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THE PARLIAMENTARY JOINT SELECT COMMITTEE ON PREVENTATIVE HEALTH CARE MET IN LAUNCESTON COUNCIL CHAMBERS, LAUNCESTON ON TUESDAY, 14 APRIL 2015.

Ms LUCY BYRNE, ACTIVE TASMANIA, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Ms Forrest) - Welcome, Lucy. The committee hearing is a public hearing and everything you say whilst in front of the committee is protected by parliamentary privilege. If you speak outside the committee hearing, you are not protected, so be cautious of that. Everything is record on *Hansard* and the transcript will be made available and put on our website. If there is anything you want to say in confidence, you can make that request to the committee and we will consider it and, if deemed appropriate, we would clear the room of media and everyone else and take that evidence in confidence. We have your submission, which members have read. We are trying to focus on the terms of reference. Some submissions have specifically addressed particular terms of reference but others were more broad. Would you like to address any particular terms of reference or make an opening statement?

Ms BYRNE - Firstly, thank you for the invitation to speak to the committee today. As a project manager of a successful preventative health care initiative over the last seven years, that is the reason I decided to put a submission into this committee, with the hope of urging this committee to make recommendations through to the Government to look at sustainable funding streams for programs like ours that operate on the ground and are making a difference to preventative health care.

I am sure you all know around the table that prevention is better than a cure, but it is a much longer process, and a process that needs a commitment for a long time frame. I believe our state needs to change its processes, and change them quite innovatively and dramatically, if we are going to make an impact on preventable disease in our state and the impact that has on our budget if we are going to be able to afford to support what we have in our community, which is an ageing demographic and a higher than national average problem with preventative health and chronic disease.

Tasmania has a lot of innovative programs and a lot of programs that are evidence-based and practise-informed that are making a difference to inequalities in our community and the social determinants of health in Tasmania.

From first-hand experience I can tell you that negotiating the current funding options to manage and keep our types of programs sustainable and ongoing is a bit of a nightmare. I also believe it is a waste of resources. At the moment the state government, the university and Launceston City Council are paying my wage to jump through hoops and play the political game to get more funding so our program can be ongoing. In my mind that money would be better spent if I was making an impact to community members running programs on the ground, but 90 per cent of my job is getting funding to make us sustainable into the future.

Resources for evaluation and research are also vitally important. We have done quite well in prioritising our evaluation and research, but I know there are a lot of preventative health care programs - and we have been in this space before - that struggle just to have enough money to operate. Then they are asked, 'Where are the numbers? Where is the research? Where is the evaluation?'. There is just not enough emphasis and funding put aside for that to occur. Quite naively, when I started working for the university I thought research was going to come for free and I have learnt that is not the process. The university needs support. It has the expertise and personnel but not the funding to support that research outcome on the ground. For us to engage researchers to support the work we do to measure the impact, it costs money. These types of funding options for us to have a clear direction for our programs to be sustainable so we do not have a small time frame. We have small pilot programs and we have three-year funding. Out of the three years, one year is spent playing the game, which we have been doing at the moment.

Yesterday I was here at a council meeting to seek funding from council and I am currently seeking funding from the state government as well for the ongoing sustainability of Active Launceston and the Active Tasmania programs.

Without the support of the state government for these types of programs, the sustainability of them will be in question. We will not be able to deliver what we are currently delivering without that support from the state government. Apart from a ministerial request, we have no direct options because we do not fit primarily into health and we do not fit primarily into sport and recreation. There is no clear direction for us to seek that funding support.

Mr GAFFNEY - Thanks Lucy, a very good submission. It was really good to get the background information about both Active Tasmania and Active Launceston. We have heard about Active Launceston and they have achieved a number of awards at different levels, which has been great. Sitting with an old hat on, I was always envious that the city council and the state government and UTAS had that because it was beneficial. Can you be a bit more specific about the funding streams in the last three years, and what percentage or what funds have you received from different groups, so we are aware of where you have had to go to get your funding because I know that takes a lot of time and effort?

Ms BYRNE - I have not brought the exact figures with me today. It is a complex process. It started in 2008 as a pilot and we received money from the federal government through the Healthy Active Australia grants program. At that time I think it was about $180 000 we received from them, plus about an $8 000 contribution from the university and the council, and that was an 18-month pilot. From them we have had two, three-years worth of funding processes where the council has put in $35 000 in that first three years and so did the state government through Sport and Recreation Tasmania at that time. There were community grants then through Sport and Recreation but they do not exist anymore. Then the university put in $75 000 at that time.

As the years have gone on, the university has carried the can for any funding that we were not able to achieve. They have topped up the budget. Last year we received $45 000 from the Launceston City Council. The Tasmanian Health Organisation North

granted us $100 000 for Active Launceston and also granted us $100 000 to run staff health and wellbeing programs specifically for staff across 12 primary healthcare sites.

It is easier, because it is a complex system, for me to explain the different elements of the way we are trying to gain funding. We started with just the Active Launceston project. We received a lot of attention from other communities that were saying, we like the way you operate; we would like your help and support to run this. We went through lots of different mechanisms of how we share what we have learnt. With my community engagement hat on, I was ready and willing, giving all our information away. The university and the council quite rightly said, 'This is our IP we have generated, and if Launceston City Council is paying for half of your wage, why should that information be given to Hobart City Council free of charge.' We went down the process of looking at commercialisation of what we had developed, but the outcome of that was that it was not viable because of the way the university operates in selling the IP and research time. It becomes too onerous for another local council to take onboard.

We then went into another model where we would develop a licence agreement for other councils to use our IP and copyright materials free of charge, and for some of my time, to help them set it up and deliver it because I think there is nothing worse than saying, 'Here is the resource, see you later, you can manage and to run that program by yourself.' That seemed to be a little bit more feasible. However, what we are now looking at is a project management model that seems to be gaining the most ground. That is a project management model where we look at the procreation of value in terms of what the university has to offer and what the university can gain from a community engagement partnership. For example, for all of the programs that we now operate we now have an overarching brand of Active Tasmania, and Active Tasmania runs a number of projects we have a contract for. One is Active Launceston, which has a contract with the Launceston City Council. One is the staff help and wellbeing program for Tasmanian Health Organisation North. One is the staff help and wellbeing program for the university across the state, and for the campuses also in Sydney. We also have a contract with the Hawthorn Football Club to run healthy game day activities at Aurora Stadium when they have AFL games there.

We are actively seeking a number of other contracts so that we can continue to generate income. We also have set up a foundational unit with the university. That is called the Foundations of Active Living, which is a free unit at very base level for community members to engage in to teach them about the importance of health and wellbeing to themselves as an individual, and the importance of health and wellbeing to the community. What that does is generate some income from the federal government and Active Tasmania gets a cut of all of the enrolments that we get into that unit.

We apply for a number of grants on the ground. We have had grants from Tasmania Community Fund, from Winifred Booth, from all the different grants available in the community; I can promise you I have applied for them. We have a sponsorship prospectus and we have a number of naming rights sponsors for different programs. We also have an annual appeals process that is run through the university foundation so that we can attract funding in that way.

There are lots of different elements to how we attract funding, but what we really need is that core level of funding, which is from the university and from the Launceston City Council.

Mr GAFFNEY - It would help the committee if you could provide a breakdown of those finances from the different streams over the number of years, because your major recommendation for the submission talks about the contribution of recurrent funding for effective preventative health care initiatives. I think that is really good. From our point of view for us to go forward we need to have some sort of picture in our head of what the actual costs have been. I know it has been mainly through Launceston Council, which has been great, but how can we transfer that to other areas using the model that you recommend?

I notice in your submission you did say there is an American study that says for every dollar invested this was the return. I know you stated earlier that it is hard with research to say, but have you been able, through the Launceston Council, to derive any sort of feedback and evaluation or is that one of the issues you have? To be able to say this saves us *x* amount of dollars in the long term is a very good selling point.

Ms BYRNE - This application was due five days before or after the green paper submission and I put together two very similar submissions. In that submission it was also asking for funding to continue. It was a bit more specific through that submission because their terms of reference were a bit more specific.

Mr GAFFNEY - You have a statement that in America it was $5.60. Have you been able to do any -

Ms BYRNE - No, the Tasmanian state government has done some figures on that and that must be in my other green paper submission. I can get you those figures. What is interesting for me and interesting in terms of the council's investment in this is that the return on investment in a monetary sense I think is more beneficial to the state government. It is the state government that holds the can for the health budget, rather than local government. The outcomes for local government are more in terms of social connectivity and the liveability of a city, which does not have a monetary impact as much as it does to a state government. I can give you the figures which have come from the Department of Health and Human Services; I think they were done in 2012.

Mr GAFFNEY - I have to admit, one of the most impressive things about when Active Launceston received some of the awards, which it should have received, was the impact it had on a number of community groups that became involved and started to network together. That was really important, having somebody in charge of those programs was obvious to me.

Did you think that was a good outcome? Was that one of the things you noticed through the Active Launceston program?

Ms BYRNE - Absolutely. I think the way we have been able to provide a variety of opportunities to a variety of different targets is one of the strengths of our programs and that we have been able to break down social and geographical barriers just by using physical activity as a means. As an example, somebody came up to me and said, 'I went

to Ravenswood to do Pilates and I lay next to a lady from Ravenswood on a mat and she wasn't actually that bad. It's not that bad up here.'

So just changing the preconceived perceptions of our community members has been really strong in making those community connections stronger has been a good outcome.

Mr GAFFNEY - Thank you. In recent years, the Launceston and Hobart city councils have been sharing intellectual property a lot better.

Ms BYRNE - Pardon?

Mr GAFFNEY - In recent years I think Launceston and Hobart City Councils have been trying to share their IP but we will get there.

CHAIR - You made a comment early on that there seems to be an emphasis on demonstrating outcomes very quickly in terms of your funding cycle, which is short by nature of the virtue of election cycles predominantly, it seems. How will you address that? Obviously outcomes are not quickly achieved. Is that your view or do you think there are ways we can show outcomes in a more timely manner?

Ms BYRNE - I think you can show outcomes. It depends what type of outcomes you are after. In utilising a program like Active Launceston or the programs we run through Active Tasmania, the health outcomes of quantifiable weight reduction and reducing health risk factors are going to take a longer time. That is not going to change overnight. You can still measure the number of programs you run and the number of people you have engaged, social connections and using quantitative and qualitative mixed methods evaluation. You can still get outcomes quickly.

That money needs to be upfront because you obviously need to do a pre-measure before the initiative starts on the ground. I think that money needs to be built into any funding proposals so that those funding options are there, and so it does not take away from the operational component of the projects.

CHAIR - You need to demonstrate the value right at the beginning.

Ms BYRNE - Yes.

Mr VALENTINE - You mentioned that you are neither purely sport nor purely health related and the difficulty in gaining funding as a result of that. Do you want to expand on any of the frustrations you have with the Government's acquittal process and which you feel is not picking up on the full benefits that you deliver?

Ms BYRNE - A good question. Frustrations with the acquittal process, the application process, are not having a clear direction or sustainable direction of where funding is available. It chops and changes all the time - which grant do I have to apply for this year? This grant funding will be here this year and then next year it will be gone. Processes change and I understand in other states there is preventative health care funding that is sustainable and ongoing. Programs like ours will just have rolling funding that comes through this bucket of money. Then they will acquit that process; if

they are not doing the right thing the funding will be taken. It is an ongoing sustainable revenue stream rather than having to fight for it every two or three years.

Also, every department I apply to has a different acquittal process and a different application process. With one of the last grants through the Department of Health and Human Services we had to meet every three months, we had to have an interview, we had to fill out forms based on that department's key performance indicators, and write an onerous report at the end of that, alongside all the financial reports that we have to submit.

Mr VALENTINE - And it all takes time to cater for the different formats.

Ms BYRNE - Absolutely, and I feel grateful that the university is backing me and we have all those finance people who can support me to do that. Other small organisations don't have that support and it is an onerous task. The last grant I received, which was through Tasmanian Health Organisation North, was less onerous. The reporting process for that was more in line with what we have to do for the university so therefore the time that took was reduced. Through Sport and Recreation Tasmania, they had a different process. It is the time it takes to work the system and negotiate your way through the system and ensure you are up to date with what's available, what different policy there is at the time.

Mr VALENTINE - Do you think those processes are picking up on the full benefits of what you are delivering, or do you feel it is just a little bit of accounting going on and it is not really demonstrating the full benefit of what you deliver?

Ms BYRNE - Obviously, the more money we have, the better things we can deliver on the ground. One of the key things, and what you were speaking about previously, is the partnerships we are able to make - the groups working together for different organisations, whether it be us with the Hawks, Aspire, Anglicare or with the university, and how we can utilise the resources of both those areas to ensure we have outcomes on the ground. The more we have core funding to enable us to operate and get on with our job, and if the funding streams we were applying to gave us that flexibility, the bigger the impact we would be able to make on the ground.

Ms WHITE - Thanks for your submission, Lucy, it's very helpful. I want to explore in more detail what you have been talking with Rob about, who the ideal department or directorate within government would be for you to deal with. I presume you have dealings with Population Health from time to time. You talked about other states having a preventative health fund that is a consistent source of revenue opportunity for organisations such as yours. Could you lay out, in your ideal world, how the department would support preventative health initiatives in a community and who your point of contact would be? Would it be in the Department of Health and Human Services, Sport and Recreation, the Department of Premier and Cabinet? Have you thought about that at all?

Ms BYRNE - I haven't put a lot of thought into that but, to go back a step, one organisation, and particularly if I have my Active Launceston hat on, with Active Tasmania we're looking at all health lifestyle behaviours now, so it does not just have to be physical activity. It can be smoking, nutrition, et cetera. If we are talking about physical activity,

I have had a number of discussions with the Premier's Physical Activity Council; I have been very involved with them since they started, and through all my roles when I worked on the council and at the university. One of my frustrations with the Premier's Physical Activity Council was that there is never funding for us to implement our programs. There was a lot of promoting and supporting the best way to work and operate and what we should be doing, but no financial support for us to operate on the ground. It was one of the things I have always pushed, that for them to have a budget other than the Active Tasmania awards, which is great, and there is some small amounts of funding that can come through that, there is no implementation money through the Premier's Physical Activity Council for population-based physical activity programs.

Preventative health is a broad space, particularly if you broaden it to its social determinants of health in your terms of reference, and that doesn't specifically fit into Health or Sport and Recreation. Whether that means it sits more suitably with Premier and Cabinet, that may be an option. My number one option, in an ideal world, would be to have one department and one area with an ongoing responsibility for working with community groups on the ground. The other thing I spoke about when we did our presentation to the Launceston City Council, was that because of the power of the partnership that programs such as ours can bring, it really is a cost-effective and efficient way for the state government, the council and the university to deliver this type of initiative. For the amount of money you're putting towards it as individual organisations, you would not be able to do it for that equivalent amount of money. I think it is really important that the power of the partnership is vital.

Ms WHITE - The other thing I wanted to ask you about was the funding you have received recently from THO North, which has been quite substantial. With the health reforms and moving to one THS, who would be your point of contact in that bigger organisation to talk about funding opportunities for the future? Have they been in discussions with you about what that might look like? Would you be able to tell us when your funding ends on that THO North grant?

Ms BYRNE - Our funding ends at the end of this calendar year. It all gets a bit tricky as well because the university works on a calendar year and the state government and council work on a financial year, but the grant deed ends at the end of 2015. That is for both of those contributions for Active Launceston and the for the staff health and wellbeing project. Where do I go to next? I have been to meet with Sonia Purse, acting CEO of Tasmanian Health Organisation North, and her recommendation was to write to the minister. Again, the only way that we have to get money is through a ministerial request, which has caused me a lot of problems in the past because there are a lot of political issues with having a ministerial request from people within the department, so that causes concerns as well - that we seem to be going around the system. In my mind we are not going around the system; that is the only way that we can get access to the system. That has become difficult at times as well.

Mr BARNETT - You have identified the issue of government operating in silos and portfolio areas and then the need, from your point of view, of a single provider for funding. I am interested in the issue of getting a return on funds invested. As a government it is very important, including in the space of health and health prevention. Your last two pages of your submission outline some of the KPIs that you have identified and then you have set them out in points 1 to 11. You have done an evaluation and you

have an extract from that evaluation that you have delivered to us. We get requests as a government all the time for more money, so how can you identify and deliver the benefits? Are there other KPIs? You have mentioned you are getting KPIs for Launceston City Council for social connectivity, for the state government on type 2 diabetes, obesity and related diseases. What are the KPIs that you suggest will help us say we are delivering all these benefits, therefore we should get more money. If Active Launceston is so good, why do we not make it in every municipality across Tasmania and we fund it across the state? Do you have any suggestions there as to where we can go?

Ms BYRNE - It is a really good question, Guy. One of the other things I have taken on, which I never thought I would, is a masters with the thought to go to a PhD. I have done that because I want to provide the evidence that what we have done with Active Launceston is making a difference and to figure out exactly what those KPIs are. What has been interesting in that process is how complex it is and how much peer-reviewed literature there is about the complexities and the difficulties in evaluating community-based health promotion initiatives, because they are so complex. If people ask me all the time what does Active Launceston set out to do, the obvious answer is increase activity, but there are so many other elements underneath that. How do you accurately measure those and how do you accurately engage the community in that evaluation? What we do is a mixed-method evaluation. We have KPIs that are around creating partnerships, KPIs that are around improving physical activity levels and sustainable physical activity levels. These are measured through different ways. We have a population-based survey, focus groups and we have stakeholder interviews. I can provide you with some of the elements of that and more detail of how that is coming together. It has been an interesting process for us to go down the track of how hard it is to evaluate these programs

Ms O'CONNOR - I am interested in the networking capacity of Active Launceston, how it might be used as a model for other municipalities in the state and how you might tap into social infrastructure that already exists. I know you have already done some work with community sector organisations like Anglicare, Neighbourhood Houses, Child and Family Centres, and you thoughts on how you reach difficult-to-reach demographics with the physical exercise health and wellbeing message.

Ms BYRNE - One of the things I try really hard to do when I am working with another community group is do not tell them how to do it; they know the community better than we do. What I think we have been able to set up with Active Launceston, which has moved into Active Tasmania, is a framework and a model and a way of working. If you said to me I need you to run a new program starting tomorrow for youth at risk and young mums, we can do it like that. We have the forms, we have the process, we have the engagement of consultants, the advertising mechanism, the venues, those types of things.

Ms O'CONNOR - Do you have the vehicle always necessary for delivering it in a community where you might not have people?

Ms BYRNE - That was where I was going to next. When we take our model or our framework to another community it is about adapting our model to their needs. So exactly what works here in Launceston with the programs - active bike, active garden

and active parks - those initiatives might not necessarily work in Hobart or in Glenorchy or in George Town, but it is the way of working that I believe is adaptable to other communities. If we were to take our model into another community, it is about looking at the lay of the land first. What have they already? I am really keen on not duplicating and not reinventing the wheel if there is something already running in that community, to make sure we are supporting them and we are not duplicating. Also, helping to promote them. So we have an endorsement process under Active Launceston where we will support anybody, commercial or non-commercial, and we will promote them back to the community. We use our resources to promote and support them.

We also engage them to run our programs. That is the other thing with Active Launceston with the model. The money that comes in, the majority of it goes back out to the community. Whether that goes back to a graphic designer or a catering business or to the judo club or to a fitness instructor, and whether that be in Launceston or George Town or Northern Midlands, it is about looking at what they have, what their needs are, what the gaps are and how we can use our model to help support them to bring that altogether. We have a lot of fantastic initiatives in Tasmania. I do not think Active Launceston or Active Tasmania is the be-all and end-all, but it seems to be, in the feedback I get, the gel that brings everything together, like how we work with Move Well Eat Well and how we work with other programs in the community. We can help support them and promote them so that there is almost an umbrella structure for everything that happens around healthy lifestyle behaviours in a community. Those links need to be made with local people. You need to find the lay of the land before you come in and start running a program because that will not be successful. We need to know what the gaps are and what their needs are.

CHAIR - Lucy, we thank you for your time.

THE WITNESS WITHDREW.

Mr JOHN KIRWAN, CEO, ROYAL FLYING DOCTOR'S SERVICE, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Welcome, John, and thank you. You are aware of parliamentary privilege and the public proceeding which this is.

Mr KIRWAN - Thank you. I have given you five papers. They were in creation when we made our submission, understanding that when I was writing the submission I was in my first four weeks of the job, so I thank you for your latitude. The green paper is a crossover with your work. There is a fact sheet that picks up the essence of our report we commissioned with KPH that follows up the work that we gave you a copy of from 2012 in the submission. There is also a more recent CIE health economics report by our federation in respect to primary health, and there is a dental fact sheet about some of the work we have been doing in Tasmania, which does go to some of the social determinants of health. Those are the five papers which I table today, in part because some of them are hot off the press.

The essence of our submission, both in the green paper and here, would be that we need to have targeted evidence-based action in respect to improving the primary health care of our population in rural and remote areas. One of our recommendations to the green paper was that the government develop those targets and use them. We have done it in the report that is there, so if they want to they can do that and we will send them the bill later. Effectively the essence behind that is not surprising. You will not be surprised to hear me say that we are constantly focusing, as we have done this week and as we have done in the performance report, on things like elective surgery waiting lists and emergency access times. They are perfectly appropriate, but what about the other health indicators out there that should also be reported and held accountable for in KPIs if we are to achieve the Health 2025 vision. We need to do that and we need to disaggregate the areas. This report is based on the local government areas. There are some fairly disturbing results in them.

It will take time and I just totally reinforce what Lucy said about funding continuity and others. I would be probably more bolshy than she was. I think funding for these programs shouldn't be subject to the vagaries of treasuries and politicians. These are long-term investments that should have bipartite or tripartite support. It is not a lot of money in relative terms to the Health budget, but you do need a model that isn't subject to variations. As a program manager over a long period of time in three jurisdictions setting up programs, you require good community-based support and the right staff in place. They can often take one or two years, even longer, if you are dealing with Aboriginal communities, so someone who is culturally appropriate. On a three- or four-year funding cycle or electoral cycle you end up with a history of just a cargo-cult mentality - another project, another report and a lot of half-finished work. If we are serious about making a difference, particularly in the cold hard yards of smoking, lifestyle and others, we have to put investment in that goes past political cycles or media cycles or treasury cycles. That is hard because governments really do budget annually. They do have forward Estimates, but that is really only a three- or four-year cycle. I know it is difficult, but it may take some innovation. It is a relatively small investment.

I draw to your attention page 31 of the KPH report where we have extracted the case mix costs of the four major hospitals. Not surprisingly it is an area that I have lived in for the last five or six years because this underpins the national efficient price argument. When you look at page 31, the average cost per separation of the four hospitals, every time you avoid one of those you are saving big dollars. In the report there are those avoidable hospital admissions, potentially avoidable and so it does not take much to do the maths. You can go back and see a lot of these are lifestyle, but they are not easy to fix. If they were easy to fix someone would have done it. I am not underestimating the size of the task before us.

I also say in one of our submissions to the green paper is that we do need to look at a workforce. I would probably be one of those heretical people who will say that our workforce is really not dissimilar in the health industry to what it was 100 years ago. In dealing with some of the demands we have now, like the epidemics, like obesity, like diabetes and others, maybe having a workforce that was designed the best part of 100 years ago is maybe not the best way to go forward. I am not saying what the solution is. I know some members or some parties around the table have had certain preferences in some areas, but I think there are some innovative areas that we need to look at. Again, we need to design that workforce to the health needs of the population, not the reverse.

We are very much into partnerships. I am happy to explain that we are into a community development model, as Active Tasmania is. The intention is to improve the health outcomes. The RFDS has a 90-year history of doing that. We were the pioneers in telehealth, in providing remote and rural health, in providing a whole range of areas like medical tests into these areas. We would like to be around in 90 years to say we were part of some of these improvements.

Page 39 is about integrated care and Lucy has touched on that as well. We really do need to try to break down the barriers, which I as a bureaucrat have been part of, so I take that responsibility, but governments have also been part of. The different care models are predominantly determined by the funding sources, held by three tiers of government, by private insurance and by self-insurers. Interestingly enough, with the RFDS generally about 30 per cent of its income comes from charity, from our fundraising, so we have a little bit more flexibility than most to fundraise ourselves and put our own money into the action that comes from our very strong supporter base, particularly in the big capital cities where they are prepared to generate funding for us. For example, we receive money for our dental program that is raised in the streets of Melbourne. The Melbourne people are quite happy for their funds to come to other parts of Australia.

CHAIR - In an ideal world, what KPIs should be reported on to give meaningful data that can then guide a long-term strategy and long-term funding security and some sustainability around preventative health care keeping people out the acute health setting?

Mr KIRWAN - The one that shocked me probably the most when I first came to Tasmania was the potentially preventable avoidable deaths. I had been used to looking at this data at a regional level, not a local government level. Some of the data, when you drill it down that next level, is quite disturbing. There is an issue in some of the small councils over that data size, but we have had this done by an epidemiologist. If you look at

figures, on average 40 remote and rural Tasmanians die per year more than the rest of Australia, and that is potentially preventable. That is unacceptable. We should at least be on the Australian average, or at least within Tasmania our remote and rural areas should be on the Tasmanian average.

Mr JAENSCH - What is the average?

Mr KIRWAN - About 180 versus about 140. It is lifestyle factors predominantly.

CHAIR - How do you measure hospital avoidance? This is the question. It is money saved, not money in a budget. It is just money not spent.

Mr KIRWAN - You extract it from the datasets, which are common across Australia. Potentially avoidable mortality and hospital admissions are two good KPIs, but they are not part of the current measurement suite.

Ms O'CONNOR - Why not?

Mr KIRWAN - I am probably not the right person to ask. I have a personal preference. I have always argued to at least weight some of the national indicators that we are bound to. For example, I do not agree that elective surgery, categories 1, 2 and 3 are all treated the same. My view is, the most important thing in my previous role was emergency surgery, category 1 surgery. Yes, it would nice to do the other two categories in time but I would weight, for example, people who have had a diagnosis of cancer, in getting treatment in the Holman Clinic are getting it appropriately and on time, far higher than someone on a category 3 waiting list is getting their time. But the waiting time for the Holman Clinic is not counted, it is not one of those measures. We do internally because that is important for us because if you are not meeting those indicators that is a real problem. It is a national suite of indicators with some variations at a state level.

I would argue, from a primary population, preventative health perspective, we need to get better indicators in there and ones, as Lucy has referred to, some of them are not easy but some of them are there already.

CHAIR - Are there any others, John, you would like to suggest?

Mr KIRWAN - If you work through all the indicators that we have included here and include them down to a local government area, at least down to a regional level, although that now becomes problematic with one THS, we need to get granularity.

Ms WHITE - The early detection of disease that you have here?

Mr KIRWAN - Yes, and a lot of it is about access and that is where we come into play.

CHAIR - Moving on to another area, the workforce issues, I would like to explore that a little bit further. You talked about innovative areas that could be implemented to try to deal with some of the workforce, which was predominantly was for 100 years ago. Can you talk us through your ideas about that?

Mr KIRWAN - The reality is, we have seen other models in place in other states. For example, the use of Aboriginal health workers, who are more of a generic worker at a lower level, working within the medical model. We have seen those sorts of workers in place. Queensland has done pioneering work in two areas. One is the rural GP generalist model which is now being rolled out in the north-west after the trial here. Another model was a physician assistant model and Queensland is working through those models.

With the LGH we did early work on a generic allied health assistant. With those sorts of models, particularly when you are dealing with rural and remote communities, you are never going to get the full range of services in those areas. You at least have to be able to maintain a level of primary care that is safe and secure in those services.

CHAIR - Are you talking more about looking at nurse practitioners having a greater role and assistants in nursing?

Mr KIRWAN - Probably not so much assistants in nursing in these areas but there is the full suite of nurse practitioners and a range of other areas that are generally still not a mainstream part of the Australian health system.

CHAIR - The partnership model - it is clear the Royal Flying Doctor Service have a very clear partnership model but you said there was more you could say about that. It would be helpful to hear a bit more about that.

Mr KIRWAN - What the other sections have been doing, particularly Victoria, for a range of reasons, is working very closely with a range of areas they are now helping provide. There are 40 dentists on their books now providing volunteer dental services to remote areas of Victoria which would never traditionally see a dentist, and working with the Australian Dental Association in those areas. The flip side of that is in the north of Queensland with QCoal sponsoring the RFDS. There is a fully equipped bus with two dental chairs that visits 2 000 people a year who would normally never get the dental service. Those are the kind of partnerships that the RFDS can help broker - not necessarily do it ourselves but in the traditional areas we do, where we will have a base and have our own staff but work with others.

I repeat Lucy's view, the local people know what is best but we can often bring innovative practices, plus we are a bit rare in that we can access services and funding from three tiers of government, although in Tasmania that is not part of the model. Those are the sorts of opportunities.

Mr VALENTINE - In an ideal world, where all parties in parliament are prepared to listen to you and take advice from you on long-term strategies and frameworks, what would be the ideal time frame - 10, 15, 20 years? Given that technology changes over that time and all those other things that might impact, if we had all parties signing off on a long-term strategy, what would you say would be a reasonable time frame to deal with, in your experience?

Mr KIRWAN - Because the social determinants of health is an underlying issue, the honest answer is, it is quite a long-term time frame. The reality is, those people don't have the access or the literacy necessarily - not only health literacy but functional literacy - and

can't access the transport - and some of the examples of access are not our 10 000 very remote members of our community or our 200 000 rural members of the community. Some of them are sitting in the outer suburbs because of transport and other issues or they have a large, young, single-income family that is very hard to get on a bus to go to a dental appointment. The underlying issues of education, employment, safe water and air and all those other areas like that, are long-term issues because they can't be fixed overnight.

However, there are a number that can be. For example, with our low breast cancer screening rates and other low screening rates, we should be making sure in those areas where we know there are issues that we provide the access to those services. As most of you would be aware, if we can in the first instance support programs such as Lucy's - prevention and promotion is the ideal thing; we keep people healthy, fit, at home, on their feet so if they have a fall they don't have a major problem or they can recover quickly, the next episode from our perspective, would be that if you can diagnose something early enough - and one of the problems with the health figures in Tasmania is that presentations are generally late and quite unwell with a lot of comorbidities, which means they're complex, hard to deal with and spend longer in hospital than they should - if we can get the screening side to early interventions, so we can pick up the cardiovascular disease, type 2 diabetes risks, and all these others areas early and then work with people and communities to address them - you can't have an episodic thing, it has to be there - that's where we could see, and should see, short- to medium-term gains.

Mr VALENTINE - Are we talking a 10-year time frame, 20 years, to put a strategy together?

Mr KIRWAN - In some of those ones for screening and others, with investment I think we're talking about a couple of years that we would see results. Unfortunately, my friends in the acute sector won't thank me because we're likely to uncover levels of disease, for example, of potential end-stage renal failure that people don't realise. We are likely to find a degree of chronic disease because we know from those mortality and morbidity statistics we talked about that they're out there because they are fronting up and dying or fronting up and going into hospital. We are likely to have a hump in the short term but I am not likely to be thanked by my colleagues in the acute sector because it will mean more referrals, particularly to Outpatients and others, but that is better than seeing more deaths.

Mr VALENTINE - But you don't want governments changing the goalposts every four years. What is the ideal time frame - 10 years, 15 years, 20 years?

Mr KIRWAN - From my background in Aboriginal health, we are talking about intergenerational change. You are talking about a longer time frame for some. If it is access issues, it's short term. Particularly with the new technology and workforces, it is core business for the RFDS. The RFDS is used to running the blue sky, red dirt clinics - put the aeroplane down in a remote community and they come in and see the doctor and the nurse and have their health checks done. I'm not saying we do that in Tasmania necessarily, but that's the model. If we're providing that level of access in screening so that everyone is getting a health care plan and check every year, that would be a big improvement. We can check and ask, 'Have you had your breast screen? Have you done your other screens? How is your tetanus shot?', et cetera. That has to be good.

Mr JAENSCH - When you made your opening comments, John, you picked up on a number of the items the previous witness raised regarding short-term project-based funding versus more certain, continuous recurrent funding for preventative health work in places. Who around the world has worked out how to do that well? Is there a model somewhere that we should consider in our process? Funding for place-based preventative health has become normal, core, and devolved between levels of government - who has that sorted out?

Mr KIRWAN - Great question. I think you would look to a number of examples. New Zealand is probably the closest but, again, they have the advantage of one tier of government plus a different funding model in this area. You would also look to a number of European countries. A number of those are interesting because they have already been through the baby boomer hump. That was 10 years ago compared to where we are. The Europeans are interesting in their health systems and some of them are similar to ours. The Dutch system structurally, other than size and distance, is not a dissimilar system and a similar size to ours. The swings and variances aren't as great and because of their political systems, which I am sure you are more aware of than I, some of these areas are just not political issues. You don't see a change of policy and direction with a change of government. You also see an investment into these areas that is relatively constant.

Interestingly enough, and I have to give the current Government a lot of credit, in the green paper they put in writing that there had been an under-investment in primary health. In my experience governments don't like admitting that. I am not saying put more in because we are not at that stage. To some extent we are getting the models right and we intend to go forward in that to various different funding sources when we are there, but you have to have an investment and that ounce of prevention is worth a pound of cure. What I am saying is that there are indicators, when you look at some of those KPIs we put in here, like potentially avoidable mortality rates, potentially avoidable hospitalisation rates and a range of others where we could, if we got it right, actually generate some of the income.

Mr JAENSCH - Is there evidence from New Zealand, if they are ahead of us in this thinking, about how they currently fund prevention? Are they getting better statistics?

Mr KIRWAN - I am probably not the right person to ask; I would probably refer you to the department on that. Certainly in one of my previous roles we looked very closely at the New Zealand Maori health model because, interestingly enough, Maori health did not have at that stage the 20-year life expectancy gap we had in Australia, so one of the obvious questions was what were they doing right that we were not? They had put in a whole range of different programs, including employment programs, so you find a lot of Maori in positions of seniority and with university degrees. It goes back to education, which leads to good employment and good health outcomes. It is a truism.

My figures are dated so you should probably ask better experts than me in this area - I don't claim to be an expert - but interestingly enough, their islander health was more similar in outcomes to our indigenous health, but their Maori wasn't. Again you look at it and ask why is this so and is this then translatable to us? Some of it is not. Maori have a very strong cultural security approach. They have a very strong culture which goes

back to the treaty which gave them rights in New Zealand that didn't happen here, although I think it is changing.

Ms O'CONNOR - John, I am interested in breaking down some of the work that has been done in local government areas. For the committee's benefit, because I haven't had the opportunity to read all these papers yet, could you detail to us some of the specific health challenges that face people among that 10 000 Tasmanian cohort that you were talking about, just painting a picture of the health issues faced by rural and remote communities and what can practically be done in the preventative health and wellbeing space?

Mr KIRWAN - Probably the easiest way to paraphrase that is on page 24 of the report. I will just read it quickly:

> The most common conditions for preventable hospitalisations in Tasmania are chronic obstructive pulmonary disease, likely linked highly to smoking rates, diabetes complications, dehydration and gastroenteritis, dental conditions and congestive heart failure. Avoidable hospitalisations increase with remoteness.

The trouble is that when you read something like that, for almost all of those we have evidence-based programs we can use today. These do not require another review or research. We can go to areas like Lucy (??) and others and ask what they can do to help us with these. Some of them are access, because they do not get to see their GP, some of them are remoteness in Tasmanian terms. I would argue that our three island populations are very remote, yet we tend not to treat them the same way as the central desert of Australia, which I think is wrong because you cannot drive there.

Ms O'CONNOR - In terms of King and Flinders islands - which I know the RFDS services and is much appreciated - are the specific health challenges there just about remoteness?

Mr KIRWAN - No, low socioeconomic predominantly and, again, Flinders comes out of this particularly. If you go to the tables on pages 23 and 25 you will see some commonality in bracketing of these council areas. I would be wrong to say these are not the only areas you have to deal with. There are outer metropolitan areas in Launceston and Hobart that have similar poor outcomes. Again, access is an issue.

Coming back to Rob Valentine's question, some of those issues of access are not intergenerational; they can be fixed now. Some of them go to technology. We have been trialling some of the technology with the CSIRO so you should be able to trial people and monitor them. There is a range of areas. Once we have them engaged then monitoring, follow-up - even just the follow-up to say, 'We notice you have not come in for your dental health check'. I have to say dental health is of a particular concern. I know it is a political football; no-one wants to deal with it, but doing the rounds I have to say some of the stories I have been told about some of the oral health outcomes, particularly in nursing homes, are alarming.

CHAIR - If you go back to prenatal dental care for the mother you can also prevent a whole lot of problems right there.

Mr KIRWAN - Yes.

Ms WHITE - John, I want to talk about the potentially avoidable deaths, particularly the prevalence of them in rural and remote communities. In the data set you provided us with it is especially alarming in some of our more remote areas. In your submission to the green paper, one of the recommendations is for dealing with role delineation issues which might see more patient transfers being required. You also talked about the potential need for a second aircraft to be considered by the Government. Could you outline why you think that might be necessary?

Mr KIRWAN - Not surprisingly, I do not want to be here pushing the role of the RFDS as a service provider; we can do that elsewhere. This is a committee whose terms of reference are quite clear. We have one plane in the state at the moment contracted with the south-east section and Ambulance Tasmania. It is busy a lot of the time, with intrastate and interstate transfers comprising most of its business. If we are to move people to the most appropriate care, particularly for the three islands and the east and west coasts, there is probably an argument to say there needs to be another plane if nothing else to back up the emergency care that occurs if we are doing a normal transfer. The plane is a far quicker way of moving. It is a 15-minute flight to St Helens versus two to two-and-a-half hours by ambulance, so it does make sense to use it in that way.

CHAIR - Wouldn't it be better to get a helicopter that you could put down at a crash scene as opposed to a person who may be presenting to a health facility in Strahan?

Mr KIRWAN - I think in an ideal world you would have all of them but you have to be able to afford them. If I put on my former bureaucrat's hat, helicopters and fixed-wing aircraft are not cheap. A second aircraft would allow us to probably support that as we develop our primary care services but again, we don't necessarily support just a fly-in fly-out service; we need services in situ. In the later part of the report it implies that we need to work with the community. Continuity of care is important. Fly-in fly-out and locum services is not continuity of care. It doesn't matter; a doctor can be as good as they are, and they are all very good in Australia, but we need to make sure that we provide those services, particularly if you want to move in to prevention promotion. That means you actually have to sit down with the patients, establish that relationship and understand, for example, what mum and dad died from. What is the family history? What can we do?

Ms WHITE - You have talked about your interest in primary health care in remote areas across other parts of Australia. In Tasmania the RFDS doesn't do a lot of that work. Is that something you are looking to have a bit more of a role in?

Mr KIRWAN - That is what I was employed to do. The RFDS mission simply is excellence in our own medical services but also excellence in primary health care. Primary health care has not been part of the function here for historical reasons, but the board now wants to explore that.

Ms WHITE - And that would be delivered using your aircraft to -

Mr KIRWAN - A mixture of areas. Interestingly enough, some of the other states are now looking at having less planes and doing more by road. In the last couple of weeks the

Victorian section has won the contract to now be the biggest road ambulance provider in Victoria.

Ms WHITE - For emergency or non-emergency transport?

Mr KIRWAN - It is a mixture of transport and emergency transport and the models that the RFDS is developing is a bed-to-bed model.

Ms WHITE - With the required transportation of patients as outlined in the green paper becoming more of a requirement to change the service delivery across Tasmania, do you see that non-urgent patient transport could be provided by an organisation like yours?

Mr KIRWAN - Or others. Again, we are not being proprietary about that, we are interested in service and the outcome in particular.

CHAIR - You have talked about the high incidence of avoidable deaths in Tasmania. Does the fact that we have a small population and hence small numbers mean we could have huge fluctuations in statistical results when you are comparing this to the rest of country?

Mr KIRWAN - It has been adjusted in the report and has the confidence ratio in there. Flinders Island is the one that jumped out at me and there is a potential issue there because of the small sample size. However, I would have to say if we are to address these areas, coming back to Rob Valentine's question, if you don't know what the problem is you cannot put targeted solutions in. For example, when I went to a rural area in Western Australia which wasn't all that remote I had the local farmers sit me down and say basically, 'You health department bureaucrat, we're not interested in your three fruit and veg program down here because that's all we see, we're more interested in the fact that we have people with significant problems because of seed spray, chemicals and others. How do we deal now with farmers who can't hear or smell?', which is particularly problematic if you are trying to work out whether something is kerosene, petrol or water. 'Those are the areas you should be giving us some advice on. You need to tailor it to what's right for our population.'. I was a very young bureaucrat at that stage and I walked away with my tail between my legs thinking, 'I've just been told off by these guys whose hands are like slabs of meat.' They were right because we take a one-size-fits-all approach. We need to know the data to target them to work out where it is, because we have the interventions, we have the evidence and we need to do it.

CHAIR - Should we then be focusing on this 'health in all policies' approach where any government policy has the health bill to run over it, so to speak? We talked with Lucy about funding this as well - where does it sit? Preventative health is not just about health, as you have said, so where should it sit and how do you achieve that?

Mr KIRWAN - I suppose given my background, which some of you are aware of, I support the purchase-provider model. It fits is in a department of ministry that is purchasing for health outcomes or gains, rather than funding services. A good example is Aboriginal health. If we are focussing on closing what was a 20-year life expectancy gap, what are the best evidence-based interventions? That forces you to go to the evidence, not necessarily to what is politically acceptable, because what tends to happen is that tends to get the pressure. If you go to what are the health economics or what is the epidemiology

telling us that we are going to get the best bang for the buck. Those are the sorts of processes.

At a micro-example, when I was in Western Australia and Aboriginal health was one of my areas of responsibility, my Aboriginal staff came to me and said, 'We want money to pay for kids with hats with reflectors on the back.' I said that is not what I am going to spend the taxpayers' health money on. They said, 'No, we need it.' I said, 'Please explain?'. They said all these Aboriginal communities don't have street lighting. If you look at the figure there is a large amount of kids that are bowled over at night because people don't see them.

CHAIR - On their bikes and walking?

Mr KIRWAN - Yes.

Mr KIRWAN - We bought the hats and we got the improvement. I had been to these communities, but I had only been there in the daytime. That is a very obvious public health intervention.

CHAIR - Where should it sit and what should be the framework for dealing with this in the big picture? Is it Department of Premier and Cabinet, or have it with Health and make sure that it works that way?

Mr KIRWAN - There is an interesting discussion between output-based management and output-based budgeting in outputs and outcomes. It is a good debate, particularly to have with accountants, but the Health department should be held accountable for purchasing of health outputs and health outcomes. It can have responsibility for its purchasing contracts with RFDS or my former employer or others like that. For the bigger issues of social determinants of health I think it is a whole-of-government issue. Whether it rests well in Premier and Cabinet or not -

Ms O'CONNOR - Where else would it fit?

Mr KIRWAN - It has to fit where they are going to make it work and they are going to want to believe to make it work. It does go to retention rates at school, employment, to making sure we have good, safe roads, that we have safe water, safe air and all of those other areas that do affect it. They are not Health. The cold hard reality is that is not an investment at the LGH, whether it is needed or not. They are investments in keeping kids at school and making sure they have a good job to go to. That is a broader issue because it includes Education. It also includes Justice and everybody else; it is not one size fits all.

CHAIR - Having Health means to put it across all policy decisions would help. Is that a fair comment?

Mr KIRWAN - It comes to those inputs and outputs and ones you have some control over. I am hesitant to say that is a solution because what you will end up with is another page on a Cabinet submission that you fill in and everyone ignores.

Ms O'CONNOR - Like the climate change ones.

Mr KIRWAN - Almost, yes.

Mr KIRWAN - That is why I am arguing for KPIs that mean something, that are measured. We intend to release this report we released yesterday every three years because that is the advice when the datasets will be updated. In part we are going to hang ourselves because by then we are actually in the primary care game, and we will be part of the problem or part of the solution, but there has to be a solution. I am a person of first principles. You have to come back to what are the outputs or outcomes that you are looking for and who really has responsibility for them? It is complex in Australia because there are three tiers of governments, all different funding services and there is a huge amount of lobby groups. It is easier in New Zealand for that reason, but maybe we need to look at a different model. I would argue for a different model.

You only have to look at the examples of even our most disadvantaged communities if you map the services going into them. Aboriginal people used to say to me, 'No more, John, there is enough money being spent. You just need to spend it properly. That doesn't mean you sitting in your office making a decision about what is good for me and my mob.' The first thing you do is stop every person coming and asking the same question. We mapped a family in Queens Park, in metropolitan Perth who had something like 19 different visits from different government agencies over a two- or three-week period. What is the first thing they did? They asked for the family history. They were a predominantly middle-class and white.

CHAIR - Thank you for your time.

THE WITNESS WITHDREW

DISCUSSION WITH **Dr ANNE CORBOULD** VIA TELEPHONE LINK

CHAIR - Thank you, Anne, for making yourself available. The committee is in a public meeting so what you say - there are some members of the public here and the media have been here and will probably be back in a moment - it is recorded on *Hansard* so what you say will become part of the record. We cannot swear you in because you are not in Tasmania, so Parliamentary Privilege doesn't apply if you are not sworn, so if you keep that in mind. If there is anything you really want to speak to the committee confidentially about then you can make that request and we would consider that. Essentially it is part of a public hearing.

Dr CORBOULD - I would like to thank you for the opportunity to contribute to this hearing today. Regarding the care of patients with diabetes in the north of the state I want the committee to realise that this cannot be described as a service gap. There is a gaping chasm in services in diabetes. Diabetes care in the north of Tasmania is in crisis. This crisis has been of such depth and chronicity that it has come to be regarded as normality. For the reference of the committee as evidence of the duration of this crisis, I refer you to *Hansard* of the Tasmanian Parliament on World Diabetes Day, 14 November 2007, when the critical shortage of endocrinologists in the north was raised in Parliament.

The focus of my submission has been on the lack of specialist endocrinologist care for patients with diabetes, but I would also like the committee to know that there are similar constraints in the north for other key members of the diabetes care team, such as podiatrists.

It is important to realise that, given the increased prevalence and life expectancy of patients with diabetes, and also the increasing complexity of care due to new drugs and new technologies such as insulin pump, the workload of endocrinologists and the diabetes team in general will only increase. It is the position of the endocrinologists in the north - that is the Launceston area and the north-west - that a minimum of 3.0 full-time equivalent specialists are needed and that would be comprised of 2.0 at LGH and a minimum of 1.0 at the North West Regional Hospital.

As evidence of the reasonable nature of that staffing I draw the committee's attention to a report of the Royal College of Physicians in the UK 2013 in a detailed publication dealing with the recommendations for the provision of endocrine and diabetes services. They came to the conclusion that for a population of 250 000 there is a need for a minimum of four endocrinology/diabetes consultants. These UK data are somewhat relevant to our situation in northern Tasmania, where like the UK in general there is relatively little access to private medicine. Our recommendation of 3.0 endocrinologists in the north is really a fairly minimal recommendation.

In the north currently the number of endocrinologists in recent years has only been 1.3 full-time equivalents: 0.3 at the LGH and 1.0 at the North West Regional Hospital. By the end of this month there will only be 0.8 full-time equivalents in the whole north unless a new appointment is made to replace a 0.5 full-time endocrinologist [inaudible]. I think you can see by comparison with the UK recommendations these staffing levels are less than a third or one-fifth of the recommended minimal staffing respectively.

I would also like to explain my motivation to the committee in bringing these issues to your attention. I would like to emphasise this is not because I want to be employed for more hours from the DHHS. I do not, and I think also for my colleagues [inaudible] two endocrinologists in the north of the state. The reason I bring these issues to your attention is that the people in northern Tasmania with diabetes and other [inaudible] deserve a better deal. They deserve access to a high quality service. I conclude my remarks there.

Mr BARNETT - Let me declare up front my vested interest as a person with type 1 diabetes, Diabetes Australia Ambassador, and also you are my endocrinologist, so I do have a vested interest in the relationship. I pick up on your opening statement where you talked about the World Diabetes Day 2007 raised in parliament. Which parliament? Are you quoting me or someone else and is that federal or state parliament?

Dr CORBOULD - No, it is the Tasmanian Parliament. I believe, if I remember correctly, the health minister was Ms Giddings and I think the question was directed at her.

Mr BARNETT - Okay, that is useful to us. I was going to recap in terms of where we are at with people with diabetes in Tasmania and particularly the profile of people with diabetes in the north and north-west. We have 27 000 Tasmanians diagnosed with diabetes, 10 000 undiagnosed, and then on top of that we have 45 000 who have impaired glucose tolerance so are at a higher risk of getting type 2 diabetes. Then the 3 000 with type 1 diabetes. In terms of the profile of people with diabetes are they any different in the north and north-west compared to the south and what about compared to the rest of Australia, because we are keen to get the overview? It is known that we have the highest type 2 diabetes in Australia.

Dr CORBOULD - I think the major point to consider about the profile of people with diabetes in the north of Tasmania - when I talk about the north I am talking about both the north and the north-west - is it is a relatively decentralised population. There are areas of significant socio-economic disadvantage. All the statistics that we have related diabetes in the north suggest there are a lot of potentially preventable admissions of these patients. If they had adequate care in the community at a much earlier point we would be able to avoid hospital admissions.

Another characteristic of these patients is that we have data about their foot health and their complications related to diabetes foot disease, that is from the PoDFAR study, a collaboration with Latrobe University and podiatry support services in the north of the state. They found that patients in the north and north-west have triple the odds of wound foot morbidity than comparable patients in regional Victoria. On talking to our podiatrist, services are severely limited in the north. One of the issues with these patients is that they may have catastrophic foot complications related to diabetes, some of them ended up having amputations. These patients present having had some access to GPs, but they have had no access to an endocrinologist, specialist diabetes podiatrist, vascular surgeons and so on. I think the restriction of services show that it goes across the board, not just for endocrinologists.

The other issue in the north of the state there are some areas where there is a particular high turnover of general practitioners, so patients are perhaps not able to access the prolonged care that they need. One of the other issues to consider is that our services in

the north, in the public system, are basically the total services that people can access because there are very little private endocrinology and allied health services. That is the difference with the south. I would say that is also a difference from most urban areas in Australia, for example Melbourne, where there is a lot of access to private health providers.

What we provide in the public system is the total services available to people. I am not actually not giving statistics here but I can tell you from patients that I see every week at the Launceston General Hospital. I still see patients at the North West as well, and all over the north. I see the evidence of 10 or more years of very little input for a lot of these patients. We have seen patients with quite severe complications with their diabetes which I believe could have been prevented had we had the opportunity to deal with it much earlier [inaudible].

Mr BARNETT - I know where you are coming from in terms of prevention and as a committee we are looking at health prevention. A lot of people perhaps consider prevention from diabetes, heart disease and cancer, but we are also talking about prevention of complications once you have type 2 diabetes or type 1 diabetes.

Dr CORBOULD - In a hospital specialist practice we're seeing people diagnosed with diabetes and our aim of course is to give them the best chance of a long and healthy life and keep them out of hospital. Secondary prevention [inaudible].

Mr BARNETT - I wanted to make that point because it's very important to me and the people in the diabetes community that type 2 diabetes can be prevented or postponed altogether through better, healthy, active lifestyles. Do you concur with that?

Dr CORBOULD - Yes, I absolutely do. That's a whole community problem when we hear that two-thirds of the adults in Tasmania who are overweight and obese. I don't by any means diminish the importance of primary prevention, and there is good data on how that can be done, but I totally agree that is very important.

Mr BARNETT - Just addressing your submission more specifically, on page 5 you talk about the current services at the LGH and in the north and north-west, and then the future or preferred services. Can you outline to us the difference between the two?

Dr CORBOULD - On our current services we are able to offer the absolute minimum. We are forced by the lack of resources to focus on certain areas, and one of those is the diabetes and pregnancy service. You can't have a patient who presents with diabetes in pregnancy waiting a year for specialist input, so we try to prioritise those patients and all those patients who are at risk of severe metabolic decompensation, meaning they are going to be admitted to hospital soon. We try to see those patients as quickly as we can. We try to target young patients as well and we also run a limited multidisciplinary high-risk diabetes foot clinic in which we try very hard to keep people in the community rather than admitting them to hospital for their foot complications. If they have a severe foot complication, we try to offer the best possible multidisciplinary service and care and try to avoid amputation. We have to prioritise. We target those particular groups currently but we keep in mind that we are offering a service at the tip of the iceberg and everybody else waits an unreasonably long time to have a specialist consultation.

Mr BARNETT - On page 6 of your submission you have outlined the services that are required at the LGH and you've mentioned the east coast. We have outlying rural and remote areas and they are the ones that are doing it tough. You talk about the outreach endocrinologist clinics on the east coast. That is one of your recommendations to the committee. Can you outline that recommendation and the other recommendations?

Dr CORBOULD - Regarding the east coast, there are all these outreach services going to the east coast. Tasmania Medicare Local offers a wonderful service with diabetes nurse educators and other members of the diabetes care team. Podiatry services also do outreach to the east coast. I was talking to the manager of the podiatry services in diabetes in the last few days and they offer a service every six weeks but their service is now getting very busy and oversubscribed. They agree with this recommendation, that if there was an endocronologist travelling at least on an occasional basis to the east coast they could offer these people a much better service for their foot complications. The other issue is that we have women now with diabetes in pregnancy on the east coast. We have looked at ways we could give them a better service, other than expecting them to drive up to Launceston right through their pregnancy. There may be other ways we can help them - for example, telemedicine - but the reality is we do not even have enough endocrinologists to put aside the odd hour for a telemedicine service at the moment. To offer any services to the east coast we would clearly need more endocronologists.

Mr BARNETT - I was going to ask you about the telemedicine, but I am glad you mentioned gestational diabetes. With 20 000 per year around Australia, it is perhaps one of those things on which there is not much focus so I am glad you raised it.

You mentioned TeleHealth and I was going to ask about that in terms of rural and remote areas. Do you see opportunity for us to improve the health outcomes and apply preventative health measures through TeleHealth and better technology in those areas?

Dr CORBOULD - I do. I believe that could be explored much further. The limitation at the moment is having endocronologist hours to participate in that. I agree that we could be doing a lot more with TeleHealth.

Mr BARNETT - As for people with type 1 diabetes and services for them in the north and north-west, being a different disease to type 2, what sort of services are currently offered and what should be offered?

Dr CORBOULD - The diabetes centres in the LGH and the North West Regional Hospital have a first-class team. I'm not talking about the endocronologists, I am talking about the allied health personnel in those units, who under very difficult circumstances offer a lot of assistance to patients with type 1 diabetes - and I am talking about starting people with type 1 diabetes on insulin pumps, the aftercare of patients on insulin pumps and using new technologies such as continuous glucose monitoring. That involves the implant of a small subcutaneous sensor that can give the patient blood glucose information 24 hours a day up to about six days. We can use that technology to help save lives and optimise diabetes control in patients with type 1 diabetes. Our specialist diabetes nurses are involved in that. We also have psychology services, and a dietician. All those services are provided as the diabetes centres for type 1 diabetes as well as type 2 diabetes. The service constraint for patients with type 1 diabetes is much like that for type 2 diabetes. The problem is getting an appointment to see an endocrinologist to get all those services

provided and underway. If you are a type 1 patient referred to me at the LGH at the moment, even if you are reasonably stable, if I think I would like to see you within a month, the reality is that only the most urgent patients could be seen in that time. I would probably have to categorise you as a category 2 patient, in which case you would be currently waiting up to 290 days for an appointment, which is clearly not optimal. If a referral was sent to me saying the diabetes control was very poor and that you can confirm about that patient being admitted, I would do my best to see you as soon as possible but the reality is that those patients are going to wait almost a year.

Mr BARNETT - I know that information is provided in your submission on page 4, so thank you for that and the wonderful services provided at the LGH.

CHAIR - It seems what you're saying is that without an increase in the number of endocrinologists for the state, and in particular in the north, we're not going to see these other innovative ways of dealing with it through TeleHealth and this screening. Even if people are being picked up early, unless they are either pregnant or at risk of metabolic decompensation, they are not going to be seen anyway. You can't provide a good preventative model without enough allied health and endocrinologists, is that a fair comment?

Dr CORBOULD - Exactly. That is the key issue. I believe that with the things that buy [inaudible], their expertise and dedication, we should be offering first-class service to patients in the north. I think we can do that but we would need some resources. I totally agree the key issue here is providing enough endocrinologists and allied healthcare professionals.

Ms O'CONNOR - Anne, I am interested in exploring with you what the human cost is of the shortage of endocrinologists particularly in the north and north-west of the state. How does that impact? You talked about this to some extent with Guy, but how does that impact on a person who may or may not know they have diabetes - the health cost?

Dr CORBOULD - I want to talk about it from the point of view of patients whom we see in more of a secondary prevention role, for a patient who knows they have diabetes and are referred to the hospital. I can't give you the figures for it, but I can tell you that if diabetes is poorly controlled, the patient feels dreadful and they are often depressed and sometimes anxious. Poorly controlled diabetes has a major psychological effect. You can image that a patient who has poorly controlled diabetes is a member of a family and that will have a huge impact on their family as well. Once a patient's diabetes control is improved they feel much better, their memory and concentration is better and they are able to function better and the family will function better as well. I believe we understand very well the psychological costs of diabetes to individual patients and that's why both the North West Regional Hospital and our diabetes centre at the LGH offer on-site psychologists. The other side of the coin here is that the cost to the patients who are being admitted for potentially preventable causes, the stress that is involved in being in hospital and away from their families, not to mention the cost to their productivity in the workplace - they may have to take substantial time off work and perhaps even lose their job because they've presented with a foot complication which means they can't function in their usual job for weeks or even months. The psychological cost to the whole community - personal, family and even workplace and the economy generally - is

very high. We should see all these people with problems related to their diabetes at the earliest possible stage so the we could intervene and prevent a lot of that poor outcome.

Ms O'CONNOR - You talked of a gaping chasm in services. As you know we have the oldest and fastest aging population in Australia. Can you paint a picture of the future if we do not deal with that service chasm?

Dr CORBOULD - I totally agree about the ageing population; the reality is people are living longer. More people have diabetes and are living longer with it. It is clear that would be an ongoing increased demand on services with diabetes. That has been the focus of this presentation today but there are certain other integral services that will be affected by ageing - for example, we treat patients with osteoporosis and as people get older we will have more work in that line so it is clear the workload will increase.

One of the issues is that along with that, of course the cost to the health budget will also increase substantially. As I said earlier, one of the major things we could be trying to prevent these people being hospitalised is seeing them early and dealing with them. That is one major issue to consider in the future. Even now, there have been studies in Melbourne metropolitan hospitals saying that 35 per cent of patients - there are all sorts of reasons why adults may be admitted to an acute medical hospital - have diabetes. If the diabetes epidemic continues, we can expect more and more inpatients with diabetes. If that is not dealt with, the issue is that patients with diabetes will stay longer in hospital and they cost more to treat when they're in hospital. We need excellent inpatient diabetes services to optimise the care of patients. They may be coming in for something unrelated to their diabetes - for example, a knee replacement or some other surgical procedure - and they need excellent diabetes care when they're in hospital to make sure their blood-glucose level is good so they do not get infections or other complications and can get out of hospital in a time that would be expected if they didn't have diabetes. I think inpatient diabetes care is going to be a very major issue in the next few years.

CHAIR - Thank you very much for your time today, Anne, and for your submission. We appreciate the work you are doing.

DISCUSSION CONCLUDED.

Ms LISA SHEARING, COMMUNITY OPTIONS SERVICE NORTH, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Ms Forrest) - Welcome, Lisa. This is a public hearing. We have your submission and have all read it. We invite you to make some opening comments and highlight anything you want in your submission.

Ms SHEARING - I had the advantage of listening to other people's feedback and in the last discussion with Anne there was talk about preventative health measures and what can achieve that preventative health measure. From my experience working with people in our community with very complex needs, a lot of the time it comes back to the person's motivation and want to change. As a health professional, we can sit there in an inpatient or a community setting and tell people what they need to do in order to get better health outcomes and that preventative healthcare model. I am finding that you get a lot of health professional talking at people and it is effective for some but that model is not effective for all. There are a lot of people who would go back home having listened to what has been said, but either do not have the motivation or a large number of barriers that make making that change very difficult for them.

I know we can stand there and tell somebody they need to do *x, y* and *z,* but I have found that it takes an investment in time to build trust and rapport with people, especially when they've had negative experiences in the service system and the health system. It is to build that rapport and look at the person because our services looks at what the person wants to achieve, looking at what barriers are stopping them achieving their goals and then trying to work with them to put services and strategies in place to overcome those barriers and support them in achieving their goals. That is long-term, that does not happen in a six-week time frame.

I have found a lot of service models out there and the health system is very much short-term focused. It makes early intervention and preventative strategies very difficult because you have to work with the person. Going in ad hoc, you might go in and see someone and then seven months later they might be re-referred back to your service, or when the wheels fall off 12 month down the track because the person has had a massive mental health episode and everything that has been put up around that person has fallen apart, if you do not have that regular monitoring and contact and a trusting relationship with that person, that early intervention and preventative stuff is quite difficult.

I am talking about clients with very complex needs in the community. I am talking about clients with multiple comorbidities. A large number of our client group have potentially cognitive issues, alcohol and drug issues, some people with both, family relationship breakdown, mental health issues, chronic health issues, risk of homelessness - the complexity goes on. We have a number of clients who have issues across all those areas and they are trying to manage through that as it is. We are regularly contacting our clients fortnightly or monthly, doing home visits and seeing the person in their home environment and working with them there. We have a lot of clients with cognitive impairment that present for a clinic review. It is not in their home environment, the specialist is sitting there doing a review and asking the client and potentially the carer, how are things going - 'Yes, fine' - but you go into their home environment and it is a very different picture you get in observation.

I have found that a lot of models, unfortunately, are very short-term focused. You have the disability gateway model which provides local area coordination for people with disability but is not comprehensive or long-term. You have the Tasmania Medicare Local model, care coordination for people with chronic illnesses, which again is a short-term model only focused on chronic health conditions. It is the same with the gateway model, it only focuses on the primary disability. Then you have Mental Health Services. A lot of their support is not long-term; it is episodic, short-term and only focuses on mental health.

For people with a large complexity and degree of areas in the social determinants of health, a lot of service models are set up only focus on one area. People are holistic. We have so many facets to our life and our being that impact on not only our social determinants but our health outcomes. That is why I love our case management model because we have the ability to be flexible to work short-term as well as long-term for those who need it.

To put some case scenarios to explain where I am coming from, we had one rural client with whom we had to meet at their farm gate for seven months before we even got to step onto their property. If we did not have the flexibility to do that, no other service provider, for example community nurses, would not have had the capacity in their role and within their funding to continue to try every week, standing at that farm gate. The outcomes that were achieved for that gentleman were massive and in a number of areas - a lot of positive health outcomes for that person.

For a client we went to about a year ago, there were no services going in. There was one service that managed to get their foot in the door but there was resistance about wanting to have services in their home. That person had not seen a health professional for over 10 years and had one form of ID on them. There were exposed wires in their home, half the lounge room floorboards gone, there was a gaping hole covered by a rug, massive rat infestation, toilet not functional, overflowing and composting. That is our client group, not all of them but there is a large percentage of our client group with so many complexities in all the social determinants of health.

Narrow models that only focus on one thing and not the whole person really create limitations in being able to effect change in preventative health because you have to work at the individual's own pace. As a service, you have all these brochures and information and fact sheets that people like to throw at each other, but we have to consider health literacy. People might be provided with a whole stack of brochures on discharge from hospital and they are not literate. Either that or they leave hospital and they do not get any. That was my experience a few weeks ago. There are so many elements in it and those elements really need to be factored in.

We had a client with severe alcohol and drug issues. When that client first started with COS, the amount of money that would have been costing in nearly daily access to emergency service call-outs, let alone admission and readmission costs and the length of hospital admission costs, it took us nearly two years to work with that client at that person's own pace. That person has now been absent from alcohol for nearly two years. But we have had to work with that person for over six years to get those outcomes and maintain them.

My point is, having the flexibility to provide longer term support for people with complex needs where it is required, and in a way that creates continuity of care so they have trust and rapport with a service provider, and utilise that. With other service providers going in, if you have a huge range of them - and some of our clients have at least six service providers involved in their care - there needs to be someone coordinating that. That is where I found our case management service facilitates case conferencing processes, we get everyone and all the key parties around the table. We involve and collaborate with everyone, but that takes time and a lot of services do not have the resources and capacity to do that.

It is those elements of our service that target and enable that ongoing preventative health care and monitoring. If we were not in with a large number of our clients, early intervention would be very difficult. You would wait and you would see re-referrals coming back into the health system once the crisis had occurred and all the wheels had fallen off. Then you have to start from scratch with that individual and rebuild that again.

I gave some examples there. Basically it needs to be done in a flexible time, not in the health professional's time but in the individual person's time for them to take on concepts, discuss them with their family, ask questions about things that they do not understand, look at creative ways of implementing strategies.

Ms WHITE - Thanks so much, Lisa. I found your submission really helpful because you have covered so many different areas but you have given a good example of the consumer's perspective on all of this.

I want to better understand what your job is day-to-day. You talk about Community Options Service, northern Tasmania. Can you explain what that is exactly and where it fits?

Ms SHEARING - I can explain it as it currently is. Unfortunately, and I will try to be unemotional about this, Community Options is on the process of being caught up in between internal organisational reform and Commonwealth aged care reform. Unfortunately there is a very large risk that in six to 12 months our service will not be in existence as part of primary health.

Ms WHITE - Can you describe what your service is?

Ms SHEARING - The Community Options Service is part of Primary Health Services, which falls under the Tasmanian Health Organisation law. You have the acute hospital and health care services that are based Launceston General Hospital, Beaconsfield District, George Town and St Marys, all of those health centres. Then you have primary health services that sit to the side of that. Primary health services has a big focus on prevention and early intervention. Community Options Service is a suite of primary health services. There are other services - Community Nursing, Youth Health, the Community Dementia Service, there is a whole range of services.

Community Options Service was developed many years ago and it was the case management funding as part of group 2 Home and Community Care - HACC - funding. That was where it was first established where it was a case management service.

In the north, Primary Health Services decided to grow the service and expand it. We were successful at getting 38 level 2 Community Aged Care packages. They are the first lot which will be going soon, they are looking at transferring those but we have, at the moment, 38 Community Aged Care packages we manage across the 63 area. A lot of those are delivered in rural and remote areas so we have had to use creativity. We have a brokerage out model so everything we do is consumer-directed already. We do not have our own direct care workers who go in and provide the personal care, domestic assistance and all of that support. We actually pay external service providers like Family Based Care, Senior Helpers and Anglicare to provide those services to our clients and that our services get to choose. They have the choice of service provider.

We also have HACC home maintenance program funding. I have a dementia nurse as part of my service who is HACC-funded and the main element of the service is case management, so it is complex. It is providing case management for people with complex needs. The main aim of every program within my service is to maximise someone's independence and quality of life and keep them in their homes and in the community for as long as possible if it is safe to do so.

Ms WHITE - So this model is quite unique to the THO North region as we know it now?

Ms SHEARING - It is. It is an active service model that was taken on following a Victorian model. It is a wellness approach and a strength-based approach to everything we do. The client is central to everything and directs everything. It looks at client goal settings so we support the client in setting goals relevant to themselves and then we support the client in linking in with the relevant supports and services to assist them in achieving those goals. The focus is on minimising early entry into residential aged care or group homes, increasing safety within the home environment and monitoring. In a nutshell, that is the core of our service.

Ms WHITE - It is directed more at the older cohort in the community?

Ms SHEARING - We have a larger number of frail aged 65 and over than we do younger people with a disability. I think partially that was also influenced by the fact we haven't sought to grow the area of younger people with a disability, and I think there are strategic and organisational decisions behind that. There was a process of outsourcing the disability area from Department of Health and Human Services to the non-government sector and that sort of thing. A larger percentage of our client base at the moment is 65 and over. We do have a few younger people with a disability.

Ms WHITE - Earlier we spoke about the progress chart, for example this one here which measures Health and Human Services activity against things such as how many people have been seen for elective surgery procedures. One of the suggestions made was that we should be measuring different things, including the early detection of disease in the community and other preventative health initiatives so that we can identify how we are tracking against reducing the prevalence of smoking or alcoholism or other indicators in

the community. Would you support measuring that data to help track how we are progressing in Tasmania?

Ms SHEARING - Very much so. It is very limited when just quantitative data is focused on. Qualitative data as well as quantitative data need to be looked at, that is, outcomes as well as outputs. A lot of the outcome reporting is coming back from the client and the health outcomes that are being achieved - client achievement of goals and more outcomes - so I think there definitely needs to be a combination of the two rather than the number of services that were provided to that client in that time frame or be more outcome-based reporting.

Ms WHITE - In order to achieve a shift like that, we and you have talked a lot about the social determinants of health and who would take responsibility for ensuring a whole-of-government approach to that because it does not sit with one department. One of the discussions was around perhaps the Department of Premier and Cabinet having greater responsibility for that whole-of-government approach to addressing the social determinants of health, but at the same time we have health reform underway. You talked about internal and commonwealth pressures on your organisation. What would you like to see as the best outcome for your clients to continue having good case management but also be supported by good leadership structures across the state? It is not just people in the north but across the whole state who might have access to these. Would that fall under the THS, the primary healthcare network or whatever they are called now - the new TML? Who would you like to see take leadership for that and how would that be structured?

Ms SHEARING - I believe it needs to be at a DPAC or likewise level. I do not believe the responsibility should sit with either an external service or another service that is part of the State Service. It needs to be an overarching body for contractual requirement and making sure people are doing what they are required to do.

I have seen - and I won't go into detail, I don't want to say the wrong thing - certain models where that has been challenging. For example, in the disability gateway model contractual compliance with things in relation to what an organisation or service should be providing within the realms of their funding, at a higher level that needs to be managed. There are things I see and hear within the community setting that create some concern. Whether that is lack of experience in the area or something else - I am not going to name names - but there is a fair bit of rescuing. I know it sounds harsh but our approach in service delivery is that it is actually doing a client a disservice by going in and rescuing.

For example, service providers might be referred for a particular thing, for example, transport, to ensure they attend a group or a treatment. That person goes in and next thing you know there are seven referrals going out. There is a referral to podiatrists, they are seeking more social support and there is a whole range of things happening which, to us, is going beyond the scope of what they were referred for. People are doing it out of the goodness of their heart and for the right reasons in the sense that they are trying to help the client and link them in with as many services and supports as appropriate, but sometimes that deskills the client and takes away that locus of control. We do not want deskill people just because the supports are there or possibly could be tapped into.

There are a lot of services that take this sort of cannon approach - they go in, do their assessment, see the needs and then start doing all of these things that are very overwhelming for people with complex needs. Quite often there could be a case manager involved but they have not taken the time to step through the clients. For example, with our client base they could have six providers going into their home and they only know that Jane comes and does the cleaning. They do not know where Jane comes from or where she fits in the picture.

There are a lot of things that happen at the ground level that have someone overseeing them at a high level that is external to that actual service delivery model. I definitely think it needs to be from a contractual and a -

Ms WHITE - A manager of that contract overseeing to be sure you are meeting targets?

Ms SHEARING - Yes.

Mr VALENTINE - You mentioned appropriate transport in your submission. I want you to expand on that. How critical is this and how acute is the problem? Are there solutions you see?

Ms SHEARING - At the moment the problem is fairly acute for our client base that is rural and remote. We are finding that a lot of the HACC-funded community transport options available at the moment are prioritised for medical, and you can understand why that is the case, but for those clients who need their shopping completed and have no transport, for them to catch a taxi from a rural isolated area to the local nearest shopping centre, a lot struggle, especially if they are on a pension and have medication costs together with a whole range of costs. A lot of our rural clients find that when they need to access those voluntary transport services they are not available. They are less available for social support aspects, which is really important especially for rural and remote clients who are more isolated than those closer to people and services.

I see the problem getting worse if it is not invested in and looked into further as part of the statewide health care reform. If they are looking at people travelling from the north-west to Hobart to access major surgery or travelling from Hobart to Burnie to access elective surgery, they really need to be looking more at the accessibility of transport. We have a number of clients who are wheelchair-dependent and available access to wheelchair transport options are very limited. Again, that limits the person if there is not a transport vehicle available that is wheelchair-accessible and appropriate.

We have had clients with dementia, for example, not being able to effectively access community transport at some times because of their behaviours. We have things on the boil at the moment where we are trying to get our dementia nurse to provide free training and education to community transport drivers, so we are finding ways to educate, skill up and support, but there are limitations. For example, the Wattle group and other community transport providers have said, 'We can't transport this person, it's too difficult,' and that is what we hear a lot in relation to service access with our client group because of the difficulties involved.

At the moment you have patient transport from hospital to hospital. We had a situation with a client who had to go to Launceston General Hospital who lived in Scottsdale. The

hospital discharged them after-hours rather than waiting until the next day and Community Transport does not operate after-hours, so that person had to take a taxi from the LGH to Scottsdale because it was transport to the person's own home, not to Scottsdale Hospital. At the moment they have the model of patient transport hospital to hospital and the community volunteer transport service. They need an extra step in here of hospital to home. That is where you are going to attract more people into their appointments, especially if they are required to travel distances as part of the health care reforms.

CHAIR - Thank you, we really appreciate your time.

Ms SHEARING - As part of our green paper submission we have done something called person-centred care, a consumer engagement we have been working on with our clients. We have a DVD with three clients telling their stories, as well as a carer and a case manager. It is about the impact case management has had on them, the benefits provided to them, and the outcomes - where to from here for the client.

Mr JAENSCH - Lisa, in terms of documents, you also refer in your submission to the community transport study that Karen Mulley -

Ms SHEARING - I wasn't there during that HACC meeting but if you contacted Launceston Volunteers for Community they are the chair at the moment in the north for the Home and Community Care forum and will be able to provide more information.

Mr JAENSCH - Thank you very much.

THE WITNESS WITHDREW.

Mr STEWART MILLAR, ALLIED HEALTH GROUP, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Thank you, Stewart. This is a public hearing and everything you say is recorded by Hansard. It will be transcribed and then made part of the public record and published on our website. Everything you say while you are before the committee is covered by parliamentary privilege. If you speak to the media or anyone outside, you are not covered. Keep that in mind if you make any comments that may not be entirely helpful.

If you have any information you would like to provide the committee in confidence, you can make that request and the committee will consider that. Otherwise, it is a public and open hearing.

Mr MILLAR - We are delighted to see the joint select committee investigate this arena because it seems to us that it has been vastly neglected for a long time. As health professionals we get very frustrated by the fact we are always dealing with acute situations and exacerbations of long-term conditions that, with a potential to intervene earlier, acute situations might not have happened. It is really nice to see a focus on preventative health. It is fantastic.

In our submission we spoke very broadly about the issue. It is such a huge issue. There are so many contributors to ill health and it is very hard to nail one thing down. We tried to be very general in our approach, although we did get to some fairly specific recommendations towards the end. It is gigantic issue. I was just listening to my colleague talk about the need for collaborative effort. One of the issues we suffer from in the health service is that we still operate out of silos and so there is very little cross-collaboration or even strategic planning around how to address common issues.

It is a whole-of-government issue and not just state government - local, state and Commonwealth - because income support is one of the fundamental drivers of ill health. In Australia we see the gap between the top and bottom socioeconomic groups growing, and that has been shown to be one of the biggest indicators of the health of a country. It is interesting when you compare the US which spend the most on health care and have the worst health outcomes, with Scandinavian countries which spend relatively less and have the best health outcomes. The determinant seems to be the gap between rich and poor. We are concerned that gap is growing in Australia and that is a national issue.

The other problem we alluded to is that the political cycle is too short to address the issues we are trying to grapple with. We would love to see a 25-year plan for the health of Tasmania that would focus on achievable objectives or clearly articulated objectives, and governments being measured by the rate at which they achieved them, rather than there being this recycling or this churning of new objectives every time a new government comes to power. It seems to us to be dysfunctional. Perhaps I should not say dysfunctional -

CHAIR - Only because it is.

Mr MILLAR - It is. The costs are so huge and Tasmania suffers one of the worst health statuses of any of the states on just about every measure, and it is a disgraceful state of

affairs. Education is fundamental and we acknowledge that budgets are really restrained, but we do somewhat despair when budget solutions are framed in terms of cost cutting rather than revenue raising. It seems to us that a lot of people are not paying their fair share. It sound slightly socialist, I guess, but it seems to us quite the case.

Mr JAENSCH - Thank you very much for representing your group. I am interested to know a little more about the people on whose behalf you are presenting as well.

Generally, in reading your submission through a few times I kept coming back to it because I thought you have unpacked the idea of the social determinants of health. We say it quickly and glibly. I was interested in the way you explain the factors of exposure to adversity and non-development of protective factors et cetera and also how later, even in your summary, you alternate the term of social determinants with enablers of health, which I think is a far sunnier way of approaching it.

In your submission you also lay out, in response to the structural reform criterion, a model around data, evidence, diagnostics and then joined-up response. Listening to the previous speaker, Lisa Shearing, whom you also heard, in this inquiry we are hearing about some groups of people who have reduced agency. She talked about some of the case management clients for whom addressing social determinants of health is about assisting their survival and interventions in some ways, to work with them to remove some of these burdens from them - which is a different area to looking at a locality, its statistics and what it needs.

I am thinking on a big scale here with how we approach this challenge as a state. Do we just talk about social determinants of health and joined-up processes and who is going to fund it, or do we need to start carving this up into some different sorts of problems so that we can deal with them properly? It seems to me there is the issue of people who have become defined in many ways by their circumstances and who need that sort of complex case management approach. Then there is the population scale we need to be dealing with on a different page entirely, and not confusing one with the other. I think too often we move across it assuming it is one problem. Do you agree we need to have separate approaches?

Mr MILLAR - I do.

Mr JAENSCH - Can you give us some examples? You referred to national and international examples. Can you give us one or two examples of people who are doing this well?

Mr MILLAR - I have a dear friend, Professor David Adams, who is one of the professors for innovation at UTAS -

Mr JAENSCH - We know David.

Mr MILLAR - He talks about a regional focus across the totality of the population because Tassie breaks into three reasonably sensible regional economic units. One of the issues is that we have social security dealing with income support. We have Health dealing with acute, subacute issues and primary health issues. We have Community Options dealing with case management and so on. Nobody is taking an overall view of a region and asking, what are the pressing priorities for our population? I agree with you there

needs to be a separation between after-the-fact interventions and what we are doing about shoring up the community's resources so they do not get to a point of needing critical intervention.

It seems to me - this is a personal view - bouncing off David's idea about regional management of health and wellbeing we need regional structures that can oversight the population to have some good data and intelligence about what is going on and what local resources they have to address those. I think that is the thing that is missing. Everybody is focusing on their little piece of the pie and there is no overarching responsibility.

I heard you talk about the Department of Premier and Cabinet, which is probably a logical place to sponsor that, but for me each of the regions are quite different and have unique needs. If we are thinking radically, I would have thought three local governments should be taking responsibility for the population but with expertise and resources from the Commonwealth and state. It needs to be well informed, so there needs to be strong intelligence from a secretariat or something like that which gives people good ideas about what is going on in their region. That used to be informed by even smaller locality-driven initiatives. For example, there is a multipurpose centre in Campbell Town and every year they have been doing needs assessments of the local population that drives their strategic focus for the next year. That sort of intelligence needs to occur at a regional level so they can get the resources they need to drive the programs that are obvious. It is a multilayered thing, I think.

Mr JAENSCH - It sounds like there is an architecture to this that has individual case management for certain conditions and circumstances and then there is that locality thing where you are talking regional as well, and you have to have a state structure set up around it.

Mr MILLAR - For me it starts locally, then becomes regional, and then state and Commonwealth. It strikes me that you have to have that on-the-ground awareness of what's happening for a particular community to inform strategies or resolve emerging issues.

I represent a small group of allied health professionals at the LGH. We saw the invitation to submit and thought it was a great opportunity because we grizzle about this stuff a lot so we got together our submission. There is about half a dozen of us, so we are not representative of the whole workforce but I believe there is a strong sympathy with the ideas in the submission.

CHAIR - I appreciate the fact you have put your submission together and addressed the terms of reference one after the other, which is very helpful for us when we prepare a report. Following on from Roger's question about doing a needs assessment of a region, there is more that joins us than there is that divides us in this state. You made a comment in your submission about a 'health in all policies' approach with an eye to equity. That is one of the big challenges. A bit later on you talk about access to services, which is what Lisa was talking about as well. When you look at this 'health in all policies' approach, surely we need to have a statewide assessment of what our needs are, but how do you achieve that equity? Rather than saying, 'Let's divide everything up

into small pieces', can we take an overarching view of the state first and then engage locally to achieve what you're talking about?

Mr MILLAR - I think you can come at it from both angles. For example, we know we are getting more obese and I don't think there are assertive health messages going out to challenge the marketing from fast food companies, so we are passive in that space. There are obvious health challenges such as smoking, teenage pregnancy, obesity and unhealthy diets. That can come from a state focus and that data is apparently available. It seems to me we need more assertion around that. You could have a statewide approach looking at marketing healthy messages that would translate down to health services in, say, Scottsdale.

The other way of doing it is to drive it upwards from the ground. Having reviewed the health status of the local population we know access to transport is an issue. We know the Patient Transport Assistance Scheme is exclusive of people and draws a very hard and fast line geographically. We believe there should be a graduated approach, so depending on how many kilometres out you are you might get more or less access, rather than hard and fast rules. This is only an impression, but there seems to be a sense that there is a migration back to the country because housing is cheaper and that isolates people from the services they need, particularly when they are impoverished and relying on income support. Rural areas are suffering terribly, as we know. Campbell Town is a good example because they have a cancer care car which people needing cancer treatment can access quite easily. The north-west coast is another good example of that. There are other areas where people really struggle to get access to affordable transport.

CHAIR - How do you achieve equity in a 'health in all policies' approach?

Mr MILLAR - I guess in a dispersed population it is very difficult.

CHAIR - But it comes back to transport.

Mr MILLAR - In part. It comes back to education as well.

CHAIR - Just going back to the Patient Transport Assistance Service, where people with chronic illness have to make regular visits from, say, the far north-west or the east coast to the major centre and have to fund it all up-front. People find that very difficult so they end up pulling back on the number of visits they make. Do you think that needs an overhaul?

Mr MILLAR - Absolutely. I would demolish it and rebuild it.

CHAIR - Tell me a perfect model.

Mr MILLAR - A perfect model would be designed around a person's need and their capacity. If people are on income support they don't have spare cash to provide travel on a daily or weekly basis, so it would have to be driven by need and should be paid or made accessible upfront without cost. As people spend more on transport they have less to spend on food or rent. I don't know what it would look like in detail, but for me it would be about everybody having equal access to the treatment they need regardless of

their economic means and I don't think we can say that at the moment. I think it would be paid upfront rather than people having to pay upfront themselves.

CHAIR - You talked about the importance of data and said South Australia has developed a data collection assessment tool. Do you have access to that?

Mr MILLAR - I can get access to it.

CHAIR - It would be great if you could provide that to the committee. Consistent data collection has been an absolute nightmare for health forever.

Mr GAFFNEY - Stewart, how long have you been involved with the medical services in Tasmania?

Mr MILLAR - I've been a social worker for 33 years in child protection, community health, and now the LGH.

Mr GAFFNEY - My question goes back to a statement you made earlier about silos. I think you probably would have heard about silos 33 years ago. It interests me, especially when it is now connected with funding. What tends to happen is that you find someone who is very good at their job and they attract like-minded people to them. They then have to go out and search for funding to strengthen their services and suddenly they start providing additional services to capture the funding that's available. We heard earlier how that is a nightmare for developing sustainable programs. Going through your summary about human rights issues and equity, is there a place for silos in our health system? Sometimes I've come across people and places where silos are the most effective way of perhaps delivering some services because there is a continuity of professional staff that know they are going to do that. How do you get a balance there?

Mr MILLAR - You need specialised knowledge and skills in some arenas, so in that sense silos are useful. One of the issues we have is that there is a plethora of service providers now. The purchaser-provider model seems to have spurred a huge number of agencies operating in very similar areas. Practitioners themselves have difficulty navigating the arena so what hope clients have I don't know, but not very much I'd think. A simpler approach would be better. The complexity is gigantic at the moment and people are unable to keep up with who is doing what with what and with whom. It is a serious barrier just in terms of knowing what is out there.

We have a service called TasCarepoint and they do a marvellous job but are quite under-resourced. They take referrals but it can be quite some time before access to a service even happens, so while we have a plethora of services there is not a lot of capacity within the system. It is very hard, for example, to get people discharged from hospital because there are inadequate supported accommodation services. We have enormous bed-block because of that, particularly with people below 65 who do not go into the aged care system. People with disabilities really struggle to find supported accommodation when they come in post-stroke or something like that.

There is a lot of concern as well about access to rehab because people sitting in hospital beds for long periods go backwards. They do not get the appropriate stimulation and support they need to continue their development. We are very concerned about the

notion that John L Grove might close because all that will do is push back a whole lot of patients into the hospital and block things up even more. Specialisation is important, like rehab, but there needs to be a joined-up overview of the whole thing so people can grasp what is available and how to access it, but there are people duplicating services. It seems to me that there are providers competing and that seems -

CHAIR - A bird's-eye view of the silos, perhaps?

Mr GAFFNEY - You can liken it to even charities at the moment. There are so many charities growing out of good causes and intentions and whatever, but the pie is only so big and in health, in some sections it needs to be fine-tuned so people can say, 'This is my responsible area'. The young lady you heard beforehand talking about transport, when groups come up to you and say, 'We need a transport service', if they look under here there is one there already but it is not being utilised or they do not know about it. It is about how to get that information into the community.

Mr MILLAR - It is ever-shifting; there are so many new services coming onstream.

CHAIR - That is one of the challenges for government, knowing which ones to continue to fund and which ones are being effective, and when you do not have good data with good and meaningful KPIs it makes it difficult for governments to decide.

Ms O'CONNOR - Have you heard of the principles of collective impact?

Mr MILLAR - No.

Ms O'CONNOR - It is a bit more than jargon but there is some really good work being done in the US and TasCOSS is starting the discussion here. The principle is basically what Mike was talking about before. There is a certain number of services being provided. There is a fragmentation of services and there are obviously gaps but there is a whole lot of activity. How do you, in a state of half a million people, apply a collective impact model so you have measurable KPIs and services accessible to all? Do you think something like that could work here, where we all take a step back - government, funding bodies, community - and say, 'What are the outcomes we are looking for here? What do we need to do to deliver that? Here are our KPIs, let's go.'?

Mr MILLAR - I think that is great idea. We need to take a long, deep breath and a big, hard look at it because it feels like it is out of control.

Ms O'CONNOR - I am interested in your thoughts. You have been a social worker for 33 years. Have you worked in the north of the state the whole of that time? In your time in that role, are you seeing any changing social trends or shifts? What is it about our community today, and particularly disadvantaged households, that is different from it was 20 or 30 years ago?

Mr MILLAR - That is an interesting question. Thirty years ago there was one child protection officer for the north and north-west. That has changed, as has I guess the rate of reporting and there is more community awareness now, but it seems to me that families with poor resources are more in number and are struggling more. It also seems that income support is harder to sustain, so people are constantly being asked to justify

their access to it. There is more insecurity around income support and that puts more pressure on families.

We have prime ministers who talk about dole bludgers, lifters and leaners and all those things which isolates and excludes a whole raft of people, through no fault of their own. I am well aware of situations where, when those comments about dole bludgers were made by then Prime Minister Howard, people were suiciding as a result because they felt they had no further worth. I think we have lost an ability to include people as assertively as we need to. It feels like we are letting go of a whole raft of people we no longer seem to have answers for and we are almost comfortable with it.

Ms O'CONNOR - Do you think it is almost like governments have given up because it is all too hard?

Mr MILLAR - Yes, that is how it feels.

Ms O'CONNOR - My final question is about how you reach young people in disadvantaged communities, rural and regional communities, so that the disenfranchisement and disillusionment of young people which might lead them to alcohol or drugs or gambling addiction can be countered and dealt with? How do we target young people to make sure when we are talking about social equity that they are included as well, because that to me is an area of really high risk?

Mr MILLAR - Yes, absolutely. We are trying to get a program going in a hospital now around perinatal health so we get involved with at-risk pregnancies at the point of almost conception, but not quite.

There needs to be a more assertive focus on those families who are really struggling. We have traditionally picked them up at antenatal clinics but the resources we have available are often very stretched. I think we need to start in pregnancy and be able to make sure the families can access the services they need so parents have a chance of delivering a good birth outcome and good parenting. Then it would go into access to child care that is educative of parents and school systems that value each child and can construct a curriculum that suits particular needs of children rather than a one-size-fits-all approach. Health education should be embedded into the curriculum so people come out of school saying, 'I am a worthwhile person and I deserve the best I can do for myself', and come out equipped to engage with the modern world. It is all very good to say that and I do not know exactly what it would like, but it seems like education is going backwards in terms of getting kids to come out of school in reasonable shape and ready to enter the workforce.

It is a funding question ultimately, it seems to me, because we continually compromise the ability of schools to provide that. We have moved towards chaplaincy in schools now which on one level is great, but for the non-secular people it is not necessarily going to meet their needs. I think having allied health professionals such as psychologists, social workers and others who can support families to ensure kids firstly get to school and get something meaningful from it is really important. I have a dear friend who has been a teacher for a very long time and she is throwing it in because she is too stressed. She goes to school and gets abused by kids -

Ms O'CONNOR - Who are getting abused at home.

Mr MILLAR - Who are getting abused at home, indeed, and so it goes on. Retaining good teachers is becoming harder and harder because the stress of the role is becoming ridiculous. Assertive engagement with families in need I think - I do not know exactly what that would look like - has to be a focus.

CHAIR - There is also another group of women who do not even present for antenatal care -

Mr MILLAR - Absolutely.

CHAIR - so they are even harder to get to. At least you have some chance if they turn up at an antenatal clinic of engaging with them, but there is another cohort out there who do not go anywhere near it until they are in labour and rock up to some hospital. The outcomes are terrible for a lot of those women and families.

Mr MILLAR - They do not want to engage with any service provision. That is a challenge.

CHAIR - Thank you, Stewart. It was a well put-together submission and we appreciate that. There is some information about the South Australian data assessment tool. We will write to you confirming that. Thank you for your time and your input to the committee; it has been very helpful.

Mr MILLAR - Thank you very much for the opportunity.

THE WITNESS WITHDREW.