspect that it probably means it would be with the Department of Premier and Cabinet and then various stakeholders come around and discuss matters with the Premier and Cabinet.

CHAIR - So Premier and Cabinet as the lead agency?

Mr DOW SAINTER - That's essentially what the collaboration is.

CHAIR - You support that?

Mr DOW SAINTER - Absolutely.

CHAIR - I'm not trying to put you on the spot here, I'm just interested?

Mr DOW SAINTER - We completely support anything Graeme said the other day. He gave me a pretty thorough briefing on what he said.

Ms WHITE - I wanted to thank you for the exchange that happened earlier about the air quality and burning. I probably have a bit of a different view to some other members on the committee because I've seen how devastating bushfires can be. The health consequences from someone losing their home from a bushfire is extraordinarily damaging. I appreciate the broad range of issues that you're considering in formulating your policy and I am happy to support the way you are tackling that. I thought Roger's question was very good. Thank you, Roger.

The question I had was about e-cigarettes and whether the Foundation has considered the health risks or implications that e-cigarettes might have? Do you have a position on whether you think they are a good or a bad thing?

Mr DOW SAINTER - The standard line from any health organisation at the moment would be that you would treat e-cigarettes in the same way we would treat tobacco cigarettes. That is all I can really say on the matter. Sorry, I'm not being evasive. There's not enough evidence in and if you are inhaling something into your lungs, which is with a pretty high level of intensity, it is probably doing you some damage. I guess the debates around the level of damage and whether you include it in some sort of harm reduction strategy in terms of tobacco cessation, but it is a really vexed subject and far smarter people than me are working on it at the moment.

Ms WHITE - In thinking about your answer, do you think e-cigarettes should be regulated in the same way tobacco products are currently regulated?

Mr DOW SAINTER - Yes, I think it is a good default position and then we can devolve from there.

Mr VALENTINE - It is recognising that the e-cigarettes don't always have nicotine in them.

Mr DOW SAINTER - It is recognising that, yes. I appreciate that.

CHAIR - Also, you need to recognise that e-cigarettes do not allegedly have, and the evidence is not all there yet, all the carcinogens that a normal tobacco cigarette would have.

Mr VALENTINE - That is the nicotine brand you are talking about? There are e-cigarettes without nicotine.

Ms JOHNSTON - None-the-less, the vapour that people are breathing

CHAIR - That is right. Into your lungs. It is still vapour.

Ms JOHNSTON - It is difficult to understand.

CHAIR - That is right

Ms JOHNSTON - My understanding of this preliminary evidence is to urge caution. There is evidence of health harms from them and I cannot recall what they are. The preliminary papers I have seen or read reports of, are ones that would say 'hey, be careful, this is not a harmless alternative'. It is a new technology that potentially has risks associated with it.

CHAIR - We thought cigarettes were safe once. Some people did. The people selling them at least.

Members, are there any other questions? Any other closing comment you would like to make?

Mr DOW SAINTER - There are two questions or requests. I would like to table this document. I have to do a slight alteration to amend that glaring error here.

CHAIR - Amend that and then email it to the secretary if you like, and we will table that at a later time.

Mr DOW SAINTER - The other thing, if I can speak on Nick Cooling's behalf, because he has a very important message about allergy, not only its relationship with asthma, but also a general public health message on our ledger here and would it be possible for Nick to come along for 10 or 15 minutes to -

CHAIR - We are having other hearings so the committee can consider that.

Ms O'CONNOR - If I could clarify something. The Green's position on planned burning is that we are not opposed to planned burning. It is about how strategic it is and the health lens that is applied over it. To correct a misconception that might have arisen as a result of this question. We are quite sensible on planned burning, it is the unchecked forestry burns we have an issue with.

CHAIR - Thank you for coming. We appreciate your evidence. Thank you.

Mr DOW SAINTER - Thanks.

THE WITNESSES WITHDREW.