THE LEGISLATIVE COUNCIL SESSIONAL COMMITTEE, GOVERNMENT ADMINISTRATION A SUB-COMMITTEE INQUIRY INTO RURAL HEALTH SERVICES IN TASMANIA MET IN THE LEGISLATIVE COUNCIL MEETING ROOM, HENTY HOUSE, LAUNCESTON ON TUESDAY 2 NOVEMBER 2021

HEARING COMMENCED AT 9.57 AM

Ms ANITA CAMPBELL, CENTRAL HIGHLANDS COUNCIL, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Ms FORREST) - Thank you, Anita, for coming to the hearing.

Members are Mike Gafney; Sarah Lovell; Bastian Seidel; myself, Ruth Forrest; and Nick Duigan. We will invite you in a moment to do the statutory declaration but by way of explanation this is a public hearing. It is being recorded and will be transcribed on *Hansard* and then made available publicly on our website and reported in our committee report to some degree. Everything you say in front of the Committee is covered by parliamentary privilege and that may not extend when you leave the room just to keep that in mind. You have the information and have read that. Are there any questions before we start?

Ms CAMPBELL - No.

CHAIR - If there is anything you think is of a confidential nature, you can make a request to the Committee that we hear that in confidence or in camera and the Committee will consider that if you felt that was necessary, otherwise all is public.

If you get to that point, what we try and do is hear all the public evidence first and then have the private session at the end; it is easier for *Hansard* for separation of things like that but let us know if that is the case.

Ms CAMPBELL - Thank you for the opportunity of submitting the written submission.

CHAIR - That is all right. We have read your submission and we look forward to hearing from you to speak to that and other additional information you might want to give to the Committee.

Can I ask you to take the statutory declaration first?

Ms CAMPBELL - Yes.

CHAIR - Thank you. If you would like to make an opening statement and add further to your submission or bring up other matters that is fine.

Ms CAMPBELL - I really do not have a lot more to add but would like to thank the Legislative Council and especially Bastian for initiating this inquiry. We are really grateful as the Central Highlands Council for the opportunity to put our points across and which we really have not got any more to add. There is one correction I will need to make in that submission.

The only thing I will probably bring up is that as I am a registered nurse in my past life, I have been involved in community since I moved to Bothwell 28 years ago. There have been so many inquiries into rural health and what are the outcomes that come from those?

I just wonder how we can get the most out of this inquiry to really make an impact, especially in Tasmania. To be honest, all of Tasmania is rural. We all live very rural lives. Whether we do live in a city or a town, we are a very isolated state because of that moat right around us.

I guess, that is all I really have to say. Other than there was one fact I highlighted in our written submission and that was the first point in regards to the Central Highlands General Practice. As you may all be well aware, that has changed in the last couple of months.

As of Sunday, we now have a new operator at the Central Highlands General Practice. The new general practice is being operated by Moreton Group. The doctor is Dr Meg McKeown now, supported by another doctor and the team around Moreton Group.

All the events leading up to that, I probably cannot talk about publicly, but it has been quite a concern.

CHAIR - Did you want to speak to those later perhaps?

Ms CAMPBELL - Possibly. If possible, yes please.

Mr GAFFNEY - Has Meg practised there before and is she familiar with -

Ms CAMPBELL - Dr Meg McKeown has done some locum work at the Oatlands Southern Midlands Practice, but she had never operated in the Central Highlands. She is the Medical Director at Moreton Group. She is a rural generalist and we are very excited to have her on board.

Mr GAFFNEY - Okay. That is good. Thank you.

Dr SEIDEL - She was also of the Vice President of the Royal Doctors Association.

Ms CAMPBELL - She did ring me. We have had quite a few conversations and she may reiterate. She has asked permission to talk about our submission. I have read hers and she has read ours. I wrote this submission in conjunction with some other representatives in the community and council.

CHAIR - You have mentioned we spend a lot of inquiries into rural health. Certainly, from the Tasmanian Parliament's perspective, there have been a lot of inquiries, predominately into the acute health services.

We did have an inquiry into preventative health some years ago. There was a joint house committee. Most of them have been focused around the acute setting as it is a money hungry beast.

What do you think would be the outcomes you would like to see from this, in terms of it being focused on rural health? We are not talking about the major hospitals like Launceston

General and Royal Hobart. We are talking about the smaller hospitals and the other allied health services and GP services in the regions.

Ms CAMPBELL - Last year, before we all got bombarded with COVID-19, I sat on a national evaluation committee, Rural Health Multidisciplinary Training Evaluation Team and that looked at how to get rural doctors, nurses, allied health out into the rural workforce.

At the end of that, I am not sure whether they even came up with any solutions. To be really honest, this is a really great start and it is not going to be solved overnight. We all need to keep talking, we need to be going out into those communities and seeing how they live and what those challenges are.

They might be health, socioeconomic challenges or they might be physical challenges of physically getting to medical help.

At the end of the day it is a financial fix. If we had a bottomless pit of money it could probably be resolved to a great extent.

CHAIR - You know the committee is looking at the barriers to access and that sort of thing which, obviously being in a more remote part of the state, geography is one of those. In terms of recommendations that you would make to the committee to address some of the barriers faced by the people you are here representing, how the system should support them, what do you think are the key things that would deal with some of those barriers or increase accessibility?

Ms CAMPBELL - I will just talk about the Central Highlands and what we know. We have two general practices - and it doesn't all revolve around general practice - but at the end of the day that is pretty much all we have in the Central Highlands. In Bothwell we only have a GP two days of the week. So that access, it might not even be physically getting someone to go down there, but if you knew you could ring up and get into a doctor Monday to Friday - and I know we don't all get sick just Monday to Friday - but that access, you sometimes have to wait three weeks to get in to a doctor at Bothwell.

Then at Ouse up until last week that was made easier because the practice was open Monday, Tuesday, Wednesday, Thursday, Friday and people can arrange to get someone to pick them up, even if they are an hour and a half away up the top end of the Great Lake somewhere. At least that way if they know they can go down, get a lift, they can make arrangements for that, but when it is such an ad hoc system of getting an appointment and not knowing if you are going to be able to get an appointment, you can't then make those transport arrangements.

Then there is the added difficulty of mobile phone coverage. Sometimes you can't even pick up a phone and make a phone call to a medical practice. I know a lot of people in the last few years, particularly in Bothwell where the medical services have slowly declined, a lot of people have stopped trying to go to the Bothwell doctors, although it is improving now. There has been a change of management there. They were going outside of our jurisdiction and going to the Southern Midlands, either Oatlands or Brighton or further afield. That was one of the problems at Ouse when there was the possibility there wasn't going to be a GP service there, that the next available service you have to find someone - if you can't travel yourself, you have to try to get a lift to New Norfolk if you can find a doctor, or further afield.

It is a combination of travel, mobile technology, telecommunications. In an ideal world if we could have guaranteed basic medical coverage on regular days, when you know that you can, even if you can't be there Monday through to Friday, if you know it is going to be spread out over Monday, Wednesday, Friday, that even makes a difference. There are other things that could help. As you would all be aware, the Ouse Hospital was closed down a good 12 years ago. I am not exactly sure of the date. There is a health centre there staffed by registered nurses but it is not well promoted. It is not well utilised and if there was more of an outreach service from that facility with the good old-fashioned community health nurses, that is something that has gone by the wayside dramatically.

Ms LOVELL - I would like to ask you a question about that. Thinking through scenarios where people would generally access a doctor, so sometimes it can be quite short notice. You get sick, it might not be hospital-worthy but an infection, tonsillitis, something like that. I imagine there will be instances for people particularly who don't have transport, where they can't get to their nearest GP. Are there any outreach services or what options are there for people in that situation?

Ms CAMPBELL - If someone was to get sick and they don't have transport, they might have a friend or a relative but really the only option is for them to call the ambulance. We do have a couple of terrific volunteer ambulances. There is a permanent paramedic stationed at Miena. In the last few weeks there is one now based at Ouse but that is not what they are designed for. They are designed for someone who has a heart attack. The ambulance service is designed for a car accident, a farm accident or a forestry accident. They are not designed for someone who has become unwell and does not have another option.

Mr GAFFNEY - Your submission mentioned the shortage of GPs and some of the medical expertise you need may not have to be at the GP level. Have you any ideas or thoughts with your background about how we could improve that by offering something different to just GPs or along that line?

Ms CAMPBELL - I think nurse practitioners, even registered nurses if they were based in - and I know I talk about Bothwell and Ouse but they are the two major populations in the Central Highlands and people go there for all sorts of reasons. If we had regular services that were funded to provide some registered nurses and some nurse practitioners that would really ease the burden and it would give the community a lot of confidence.

There is also preventative health. If we can improve the health of our residents and there is a really good service in the Central Highlands that works towards that but that is constantly begging for funding.

CHAIR - What is that organisation?

Ms CAMPBELL - That is the Health Promotion Coordinator and that is a great service but we really want to know that can continue because that works on trying to keep people well, keep people connected on the mental health side of things.

CHAIR - How is it funded?

Ms CAMPBELL - It is funded through the THS at the moment.

Mr GAFFNEY - Going a bit further, there seems to be a bit more success in communities where you have homegrown health nurses or whatever from that community because they are quite comfortable to go back. Do you have many from the Central Highlands who actually are a part of the profession? Or is there a way that with bursaries or something that we could attract people back to the Highlands? I imagine for some people, not from the Highlands, accommodation and social connectivity and that sort of thing might be a bit difficult for some people.

CHAIR - Fishing is good.

Ms CAMPBELL - I actually think that with the progression of all the things that are happening in the Highlands, the mountain bike riding, the fishing and all of those things that could bring more people in. I was a registered nurse and I could not get work in the Central Highlands and I used to travel to the Royal Hobart Hospital to work because it was easier and more effective for me to go to Hobart than try to find work. That was very frustrating, our daughter is a registered nurse now but she works in Hobart.

The staffing for the Central Highlands Health Centre at Ouse which has the nurses, they are staffed out of New Norfolk and they travel from New Norfolk. They are getting paid to travel so that it almost an hour and a half where they are not performing a duty but getting paid. You are right, we do need to encourage some bursaries and encourage employment from locals to come back and live and work in our communities.

Mr GAFFNEY - Is there any accommodation associated in the Highlands with health services because down the west coast sometimes they used to provide accommodation.

Ms CAMPBELL - There is a little bit at the Ouse Health Centre, not a lot, but there is.

Mr GAFFNEY - Nothing in Bothwell?

Ms CAMPBELL - There is a council house that is provided to the current GP to provide accommodation if someone needed it so that would be available.

CHAIR - Like a locum?

Ms CAMPBELL - A locum or if a GP wanted to stay there or if the nurse practitioner who works for the private practice at Bothwell. It is available and there are rentals that could be made available.

CHAIR - Anita, you talked earlier about the Ouse Health Centre being staffed with nurses from New Norfolk. They may not all live in New Norfolk either; they might live in other parts. You made a comment about it not being well-utilised. We can ask the THS, but do you have information about how often they have gaps in service?

Ms CAMPBELL - It's a subjective observation that I've made. I've been there a couple of times. It's a magnificent facility that's been upgraded and very often you're the only one in there. I think when it was downgraded - and I'm not saying that was the wrong thing or the right thing - it possibly lost its momentum and its purpose.

I also think that the staff there are quite restricted in what their scope of practice is and what they're able to do.

CHAIR - That may be a barrier, do you think?

Ms CAMPBELL - That could be a barrier.

CHAIR - Rosebery and Ouse were in that firing line at the time.

Ms CAMPBELL - I'll get back to the community health nurses. It's just been obliterated. They don't really exist anymore. When I first moved to Bothwell and worked for the general practitioner there, two community health nurses funded by the THS - it wasn't called that back then - travelled from Hobart. They would communicate with the community. They'd then come in and talk to the GP. There was that relationship. I think we've lost those relationships with the community, the GPs and the nurses.

CHAIR - One could ask where the community health nurse service has gone. The building and facility at Ouse was purpose-built for that to occur, as I understand it. That's what happened at Rosebery.

Ms CAMPBELL - It doesn't seem to be happening, and if it does it really only happens around the little Ouse area. It has an outreach but it doesn't happen enough, because of the distance.

CHAIR - Is there a travel radius, are you aware? I'm interested in how it works and why it's not meeting the needs.

Ms CAMPBELL - I don't think it's staffed adequately. They would have to have staff at the health centre and I guess no one really wants to work on their own, so there always has to be two there. It doesn't give the flexibility to travel an hour up to Miena or half-an-hour over to Ellendale.

Dr SEIDEL - Thanks, Anita. Thanks for the coming up. You mentioned you've been living in the community for 28 years. You're a health professional by background and you are a councillor now.

Ms CAMPBELL - Yes.

Dr SEIDEL - How much influence does your council have on health service planning, about those decisions on the Ouse District Hospital being downgraded and not having community nurses there? You mentioned there are lots of inquiries and so forth, and I think you must have made dozens of submissions over the years. Does the Government care?

Ms CAMPBELL - Very good point. I've only been on council for three years. The reason I stood for local government - whether that was a good idea or a bad idea, I'm not sure - was there didn't seem to be a lot of knowledge on council. I thought, 'No, there needs to be someone with a little bit of medical knowledge and someone that's going to drive it a little bit more and come and do these things'.

Even though we've had the opportunity to make a submission, I'm not sure that any government really listens to local government about those sorts of health issues. The challenge is that a general practice is essentially a private business, and it's very hard to tell a general practice how and when it should be open and running. That makes things quite a challenge.

One of the things I think would help in all rural areas is for general practices to be funded by the government; if they employed rural generalists in those areas.

CHAIR - By the state or federal government?

Ms CAMPBELL - Technically, general practitioners are funded by the federal government but -

CHAIR - Rural generalists at the Mersey Hospital are funded by the state.

Ms CAMPBELL - There's an option. It comes down to money, doesn't it?

Dr SEIDEL - As a follow-up, 15 years ago we were talking services delivered from a rural district hospital - fully-fledged practitioners, nurses, community nurses and, yes, some GP practices. Fifteen years later, we are desperate just to find GPs who are open five days a week. In ten years, are we going to be desperate to have any health practitioner, regardless of background, in rural areas? Do you think there is a trend and, if so, how do we stop the trend, because we currently jump from one crisis to another?

Ms CAMPBELL - We do.

Dr SEIDEL - And governments seem to only react when there is a crisis and councils do the same. I think there's almost a level of desperation to ensure some form of health service is still there. That doesn't make sense, does it -

Ms CAMPBELL - It doesn't make sense.

Dr SEIDEL - - because people are leaving if there's no health service. In rural communities, if you don't have a health service, people are leaving, aren't they?

Ms CAMPBELL - One level of government alone can't solve this problem. A lot of it has to do with the federal government's funding of the Medicare rebate and how they fund the GPs to make it viable. But it also comes down to the training of staff at the universities. Are there enough doctors, nurses, allied health, all those other support professions coming out of the universities to service all these small communities? I think also it comes down to communities.

We need to make our communities a wonderful place to come and live and work. We need to have that really good culture in a community. There's a very good example. On the east coast at Swansea they have a great service, and it's a wonderful culture at Swansea and the east coast. But then, half an hour down the road at Triabunna, it's completely different. I'm talking about another -

CHAIR - You can't have it single-person dependent, though. That's the problem, isn't it, the single-person dependency? The system at Swansea relies on two GPs.

Ms CAMPBELL - Yes.

CHAIR - If they decided to leave or one of them became very unwell or whatever -

Ms CAMPBELL - That's right. Still, I think the culture of that community makes it very enticing to stay there. I think if we can improve the cultures in our community, and improve people's health, it's not going to be such a challenge for GPs and nurses to come and work here.

Dr SEIDEL - Do you have a basic idea how many health practitioners are commuting to the Central Highlands area to provide a service, and how many of them actually live in your council area?

Ms CAMPBELL - Do you mean all sorts of health?

Dr SEIDEL - That's right - nurses; the pharmacist in Bothwell, for example.

Ms CAMPBELL - Yes. We have the pharmacist at Bothwell, Terry Burnett, who I know also made a submission. He travels from Hobart every day to provide that service. We have a GP at Bothwell two days a week. They don't live in the town and it may not be the same GP. They are based at Brighton, but they could travel from further afield to get to Bothwell.

The nurse practitioner that comes to Bothwell doesn't live in the town. There are some mental health outreach workers employed by RAW, and a couple do live in Bothwell. At Ouse, one of the GPs that had been working up until a few weeks ago does live in the district, and his wife was a registered nurse, but they have retired.

The other nurses that provide nursing care out of the health centre travel from New Norfolk. They are not locals. There aren't really any local people working there.

Dr SEIDEL - Are you aware of local health practitioners who are working in Hobart?

Ms CAMPBELL - Yes.

Dr SEIDEL - Like the nurses you mentioned.

Ms CAMPBELL - Three travel out of Bothwell to Hobart most days. I am not 100 per cent sure about the ones that travel from other areas. I am aware of three registered nurses that travel out of Bothwell down to different hospitals and employment.

CHAIR - From your discussions with them, do you know why they choose to travel?

Ms CAMPBELL - One of them is in a management position and ften they can get childcare in town so they can take their children with them. Childcare's also a challenge and it's becoming more of a challenge. There's no clear-cut answer. It's very disappointing.

CHAIR - In the submission you talked about the Modified Monash Model and how the Central Highlands Council is classed as 'outer regional'. This has been raised in other parts of Tasmania where it seems that these decisions being made a long way away about what the community needs don't have a lot of local input.

Has council tried to lobby the federal government about that?

Ms CAMPBELL - Not as yet. It's very hard to get all the other councillors to understand. They don't understand; they don't have that -

CHAIR - Draw pictures and maps.

Ms CAMPBELL - Yes. I've made a note here. Even in the Central Highlands different towns are classified as levels 5 and 6. That makes things very hard for funding as well. Some people come from an area where they're a level 6, and some people live in an area that's level 5, but the GPs are servicing in an area - both Bothwell and Ouse are classified as level 5 - but they're servicing people coming from an area that's classified as level 6.

Is it really a local government responsibility? Essentially, most people would say that local governments are footpaths and roads and rubbish, which I don't agree with.

CHAIR - Caring for the community.

Ms CAMPBELL - Caring for the community; we've developed a great health and wellbeing plan. Bastian alluded to this: I don't know whether we have any sway in saying, 'Can you come and look'. When people make decisions do they always go right around the boundaries of those areas and see how isolated they are?

CHAIR - I think we know the answer to that.

Dr SEIDEL - They consult but they don't actually listen.

Ms CAMPBELL - Yes, or they don't look. The Central Highlands is the second largest municipality by area and the second smallest by population. That makes everything we do a massive challenge.

Mr GAFFNEY - Provision of aged care. I imagine people in the Central Highlands want to live there and that's where they want to die.

Ms CAMPBELL - Yes.

Mr GAFFNEY - Does the council have any inroads into providing units and accommodation for palliative care or homes or whatever?

Ms CAMPBELL - So the Central Highlands Council owns some independent living units. There are some based at Bothwell and some based at Ouse. In the budget there is provision to build some at Ellendale. But if we continue with that, we still need the support of health services. There's no point having elderly people living there if they haven't got those services to provide for them.

I am not sure if I pointed out that Corumbene community services provide some outreach services to the aged population in the Central Highlands but again that's a lot of travel for them. Essentially, they provide for their own community before they'll provide for other communities.

Ms LOVELL - Are there any palliative care services?

Ms CAMPBELL - To be honest, I don't know. I doubt there is very much.

CHAIR - There's no palliative care room at the Ouse District Hospital?

Ms CAMPBELL - No, not overnight.

Mr GAFFNEY - Do you know what the budget allocation is for the provision of those units and aged care facility?

Ms CAMPBELL - I don't have the actual figures on me but we do budget for the units. We really only provide the bricks and mortar. There's nothing else that's allocated.

Mr GAFFNEY - Okay. Is it council staff who look after those units and that sort of thing or is that covered in a different area?

Ms CAMPBELL - Yes, the units are maintained by the council. I wouldn't say there's a dedicated staff member.

CHAIR - You mentioned at the outset that there are some things you would rather talk to us about in camera. Can you allude to their nature? We need to deliberate as a committee as to whether that is acceptable.

Ms CAMPBELL - I didn't know whether you wanted me to talk about the sudden change in the circumstances that led to us nearly being without a GP at Ouse in the last few weeks due to the COVID-19 vaccine mandate? I am happy to leave the room.

The witness withdrew.

CHAIR - Thank you all for appearing before the committee. I will explain how things work, particularly for those who may not have presented to parliamentary committees before. This is a public hearing. Everything that you say will be transcribed by Hansard and will be subsequently published on our website and may inform our committee's report. Everything you say way before the committee is covered by parliamentary privilege. That may not be the case when you leave. It is sworn evidence. We will ask you to do the statutory declaration in a moment. If there is anything of a confidential nature that you wanted to share with the committee you can make that request and the committee will consider that, otherwise it is all public.

Are there any questions before we start? I will invite each of you to make the statutory declaration and then introduce yourselves. We have your submission and we have read through it. It is a quite extensive and interesting submission, thank you and we invite you to speak to that. The committee will have questions.

Mr JOHN KIRWAN CEO, RFDS, **Mrs NICOLE HENTY**, MANAGER OF THE MOBILE PRIMARY CARE PROGRAM, **Mr JUDAH MORRIS**, PRIMARY HEALTH CARE MANAGER, ROYAL FLYING DOCTOR SERVICE (TASMANIA), WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

Mr KIRWAN - I will just make an update from our submission and some comments and then I am than happy to answer questions.

As I said Mrs Nicole Henty is with us, she is our Manager for Mobile Primary Care. Nicole is the longest serving member of the RFDS. She was there before me. Nick would remember there was Mary Frost, and Nicole and then myself. That was three staff and now we have about 40 staff. Judah Morris, despite his interesting accent, was actually born in Launceston, but has returned to Tasmania and is our second primary care manager and that is both a mixture of mobile and fixed services as you will see in the submission.

I want to provide an update of the current map of our services. I will pass the maps around. That gives an idea of our spread across Tasmania. As we said in our submission and various other submissions that a number of you would be aware of, the Royal Flying Doctor Service across Australia is a primary care service with a strong interest in aeromedical. Aeromedical because that is the distance; be it to an island or be it to the outback of Queensland. We have always been actively involved with telehealth right from the beginning. We are a not-for-profit provider in this sector.

We are the largest of our kind in the world. Pre-COVID-19 we were the third biggest airline in Australia. In the middle of COVID-19 we were the busiest airline in Australia because we kept flying. We are still busy, although generally the aeromedical work is trending down to pre-COVID-19. The populations in the outback rural areas of Australia have been either fixed or are in decline. In some of our sections on the mainland 50 to 60 per cent or more of our clients and patients are Indigenous.

As per the submission, providing aeromedical retrieval, emergency evacuations and primary care provides a unique opportunity and a very strong brand. An example of that is in Nicole Henty's area. A mobile dental vehicle, which is operating across the east and west coast at the moment and we have just ordered a second one for the west coast, was funded through support from Her Excellency the Governor at a fundraising ball. Woolnorth Renewables made

up the difference and funded the second truck, which will come next year. The ability to leverage off the brand, as a not-for-profit, allows us to do that. We recently attracted some philanthropic money, which will allow us to do some dental work. We are planning for the schools in the Dover area. So, that is very positive.

The other thing the brand brings, is that it is generic. In areas like mental health, for example, people trust the brand for vaccinations. We did work with Bastian's practice for vaccinations, going back to the Huon Show. The specialist medical immuniser that came with us really found that leveraging off, and working out of our area, really helped people to access that area.

We have recently found that within the last two weeks. We are in the third week of the buses. People are trusting the brand, and saying, 'If the RFDS is supporting it, if we were hesitant, we are not now'. That's good. I'll give a brief update on that. If there are any specific questions, I am sure Judith can answer them.

Those of you who know me, and I think you all do quite well, I come from a first principles position when it comes to rural health and primary health generally. The two sayings, which unfortunately are truer than you would like to admit, are: What gets measured gets done, and what gets funded gets done. That is the cold, hard reality.

We never fix the blame game that a former prime minister said that he was going to do. So, we still have a situation of three tiers of government. In my view, primary health is squeezed in that. It should be the base of the pyramid, the largest part of the pyramid but it is inverse to that when you look where the resources go. When you come to rural and remote areas for access and other reasons, they are the poor country cousins. I don't think you can describe it any other way. The state government's submission to your committee is sobering reading because they admitted it themselves.

Funding in our current systems are not needs based. If they were needs based they would address the inequities between rural and remote populations within Indigenous populations and white populations, and they don't. That is a fundamental issue.

Since we made the submission, we entered into an MOU with the Government. Seven areas. There are two areas that are under active discussion at the moment and two areas on which we have reached agreement.

We have also provided support to the state government with our buses. That is the second time we have done that. The first time was when the bus was driving from Penguin Composites to us to be fitted out, to be signwritten. It was redirected to the LGH to work for two weeks as the testing clinic. They couldn't set up their tents quickly enough, so we did that. They then used that model that we had agreed, and fitted out and designed with Rotary, to then get another six buses on the ground. We gave them those designs free. I think that Penguin Composites did well out of that business.

Across Australia, we have seen almost 60 000 people for vaccinations over 300 locations. In Tasmania, in the first two weeks - the third week starts today - 453 people over 13 locations.

Another comment, and it is in the paper. Through the Commonwealth RFDS Tasmania brings in just over $1 million to support the Ambulance Service, and the three Bass Strait

islands with visiting services. We have just pulled out last year's figures and, interestingly enough, we paid $40 000 rent to the Tasmanian Health Service for us having our staff, like our dental staff and primary care staff, working out of their services.

We started the dental service on the strength of an election commitment and funding announced in the state government budget. We have already seen 50 adults. There are 50 adults in the Queenstown Clinic who would have had to travel to Burnie or, probably more likely, they wouldn't have sought service. They would have waited.

The issue, the 'tyranny of distance', the phrase Geoffrey Blainey coined, really is a challenge for us here in Tasmania. I don't think we can emphasise that strongly enough. Even if the next town is potentially a good half-marathon run or walk away, people just aren't prepared to travel. We keep uncovering all sorts of reasons for that,.

I will just finish by saying we have made 10 recommendations. I will focus on number 3 which is, what gets measured, gets done.

If you look at the health indicators, there is a scoreboard. This isn't a party-political comment because that scoreboard was put in place under a Labor government. It does not have rural and remote areas. It has very poor primary care. You could argue breast screening rates and dental waiting lists are probably primary care, but they certainly are not drilled down at a granular level. If you look at the state government's report, which I read with interest...

CHAIR - The submission?

Mr KIRWAN - Yes, their submission to you. All the indicators are in there, so it is not the fact that they don't have it. You could extract out the top five or 10 quite easily and have a rural scorecard, from their own submission.

I draw to attention that the work we are doing with them on COVID-19 is at a postcode level, it is at an LGA level. It is quite clear that they can drill when they need to and want to down to that level, and that is what we would say we need to focus on. That is where we see the differences. 'One size fits all' does not work. What is going to work on Cape Barren Island is not necessarily going to work across the water at Lady Barron, so we need that degree of granularity if we are going to make a difference in those health inequities.

That is the update and the opening statement. I'm open to questions.

CHAIR - There are a couple of questions on the vaccination program, and the dental truck as well. With the vaccination rollout that you had quite good success with, have you had full bookings or people rocking up, or have you had unmet or unutilised vaccinations?

Mr KIRWAN - I should have said so we are not misleading, we provide buses, the logistics, the driver and the reception and medical records support, and the THS does the nurse vaccinations.

Mr MORRIS - A lot of the feedback we are getting in the first two weeks is that we are removing those barriers for people, especially farming communities. They are able to come and it fits in with their schedules. People come in on their lunch breaks. As they are driving down the road and hear the radio and see us, I guess these are people who are putting it off

because they had life get in the way. With their health literacy, they probably didn't understand the real importance of the health letter they received until we have put it at the front door of their house. As John said, there is that trust they are able to put through our brand. We are having positive results, noting as well we are making it easy for them. They can come, walk in and get their first dose and they will be told we'll be back - same place, same time - three weeks from today for you to get the whole process done.

CHAIR - It is a good snapshot of reasons why people don't access preventative health care. The vaccination is preventative health care. I don't know if there has been any feedback at all, and maybe you are not the right person to ask, but are these the sorts of reasons, such as life getting in the way, that you have to have it in their face for them to access it? Most of the people I represent are farmers in one way or another, and they put up with stuff until it is really bad, until you can't get on the tractor any more.

Mr MORRIS - Completely. For example, we run cardiac rehab programs. We will often be in town not for that specific reason, but we will have people come up to us and through simple conversations they will realise that in the hall next door we run a weekly cardiac rehab program which they need. Again, they probably thought they would have to travel to Launceston or Hobart to access those services. There might be some of those services directly in that town, but we know that when people aren't fully engaged with the health system they are missing out on the full variety of services.

CHAIR - Is that a communication thing - they don't know what is there?

Mr MORRIS - Completely. For example, if they have had an admission at the LGH, or a lot of GPs we see might be locum GPs in the regions who might not understand the different services such as ours that are available in the region. You really have that disconnect of what they can potentially access.

CHAIR - Dental care is such an important thing for social inclusion, as is general health and wellbeing. You talked about access to funding, with Her Excellency the Governor and the fundraiser, and you also have some philanthropic donations. Are those just to fund the dental truck, and then staffing beyond that is separate? If so, how is that funded?

Mr KIRWAN - I'll explain the first bit then if Nicole also goes to the issue of access, particularly in why people aren't travelling and why we have to go out. Noting that is the original model of Reverend John Flynn, which is 'The furthest corner. The finest care'. That is philosophically how we operate. Under our Commonwealth funding, we can't fund capital. For us, that means anything over $5000. You'll see that X-ray equipment for our fixed clinics - $25 000 - so we have to fundraise that ourselves. That's where the partnership with Rural North Renewables is excellent. Those trucks are $350 000 each, so they're not cheap. They are the first of their kind in Tasmania, because they've also got sterilisation X-rays so we can do restorative work in them. That is quite normal, unfortunately, in Commonwealth contracts. They won't fund capital. The way we get around that in some areas is to lease the equipment. The lease cost is renewable but the capital isn't; but that's not necessarily the best way of doing it.

The not-for-profit leases are not overly attractive to us, so that's one thing.

The advantage of being a charity is we have the ability to fundraise for that capital, be it minor or significant. The recurrent cost and ongoing recurrent funding is the holy grail and is the curse of the not-for-profit sector, because of short-term contracts. That's why we sought a ten-year strategic partnership.

Our Commonwealth contract is coming up. At the moment, we're probably running at about $1.5 million of services coming into Tasmania from Commonwealth funding. It's not confidential, but it's mainly because two the biggest states have been locked down and haven't been able to operate so they've been happy to redistribute their surplus to us. Where we've had full dental teams, we've been able to provide extra services.

The access issue - Nicole, do you want to comment about why people can't travel?

Ms HENTY - Through having regular meetings with stakeholders within the community, be it schools, GPs, aged care facilities or pharmacists, the barriers really are - for example, if you've got children in a school sometimes you can't get on a bus, because there is no public transport or very limited public transport to get you to a major town to be able to access the care of a dental appointment. Through meetings with council, they have also explained that even though people may have a partner who is in well-paid employment, by the time mum - looking after several kids (mum doesn't work) - that depletes what that person is earning and it doesn't go beyond their earnings.

That means some people are putting off their dental care. Much like what we were talking about within the primary healthcare program, they delay. On the west coast it was identified that people aren't able to put petrol in the car. Some of them don't even have licenses; the cars are not roadworthy. They're actually waiting for when the pain gets bad enough they get transported in an ambulance through to Burnie, which then takes that resource out of that community as well.

CHAIR - Bastian, do you have a follow up?

Dr SEIDEL - Yes, thanks. John, I think you have been around for quite some time and as a team, you have probably seen the way healthcare is delivered to rural areas has changed a fair bit over the years. You mentioned that when you started there were three employees for the Royal Flying Doctor Service and now you have 40. There must be a need there for the RFDS to step in, step up or start from scratch, to provide more than just a rescue type of service. On the other hand, we are hearing as part of the inquiry lots of the services just disappear: GPs go, community nurses go.

What's not going right? Arguably, the more successful the RFDS is, could also be the indicator that the provision of basic services by state or private might just fail, which potentially could be case.

What is the RFDS doing right? You already mentioned branding; you have expertise, a powerful management team. What has the cottage-type industry of rural primary health services done wrong? How can this be reconciled; or do you see that the RFDS is going to step in more and more, for example, because you are so successful and competent, and the other services will just disappear?

Mr KIRWAN - Thank you. I think if I answer this question right, I will win a Nobel Prize for health economics.

CHAIR - We will let them know.

Mr KIRWAN - What we are doing isn't new. People say, 'This is new and innovative'. If I was trying to get an award for something we would be saying, 'This is new, innovative, ground breaking'. The reality is, this is doing what we used to do well, 20, 30 years ago, and that provides an on the ground. I might regret saying these words on *Hansard* - we dress it up with a modern terminology of 'place-based', 'integrated', 'holistic', but good services were always that way. The good GP service with a GP who knew the three generations and knew very well that when they were seeing the third generation, they have treated the mum and the grandfather for what they were likely to see.

To some extent, we provide that with our place-based services, we complement that with our visiting services where appropriate. Dental is a good example and we have some fixed clinics but we are not there every week of every month. We will be there sometimes two weeks out of a month. It is demand-based. Again, it is taking the services out to the community.

I would say we have made a mistake in Australia, and Tasmania is in an interesting situation because of our population demographics with everything not being so dominated in a capital city - with all due respect to the member for Rumney. In health, we used to say we will have a hub and spoke model. The reality is that when things get tough, the spokes get cut off or ignored.

Dr SEIDEL - Why do you think that is?

Mr KIRWAN - Because the focus and the triaging is what is on the front page of the paper and what is sitting on the ramp at the ED -

CHAIR - It is easy to get a photo of that.

Mr KIRWAN - and where the noisiest advocates come from. It is probably best I do not name them up otherwise I will miss out on some Christmas invitations. Again, it is that old adage of what sort of model should we have, should we have an illness model or a wellness model? The trouble is with relatively short-term - although four-year is better than three-year political cycles - we cannot build the long-term solutions including funding solutions for complex problems such as smoking rates and chronic disease issues.

Dental is a classic example. Most dental admissions to a hospital for surgery under general anaesthetic should never be there. They should not be there. You can say that for a whole range of other chronic diseases.

Ms LOVELL - It comes back to what you were saying before about what gets measured gets funded. It is much easier and quicker to measure acute health outcomes -

CHAIR - The number of ambulances.

Ms LOVELL - Yes, ambulances - than it is to measure wellness outcomes.

Mr KIRWAN - If the focus is on someone who has waited five or seven years for an elective surgery, they are not in pain, it's not affecting anything, it is not affecting their quality of life, their family life or their work life - that is the issue the money is being thrown at. Yet the life expectancy of people on, say, Flinders Island is unacceptably low. Where is that debate? Where is the debate about delays in cancer treatment, where is the debate about delays in re-admission rates because there is not a cardiopulmonary rehabilitation program? They go back to the farm because they cannot get off it and what happens is they have another incident which, more often than not, is probably terminal.

Dr SEIDEL - Do you think in a rural area people do not matter that much or matter less? You know where I am heading.

Mr KIRWAN - Yes. I think rural people are stoic and generally do not complain. That is my experience. They know what they want. They are the salt of the earth. I remember when I first met the mayor of Flinders Island when we became an aerial health service, Carol said, 'I have all these issues but I do not expect you to do anything about it because every time I have raised it with bureaucrats in the past, they haven't. We'll just get on and fix what we can.'.

I said, 'I will see what we can do.'. She said, 'If you can do something, that'd be good, but I don't expect it'.

CHAIR - Are we our own worst enemy then?

Mr KIRWAN - Yes. Hence why I come back to what gets measured gets done and then what gets funded gets done. If we are funding waiting list reductions for category three elective surgery - and that is where the money gets thrown, thrown and thrown - one has to ask why we are not throwing the same into addressing cardiopulmonary issues, addressing a whole range of other things. Dental is the obvious one because it is not complex. If we start the programs as we do in the schools -

CHAIR - And if we could get every pregnant woman seen.

Mr KIRWAN - Yes, we go all the way through to aged care, as it says in our submission. When we first started in aged care, it was not nice. The Royal Commission addressed that too and, somewhat worrying, the Royal Commission does not include the 200 hours including dental care they are talking about having to put into nursing homes. As our dental clinical advisers tell us, it was all very well 20-30 years because by the time you got to aged care, you did not have teeth. Now you do. We have to take that holistic approach

The other thing I would say is I think that we have missed that integrated approach and the member for Murchison touched on it, that there is a strong correlation between these areas. Very rarely does a mental, a physical or a dental health issue not actually have more comorbidity than others, yet we treat them in silos in sequence.

CHAIR - You have talked about what gets dealt with. Measuring identifies the problems, so let us assume the Government take it up and start measuring and eventually identify where the money should be. What would you do if you were the minister next?

Mr KIRWAN - As many of you know I come from Western Australia originally. We had this challenge when we went through the fundamental challenges of moving from a

traditional government department model to a purchase provider model, which was a big challenge for us. It is easy sitting in the department making decisions and every now again going out and having a look. It is easy as you have three or four levels between you and the real coal face and in WA the majority of people - 85 per cent or so - live in the south-west corner. The rest could, jokingly once said, the north-west could have succeeded to join Indonesia before we would have known about it because it is that care and responsibility.

The challenge goes to identifying the need and identifying the solutions. There is report after report. We have all seen the reports, we know what works, we know early intervention works and then getting the resources freed up. The Government has attempted in the Healthy Tasmania programs and things like that. They have done work on participatory health care which is good, but we have to put them in place. That is a challenge for state governments. I do note with some real interest Kim Atkins' submission and I would have to say she has nailed it. She has nailed the issues as someone who used to manage the TAZREACH program and has an average understanding of rural health issues from a department perspective.

CHAIR - If I take you back to your comments around throwing money at dealing with category 3 waiting list surgery, at the risk of making people think she's got no idea what she's talking about. There would be a lot of people on those lists who actually would not be there, in my view, if they'd had good access to all sorts of preventive health measures - whether it be regarding their weight, smoking - because a lot of them are waiting for hips and knees and other joints which we know become worse with pre-existing obesity and things like that.

How do you think the messaging should be considered regarding this? We are going to take $50 million or whatever the figure is, you probably need more than that but let us say $50 million out of here. So that means some people on category 3 waiting lists will not get their surgery in whatever time it takes now, which is never, for some of them. We are going to put it over here and help those people on the list that have pre-existing and underlying conditions, but also help, over here, prevent anyone getting onto that list. To me, that makes eminent sense but how do you message? How do you get the Government to see that, as obviously it takes a longer-term view?

Mr KIRWAN - And the challenge - at the risk of being defensive of the bureaucracy - is new money is rare in health, except at the moment with COVID-19, there is a lot of COVID- 19 money. Discretionary new recurrent money is rare.

CHAIR - I am talking about taking some over from here and putting over there.

Mr KIRWAN - You really have to take it from someone and that is not easy, in fact, it is very hard or you have to use that opportunity. There are a couple of national new partnership agreements coming- primary care and preventative health. Hopefully, they will deliver money with them and we would like to see those flow through to the coal face. There have been some attempts federally in respect to enrolment of populations. Where I have seen success, these are old models, but some of the coordinated care trials we did both in the community sector and Aboriginal sector, you can give people care plans. You can sit down with them, with their GPs, with their primary care providers, with their ACCHO if that is the sector you are dealing with and you can make sure they are getting their dental check and eyes checked every year, getting their heart rate and vaccinations, tetanus and things like that. You can do it.

In one of the areas in Western Australia we found 30 per cent didn't have Medicare cards and you're going, 'This can't be so.'

CHAIR - Thirty per cent?

Mr KIRWAN - Thirty per cent. What they did was, when they have to go to the doctor, they borrow their cousin's or the brother's. As a funder, I'm going ballistic because we needed everyone who was registered to have a Medicare card because that brought a dollar from the Commonwealth but we found that in a whole lot of other communities too. We found that in the migrant -

CHAIR - Some people were very sick, according to Medicare, and some were not sick at all.

Mr KIRWAN - We found that in the migrant communities because they weren't necessarily legal.

CHAIR - True.

Mr KIRWAN - There was a whole range of - when you started putting in coordinated care models with the GPs, and that way you have a wellness model, but if you have got a piece-rate payment system that says you only get paid when someone is sick, then you've got a problem. I go back to when Brian Howe was the federal minister and there was talk about Medicare mark IV and that was very much going to be a wellness model of how can we fund general practice and other areas to keep people well.

Now, we talk about it but we never get there. But, again, I think it's more than that because what we see in a whole lot of areas - our programs as per our submission, you don't need a referral. If your mental health, physical - if your mental health, so, it's emotional, social wellbeing, you don't need a diagnosis and we think that's a barrier in some instances.

It's also a huge stigma. Some people still think if they get a diagnosis they will lose their licence or lose their job. Nothing further from the truth but, if that's what they think, you can't change their mind. Some people, surprisingly, are scared of going to the dentist because of some incidents early in life so it's important for us to have the right staff to put people at ease.

CHAIR - The same with needle phobias, with vaccination, yes.

Mr KIRWAN - Or, as a friend of mine did, faint at the sight of blood.

CHAIR - John, I have sat on committees for longer than I care to remember, looking at health. One of the challenges has been the cost shifting that has gone on between federally funded and state-funded services. You just talked about some new national partnership payments coming that, hopefully, will address -

Mr KIRWAN - Hopefully.

CHAIR - - hopefully will address some of this, not the cost-shifting. While we continue to get an MPP for here - preventative health or whatever - and then we have the state funding or the complexity about that, what comes from where and to whom, is this something that really

needs to be called out and dealt with so there's full transparency about funding and who is responsible for what, to avoid that?

Mr KIRWAN - Yes.

CHAIR - How?

Mr KIRWAN - Mapping is the first thing and, again, I didn't repeat what I've read in a whole lot of the other submissions, but we need to know what we're dealing with. Somewhat heretically, I'm not sure more resourcing is what is needed because I don't think we know what we're doing well enough with what we have now. I don't think we know well enough what's working now and what's not working and that includes some of the hard decisions of stopping stuff that isn't working.

We can keep doing more of the same but that may not be - and that might mean going to the community and saying, 'This service isn't working' or 'This is not our contemporary best evidence-based practice'. Again, we did this with some considerable difficulty in Western Australia when we were looking at how do we close the 20-year life expectancy gap and it was challenging for us because we saw it through middle-class, white eyes.

We had all these nice programs like Stronger Mothers, Stronger Babies and we thought they were wonderful. We went out there and spoke to the Aboriginal community and said, 'This is good but we're not making a big difference' and they said, 'Well, it won't work.'

CHAIR - Exactly.

Mr KIRWAN - We said, 'Oh' and they -

CHAIR - Take mothers away from country for birthing and what happens, yes.

Mr KIRWAN - They said the best thing you can do is have the average age that an Aboriginal woman gives birth to be the same as a white person which means not at the beginning of high school because then -

CHAIR - But also as I understand it, John, not understanding the cultural sensitivities around their birthing practices means that babies don't thrive.

Mr KIRWAN - Yes. Again, we have to have that - I mean, the current word is 'co-design'. We've got to have that approach, we've got to have that lived experience in those areas but that's what we used to do. That's what we used to do when we had that - strong community health nurses, a strong general practitioner, a strong community that would look out for each other in those areas.

Again, we would say through an analytic model, getting back to that - we work within the medical model, wherever possible our staff work with, and closely with, the GPs. They're our most important referral pathways but we take other referrals as well because it is important to have that wraparound service. That's critical for us.

CHAIR - John, in terms of talking about outcomes. You obviously would - I would be very disappointed if you don't - keep data about the services you are providing to the regions like the dental down the west coast, and east coast, and other places, and other services.

Do you have data related to outcomes for some of those people? I know it is probably early days, but in children accessing dental care and those sorts of things.

Mr KIRWAN - We've got both activity data and that is quite good because that is contractually what we have in reporting, particularly to our Commonwealth and to our Primary Health contracts. I notice Phil's appearing, and it is mentioned in his submission. We are one of those primary contractors there.

There is some outcomes data, and particularly in the Primary Health Tasmania contract, and Judah manages that and meets with them quarterly, and goes through those. I'm just making a difference between activity data and outcome data.

Some of the activity data you can extrapolate that the preventative work we are doing in schools will lead to good outcomes, because that includes not just doing cleaning of teeth and things like that. That means teaching them how to brush their teeth and things like that, which I should say, that is not actually part of our funding. We have to do that ourselves.

We are only funded, in this instance, under a fee-for-service model, for doing things. We manage that ourselves.

Do you want to comment on the outcomes data?

Mr MORRIS - Recently with our Primary Health Care programs, through Primary Health Tasmania, we have had the results of the first four years of the program. What we found is statistically and clinically significant results. We are seeing a decrease in blood pressure across the whole cohort for our Mental Health programs, improvement with the K10s, which is a standardised tool.

Probably most importantly across the whole cohort, we are seeing improved quality of life. Really, if we are looking at health measures, that is probably one of the most important when we have that understanding of that holistic model of health, that it is not just some of those clinical results. It is how it is affecting them socially, emotionally, and their overall wellbeing, which is really important. We know that when we can improve quality of life, where we are starting to see people interact more with their community, starting to get back out there, their work is going to be improved. A lot of those measures which, while we can have some of those important health-related ones, it is really important to be looking at the full picture, to how that will affect the health of their family as well.

We know that, for instance, with mental health, as well, it is a really big indicator if you have negative quality of life. For example, parents relating to their children. We know if we can start to break some of those cycles of negative health outcomes, it is going to be really powerful, not just on the individual level, but through the family and community level as well.

CHAIR - Can I just ask, Judah, how you established your outcome measures? This is a thing I find very frustrating. I know other members of the committee have as well, when we scrutinise health budgets. There is a lot of activity measuring but very little outcomes measuring.

How did you establish, and are you able to provide your outcomes focus performance information?

Mr MORRIS - Part of our contract with PHT is that we are actually required to use standardised measurement tests that includes for our physical health programs, capturing BMI, blood pressure. Through our mental health programs using some of those standardised assessments, such as K10 and a-qual to measure quality of life.

And the point of that is, I admit it is a bit of a nightmare to the patients sometimes, and obviously our clinicians actually going through these formal processes. We know they are important and like you said, to actually measure the impact that we are having, to use that to justify the work that we are doing. And to help, I guess, advocate across the broader health sector of that primary health care does work and it does prevent future occurrences from happening.

CHAIR - Is there some information that you could provide to the committee about your performance information?

Mr MORRIS - We report quarterly and we have a pretty comprehensive report that we provide to PHT which includes everyone we have seen in the last quarter. So, for our physical programs it is the BP, BMIs, and there is the K10. We have about a 95 per cent adherence that we have to achieve for everyone who comes to our service to be collecting those measures.

CHAIR - I don't want the patient details. I am just interested in the framework.

Mr KIRWAN - We probably just need to check with Primary Health Tasmania that they are happy with that. You could ask for that this afternoon.

Just also, to reinforce, as an accredited health service, we have to have a quality of service monthly report. That will have a whole range of indicators in there, including whether in the referral pathway if someone has been referred to us we have seen them within the recommended time and follow up in those areas. All government accredited health services would have similar quality of service reports and those include dental primary care, physical primary care, youth and adult which are our four major programs in those areas. There are a range of indicators in those we review internally monthly and then go to our quarterly clinical advisory committee which has external people on there to go through. In some areas we have struggled, but those areas are pretty right now.

Dr SEIDEL - The RFDS is one of the few national health organisations that made a submission to this inquiry. Is there anything about Tasmania in your experience or the RFDS's experience that is unique or a challenge no other state has had to face? You mentioned people do not necessarily want to travel even though it is only 30 or 40 kilometres, but is there anything there that is hard to overcome other states do not have that holds us back when it comes to life expectancy, health literacy, access to care?

CHAIR - Digital literacy.

Mr KIRWAN - Accepting that everyone is different, I would have to say from my experience of the Northern Territory and Western Australia and sitting on our national CEO's committee for the last seven years, it is quite similar because we are dealing with areas of

functional health literacy, we are dealing with an older, sicker population, particularly Aboriginal populations in some of those areas and interesting challenges. Distance is an issue, but we have our own distance issues here, particularly the three Bass Strait islands, east and west coast and as we said earlier, even what seemed to be close-by towns such as going from Rosebery into Queenstown is not easy. We have some of the climatic issues here that are an interesting challenge.

For where we operate traditionally - and I am talking about outside the big cities - it is not dissimilar, I would have to say. Having said that, we would probably see here less resistance, and this is more anecdotal to travel, than on the mainland. On the mainland people are probably happier to travel longer distances. Here I think people are hesitant to travel. The functional literacy issue here we know but also, as you alluded to earlier, in many of those areas they still have active health services of a critical mass. We are dealing with quite small communities. I do not know, Bastian, you would know better than me, what the critical mass is to have a GP under a traditional Medicare billing model, whether it is 1500 or 2000 people. I do not know, but you take that rule of thumb across a lot of our services and it is going to be a struggle.

The other commonality which we are all suffering and we will see the challenge after COVID-19 and the dust settles or whatever the new normal is we were facing some significant workforce challenges pre-COVID-19 and I mentioned that in the submission. We were facing international shortages of pilots, aircraft engineers, doctors and nurses. Obviously, we still have a surplus of pilots.

CHAIR - Let us hope they stay.

Mr KIRWAN - Exactly. The reality is they probably will not but we had seen just before COVID-19, places like Mt Isa and Broken Hill having to have fly-in fly-out doctor services. We have always had people wanting to work for us but the international and national market was tightening up and now not being able to recruit overseas - we have an older population as we know in our workforce. Nursing is looking to be a real challenge going forward. We would say, as we have said in the submissions, new models of care, new models of workforce, is probably the only solution, because I do not think we will ever be able to traditionally staff some of our health services under a traditional model of doctor, nurse, allied health. We have looked at examples of that. For example, in primary care we will employ physios, EPs and exercise scientists and we could see a model where a generic allied health assistant could be supervised by them. Getting TAFE back into training those sorts of staff. In Nicole's area we can see dental assistants being skilled up, as they are on some mainland areas, to provide additional work, again, under the supervision of a dental therapist or dentist in areas like aged care so we can provide a service within a safe model.

CHAIR - How many EPs do you employ?

Mr KIRWAN - You can ask Judah that; Judah is an EP.

Mr MORRIS - Currently, we have five EPs and one starting in a few weeks. Across our physical health program, we have a team of ten which includes EPs, physiotherapists and health science backgrounds and we have a team of roughly ten mental health workers.

CHAIR - With EPs being unregulated or effectively self-regulated, does that present barriers for not being registered under the Australian Health Practitioner Regulation Agency, for example?

Mr MORRIS - They are registered under Exercise & Sport Science Australia. Even though it is separate from AHPRA they still have a governing body. One of the challenges has been we know they are not particularly well-utilised in the healthcare system. This is why you see some of those barriers to cardiac rehabilitation and some of those different areas many people are familiar with - a physiotherapist helping you with your knee injury because that is something you access in a public system. Some of those other critical health services, if they are not there as part of the traditional model people might not even be aware of access in their community.

Mr GAFFNEY - Mike, do you have a question?

Mr GAFFNEY - Yes, some of that was covered thank you. Do you have many people wanting to relocate to Tasmania for the RFDS because they are situated somewhere else and they want a wetter climate?

Mr KIRWAN - Interestingly enough, pre-COVID-19 we were really struggling in a couple of areas. In the Tasman, for love nor money, including good support from HR+ we could not fill that vacancy and were almost in a very embarrassing position of having to go back to Primary Health Tasmania and saying: 'Here's your money back, we just can't fill it'.

When COVID-19 started to crank up, we had four or five potentially good applicants all from the mainland. Most of our staff with a couple of recent exceptions are not from Tasmania. One of the physiotherapists, his wife is a GP and now going to become a rural generalist so at some point in time, a country town - hopefully in Tasmania - will pick up a very good GP and a very good physio. We have found some good and dare I say it, the right age group, so they are at the beginnings and middle of their careers, not where I am in my career. That is great in that respect and we have some good models. Huon is a good example where an experienced EP is matched with a recent graduate and is working well and we have those areas.

Again, we work in a generalist model and we were happy to EPs, exercise scientists and physios. We could not get physios to start with, but we have two or three at the moment.

Mr GAFFNEY - If you look further down the track about what staff or what skills you need in the allied health section, do you have any input into TAFE or any of those training institutions? Are you asked for your feedback from government bodies and agencies about what you think your requirements might be, and are you satisfied with the amount of training or specialisation those people are getting?

Mr KIRWAN - We are both members of TasCOSS and the Mental Health Council of Tasmania so through those and through the TasCOSS work. We probably make ourselves unpopular by reminding everyone about rural and remote Tasmania. That makes me probably very unpopular, but they are now used to it.

With TAFE, we have recently engaged with a new person who has come from Victoria who has a good industry and we are engaging with them to see whether they can restart their Allied Health Assistance Program because we see that as having some potential. They used to

provide trained generic allied health assistants. We can see them again working with one of our degree-qualified people. As I mentioned in dental, we are probably never going to have enough to cover the demand but we can see, particularly in areas like aged care and schools, dental assistants we can train those up and working with Professor Len Crocombe - he has some fairly good ideas about what can be done in that area.

We have engaged TAFE and asked: 'Can you do this?', and they are looking at it.

Mr GAFFNEY - Have you been satisfied in the past with the support, the studies and programs that TAFE run? Do you think that TasTAFE is able to provide you with the skills you need within the framework they have?

Mr KIRWAN - The direct area we probably have the most contact with is dental assistants. Since 2006 we have run a scholarship for dental assistants. We send the dental assistant to New South Wales to work on one of the planes, doing clinics, so they get experience.

My observation since I've there is that - and Nic's been there longer as I said earlier - the quality of those graduates we see coming through TAFE is impressive. The competition is strong. In that program, which is our direct touch point, it's good. In fact, from her experience with the RFDS in New South Wales one of those dental assistants then had the confidence to study medicine. She is now a GP.

We've been impressed that all our dental assistants are TAFE trained.

Mr GAFFNEY - Is that the case in other states?

Mr KIRWAN - I couldn't comment. Nic can.

Ms HENTY - You'd have to have your Cert III as a dental assistant which goes through a TAFE qualification.

CHAIR - Thanks, everyone. Are there any closing comment that you wanted to make?

Mr KIRWAN - No. Good luck.

CHAIR - Thanks, John. You're supposed to be here to give us all the answers.

THE WITNESSES WITHDREW.

The committee suspended from 11.37 a.m. to 11.47 a.m.

CHAIR - Welcome to the hearing, Peter, and thanks for your submission. This is a public hearing. Everything that you say is protected by parliamentary privilege while you are before the committee but that may not extend beyond. It is being recorded by Hansard and will be published on our website once it is all available. It will form part of our committee's deliberations and report. You have received some information. Do you have any questions?

Mr BARNS - No.

CHAIR - I invite you to make the statutory declaration and then introduce yourself. Then we have read your submission but if you would like to add further to that, please do so. Then the committee will have questions.

Mr PETER BARNS, CEO, HR+ WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED

Mr BARNS - I have been CEO at HR+ since we started in about 2007. We have various government contracts from the Commonwealth to ensure that communities have access to quality, sustainable health services and primary care. We also have an NDIS arm to our business where we provide coordination of supports and plan management. We don't directly provide supports to people but we help them connect to the supports they need. As I said in the submission, the connection between the two arms is the primary care-allied health services that people need.

Our bent is more to rural and remote areas. We tend to think that Launceston and Hobart are big and ugly enough to take care of themselves in terms of the marketplace. Everywhere outside of that usually needs some assistance to make the market work for them in both the NDIS and in primary care.

I am open to questions because I would rather be interested in what you have to say than what I have to say.

CHAIR - The terms of reference look at the barriers to access and some of issues around workforce, which are areas that you are looking into. If you had to make a list of priorities to address the access barriers and the workforce challenges, what would you do?

Mr BARNS - We used to try to recruit doctors and say, 'If we can get a doctor there, it'll be okay'. We worked out over a number of years that it was actually the systems that surrounded the doctors that were more important.

I place a caveat on my number one priority. If anybody came to you with a silver bullet, saying that there is the one thing you should do to fix everything, I would be very nervous. We're not dealing with werewolves; we are dealing with complex situations. If I had a silver bullet it would be practice management. What we discovered is if a place is well managed, then their ability to recruit and retain their professionals and ancillary staff goes through the roof.

When HR+ started back in 2007, I had been working in the sector for 10 years before that. Most of the doctors who come into Tasmanian rural areas are from other states. That is a broad reality. The retention rate after three years of being in the practice was only 45 per cent. So, more than half the doctors moved after being placed in rural Tasmania.

We put a lot of effort into practice management. We did professional development. We provided scholarships so people could do their Cert IV in professional practice management. We did networking. We did all sorts of things. Within three years of starting that, the retention rate had gone to 90 per cent. We had doubled the retention rate over three years. The key element was the professionalism of practice management. It's not rocket science. If you are working in an environment that is positive to work with, then you are more likely to be attracted to it and more likely to stay. That is the first thing that I would say.

The second thing is ensuring that people have access to a life. Expecting people to work as they used to do - 24/7, 365 for 20 years in the one community - does not work anymore. That is important to recognise as being, I suppose you could call it, a demographic recalibration. Nobody likes to work like that anymore.

CHAIR - Does that mean you need to recruit two doctors where you may have been able to recruit one in the past, for example?

Mr BARNS - In a bald way you could say that, but I think it still comes down to the systems and thinking about the supports that are around it.

For example, it used to be that everybody had to be on call all the time, which is an absolute killer for small practices in particular. It is not so much fun for the large practices either. Things like GP Assist allows a community member to ring a number and talk to a doctor or a nurse in Hobart who will work you through whatever the issue is to work out whether you need to see a doctor, a nurse or if you could wait until the next day or whether you need to call an ambulance.

What that does is it takes care of about 80 to 90 per cent of the nuisance calls that doctors get in the middle of the night. As a single dad, I might be worried about my child who has an earache. It is a big deal for me but it may not be a big deal. Being able to use those sorts of supports, use the system in the way it works makes life a little better. The same with using nurses and allied health professionals. As a doctor, if I decided I need to see everybody for everything, then they will be overworked. With the variety of ways you can do medicine through mental health care plans, chronic disease management plans and so on, you can use your other workforces to make your life a little better. It is not always about replacing two for one. It might be about saying: how else do we get all the systems to work together to make it a better place to work?

CHAIR - You actively work to recruit Allied Health workers and nurses as well as medical doctors as well?

Mr BARNS - Yes. Allied Health is fascinating; you don't think there is any need for it but it is all latent. If you recruit a physiotherapist into a community and they have never been referred out, all of a sudden, they are full time. The 'need for' is either not understood or just not expected. Who would have thought? At my age, a 55-year-old male, I probably need a dietician and an exercise physiologist more than I need a GP. They are probably more valuable for me in terms of health. Illness is a different story but in terms of health, Allied Health is probably the better way to go. The more we recruit, the more the demand is. I am almost attempted to say, 'Stop'.

CHAIR - Once you open the door, people come in.

Mr BARNS - It is a good thing, but it is an interesting thing.

Ms LOVELL - Peter, there were a couple of things that really stood out for me in your submission. You and I have spoken about this before in instances where this has happened.

The two things that stood out for me was where you said that 'it is rare for the transition to be planned and organised' when you are supporting working through transitions in communities and when you talked about the fact that you haven't yet been faced with a situation where you have not been able to find an alternative provider but that is luck more than anything and you are unaware of any plans within government to deal with that scenario. Why is that? Why is that happening in the way that it is happening? Why is there not that foresight being given? What should we be doing better?

Mr BARNS - Partly, it is due to success. Since 1999, the community has been both resilient and successful in finding transition entities. It is kind of like if the model is not broken don't try to fix it. What I'm saying there is we may have been fortunate in a number of cases where, for example, Ouse recently. Ouse - you can't predict that - and for the reasons that happened, closes down. Within a month, it could have just closed. The media kind-of did us a favour, they put it out there, two interested parties, one party put their hand up and they've been contracted to provide the service on-going. That's a great thing but it was an accident. As much as we'd like to say, 'We did a good job and made all this happen', we didn't, all we did was advertise it and connect people to make it work.

I think sometimes we have become blasé because of success. The other thing too is I think the department has so many other things on its mind that they go, 'Let's not worry about the future, let's deal with what we have to do today'. Say we have a bed block, we have COVID-19 and all these other things, and to spend time on something that may be a problem in the future, that might be a luxury, I'm guessing. I don't know.

Generally, most of us don't prepare anyhow. Apart from superannuation for some of us who are rich, we're not really thinking too much about the future.

Ms LOVELL - The other side of that, though, is if you don't plan for those scenarios, we are faced to make those things worse.

Mr BARNS - Yes, absolutely. That's why I said in the submission, it would be lovely to be able to have something in a drawer for the 24 sites that I can pull out and I can just look at once a year and go, 'Has the environment changed? Do I need to tweak that a bit?'. I know it's not my gig, it's not my call. They can just tell me to get stuffed. It's not an issue.

It would be nice to be able to think that through and say, 'Now what's changed in terms of the workforce? What's changed in terms of that town? What's changed in the policy of the Government to say, yes, we can tweak that'. So that when an accident happens or somebody dies - and we've had this before - or a practice closes for some mandated vaccine reason, you can pull that out and say, 'Okay, we know what we need to do. That site knows what it needs to do, the Government is aware of what it needs to do, the THS is aware'. You can make that happen quickly almost like a SWAT team, make it happen and put it into place because we won't always be fortunate. That's my argument.

Dr SEIDEL - Are there similar organisations to HR+ in others states and how are they funded? How often do you communicate? Do you strategise together and how do you make sure that you get the best doctors for Tasmania that you can get? It's quite a marketplace, isn't it? It's an international marketplace.

Mr BARNS - Yes, it's very competitive. We're called a rural workforce agency - that's what the Commonwealth calls us - and there's one in each state and territory apart from the ACT. We do collaborate. The CEOs get together once a week on a Thursday and we discuss all sorts of things. We also have a national coordination unit which is based here in Tasmania.

The Commonwealth has funded that to do promotion, representation, engagement and development nationally. We don't have a peak body, as such, but we work collaboratively to make that happen. Everybody gets their runs on the board but it is competitive. Rather than thinking, like in Tasmania, we have a monopoly so we can relax, we tend to think here at HR+ we have to be better than everybody else to get the talent to come to a place that nobody knows about.

Dr SEIDEL - Why do you think that is? Is it because nobody knows about Tasmania or is it just a quirky difference? Are there other factors like income potential, support in terms of education and jobs for the spouses and so forth?

Mr BARNS - We haven't found any of those to be the defining factors. Our guys work pretty hard to match people but, like I said, most people come from overseas. It'd be 80-90 per cent of doctors who come in to rural Tasmania will be from overseas. Tasmania has an excellent reputation for ensuring that people pass their fellowship exams so they get the gold standard here in Tasmania.

It's pretty rare that anybody ultimately fails. In fact, over 20 years I can only think of a couple of people who didn't pass eventually. This is something that Bastian has a lot of experience with. Tasmania does have a good reputation for ensuring that, again, the supports are in place. If you look at the Tasmanian success for getting people from non-vocationally recognised to vocationally-recognised, we have the best success in the whole country. It's partly because of our size. We know all our practices, we know all our practice managers, there's a pathway for every practice from here to there.

Income potential? That kind-of works the other way. Locums will ring us up and say, 'I'm interested in doing a locum at St Helens and I want $2500 a day.'. We say, 'That's sweet, but we can give $1900 a day.'. 'But I earn $2000 on the mainland.'. I'll say, 'Feel free to find St Helens on a map on the side of New South Wales because that's what you can do.'. If people want to come here then the income difference doesn't make a great deal of difference.

Generally, people - and again from overseas - are looking to get in, to get started, so they will take any job they can find. We make sure it's not the worst job that they can find and then we make sure that they've got a pathway for their kids, for their spouse.

Like I said, the retention - you will see a lot of news on the mainland that says people won't stay where they start on the mainland. They will start in Bunbury but they will end up in Perth or they will start in Mildura but they will end up in Melbourne. It does not happen quite so much here. That's what I was saying about the retention rate.

All the way along the north-west coast where most people from overseas will go - that's the biggest area - 95 per cent of practices are owned or managed by people who have come from overseas, either partly or fully owned. Now, that indicates that people are putting down roots, wanting to stay, and, basically, integrating into their communities so they are not using here as a stepping-stone. We get a few but not that many. Tasmania is a good place to work, the reputation is out there.

A lot of it is word of mouth so you will get Nigerians come as a community, Sri Lankans will come as a community. They build their supports around that, which is cool, but they're not exclusive. They go and join the local cricket clubs and other things. Tasmania has some advantages even though we're at the end of the earth and most people confuse us with somewhere else.

Dr SEIDEL - We heard earlier from GP Training Tasmania that we could probably train 52 GP registrars every year but funding only allows for 40 funded places. Is there any discretionary funding available through HR+, for example, to allow those potential candidates to enrol into a training pathway whether it's self-funded or otherwise supported?

Mr BARNS - If it was self-funded, you could probably make it work. We don't have enough money in what we're paid to do to be able to pay. It's about $45 000 per person per year. We don't have anywhere near that sort of discretionary funding. It would mean that something else would miss out in order to make that happen.

I actually think the issue for - and GPTT have looked at whether they could get a practice to pay in order to make that happen and that would be economically sensible because you can write that off as a tax, as a business arrangement, and recognising that you're paying your 45 000 a year for somebody to generate $300 000 to $500 000 a year eventually.

I would do it if I was a practice because I'm going to invest in somebody who is going to come and work. They're going to have the best time ever. The training is going to be excellent, the support is going to be excellent, the range of medicine is going to be fantastic so they will want to stay because the two or three years they have spent with me they have built up a client base. Why would they want to move on? I would make sure that their family was happy. I would make sure their spouse had the job that they were trained in, all the things a practice can do with the money that they have available to them.

Should the Commonwealth be doing more in terms of putting money into that? They could do but at the moment it would be hard to find enough places to put them where there is supervision - because you have got to have supervision capacity to do it. That's a bit of a great limiter at the moment.

Mr GAFFNEY - You're accountable to the Australian Government. Do you tender your work or every so many years you have to put in a report or how does that work?

Mr BARNS - Yes. We have to put in a report every six months just to demonstrate what we are doing. We try to surprise and delight rather than just meet the compliance level because we want them to think we're fabulous. Sometimes we do competitive tenders for some of our contracts and sometimes they will come to us and say, 'We've identified that you're the only type of organisation who can do this.'

For example, in Tasmania we run another national program called the Visas for GPs Program where we have to issue certificates based on workforce need for a practice to approach the Immigration department to become a sponsor for a visa. They came to us and said, 'We think you're the only people who can do this' and we went, 'Okay. You don't want to check the market first?' and they said, 'No. We've already done that' so sometimes it's not a competitive tender and sometimes it's a competitive tender.

Mr GAFFNEY - The reliance on international work that you've highlighted, pre-COVID-19 and post-COVID-19 or current COVID-19?

Mr BARNS - What happens?

Mr GAFFNEY - Yes. What's your crystal ball looking -

Mr BARNS - I was a bit surprised because in the 12 months, the last financial year, I assumed that our recruitment would be down. Our average is about 23 to 25 GPs and about 30 to 35 allied health.

CHAIR - Per annum?

Mr BARNS - Yes, per year. Last year, in the middle of COVID-19, it was 47 GPs and 53 allied health so we had almost doubled the numbers in a time in which it was difficult to get here and to come in from overseas. There was a slight increase - it was about 75 per cent overseas-trained and 25 per cent Australian trained, so the Australian numbers went up a bit, the overseas numbers went down a bit; but overall, the numbers went up. I am assuming - here is my crystal ball moment - that because of our success as a state in keeping the numbers low, that this might work in our favour for people to say, 'I want to come.' Same for both overseas trained professionals and for locally trained professionals. In the future, with more pandemics possible, is it good to have a presence in Tasmania? It probably is; or a house or somewhere to work and so on; so, it could work in our favour. I am hoping it will. We are not resting on our laurels because, as I said, I was surprised about the 100.

CHAIR - The retention will be the interesting thing, over time.

Mr GAFFNEY - Dr Saul highlighted to us the other week that they could do with another 100 GPs. I'm not going to say that is a catch-cry, but it is not something we haven't heard before.

Mr BARNS - No.

Mr GAFFNEY - Do you think that is possible? And with our ageing doctor workforce, with exceptions here, how does that look for the next, say, five years or so? What is the baby-boomer doctor looking like?

Mr BARNS - I saw the 100; I've always said to my kids that if anybody who gives you a round number, think about that one. Anybody who says we need 72.6 doctors is probably closer to the mark. I did wonder where would put them, because we have 75 active vacancies at the moment, but that is for people retiring. When you say vacancies, there are a number of reasons - some of them are business expansion vacancies; sometimes it's 'We just want to

compete with the people next door' vacancies; sometimes it's 'We had someone die and we need to recruit.' The bald answer is I don't know, because I can't control the behaviour of the people.

It used to be that we would say let's look at the number of people who are 65 to 70 and then we can predict how many people will retire. Then something happened with superannuation so people stopped retiring; they started working a little bit less, but they were still working.

CHAIR - There are more women in the sector now too, that often take some leave when they have children.

Mr BARNS - They take leave, yes, for maternity leave - do we need to bring in that sort of thing. The right answer is the number of people is how much the market can cope with. I know that is a weasel answer. I will give you an example. About 10 years ago, Launceston doctors came to us and said, 'We don't have enough doctors. Could you start recruiting for us,' because as I said, the market is usually big enough to take care of itself. So, we did. We brought in about 10 doctors over a 10 month period. They came back to me and asked me to stop, because there were too many doctors.

I said, 'How do we determine how many is too many?' It became a small business argument; the average income was dropping as the number of people went up. That is clear.

CHAIR - Supply and demand.

Mr BARNS - I had not thought about it. They had not thought about it either. I don't know what the right number is, given that demographic recalibration where some people like to work part time, some people have other interests. We can accommodate all that; but it is not community-based, it is more small business-based - what decision does a small business make, about how they want to run their business - and I respect that. Medicare is a form of income for that, but you could not just use Medicare as the, 'How many people do we need here on the ground?' It used to be simple. People used to say 1200 people, that many doctors; but it doesn't work.

Mr GAFFNEY - The relationship between the different professions, whether it is a doctor or a nurse practitioner or a paramedic practitioner. Have you got any comment on some of the recent media releases about New Zealand for example, where they have invested a lot more money in the next so many years to do with nurse practitioners, because they are not getting the GPs and they can see the scope of work is going to be improved. They can fulfil a role and perhaps we won't have to rely so much on locums or whatever.

Do you have a comment on that from your point of view, with attracting professionals?

Mr BARNETT - Tasmania has been very lucky in terms of attracting GPs. We haven't had the situation that they have had on the mainland where they have had to use different models. In all these transitions it has almost been a like-for-like. We have had a doctor leave practice with allied health and nursing around it, and we have almost always replaced like- for-like. Sometimes necessity is the mother of workforce invention, and we have not had that need or that luxury or that opportunity.

When I started, years ago, I had never heard of a nurse practitioner. They put it on the table and everybody was very excited about nurse practitioners, and I thought it would be great. It didn't pan out. We have half a dozen or something, and very few in primary care. It is only places like Bastian's practice who are prepared to say how are we going to make this work, where they are prepared to give it a crack. Otherwise they go, no, I will get a GP to do the GP work and a nurse to do the nurse work. We are not very innovative as a sector here in Tasmania when it comes to that. I love it. I am a bright and new shiny thing kind of guy. If there is something new I get very excited, and my staff have to dampen me down. When I hear about how that could work with this, and how this could work with that and make it all work, I get excited and then I get tired because it didn't translate into something.

Mr GAFFNEY - My last question - I was interested when you said that you had the business come and say look, we don't need that many doctors now. Does the doctor or the AMA or the GP, whoever it is, have that much say in the doctors or the GPs? We have one group saying we need 100 more, and then you have a group going, just slow down a bit, you are over-cooking the boat. How does that work?

Mr BARNS - It is small business-run. We have set up primary care, so it is based on the model of the business that you do want to run. Again, I can respect that. In some ways it is not a bad thing because it drives competition, or it could drive competition; but if the practice doesn't want to employ anyone else, they don't have to. It wouldn't matter whether the community turned up with pitchforks and lit fires, if the business says no, we are comfortable with what we are doing.

Organisations like ourselves and probably Primary Health Tasmania, do the health needs assessments. They could work out that Smithton, given the profile of the community and the health status and so on, they could do three more of these and two more of those; and they could come to us and say we need this. And we would go to the local practice and say, given the data that Primary Health Tasmania has put together, we reckon there is a business opportunity for you here to expand. The practice can then go, we like that, can you help us recruit some more people; or they could say we are stuck the number of rooms we have. There will need to be an investment from someone.

CHAIR - They are not going to do it if it is not going to be profitable for them though. It is like any business.

Mr BARNS - Yes. I'll give you an example of what we are doing with allied health. We've have been recruiting, based on the small business need. We thought, how could you do it if you did it on a community need? We have been engaging with George Town to say, what are your needs around not just primary care, but the hospital, the aged care system and the NDIS? They are all related. If we looked at a community need basis, how would that change? The doctors were happy enough with what they were doing, so we concentrated on the NDIS. What we discovered was George Town is the healthiest place in the country, according to the NDIS, because there is not a single person there with a mental health NDIS plan - not one person. Given what we know about George Town, that is a nonsense. We thought, there is something going on here.

We have dug deeper, and we got the community to identify 26 people that they thought should be on the NDIS, but weren't. Then we discovered all sorts of reasons why it is absolutely impossible for most people from a rural area to get on the NDIS. That told us that there is a

market there that is latent. When we did further figures, there were 129 people on a plan, which represented $4.2 million. They are only spending about $1.9 million or something like that, so they are only spending about 40 per cent of the money that was available to them. Statistically, there should be about 700 people on the NDIS in George Town and they are not there. We thought, what can we do?

We started working with these 26 people. We identified most of the barriers and we tried to mitigate some of them, and then we helped people to at least assess their eligibility. We also worked out that there is nowhere for all the allied health providers to practise, so we rented a building and we are renovating a building and putting in five extra rooms. We have been working with everybody to see what the latent need is to bring people in. About eight providers put their hands up to rent the rooms. We have been working hard with the community to say, let's work out what your NDIS needs are. Can we build the market place? Conservatively, if there are 300 people on the NDIS there should be about $17 million. A lot of that is going to be spent on personal care workers, so we are working through how we find that. A lot of it will be spent on allied health as well.

If there is $17 million in the community to be spent, I can go to Mouth Works and say, we have a business opportunity for you here in George Town, come on in. It is this process of saying where does this circle begin and end? But the market needs to be there, in order for people to come and run their business. We are trying to do it that way. It is called the heart initiative. In case you are interested, I brought a picture of it. We are thinking that sort of work might complement our dealing with individual practices and what their business needs are; so, what are the needs of the community? Can we make that work or not?

Dr SEIDEL - Peter, does your organisation do some work in terms of workforce prediction? Can you tell what the number of GPs and nurses would be per LGA in Tasmania?

Mr BARNS - I think so.

Dr SEIDEL - That work exists?

Mr BARNS - Yes.

Dr SEIDEL - I am not sure if you have the data now, but do you know how many GPs we need in Tasmania and how many GPs we have?

Mr BARNS - We have 549 full-time equivalents. We currently have about 940. We do that by statistical area level 2 (SA2) and we do a yearly health workforce assessment. I would not say it was sophisticated. It is adequate for a base level, what should we have. What I would love to be able to see is the connection between the health needs of community and the workforce requirement.

Dr SEIDEL - Do you work with the Commonwealth on that, because they collect data on a greater level now? They know exactly what sort of medical services are being delivered in real time.

Could you have access with other national -

Mr BARNS - The tool they use is called the Heads-Up tool. It is not quite real time. It is probably three to six months behind. There is so much more that can be done between the workforce needs, which is what the Heads-Up tool tends to do.

The work that Primary Health Tasmania and the other primary health networks do is one of the health statuses of a community. The conversation we have started between ourselves and PHT is, can we get those two datasets together. To do what I said before.

Some of the biggest needs are probably not rural. They are probably Ravenswood and Risdon Vale. What are the health needs there and what are the service needs and therefore the workforce needs?

I would love it if they did all that work. Work out the services then come to me and say fill them, this is what we need to do. I would love that. That would be great.

Dr SEIDEL - Who is doing the work now? Is anybody doing it or is that an issue?

Mr BARNS - No. That is aspirational. We have started the conversation. I would like to think within twelve months. Hang on, is this being recorded? Let us go with twenty-four months. We might have a model that allows them to do, because they are paid to do that work. We are paid to do this work and we have integrated it.

At the moment, everybody tends to work in silos. They do their work, we do our work, we talk to each other nicely, but -

Dr SEIDEL - But this is Commonwealth funding, right? Have you been approached by the state government to actually understand what you could do?

Mr BARNS - No. This is another one of those silo things. Generally, state governments look at tertiary care. Stuff in the hospitals. And then they leave the stuff, primary care, to Commonwealth. If I was sitting outside and looking at Tasmania, it is not that bad. It is not that good, but it is not that bad. We can probably leave them alone.

If we had more crises, but like I said there is a crisis at Ouse, it gets dealt with. If there is a crisis at Bruny Island, it gets dealt with.

CHAIR - Putting out fires though.

Mr BARNS - Yes.

Dr SEIDEL - But if service need is not met in the community, those people are going to end up in tertiary system anyway. If it is not being met by the paramedics, it is being met by the police. That makes headlines and then we say what happened.

It is predictable stuff, because you are saying the data is there and been collected. The data has been analysed but is not being acted on.

Mr BARNS - It is like Lego bricks. Everybody has got the bricks. They are just not translating into a house or some sort of bionic, or whatever the age where kids might be at the moment.

CHAIR - If that can be done as a body of work, who should do it and what would it look like?

Mr BARNS - I do not want to do it. It is almost like it is all being done. It just needs to be connected.

The Commonwealth departments look after the Heads-Up stuff. They have that data.

You have got us who look after the on-the-ground workforce stuff and we know those communities pretty well.

You have got Primary Health Networks across the country who are collecting health needs assessments all the time. You have that and then they do commissioning.

But it is not connected. It is a bit like our heart program in Georgetown where we quickly discovered none of these silos talk to each other. It is stuff I already knew. It is not a malicious comment and just the way things are set up to be. We are so large in all of our organisations that we can do our job. I remember saying to somebody, we could all do an excellent job and everybody could be absolutely ill.

CHAIR - It is like the hospital with no patients in *Yes Minister*.

Mr BARNS - Yes, but we have all done our job. I can put my hand on my heart to say: HR+ has been fantastic, but what is the actual outcome? For us the heart was about breaking down the barriers. If you were a person in George Town on a mental health plan and a chronic disease management plan and a National Disability Insurance Scheme plan, all those plans will fail you. With the best of intentions in systems that are in place, they will fail you.

I went home and said to my kids: 'Look, these systems are designed to make us cry before they'll ever allow us to laugh'. It is just so hard and I am educated, I am rich, I have all the things that are to my advantage, and with some of these things I would tear my hair out.

If you are non-verbal, if you do not have agency, if you are Indigenous, if you are rural, we do not set up systems to work for the people who probably need them the most. That is why we have to do things like heart where we say okay, if the systems are going to fail you are going to have to get back into the community at this level and make it work for them. Then we can make some policy recommendations, but they will probably be ignored, so we just have to try and make the system work for the people that it is not working for at the moment.

I do not mean to sound pious about the whole thing. It is just where we have ended up and we could completely and utterly fail. Do not get me wrong, it is aspiration.

CHAIR - I will finish off with you, Sarah, if we can?

Ms LOVELL - Peter, we have talked a bit about recruitment and particularly retention. I know in the past particularly, there have been different tools used to try to encourage people to work in rural areas like financial incentives or scholarships that require a term in a rural area.

Do you have any comment on the success or otherwise of programs like that, and whether they are things that should be considered, or whether there are better or more effective ways to encourage people to stay?

Mr BARNS - None of that hurts but I think it is 'icing on the cake'. I do not know too many people who go somewhere because you offer them a relocation grant. It does not make a difference. I remember a survey a couple of years ago that said, 'GP registrars would only go rural if you gave them $300 000' which is more than they were going to earn and it was not reasonable. Scholarships, relocation grants, there are other incentives like time served, return of service obligations for people who have Bonded Medical Places are all useful but do not make the difference, they can only …

CHAIR - They are incentives.

Mr BARNS - Yes, it is an incentive, but if a person does not want to be there it does not work. It is a bit like telling a policeman to go to Queenstown and if they do not want to be there it is negative, they are going to disappear. Whereas if you can say here is an option, who is interested in Queenstown, and talking that through is generally what we do and we say, 'Here's all these things. We do not concentrate on that for a minute. Think about you; think about your family; think about your career progression; think about what you want out of this; think about all these other things and then think about how that matches'.

Ms LOVELL - Where that tends to happen and quite successfully seems to be where it happens pretty organically where communities will wrap around a new doctor and their family or where there are jobs and opportunities for their kids and things like that.

Is there a way that some of that could be done in a more structured, systematic way to encourage that type of intake

Mr BARNS - We do it systematically with our practices here in Tasmania through checklists and again the training of -

Ms LOVELL - The work you've done around practice management.

Mr BARNS - Yes. For example, practice managers who go out of their way to find options for where people can live. That makes a significant impact on someone when they turn up, the practice manager can say there is a real estate Tasmania website, go knock yourself out. That imprints so that the doctor and their spouse when they are find and get a house, you can just see they go: 'Wow'.

It is not that they have an obligation to them, but they feel valued. This is organic stuff rural communities can do, but they do need that other stuff of how are we going to make this happen - and that is where organisations like ours do play a part. We know how a foreign investment review board works. When a person says they cannot get a rental property because they are a temporary resident, we can say to them: 'Don't worry about that because we will help you do this'. Sometimes, it is organic and sometimes it needs to be planned or at least thought through. What will it mean here? It does not really matter whether they are Australian graduates or international medical graduates. People are people. They need to feel valued, they need to feel some security, they need a sense of future and they need a sense of purpose so that is the bit you have to find. Having said all that, there are still places where people will

not stay forever and that is just reality. We cannot set up a system that forces people long term because it would just be negative, but that is easy for me to say because Tasmania is lovely. My colleagues in WA, they go, 'You have got to be kidding me. I have got to find a way to force this person to stay in Kalgoorlie.' We do have a different context.

CHAIR - Okay. Thanks very much.

Mr BARNS - I did have a little hand-out. It is a tapestry of how the program will work where it links the people who are looking for work with the services that they need and the trainers they are going to need to train the workforce. It picks up what all sorts of other organisations are doing as well. They are probably doing one little bit of it but we are really keen to see that there are pathways in George Town for a person who may never have - there might be three generations of unemployed family but they can find a way through to being the local GP. They are going to need to leave but they can come back.

Looking over here, the NDIS service is a little frayed. Some of those services are hanging by a thread. That is the point. They always talk about thin markets and one of the reasons they are thin markets is because nobody knows who needs the service so that is an example of what we are thinking about in terms of program logic for a community-based workforce planning development process.

CHAIR - All right. Thanks very much for that. I really appreciate it.

Mr BARNS - If you do have any other workforce issues you can call us. We did not go to community meetings where you are going to get sacrificed.

THE WITNESSES WITHDREW.

Ms JAN DAVIS AND **Ms ANDREA DAWKINS,** RSPCA, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Welcome to both of you. I probably do not need to go through all the formalities around appearing before a committee, do I? No. Okay. Save a bit of time. We have received and read your submission, so thank you for that and we will get you to speak to that and we will have questions for you.

Ms DAVIS - Thank you for the opportunity to speak to you. This is a bit left-field for us, as you can see. It is not somewhere where we are probably expected to be. I am the CEO of the RSPCA and Andrea is my deputy. One of the things that we are really focused on doing in our advocacy work is expanding the recognition of the role that animals play in areas like human health. Certainly during the pandemic we have recognised more and more the relationship between human health and the animals that live in our lives as well so this is an important opportunity for us to talk about some of those issues.

I will very quickly, with Andrea's help, because she is very much across these areas too, talk about the sorts of issues that we are really interested in and then we are very happy to take any questions from the panel. One of our biggest issues that we deal with at the RSPCA is areas of rural disadvantage and low socioeconomic populations where the education and understanding of the role of animals and the care of animals is not as high as one would like it to be. There are some parts of our community where not only the people are disadvantaged, but the animals are too and we are very focused on how we might be able to address that.

One of the things that we would like to see - and we are the only state in Australia that doesn't have this - is a funded animal welfare awareness program. The RSPCA runs this nationally. We are the only state that doesn't have it. The program helps bring that education through schools to make sure that people are aware of their responsibilities and of the important role that animals can play with the interface between people.

The three key areas that we are focused on in this area of interest are relating to domestic violence, aged care and the situation with pets in rentals which, as you know, is quite problematic at the moment. We find that we are first responders in many of the situations in rural communities. The animal welfare inspectors are often the first people who get into a situation where there is an at-risk person and they are not recognised within the social welfare network as being part of that community of professional advice and professional skills.

One of the things that we are really keen to continue a conversation is how we can integrate the RSPCA and animal welfare into the welfare agencies' awareness and their professional development so that their workforces are aware of what our teams can do and how important that can be? Also, to understand the role that we can then play in assisting in broader community issues.

Ms DAWKINS - We are branding it all as emergency boarding at the moment, so whether it be somebody who is homeless due to a domestic or family violence situation or whether it is because of the incredibly tight rental market. A case study that I am working on at the moment, a person in the north-east of Tasmania who had been living on a rural property for many years, one of those people who was able to do a bit of work for the property owner and live in one of the accommodation sites on the property. The person had been made

homeless due to that property being sold, a completely reasonable thing, move on and find somewhere else to live.

In this instance he is a sole parent, he has three children and two dogs. He called me on a Friday afternoon six weeks ago, crying, which is always the most incredibly difficult thing. It is hard enough when a woman is crying but when it is a man who is clearly broken, we went to extreme lengths to help him. I know this is anecdotal but it is really important. We have about 10 000 phone calls a year to our contact centre, so this is just one of them. He wanted to surrender one of his dogs because he could not manage anymore. He is living in a tent with three children and two large dogs. He is in the care of Community Services who have been unable to place him into emergency accommodation or find him anything in the Housing waiting list.

We were able to talk to him about what would be the best outcome for him and his family and in this instance, it would be for us to take care of one of his dogs while he gets himself back on his feet. We will do that, we will take care of that dog for as long as we need to to put that family back together again because we do consider his animal to be a part of his family. In the past, we would have recommended that animal be surrendered and we would rehome it, that is the way that any organisation like ours would have managed it in the past. Now, because we are looking at what is the best outcome for the people as well as the dogs, we have grant funding to be able to take care of his and any other dog in that situation, or cat or any other animal, through our Safe Beds program which has been funded through the Petbarn Foundation. We will seek ongoing funding for that program, forever.

Dr SEIDEL - That is throughout the state or in certain areas?

Ms DAWKINS - Throughout the state, anywhere in the state, we receive that funding for the RSPCA in Tasmania. That program in the past had been funded through the Tas Community fund but because it had been annual funding, as you know, a program funding that runs for a finite period. The organisation in Gender Equality Tasmania had not been able to continue to keep seeking funding, so in 2008 they had stopped that. Since then, there has been nothing like that available statewide. A Paw Up do their best but they are a one-person organisation trying to place animals into foster care and once the foster care network is expended there is nowhere else to go.

We have made ourselves available now for any animal in that situation and we have stopped our commercial arm. We used to have commercial boarding; we have stopped doing that so that all of our boarding facilities are available to emergency boarders.

Ms LOVELL - Who did you say that is funded through now?

Ms DAWKINS - The Petbarn Foundation. That is just one case study but there are many more situations like that where people are finding themselves in between. This person couldn't even afford a rental. If animals in rental properties was a possibility, but generally, it's not. He's still in a tent. He comes in to Hadspen Caravan Park every Friday so his kids get a good wash and sleep in a bed. Sometimes I might pay for that, and sometimes others might pay for that; but he's doing the absolute best he can.

CHAIR - I'm just trying to process that.

Dr SEIDEL - My question is about companion animals and access in Tasmanian health care facilities. Do you have any impression how companion animal-friendly THS facilities are, whether it's in a hospital, day centres, a day surgery centre, or where there's respite care? Is there any data? What work do you do with the THS to ensure those facilities are able to cater for companion animals?

Ms DAWKINS - We've just begun collecting data. Because Jan and I are relatively new to this organisation, it's run on the basis that a phone rings, and people try and act, and then there's no real collection of what happens after that. We will be able to come back to you in 12 months and say we now know, we now know the answers to this and we know what you need.

Dr SEIDEL - Does the RSPCA have standards for health facilities? I would imagine that you do.

Ms DAVIS - Yes, we do. I met some time ago with the then Secretary of the Health Department. He personally was quite supportive of us moving down that path. It's not unusual in other jurisdictions. However, there are, as you can well imagine, internal barriers to change that make that - I chose those words carefully, didn't I - internal barriers to change that make that very difficult.

In New South Wales, for example, the RSPCA receives government funding to do a lot of work in that area, particularly in aged care, but also in health care, and we're very keen to run those programs here. It comes down to what money I can afford to do it with, and then getting in and the permissions to be able to do that.

Dr SEIDEL - Do you currently do any work with aged care facilities?

Ms DAVIS - Do you want to talk about that?

Ms DAWKINS - We've just started. Eskleigh, which is, I guess, disability support, they approached us to run a program, so we thought, this is a brilliant way to be able to match our Safe Beds foster carers and somebody who has temporary capacity to look after animals. We thought that's a beautiful way to be able to - we can keep the identities of those animals safe which is a really important part of the Safe Beds program, and we can give people some temporary care of animals.

The difficulty has been around the board and the decision makers there, being able to decide how that can be done safely from a health perspective. It's ongoing and there's also some work RSPCA Australia are doing in this field. You have seen all of the beautiful heartwarming stories about facilities that have chooks or cats. Any of us who have poultry know it's pretty hard to toilet train a hen. We've got to have standards around this, from an animal safety perspective but from a human safely perspective.

Dr SEIDEL - There's some anecdotal evidence that people will delay access to health care even in emergency scenarios when they have to look after a pet, for example. They would rather make sure the pet is sorted before they call the ambulance and often the delay is quite substantial and leads to adverse health outcomes.

Ms DAVIS - It certainly does.

Dr SEIDEL - Is there any work done similar to what you've already mentioned about having a 24/7 hotline to be able to allow -

Ms DAWKINS - Absolutely.

Dr SEIDEL - - almost like emergency respite.

Ms DAVIS - Yes. We've got all these things ready to rock and roll. The only issue for us is how we fund them. Both of us are very focused on learning from what the other jurisdictions are doing. They have all got bigger teams than we've got, they've all got a lot more money than we've got. They are all doing programs in these spaces and we would very much like to bring them here.

It's not just anecdotal evidence; there is some hard evidence, not so much around the health delays but around domestic violence where people will stay, and around emergencies like bushfires where people will stay for their animals. Carrying it across into a health emergency is not a difficult line to draw.

Dr SEIDEL - The limiting factor then is funding, or is it political will, or is it a combination of the two?

Ms DAVIS - Both, really. We don't get any government funding except for an inspectorate, and that is a fee- for- service. We get no other funding from them at all. Any funding we get at the moment is what we raise from generous donors. That is challenging, when you are providing what is essentially a public service.

Dr SEIDEL - Do you know of any data, for example, on how many people would not go into respite care because they can't place their pet or companion animal?

Ms DAWKINS - Our inspectors, because we already have that agency, they have excellent relationships with a whole range of people in the police force and social services sector. We had a phone call this morning from somebody who is in hospital, whose neighbour is looking after their dogs. It's not ideal because they are probably not getting out, so we will take care of those animals. As much as data is concerned, we could get some numbers to you from the inspectorate. The difference is between us taking the phone call when someone realises that the inspectorate can help, as opposed to us making it really clear to everyone in the state that we are here for that service. That is what we need the funding for.

Dr SEIDEL - Interestingly, a lot of our care plans and so forth are done by GPs. In part, those care plans ask who is at home, next of kin; nobody asks are there any animals to be looked after in case of an emergency. What do you do? What other dependants do they have?

Ms DAVIS - We are usually the last call. Somebody is about to get in the ambulance to go to hospital and the care provider will say, oh, the cat; and then we have to run around, and we are not well-resourced.

CHAIR - We came across a car crash on the Midland Highway and there was a dog in the back of the car, and the driver had to be taken to hospital in an ambulance.

Ms DAVIS - We don't have an ambulance service. We don't have a vet. I have six inspectors that cover the whole state. It is not a lot of people to be doing the work that we are doing. We really see a need for the integration of animals, particularly companion animals, into the broader social services and community services.

I saw Mike was raising his finger.

Mr GAFFNEY - Organisations like Delta Dogs, for example; and I know there are some aged care facilities that do have chooks. What is the line between raising an issue like chooks in aged care, and then somebody from the Health Department says you can't have that? When you have some examples already, where there are some aged care services that I know or places that actually do that because they see the benefits for the people there.

Ms DAVIS - There's a couple of answers to that. One of them is that the RSPCA, nationally and internationally, is quite well resourced and has a large bank of knowledge about how you do this. There will be a practice note about how you would go about doing that, and if it is an RSPCA one you would expect that we would be able to get a tick for that. It comes back to overcoming that internal resistance to what old school people think is an unacceptable health risk. Then we would have to work through the relationships and the political system to do that. Anything that is an actual risk, we can cover off with practice notes or living examples of where it is happening somewhere else.

CHAIR - Somewhere they could look.

Ms DAVIS - Exactly.

Mr GAFFNEY - And the Delta Dogs?

Ms DAVIS - They are great. They do a really good job. There are a couple of other groups as well. We would like to be able to work with them to encourage more people to be able to train their dogs through those programs, so they are available to be able to do the work that needs to be done. In years gone by, we might have been able to do that with the stock of animals that we would have in our care, but these days we don't have them. We don't have the capacity to train a dog and to put it into those work environments, because they are not around. We need to rely on members of the community with dogs or other companion animals, to be able to take that responsibility and do that as something they are passionate about. We would be really keen to be able to expand those programs.

Mr GAFFNEY - My last question, Andrea, you mentioned before the arm of your organisation used to have boarding kennel situations and now has closed.

Ms DAWKINS - It is closed to commercial boarders.

Mr GAFFNEY - Have you found anybody come and say, what are we going to do now with my dog?

Ms DAWKINS - Tell me about it. We made sure there was capacity in the commercial boarding sector. Because of the pandemic, it was the right time to do it. It was pushing people into the commercial sector who needed to be there because there weren't many tourists.

Mr GAFFNEY - Is it the same affordability?

Ms DAWKINS - Yes, it is. I was surprised by that.

Mr GAFFNEY - No, I always thought it was.

Ms DAWKINS - I thought ours would have been a bit cheaper but we were charging about the same. In the end, because we don't say no, we were probably taking a couple of difficult dogs. Commercial facilities might have gone, 'That dog really has not stopped barking the whole time it's been awake.'. Somebody did call into a radio station last week with a concern but it turned out to be very personal. It's worked out well.

CHAIR - Going to the family violence matter, where you are looking at slightly different issues where people are escaping family violence. Family violence can be perpetrated by threats of violence against an animal as well the victim. Do you get flags like that and what do you do about that?

Ms DAVIS - We work wherever we can with other agencies to bring that in. A couple of weeks ago we made a submission to the review of the family violence laws. As you'd be aware, there's a proposal. We've said there are three triggers - I can't remember what they were - and there should be a fourth trigger; that is a threat to violence to an animal.

CHAIR - Or actual.

Ms DAVIS - Or actual violence, exactly. They, as you rightly point out, are often the first risk factor that can be identified.

CHAIR - The first perpetration of harm can be to an animal rather than the person.

Ms DAVIS - Yes, that's really, really important. I like to think more positively than this but one of the challenges we face is we are often marginalised in these conversations because people in other agency environments don't understand that relationship.

I turned up at an emergency bushfire thing a little while ago and they're all going, 'What are you doing here?' It's that lack of understanding of the breadth of the scope of animal welfare and the one welfare concept where animals are so integral to human welfare that we've all become so familiar with. The pandemic brought it to the front. It's something that we're seeing more and more reflected in the fact that our attitude to our pets has changed so greatly, which is why we don't have any dogs any more. People are much more responsible about how dogs are reared and raised.

It's a really important thing for us to do. I know these guys are in a hurry but you might like to talk about the proposal that we're putting to the department about dog regulations.

Ms DAWKINS - As an ongoing part of the community understanding exactly how their response would look after their animals, as Jan was alluding to, there's been such enormous success with de-sexing dogs, and we're hoping that will now move into cats with the new amendments.

The majority of phone calls that we get around dogs in communities where people are concerned that neighbours are not taking care of animals is about how dogs are tethered. Tethering dogs is part of the 2016 dog regulations; you can do it under these provisions. You can't just tie a knot around a dog's neck and tie it to anything. That does not pass muster. We're partnering with the department. We're at the beginning stages now where they've accepted that it's really important to start educating the community and helping dog owners do the right thing with their animals.

Where you have two people living in perhaps high-density housing in a low socioeconomic area, where all someone can hear is a dog barking all day and see what they consider to be a miserable situation, it can have a genuinely horrendous impact on your life. If people are going to tether their dogs, and that's just one example, there's a real imperative to do it under the regulations so they're not contravening the law. It gives people a bit of agency in conversations about how dogs are being taken care of in their communities.

Ms DAVIS - One of the most important things is that the data that we get through from the inspectorate helps us to identify the at-risk areas. This flows through in here. We can identify via postcode where most of the issues are. That runs across into domestic violence, into rentals, into all those sorts of things.

We do have an ability to drill down into the data that we get through those calls. We're now working on how we database the other 10 000 calls that we get that come in to the office itself.

CHAIR - I certainly get my fair share of those complaints in my office too.

Ms DAVIS - Of course.

Ms LOVELL - You mentioned the pandemic a couple of times and the changing attitudes towards pets. During lockdown lots of people got dogs and puppies, which is lovely. Now that people are coming out the other end of it and going back to work and not working from home, are you anticipating an increase in surrendering animals or anything like that?

Ms DAVIS - No, we are not. The Pet Industry Association released a study only a couple of months ago where they have been tracking that. What they are finding is exactly what we have been seeing. Those people that got a pet during the pandemic made a conscious decision to do that. In many cases, particularly if it is a dog, they have had to work really hard, and generally pay quite a bit of money, to get that dog. They have been integrated into those family units; they are not coming back, which is great.

CHAIR - Thanks for the really interesting submission, the connection and the process where those messages need to get through. I guess that is still an ongoing body of work.

Ms DAVIS - It is. We are never going to get bored. Never.

CHAIR - Thanks for your time. It has been really good.

CHAIR - And thank you.

THE WITNESSES WITHDREW.

The Committee suspended from 12.51 p.m. to 1.30 p.m.

Meeting commenced at 1.30 p.m.

Dr ROSEMARY RAMSAY AND **Dr MAXINE GLANGER**, ANZSPM, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Welcome. Thank you very much for appearing before the committee. Members of the committee, Mike Gaffney, Sarah Lovell, Bastian Seidel, myself, Ruth Forrest, and Nick Duigan.

We thank you for appearing. The evidence you will give the committee in is this format is a public hearing. All information you give us will be transcribed by Hansard and then form part of our public record and will be published on our website.

Everything you say, while you are before the committee, is covered by parliamentary privilege, but that doesn't necessarily extend beyond this hearing. We did send you the information about attending. If you have any questions, I am happy to answer them. If there is anything you felt you wanted to discuss with the committee in private, you can make that request, and the committee will consider it, otherwise it is all a public hearing.

We have some witnesses in the room from King Island who will be coming up later. Welcome to them too.

We do thank you for your submission. We have all read that and we will have questions following your introductory comments.

Dr RAMSAY - The Australian and New Zealand Society of Palliative Medicine, ANZSPM, would like to thank you for this inquiry and the opportunity to appear before you today. I am Rosemary Ramsay and I live in Forth and work across the north-west of Tasmania.

CHAIR - Keep going.

Dr RAMSAY - I am employed part-time as palliative care specialist in North West Specialist Palliative Care Team and I also work part-time as clinical senior lecturer for the Rural Clinical School in Burnie.

I would like to emphasise that I am appearing today as a representative of ANZSPM. I am not appearing on behalf of the Specialist Palliative Care Service North West or the Rural Clinical School.

ANZSPM is the specialist society for medical practitioners across Australia and New Zealand who provide palliative care for people with a life-limiting illness. We promote the discipline of palliative medicine in order to improve the quality of palliative care for patients and support their families.

Our members are all doctors with an interest in palliative medicine and they may include specialists, doctors who are in other disciplines such as oncologists or geriatricians. They may be general practitioners. There are 561 members, including 18 members in Tasmania.

Palliative care is an approach that improves the quality of life for patients and their families facing the problems associated with life-limiting illness. Palliative care is not just for

those in the last weeks or days of life, but occurs from diagnosis, right through to death and supports families in bereavement.

People who are dying and their families require care and support, 24 hours a day, seven days a week. There are a number of challenges in providing palliative care to those living in rural and remote Tasmania.

The provision of palliative care in the rural areas of Tasmania is variable. In rural Tasmania palliative care is mostly provided by GPs, community and palliative care nurses and residential aged care staff. Specialist palliative care services support GPs in their provision of palliative care but do not have workforce sufficient to take over the care entirely. These various combinations of health professionals and services create disparities in access and quality of health services for rural and remote patients. It also means it is difficult to determine exactly who delivers palliative care in rural and remote Tasmania.

Some patients can be admitted to a specialist inpatient unit, others only have the choice of dying in their local hospital or aged care home if home is not an option.

There are many positive features of providing palliative care in our rural and remote settings. Local services and local practitioners offer a sense of familiarity, community and continuity and ANZSPM wishes to see equitable, consistent and high-quality provision of palliative care across our whole population. We believe that this inquiry represents an important opportunity to understand the exact needs of patients, families and communities in rural and remote Tasmania and understand the true state of palliative care in these areas.

CHAIR - Thanks. Do you want to say anything?

Dr GLANGER - I will introduce myself. I am Dr Maxine Glanger. I am a palliative care specialist. I'm based at the Specialist Palliative Care Service in northern Tasmania. I am currently the only locally-based palliative care specialist for the whole of the north and north-east of Tasmania. I've come to support Dr Ramsay and to answer any questions you might have relevant to the north.

CHAIR - I am from the north. Nick, do you have questions initially?

Mr DUIGAN - No, I will wait for you, Ruth.

Dr SEIDEL - Thank you very much for making time today. It is really great and it's great to see specialist palliative care being represented here and also thank you so much for your submission which was really informative.

I have some specific questions if you don't mind and I appreciate that you are both based in the north and north-west and not in the south. In point 4.2, page 3, you say:

> In areas without specialist palliative care services, access and quality of palliative care is often determined by the interest, knowledge, initiative and capacity of GPs.

Are you aware of any specialist palliative care services in the south where palliative care specialists actually do see patients in the southern area or is it more just telephone advice to GPs?

Dr RAMSAY - I think I would ask Maxine perhaps to answer this because Maxine did her training in the south so she would have direct experience.

Dr GLANGER - There is a palliative care service in the south and it certainly has higher staff to population ratios than we have in the north or in the north-west and it operates a consultative community palliative care service. It operates a 10-bed inpatient hospice facility at the Repatriation Centre with six additional flexible beds and a hospital consult service. It also reaches out to rural areas down there and then again, also similar to us, relies on the interest and largesse of GPs.

Dr SEIDEL - Do specialist positions or specialist palliative care doctors do home visits or is it predominantly delivered through the Whittle Ward environment or the private facility?

Dr GLANGER - In the south? Yes, they do home visits but limited by their capacity to provide and to get to remote areas.

Dr SEIDEL - In terms of training for specialists and training placements in the hospital in the community, do you believe we train enough palliative care specialists? Are there any projections on how many specialists we need? Is there any work that you are aware of that has been done in that area?

Dr GLANGER - The ANZSPM also has a health workforce group, a special interest group, and I would refer you to that committee.

I think Palliative Care Australia has looked at recommendations for health workforce for medical practitioners, nurses, social work, allied health and that is freely available on Palliative Care Australia's website and you could refer to Palliative Care Tasmania. I could also say our service or from the rural clinical school did recent research, that is unpublished on a qualitative review of our registrars. The small number we reviewed found they are not experiencing palliative care during their student years, they are not experiencing very much in their junior doctor years and they are certainly not experiencing it in their registrar years in rural Tasmania.

Dr SEIDEL - And why do you think that is?

Dr. RAMSAY - I am not sure because certainly there is curricula with ACRRM and with the College of GPs. There are certainly modules available, the PEPA placements are available, so this was a wake-up call.

Dr SEIDEL - There is some evidence GPs would like to do a diploma on palliative care and find it really quite difficult to find accredited training placements or even accredited supervisors? Is it something you have heard of from your members?

Dr RAMSAY -There are two accredited places in the north-west and the North-West Specialist Palliative Care Service have at least five diplomas gone through in the last four, five years.

Dr GLANGER - The north has a place in the Melwood unit that is accredited for the diploma, but it is funded and operated by the Department of Medicine at the LGH. It is a rotation for medical registrars, not accessible for GPs, however, we hope sometime next year to have a community-based registrar place up which will be accredited for the diploma. Those applications are in place as we speak.

Dr SEIDEL - Okay, great.

CHAIR - Where are the ones in the north-west based?

Ms RAMSAY - They are based at Burnie with the specialist palliative care service. Currently, we have one registrar who is doing a diploma. In 2022 there will be three registrars; two are approved for the diploma and all three are approved for extended skills and advanced skills for both rural colleges. Not all for the diploma, but that application is still pending for the third position.

Dr GLANGER - May I make a comment referring to your question about whether there are enough palliative care specialists? Presently, there are not because we are trying to recruit and cannot get anybody. Part of the problem is a vicious cycle that arises because it is very difficult to get your training centre accredited for advanced training to make new specialists if you cannot get specialists to train the new specialists. We are caught in that little cycle at the moment.

Dr SEIDEL - Why can't we get them? Is it a culture thing or is it just we have not planned properly, it is not attractive, it is a funding thing, salary? What are the limiting factors here that we cannot get the trainees, the quality supervisors we need for the specialist pathways and for the diploma pathways for GP specialities?

Dr RAMSAY - All the things you said are combined, that the remuneration within the THS, from my understanding, does not compete with some of the other states and you cannot really supervise if you do not have enough senior people to supervise these young inexperienced doctors. This is because it is a very precious thing they are doing and it has a huge impact on them. You cannot just leave them unsupervised and will not pass the college's committees. Partly it is planning.

CHAIR - I am probably stating the obvious, but we need to recruit palliative care specialists ahead of trying to roll out further training, because of that is there a shortage nationally, globally, or is it that they just do not want to come here?

Dr RAMSAY - I think there is a small shortage nationally, but it is my view there probably has not been enough planning going forward down the list in terms of priorities.

CHAIR - You are saying it is a workforce planning issue?

Ms RAMSAY - Yes, I am saying that.

CHAIR - Yes. Is that something the state should be addressing or is it someone else's role to address?

Dr RAMSAY - It would be my understanding that would be the state's role.

CHAIR - Have you in your capacity had discussions with the state about actually being much more proactive in this space?

Dr RAMSAY - Certainly.

CHAIR - What has been the experience and the outcomes? Obviously, it is not very good outcomes because we are talking about it.

Dr RAMSAY - It seems to take a long time, but my understanding is there should be some more workforce, particularly in the north-west early next year and in lieu of that, there's a locum support for an extra position. That position is not one that could be put towards the College of Physicians as a suitable supervisor.

CHAIR - They are not?

Dr RAMSAY - No, because they are only there for two months or two weeks.

Dr GLANGER - The recurrent locum positions.

Dr RAMSAY - A recurrent locum cannot be named.

CHAIR - They are all locum positions.

Dr GLANGER - Both services rely heavily on locums, which makes it impossible to train future specialists.

Dr SEIDEL - Currently, we do not advertise for staff specialists in palliative care? Currently there are vacancies and people do not -

Dr GLANGER - Yes. We have a 0.8 to full-time vacancy at the moment being advertised nationally.

Dr SEIDEL - That is a permanent position?

Dr GLANGER - A permanent position.

Dr SEIDEL - And people just do not -

CHAIR - In the north?

Dr GLANGER - In the north.

Dr SEIDEL - North, yes.

Dr GLANGER - That we cannot recruit to.

Dr SEIDEL - I want to ask you about integrated rural training hubs because that was an issue just a few years ago to actually encourage undergraduate exposure to rural. Earlier you said even in the undergraduate curriculum and training, palliative care does not really feature

much. Am I hearing the integrated rural training hubs didn't really make that much of a difference then to palliative care?

Dr RAMSAY - Can you explain the integrated rural training hubs?

Dr SEIDEL - Yes. Integrated rural training hubs were a Commonwealth initiative where universities as well as regional training providers would look at rural training facilities - bricks and mortar facilities - and manpower to ensure the rural health workforce. This is whether it is an all medical stream, all nursing stream, allied health stream is being exposed to rural medicine, rural health care. In particular, addressing the issue of dementia, sometimes a really quite heartrending exposure to palliative care or other speciality areas regardless of whether it is an all-nursing stream or medical practictioners stream.

Dr RAMSAY - I could try and answer that, yes. I think there has been success. For example, of the rural generalists that have come through the north-west specialist palliative care service to do their diploma, the majority of those were from rural clinical schools. One was from Townsville and many of them were from Burnie. Except for two, they have all remained in Tasmania. One is Dr Glanger and one has gone to Melbourne. There are two emergency doctors who did the diploma and they were all from our district. It is successful but takes a long time to pipeline those doctors in.

Dr SEIDEL - Yes.

Dr GLANGER - In the north, even though the north covers a large rural area, our medical students in Launceston now have the privilege of having them in palliative care for a week. Up till last year, they had one day of palliative care education in five years of medical training. We try and cram as much into that week as we possibly can, again with our limited workforce.

CHAIR - You would not do it for obstetrics, would you, which is the other end of life?

Dr SEIDEL - In terms of the small or district hospitals we have, quite a few of them have dedicated palliative care beds, for example. Is there a system in place that specialist palliative physicians would go to those small hospitals physically to see patients there and supporting the predominantly rural generalist GP workforce or is it more phone calls and video links?

Dr RAMSAY - In my experience the ability of the specialist palliative care service to drive to the west coast and fly to King Island has diminished in the last two years. We are relying more on phone calls and video conferencing.

Dr SEIDEL - Do you think that is an issue when it comes to exposure for specialists to actually see what is happening on the ground?

Dr RAMSAY - Absolutely.

Dr SEIDEL - On the other hand, the patients and the GPs or the healthcare teams may feel they are being left pretty much unsupported. It is just a phone call and that is sometimes hard. It just changes the way we practise specialist medicine in a delicate field where the evidence base isn't that strong for quite a few of the interventions we offer.

Dr RAMSAY - I know that when you do send your specialist doctor and nurse to those centres it is not just seeing the patients, you actually do some mentoring provision of education and upskilling so it becomes a very rich visit.

Dr SEIDEL - Yes, not only are we not doing the service delivery but we also do not do the other things that we do as a profession which is the education and the mentoring support.

CHAIR - Also, it is the support of the families.

Dr GLANGER - Similarly in the north, I have had one rural day in the last three months that was getting down to the east coast, otherwise the east coast is supported by one palliative care nurse who goes down fortnightly. We also cover places that are even considerably more remote. We have had a patient on Cape Barren Island with extremely complex issues that we have been having to manage remotely.

CHAIR - The outcome with palliative care is usually the patient dies, that is part of the life we are talking about here. The dying process is a terribly important part of a person's life. It is not just a death, it is all the other care that surrounds the person and the family as you know. This lack of reach in services into the person's home, even into the rural hospitals, what impact do you think that has on the dying experience of the person who dies but also the family who would like to be able to support their loved one, particularly, if they want to die at home?

Dr RAMSAY - I would say it would have a big impact. The other thing that is lacking in some of the small rural towns is the older GPs have retired or moved on and the doctors who do come are short stay, fly-in, fly-out. So there is not even that support for the family during that time.

CHAIR - Does it mean that we are removing an option of dying at home for a lot of our regional residents? Is that a fair statement?

Dr RAMSAY - I think that is a fair statement.

CHAIR - They are being disadvantaged, particularly for those who would like to die at home which is often a lot of rural people because they want to die on their farm or on their rural property.

Dr GLANGER - Or Aboriginal people who want to die on country.

Dr SEIDEL - Those patients if they are pushed towards a tertiary environment and let us say the Whittle Ward is full, so are they then ending up in the mainstream hospitals this time? Is there any evidence for that?

Dr RAMSAY - They would more likely to be in Smithton Hospital or their local hospital with the current GP support and nurses. There is also the other deficiency in the community is that some of the rural towns only have nurses Monday to Friday, so there is no nurse for a syringe driver or symptom management or observation of that patient.

Dr GLANGER - You don't have to get very far out of town for that to happen. For example, that applies in Deloraine.

Dr SEIDEL - Huon Valley, 9 a.m. to 5 p.m.

CHAIR - West of Wynyard. From personal experience, the Community Rapid Response Service (ComRRS) nurses supported my dad who died on a weekend. He died at home but they were ComRRS nurses did provide that service. However, I spoke to another constituent who lived just outside the town boundary of Wynyard and couldn't go to them because they were just outside the line. The imaginary line that goes around there. It is a geographical disadvantage.

Mr GAFFNEY - I am interested to know what does your week look like when you work? Do you work with individual patients and other doctors who are asking for your requests or services? I am interested to know, in your role, what does that look like?

Dr GLANGER - The palliative care service in the north is structured such that there is meant to be one consultant who covers the consult work at the LGH, one consultant who covers Melwood and issues in the community are fitted in where possible by whichever consultant has capacity. At the moment we are down a consultant. We are trying to recruit to that position.

The only other palliative care specialist working for our service is a palliative care physician who flies in, flies out when possible, depending on his potential COVID-19 exposure from Melbourne. I would say maybe 50 per cent of the time he hasn't been able to come and he comes for a few days a fortnight. When he is unable to come but is rostered to be on, he covers the Melwood Unit remotely with the registrar in Melwood doing a ward round with an iPad, trying to consult with in-patients remotely. Otherwise we have had assistance from Dr David Cooke who is a very experienced GP with an interest in palliative care.

We patch together what we can. My day consists of trying to sort out community problems remotely by supporting and advising the nurses where I can, taking calls from GPs and giving support. The hospital consult job is probably the more difficult and changeable job so I try to see as many patients at the LGH as possible and I try to fit in a community visit within the bounds of drivability, say Deloraine to Launceston sort of area, most afternoons where I can. My thought is that for our population we really could easily employ 2.4 or more palliative care specialists because I think the community part of the triad is under served, particularly in the rural areas.

Mr GAFFNEY - How long has it been like this that you are under-staffed?

Dr GLANGER - I was recruited to the position in June and at the end of July we lost our other palliative care specialist who was a gentleman who had come to the position about a year or 18 months before. He had come from Melbourne. That is part of the problem about not training people locally is that people come down for a change and then have commitments that pull them back to the mainland.

Mr GAFFNEY - Whose responsibility is it to try to recruit another person? Is it the Tasmanian Health Service?

Dr GLANGER - Yes, the THS.

Mr GAFFNEY - Are you aware of how far and how wide they have been trying to do that in recent times?

Dr GLANGER - Yes. They have advertised nationally. They have advertised through recruiting agencies, advertised through ANZSPM. We have been in touch with the palliative medicine training organisations interstate to try to see if there are any newly-minted palliative care specialists who are interested in moving interstate. We managed to interview one person who couldn't potentially start until August next year and then let us know that she was not interested.

Mr GAFFNEY - Okay. And is this commonplace across Australia? Are you aware of being under-staffed in this area? Are you aware that there are staff shortages or personnel shortages in other states as well?

Dr GLANGER - I am not aware. I have not got that information, sorry.

Dr RAMSAY - I think if you look at the New South Wales inquiry into rural and remote outcomes, Sarah Wenham from far north New South Wales spoke about the percentage of positions that exist that are funded, that are not filled, and you could look at that to find that information for New South Wales.

Mr GAFFNEY - Okay. And Rosemary, on a question to you, what is the relationship between you guys and Palliative Care Tasmania? Is there a relationship and how does that work?

Dr RAMSAY - My understanding is that Palliative Care Tasmania is a lobby group and sort of a support for us, and for the community and the patients. Generally, their reach is as a peak group for us, so they are very key.

Mr GAFFNEY - Yes, okay.

Dr RAMSAY - They do not employ doctors or nurses.

Mr GAFFNEY - Okay.

CHAIR - They do provide services for the patients and their families in terms of walk and talk and that sort of thing.

Ms LOVELL - In relation to point 449 on page 11 of the submission; you briefly mentioned before, Maxine, around Indigenous patients wanting to die on country; is that a practice that takes place in Tasmania at the moment that you are aware of? Are palliative care specialists able to facilitate that, or are there restrictions or limits around that in terms of access and capacity?

Dr GLANGER - We do our best. We take it into account that Aboriginal patients often wish to die on country and, where humanly possible, we try and facilitate that happening. Sometimes patients are remote, and patients may have issues that are complex and are not able to be adequately managed in place.

Ms LOVELL - And are there perhaps issues that are not necessarily related to their condition or their medical status; transport or access to specialists or other things like that that can impact on your ability to provide that?

Dr GLANGER - There are all sorts of quirky hurdles that we need to cover; for example, getting patients back and forward to the mainland with syringe drivers tucked under their clothing and hoping that they do not go beep because they are worried that the plane will not take them if they are connected to a device. All sorts of problems we try and sort out on a day-to-day basis.

CHAIR - A syringe-driver will last you about 24 hours but then you have to top it up with Schedule 8 drugs. Is that a challenge if they manage to get back to Cape Barren Island or somewhere?

Dr GLANGER - Sometimes it can be having access to specialist palliative care medications. It doesn't necessarily have to be schedule 8 drugs. It can be things that we commonly use but most doctors don't - such as Cyclizine for nausea. It wasn't available on Flinders or Cape Barren for a patient recently, and someone had to wait several days for a supply for it to be shipped across. Then there are to schedule 8s, stronger formulations, 30 milligram ampoules of morphine, things like that.

Ms LOVELL - And is that to do with logistics of -

Dr GLANGER - They don't use them very often and they don't necessarily have them on imprest in the hospital there.

CHAIR - Following on from Mike's point, we talked earlier about recruiting more palliative care specialists to Tasmania generally, but certainly to the north and north-west. You said there are also challenges in northern New South Wales, according to their inquiry. Are you aware of what particular barriers there might be to coming to Tasmania? We often think people come for a bit of a change and they may go back, but if they are having trouble in a rural area in New South Wales as we are in Tasmania. Is there something else the Government needs to consider, to make it an attractive proposition for palliative care specialists to come and work here?

We did talk to another witness, Peter Barns from HR+, about how it is not just supporting a GP - we need a GP, here's a GP. You need to put in the support around the GP's family and the community to support them, and make them want to stay.

Are there identifiable barriers that could be addressed as part of the recruitment? Not just saying we need a palliative care specialist here, this is what we offer?

Dr RAMSAY - That's a really difficult question. I think, as one of you said earlier, if you could train somebody who came from here through their specialist training, then they are more likely to stay.

CHAIR - It's chicken and egg, isn't it? A lot of it.

Dr RAMSAY - Yes.

CHAIR - Is it not seen as a sexy enough profession? Being an obstetrician is a nightmare because you never know when you are going to be up, you never get a decent night's sleep. Dermatologists not so much; they tend to get a full night's sleep quite regularly. I am not saying it is a particularly attractive proposition, being a dermatologist either; but it seems that there are certain specialities that are more difficult to recruit because it is seen as a more prestigious pathway perhaps.

Does palliative care specialist need a makeover?

Dr RAMSAY - I don't think so. I think it's a matter of selling the region and selling the lifestyle for the whole family, the spouse and the doctor.

It's also giving them something very special to do here. The option of research and education within the Rural Clinical School could be something that attracts them.

CHAIR - Do you think there is enough backup and support from GPs? The palliative care specialist comes and provides that specialist advice, but obviously, it is part of a team. They are not just one person caring for a dying person. There is the person's own GP, and there may be other health professionals that have been engaged.

Do we need more work there, to make the palliative care specialist feel that they will have that backup?

Dr RAMSAY - I think that is a really pertinent point. The GPs are really in short supply, even in some of the bigger centres.

That means that they tend to be too busy to see their patients, and then they can't do their prescriptions and their reviews. Then it becomes more heavily that the palliative care service has to look after those people.

CHAIR - Maybe we need to take a more comprehensive approach to support GPs as well?

Dr RAMSAY - Absolutely.

Dr GLANGER - That becomes quite tricky, in the sense that general practice isn't funded in a way that encourages complex medicine - such as palliative care - that is very time intense.

CHAIR - How do you fix that?

Dr SEIDEL - Do you think the fee-for-service model we have in general practice is a significant barrier for palliative care patients? Particularly in regional areas, where the Medicare rebate for a home visit an hour away is exactly the same as the home visit across the road. It is nonsense.

Dr RAMSAY - There is no payment for travel. There is no payment for the phone calls from nurses, and they are essential to hear what is happening on the ground.

Dr SEIDEL - In the evening or weekends, there is no GP there, because the fee-for-service model almost prohibits them to go out. You also don't have a palliative care nurse available because they only work from 9 to 5 in certain areas.

You don't have a specialist service there. The only thing you have is to call the Volunteer Ambulance out, to transport the patient from any regional or rural area to the metropolitan centre.

CHAIR - Doesn't sound too attractive to me.

Dr SEIDEL - Doesn't sound too attractive. Could that be another reason why certain specialities are suffering because it is just so hard to provide world standard care, which is what we have been taught in medical school, and you just can't apply it in regional Tasmania?

Dr GLANGER - Yes.

CHAIR - To try and encapsulate what you are saying Bastion, is that the fee-for-service arrangement that GPs work under, is not fit for purpose?

Dr SEIDEL - It's not.

Dr GLANGER - Not for providing palliative care. It is not just seeing the patient that is time consuming. You might see a patient who is changing rapidly and when you get back to base you basically have an hour of work to do organising scripts, ringing the authorities line for authority - because virtually everything is an authority for palliative care - you have to chart everything plus, you have to phone the community nurses. Basically, a 40-minute patient home visit to a patient can involve half an hour, an hour of travel each direction plus an hour of paperwork to get funded.

CHAIR - None of which you are paid for.

Dr GLANGER - Yes, the Government gives you - I do not know what the Medicare rebate for a level C is these days - $70 for two and a half hours of work does not cut it.

CHAIR - I can see why it is not so attractive. Has there been any lobbying from your organisation to the federal government to perhaps look at that model?

Dr RAMSAY - In the New South Wales inquiry, ANZSPM did present to that and there is certainly a rural and remote workforce group within ANZSPM. There is also a GP group. I am not sure what their work has been so far.

CHAIR - Would they have information about the work they have done in trying to lobby for a change to enable these support mechanisms to be in place and an appropriate remuneration? These are highly skilled health professionals we are talking about who have done years of training. I am not telling you anything you do not know, but to be remunerated $70 or thereabouts for providing that sort of care and literally, two or three hours of work. There are very few people who would do that.

Dr RAMSAY - If you are referring to the GPs, if you are trying to recruit a rural general from Queensland to here, the remuneration is starkly different. They will not want to come for the remuneration.

CHAIR - Who remunerates them in Queensland?

Dr RAMSAY - The Queensland Health Service.

CHAIR - Tasmanian Health Service here?

Dr RAMSAY - We do not have those models, because they are usually more of a private practice model here.

CHAIR - We are getting some at the Mersey.

Dr RAMSAY - Yes, we believe so.

CHAIR - To be funded through the THS? That is a question I am asking you to answer.

Dr RAMSAY - No, that is not a question I can answer.

CHAIR - Obviously there are lots of barriers to this. Any other questions, members? Thank you, that has been very enlightening, helpful and somewhat depressing because it is such an important part of everyone's life, the dying process.

Is there anything you would like to add in closing?

Dr RAMSAY - I refer you to the submission from ANZSPM and particularly, we are really looking for solutions and for the different stakeholders, state government, federal and private enterprise to work together and to help our communities and to help our patients.

CHAIR - Critical pain services.

Dr RAMSAY - The right care, the right place, the right time.

CHAIR - Thank you very much.

THE WITNESSES WITHDREW.

CHAIR - Welcome, thank you for your submission and for appearing before the committee. I would like to remind you and I am sure you have done this many times, but you are covered by parliamentary privilege while you are before the committee but that may not extend beyond. It is a public hearing. Everything you say will be recorded on *Hansard* and form part of our committee deliberations.

We do have your submission and thank you for that. We will ask you to do the statutory declaration and then introduce yourself and speak to your submission and we will have questions.

Mr PHIL EDMONDSON, PRIMARY HEALTH TASMANIA, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

Mr EDMONDSON - I am Phil Edmondson. I am the CEO of Primary Health Tasmania and have been for some time across several different iterations. In giving this evidence I give it with some degree of repetition. I do not know if that is the right word to say or not, but I have some degree of confidence things we have tried to do over successive decades - because that is how long I have been there - have failed to really address what are some of the fundamental underpinnings of sustainability for rural health services, in particular. I have to add this is not something isolated to Tasmania or this state. We are dealing with an issue here that is common across rural locations nationally. The solutions we believe need to be implemented are system-wide solutions. They are national in many respects, but they are certainly solutions that require us to think significantly differently about how we provide and fund services and how we use our workforce in provision of services for communities.

From my perspective, the rural health service issue in Tasmania has long been marginal. There are a variety of reasons for it. In the public sector it is about distribution, affordability of resources, workforce challenges, population expectation, system balance and about the design of services and solutions. In the private sector it is about workforce recruitment and retention. It is about business viability, access to education, housing and work for clinicians and clinicians' families. Community expectation again versus capacity to meet that, that is, 24/7 expectations about service response and the capacity of the individuals working alone to be able to respond in that way. It is also about access to support structures when clinical needs escalate.

The solutions are not simple and they are not singular. I would stress the points I am going to raise really are points long been known and understood and I am not going to set the world on fire with any great revelations here. It does behove us to consider why it is that some of these things we should have been implementing for a long time have not been implemented before now. I also stress unfortunately, we are working in an environment where our competitive tiers of government, our system policies, payment structures and the limitations that apply or workforces apply on themselves often work against the best intentions and desires we have for the system.

The paper I have provided gives you a fairly rudimentary rundown on what those things are and it also lays out some of the statistical situation that befalls us in Tasmania which is typically older, sicker, poorer, more overweight and less educated. Against that backdrop we have an obligation and responsibility to deliver differently for our community. We have an obligation and responsibility to work with the community in doing that because the other thing

we have failed to do spectacularly, over many decades, is to engage consumers as part of the development of solutions for our system and our state.

The other thing we have failed to do is we have failed to articulate a vision and a plan for a whole system. Each of us readily goes about own business and we do our own little pieces of planning in our own spheres. For example, Primary Health Tasmania is largely funded by the federal government so we largely work to federal government policies and plans. The state funds itself. Obviously with money that comes from the same source in the end - the taxpayer - but, ultimately, those plans often occur at different paces, at different times, with different imperatives and priorities around them. We have consistently failed to put together a vision that communities can understand and can buy into, that providers can see a pathway for delivery against, and that governments can set a consistent and structured policy direction against.

We plan effectively in opposition and often the net effect of our investments counteracts what happens in respective sectors. That's a source of huge frustration not only for probably all of us around the table here but also those, importantly, who are dependent upon the services that are provided in order to remain well, out of hospital, and in the community. I wanted to pick up a couple of those, if I could, please.

The first, as I've said, is planning. We're over-conditionalised and over-circumstantialised in respect of the fact that we have a whole system that demands things of us, yet we choose to see the bits of that demand that apply to us only. Rarely do health conditions arise as a result of one thing and one thing only. We spectacularly fail to understand and address that.

We have a huge equity imbalance in this state. In terms of rural and urban areas, there is a significant access imbalance in relation to equity of access to service. Again, that's not Tasmania-specific; it happens across the country. As governments, as organisations, we have an obligation to look at how we raise the bar for those least able. That's not to say that we ignore the rest but we do need to differentially invest in order to get our whole community up the rungs of the ladder in a sort of even-paced and more effective manner.

Health systems are hugely complex. It's not just about one service, one provider, one patient. They are very complex beasts as I'm sure you understand. There are massive numbers of streams of resources that work to fund the health system. Again, they work at different paces, they work at different time frames to different expectations; they dance to different tunes. It's little wonder that we have a system that appears to be rather pizza-like because it's paid for in a rather pizza-like way.

I've got myself into trouble by saying this before: in many respects we don't have a health system, we have multiple systems for health care. Sometimes they work well together and they fit neatly at the boundaries. More often than not, however, they exist in isolation. Inevitably, it's the unwitting patient, the unknowing practitioner, who finds those gaps and they're the spaces into which patients fall. They're the people we need to do better for in planning within this particular system. We have to plan for and deliver as a single system rather than as multiple differential elements.

The next challenge is navigation. In that complexity we expect that it's the patient, their poor, elderly and unwitting carer, or an overworked practitioner in a health care practice, pharmacy, allied health practice or otherwise, who is expected to find this complex path

through all of these often intertwined and unfitted elements. The issue of navigation is a huge challenge and we need to support patients to make informed and best-placed decisions for their needs. We need to do that by supporting navigation through the system.

The cost issues - we tend to focus overly unhealthily on cost. Cost is often what drives rationalisation, it drives cessation of service, or it drives funding of other services. Rarely do we stop and think about the flow-on impacts that arise when a particular element of service is stopped, moved, changed, or otherwise.

Rarely do we stop to think about what it takes to make a new investment work most effectively in the system. We tend to see cost as the end point, 'We've invested some money. Isn't that fantastic'. The government, whatever shape or form, looks good but at the end of the day - is it working for the consumer? The investment alone is not what's required. You've heard probably -

CHAIR - It's is the biggest spending budget in history.

Mr EDMONSON - That's true, Ruth. You've probably often heard that sort of notion that it's not about how much money you're investing, it's about how you're investing it. We don't necessarily need a whole lot of new expenditure in the system. We need to change the way in which we currently expend funding in the system.

Hearing the ladies talk through palliative care a moment ago was a classic example. We tend to run things in silos. We see palliation as one thing; we see skin conditions as another; we see general practice as another. We don't stop to think about how patients move through systems using multiple providers at different times. The costs associated with trying to traverse that often result in duplication or entire areas where service is completely missed or omitted.

In those environments, there tends to be an overdependence on public services because navigating private systems is sometimes just too hard. Often we tend to default to public investment instead of looking at how we can make better use of other services that exist outside.

Tied to that is the whole issue around workforce. We, like our health system, deliver services in silos. There has been a lot of politics around workforce for a long time. There's a lot of boundary protection by individual specialities and disciplines. There is a lot of frustration but also suspicion around what happens when people try to blur some of those boundaries - what they need to do in order to enable people to work together more effectively.

We have to be providing an environment and an incentive for practitioners to work more effectively together at the local community level. This notion of 'see me until I can do no more for you, then I pass you on' is great in a normal sort of escalative sense but we could do so much better for people if we had teams of people working at the local level together that stop people from escalating. We make an assumption that escalation is normal and it just happens, rather than actively working to try to prevent people from moving through that system. That can only be done if resourcing at the local level - and we're talking in local communities, regions, rural areas - is provided to support practitioners to work together.

Fee-for-service models are not good for that. They never have been good for that. We need to be looking at how we can blend those payments more effectively to support that notion of team-based care. That's particularly important in Tasmania where our burden of chronic and

complex care is huge. It's growing and it's going to overrun us in the blink of an eye if we don't do something more purposeful around that.

Ms LOVELL - Can I ask a question on that, if I may?

Mr EDMONDSON - Yes, absolutely. Interrupt me or I'll keep going for a week.

Ms LOVELL - What an alternative to a fee-for-service mode look like? You talk about blendings, payments, more. How would that work?

Mr EDMONDSON - Largely, it is about looking at the skillsets within a group of practitioners and it's about saying, 'How do those skillsets match with the need of a particular patient?' So, let's take, for example, those with multiple chronic conditions. Invariably, what we tend to do is treat the conditions separately. So a patient with respiratory needs might be referred to a respiratory physician; they might be referred to a physiotherapist; they might be referred to a community nurse or otherwise.

All those things happen separately. It's a separate singular path. You bring those people together to understand the needs of a patient in a context; you put a plan of care around that particular patient's needs and then you deliver against that plan. It sees everybody working towards the same common end. It respects and values the different skillsets that are brought into that space. The medical diagnosis is the initial driving point but it says who is best placed to provide that care.

More often than not you will find that there are skillsets that we don't adequately use that could be much more effectively engaged early on in the care process that are not as expensive as GP or specialist care. At the moment our only mechanism for remuneration of those means that you've got to refer through those pathways. So it's about looking at the funding model differently and it's about also looking at how that model of care can be delivered.

In a rural sense, there is one other element that's really important. That is local level management of that response. Increasingly this is now being realised as a major driver and a determinant of recruitment and retention. Communities can manage their own service in their own location to a particular agreed clinical pathway or otherwise, and to be able to centralise and pool those funds at the local level means you can get local level investment as well from businesses and others who will participate. It's determined, it's driven at that local level. That is the rural model. There are variants of that as you move closer to urban centres or otherwise but ultimately it is about team-based care for chronic need.

Ms LOVELL - Where is that happening well?

Mr EDMONDSON - That is a really good question. At this particular point in time there is not a huge number of examples of that. We are about to implement one in the north here that we are paying for so we will pay for that for two years in order to be able to evidence the value and benefit that will bring. We can then put a case back to the federal government for block grant funding for that group. That is the way you have got to work.

No-one comes up with the funding any more. The old concept of someone throwing a heap in to try something does not happen at the moment. You have got to create it for yourself but ultimately there are several trials of this happening in New South Wales, northern Victoria

where they are looking at whole communities coming together and developing and implementing local community-run and funded service models. It is about everyone putting their funding in.

Ms LOVELL - So that will be the type of trial that you run here?

Mr EDMONDSON - We are actually salarying all the staff here. We will be collecting - we have Menzies as a partner with that so that we can look at what the care outcomes are, what the actual input costs are, what the eventual savings are in reduced hospitalisations et cetera, for that particular group.

Ms LOVELL - What time frame do you expect that to run over?

Mr EDMONDSON - It will be done for two years so we hope in that time we will be able to evidence something reasonable but we are also looking at funding through the Medical Research Future Fund (MRFF) federally to extend that for another year.

CHAIR - Does New Zealand provide similar models to that?

Mr EDMONDSON - Yes they do, and they have a significantly easier path, obviously because they have got a single layer of funding within their government space. Yes, they do provide variants of a model like that but they also have quite different approaches to the transition of care between community and hospital. They have structures set up to provide that intermediate level of support, high level care and support for people who need it within community-based structures rather than publicly funded hospitals.

CHAIR - It's a much more mature model, isn't it?

Mr EDMONDSON - Absolutely it is, yes. We are sadly way behind the 8-ball on that sort of thing in Australia. It is not because people do not want to do it, it is just because we have so many challenges and issues associated with payment funding models et cetera, that actually mitigate against it. The federal government is very keen on exploring this and they are trying to do so but it is a hard slog.

Dr SEIDEL - As you mentioned you have been in a leadership position for decades now and reading through your submission, in particular the paragraph on planning, it is actually using strong language here, 'reactive political solutions'.

Mr EDMONDSON - I have got to the stage where I do not mask my language any more.

Dr SEIDEL - 'Constantly pushed to be making reactive decisions', merely plug holes or extinguish spot fires.

Mr EDMONDSON - Yes.

Dr SEIDEL - There is 'poor long-term planning', 'piecemeal services' and on and on and on it goes.

Mr EDMONDSON - Yes.

Dr SEIDEL - At what stage, politically, is change going to happen because the experts, and you are part of the expert organisation - government organisations - who do not argue because you want more money and a higher salary -

Mr EDMONDSON - I wouldn't say I don't argue, Bastian.

Dr SEIDEL - or higher profit or you are looking for a float, at what stage are governments actually listening? The question I want to ask you, what is in it for politics to leave things the way they are? Every election, state and Commonwealth, we talk about health all the time, yet it almost feels like somebody wants to protect the problem to be perceived to be part of the solution, right, which is one of my favourite phrases.

So at what stage are the experts taking over and saying, 'no more, we have reached desperation point'? Once again, we have these initiatives and photo opportunities and a million in funding here, five million there, it all leads to nothing, right? You all accept this. You have already provided evidence of that.

Mr EDMONDSON - Yes.

Dr SEIDEL - What does it take, and it is probably part of the problem rather than an enabler of solution.

Mr EDMONDSON - I will start with the last one because it is the easiest one to answer. Absolutely, politics is part of the problem, not the enabler but the problem in health is that it is so tied to funding from government, whether it be through the MBS, PBS, through public hospitals or otherwise, the ties to the public purse are so strong that the challenge of separating those things is just so great.

If you recall back to 2005, the National Health and Hospitals Reform Commission released a report. The number one recommendation in that report was to take funding out of government and give it to a commission. That was their number one recommendation. Between the release of the interim report and the release of the final report, that one had been mysteriously wiped from the whole report. It was completely taken out. It didn't even feature in there.

Therein lies the challenge. There is too much GDP tied up in health for any government to willingly relax their grip on it to the extent where we can sit down and say, 'How should this work differently?'.

I don't believe, however, that it even needs government to relinquish that responsibility. What it needs to do is to work in partnership with clinicians and the community to develop solutions and agree to fund those. The problem is where does the hump-funding come from?

All the money is tied up in trying to deliver against current demand. Where do you get this extra resource from? That's the challenge.

Dr SEIDEL - You said earlier when you started giving evidence that it's not necessarily a call for more money, it's the question of how money is actually being spent. Going back to practitioners in regional areas, they probably couldn't care less whether they receive an income fee for service or block funding or other means as long as the income is the same. You

redistribute something that's more fit for purpose knowing that, as we heard for palliative care, fee for service doesn't work if you have to do a home visit that is 100 or 150 kilometres in the middle of the night.

Even saying that you probably don't want to have more money, you just need to have some freedom to redistribute the existing funding in an evidence-based way, would that be a starting point?

Mr EDMONDSON - It absolutely would be. Rural health is the place to start because that's where you have an engaged, motivated community and you have a self-contained population in many respects. You have a population that has been systematically deprived of access in an increasing sense over a long period. There is a high degree of motivation and there is a high degree of matching need there.

The ability to do that in a confined area and to show that evidence, I think is unargued. It's a question of how you get to the point where that can be introduced. You know as well as I do, the defence of fee for service has been very, very strong for a long time. I think the realisation now with this tsunami, as everyone likes to say, of chronic disease is that it is clear that fee for service no longer meets the needs associated with certain large groups within our population.

I think it's changing but there has to be some really bold decision-making that accompanies this and that is a willingness to go out and test and try.

Dr SEIDEL - In your long career making submissions, engaging with governments, how often did you feel governments are listening to you and implementing what you recommend?

Mr EDMONDSON - Governments have been willing to listen. I don't think there's been a lack of listening. How often is that translated into action? Probably the fingers of one hand. That's the problem.

Dr SEIDEL - Because we're not even talking about implementation failure of a policy. It's the political will for not doing anything, isn't it? We don't have the political will to actually do things.

Mr EDMONDSON - I agree with you. I think government wants something to happen and doesn't quite know how to go about it. My other observation would be the Government lacks the confidence in working with what it perceives to be a very strong, well-informed and intelligent health provider community. It worries about the potential for loss of control - I'll say that. It's speculation but at the end of the day -

CHAIR - Control of what?

Mr EDMONDSON - Control of the agenda. There is a lot of money tied up. What is it in Tassie? Is it 17 per cent of the Tasmanian budget is tied up in health?

CHAIR - It's more than that, it's 30-odd per cent.

Mr EDMONDSON - Is it 30-odd per cent now, there you go. That's a massive amount of government power tied up in that money. It's the wrong word to use, what I'm not doing

here is basically saying governments shouldn't have power - I'm not saying that at all. What I am saying is that the extent to which their whole budgetary process is tied up significantly with healthcare investment is huge and making big decisions is really hard to do.

They need to know that community support it, they need to know that voters support it. They need to know that it's going to be supported by providers and I am not sure that the work has been done to understand whether that is the case. We tend to have peripheral planning, we have planning that is done around the outside that doesn't get to the core of the problem.

Dr SEIDEL - Last question, in your position when you receive funding from state and the Commonwealth as well, were you ever put in a position where that funding has been antagonistic or one project is trying to achieve exactly the opposite of what the other project achieves?

Mr EDMONDSON - In the good old days we used to have the situation where if we invested federal money the state would pull money out. That doesn't happen anymore. There is a much higher level of cooperation and collaboration. We have made significant advances in that respect. I think there is now a very healthy relationship between what we would call ourselves as service or system administrator partners if you like. To be honest with you, we receive absolutely nothing from the state government. We get virtually no money from the state. All our money comes from the federal government. We do not have a huge amount of leverage over the way in which we put state money alongside federal money. We only do that by nature of the state's willingness and our willingness to do that.

Dr SEIDEL - Nothing would prevent the state to fund initiatives?

Mr EDMONDSON - No.

Dr SEIDEL - You would have the data.

Mr EDMONDSON - Yes, we have a large amount of data to support the validity and appropriateness of approaching things in a different way.

Dr SEIDEL - You would be a natural partner if the Government said they want to improve health outcome X, Y, and Z in area A, B, C - they could probably come to you and ask what can you do for us?

Mr EDMONDSON - The space that that is happening in most readily at the moment is mental health. I would say mental health has gone from being probably one of the worst examples of system reform - and attempts to really address major evolving expectation and demand - to being one of the best. A lot of money has been put into mental health, so there is a lot of new investment going into that; but there is really good collaboration and cooperation that occurs across sectors in relation to that now.

CHAIR - Did you have some more points you wanted to make from that?

Mr EDMONDSON - I have probably talked through half of them. From our point of view, the other elements are around technology. We need to look at how we utilise technology and our infrastructure more effectively. Every town in this state has a state health facility sitting

there somewhere, used at a level that varies significantly. We need to know how we can use those pieces of infrastructure that we already have more effectively, to bring providers together.

We also need to look at how we use technology more effectively to provide people with access, professional supervision and support, advice and assistance to enable providers across different workforce groups to work up to the level of their training and capability with confidence, knowing they have backup and support there. One thing we cannot do, is put one of everything into every rural community. We can't afford it, it is impractical, it is impossible and, in many cases, it is unsafe for individuals in certain professional disciplines to work in isolation anyway. We have to look at how we join professions and groups up to work in support of patient need.

Ms LOVELL - For IT, in terms of hospital system talking to GPs, for example.

Mr EDMONDSON - Our PESRAC submission, for example, said that the first thing that the state should invest in if it wanted to make the biggest difference in relation to health, would be to invest in a contemporary IT system. You can't run much on an Atari nowadays and, sadly, it is not much better than that in some locations, and some aspects of the system. A major system upgrade and a commitment to implement solutions that talk to and across, system boundaries. For example, for general practice systems to be able to talk with hospital-based systems.

No, general practice doesn't want to sit there and read every patient's hospital record, that is not what it is about. But when a question arises that is critical to patient safety, the ability to dip in there and see that information is hugely beneficial. Likewise, when a patient turns up at a hospital and the hospital is about to go through its usual process of pre-ordering a pre-set barrage of tests, to be able to look into the patient's record and be able to see if they have had any of those tests recently saves masses of money, just with a simple push of a button. That is the sort of thing that has to happen pragmatically, and any idiot could tell you that. It doesn't need this idiot to tell you that really has to be stage one, barrier number one, overcome. That is a critical need, I think.

CHAIR - A bit more commentary on your submission - page 8, on the funding and investment. You said specifically funding for primary care should be identifiable and protected in the state budget process, not placed or forced into a competitive space alongside acute care. We talked about the second dot point in Funding and Investment.

We have talked about the predominant funder of primary care is the federal government; acute hospitals is the state government. We see cost shifting, that has gone on forever. The federal government gives us money from different processes - the GST is untied and government can use it how they like, regardless that the Commonwealth Grants Commission assessment is around our disadvantage or disability.

We have some grant block funding for different things; there is a whole hotchpotch of arrangements. When we established one of the iterations of the health system we now have, I asked for a flowchart of the funding. It was worse than spaghetti.

Mr EDMONDSON - It would be worse now.

CHAIR - Yes, exactly. In terms of a meaningful recommendation from this, you have suggested that. I don't disagree at all, but how do we meet the needs of programs such as you have just talked about, deal with the state-funded acute health system, separate out the primary care funding, in a way that is meaningful and identifiable, so that when we get to Budget Estimates we can say, last year there was $300 million for primary health in the north-west, and what was that spent on? Is that what we should be seeing?

Mr EDMONDSON - The challenge here, is that you see a different picture in relation to what the state purchases, with its primary health investment, versus what the federal government purchases with its investment.

The federal government's primary health investment is primarily tied up in the MBS - it is funding for doctors through that system; and the PIP system, and the incentive system goes with it, that pays for nurses et cetera, in practice.

The states receive money from the Commonwealth to pay for a whole range of other things - allied health providers, hospital services, and a whole range of other things that sit in that space.

I am not sure that, unless we have a single funding source, you are ever going to be able to see how dollars flow through in a way that is going to give you the flowchart and the flow that you are looking for.

There is always going to be some separation in that. The question is, who is tasked with the responsibility of ensuring that those things intermesh appropriately at the boundary, and are not sitting...?

CHAIR - And doesn't get dragged over here into the hospital.

Mr EDMONDSON - Get dragged, or get duplicated, or that we end up with inadvertent holes in what we are actually spending money on. There are plenty of examples of all those things - holes, duplications, omissions. Previously our job has been around filling gaps. We now have much more of a substantive, commissioning role. For example, in the mental health space, we invest the same amount as the state government in mental health.

So, from a primary care, federally-funded perspective, it is about a 50/50 balance, at the moment; which may explain why there is a very good level of cooperation in respect of that, because we are equal partners in the process, to all intents and purposes; hospital funding aside.

CHAIR - Even when we ask at Budget Estimates, how much of the state budget is being spent on preventative health measures, you can't get an answer to that question.

Mr EDMONDSON - Sorry. I can't speak for how the state government accounts for that.

CHAIR - Nobody can. That is the problem.

Mr EDMONDSON - The whole preventative health question has been a vexed one. It was a vexed one from us from a federal perspective for a long time as well.

Under the previous system, Medicare Locals - strong investment in preventative health. Under the most recent system in Primary Health Networks - a much reduced focus with the focus and intent being put on preventing avoidable hospital admissions. It was shifted up to that end.

In my view, balance has to be the overriding flavour of this. You cannot invest in one without the other, otherwise you create a system that becomes inadvertently dependent on the wrong part of the system. It has to work harmoniously.

You can't have good primary health care without having good escalation points in secondary and tertiary care. This is not about taking money from hospitals and giving it to primary care or vice versa. It is about saying, when we make investment decisions, make them in a balanced and proportionate way, recognising that 75 percent of health care, or more, happens outside the hospital environment.

When people come into a hospital, they come from somewhere and they go back to somewhere. We have to be making that pathway smooth, and we have to be ensuring that there are no tripping points on that pathway. The transitions of care as they occur, need to be well supported, well documented and people need to be supported in the decisions that they make at those particular points.

It is such a complex mix, Ruth. I don't think it is one you can bring down to simply following a dollar, because it doesn't happen that way in a health sense.

CHAIR - People don't have one health problem generally either.

Mr EDMONDSON - That's right.

CHAIR - It would be helpful if you could expand a little on the last dot point in planning. There are number of good points you make there, 'all the state planning must start with strong governance'. 'Health system governance must be more inclusive of primary care.' We have seen a number of iterations of the governance structure, and many of them failed us dismally over the last 10 or more years. How do you think we are now, in terms of governance of the health system, particularly as it relates to care in the rural parts of Tasmania?

Mr EDMONDSON - Not strong. There are some positive signs, but I guess the jury is still out on whether, for example, the process that is happening in relation to Our Healthcare Future now will actually do what one health - one hospital system. That is what the focus was. I understand the nature of the pressures at the time, but primarily it was focused on hospitals.

Our Healthcare Future is making positive statements about needing to focus on primary care and needing to push the focus to a different state in that continuum if you like.

CHAIR - How should the governance structure look in that, then?

Mr EDMONDSON - The idea of having things like clinical senates is a sound one. There is plenty of evidence to support the notion of having a committee of clinicians who work with service administrators to make good decisions within the system. That can only be of benefit. It hasn't happened to this particular point. The investment that has been made in consumer engagement I think is really sound; and again, that sort of partnership between

clinician, funder and consumer is critical if you are going to have a system that works for everybody. You can't do everything that everybody wants, so understanding where those points of compromise need to be made is important for all of those three levels.

CHAIR - It is particularly important for consumers to understand where they can access what they need, ideally outside hospitals.

Mr EDMONDSON - At the moment in the state Health Department sense, there isn't a really engaging governance structure that brings in the rest of the system, and that is typically not how governments and departments work. Again, I understand there is a pathway to take to get there. I don't say this from the perspective of not having access to government. I have strong access to government from the minister down, and have good and sound working relationships. It doesn't stop us saying what we think. It doesn't stop us saying what we believe should happen; but at the end of the day, there is an increasing understanding and acceptance that it is okay to have discussions outside of government with external bodies like us, and that can be done respecting the normal challenges and issues associated with parliamentary privilege or otherwise that governments often historically have tended to use as an excuse for not engaging more broadly.

CHAIR - Thank you very much. Is there any closing comment you wish you had said but haven't?

Mr EDMONDSON - No, I have probably said enough. Bastian has already accused me of offending everybody in my statement so I will wait for the comeback on that one.

Dr SEIDEL - That is why we have parliamentary privilege.

CHAIR - If you offend everybody it is fair.

Mr EDMONDSON - That is a public document though.

Dr SEIDEL - You can repeat it.

Mr EDMONDSON - I am quite comfortable to repeat it.

CHAIR - Thank you. We will take a short break.

The witness withdrew

The Committee suspended from 2.54 p.m. to 3.00 p.m.

CHAIR - I did go through the introduction comments for those who have been there. Do you need me to remind you of any of the issues regarding parliamentary privilege?

Mses MAURIC and THOMAS - We're good.

CHAIR - I will invite you both to make the statutory declaration and you can introduce yourselves. We thank you very much for the very lengthy submission. It obviously included hours and hours of collecting information from the community and it really helpful to have that. Thank you.

Ms KATE MAURIC, AND **Ms HELEN THOMAS**, KING ISLAND COUNCIL, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Thanks, if you would like to introduce yourselves and what your roles are and then speak to the submission that would be great.

Ms MAURIC - Thank you, Chair and committee members. My name is Kate Mauric from King Island Council. I am the acting general manager at the moment and also a committee member on the King Island Hospital and Health Services Committee.

Ms THOMAS - I am Helen Thomas. I am the growth and strategy manager at King Island Council, which you may remember includes quite a broad remit and I am also the municipal recovery coordinator on the island.

In terms of an opening statement for our submission, as you have mentioned, it is rather lengthy. We have had to address every single part of rural health because that is what we do.

In many ways, King Island is a microcosm of Tasmania. We do not have different issues from the rest of the state. Access to specialists, interdepartmental communications, patient advocacy and mental healthcare are things we have heard just in the couple of hours we have been here in the room. It was definitely evident in the submissions we read that came through to the committee. Our small population and remote location mean those issues are exacerbated. On King Island, a specialist might be something as simple as a podiatrist, a dentist or a pathology appointment. It really is painful trying to access any of this. If you want anything more than a basic GP appointment or basic triage at the hospital, you are looking at either waiting for a visiting service provider or flying off island to access those services on mainland Tasmania.

Overall, we have so much detail in this submission, so many individual case studies and stories that were really quite heart-breaking to listen to as we were going through this process. Really, what everything came down to was the first improvements that could be made would be through addressing the process, rather than just throwing more money into something. We see a lot of money thrown at initiatives and visiting services, without there being much tangible benefit to the community as a result of those funds being spent.

CHAIR - Why is that, is it the lack of community engagement and what the community actually needs? I accept everyone has their own individual needs, because there are a whole range of personal experiences there. Why is it not meeting the need? What is the issue?

Ms THOMAS - One of the examples would be the outsourcing of specialist care. For example, mental health is an area where that service is outsourced. We have providers arriving on the island for a week's visit with the intent of delivering all of these workshops and community engagement events, but they will not have told anybody they are coming over. They will not have engaged with any members of the community and end up sitting in a room by themselves with their PowerPoint on the screen behind them wondering why King Islanders do not engage.

Dr SEIDEL - But they are getting funded anyway for this, for sitting around doing nothing.

Ms THOMAS - Yes, they are getting funded so they turn up and have met their KPI.

Dr SEIDEL - Can I ask a question?

Ms THOMAS - Yes.

Dr SEIDEL - Let me know if it is too far out but we have heard earlier evidence about funding and design of the system being all too difficult. It would be nice to have one system, one funder to streamline it and then to have a needs-based service delivery model strongly influenced by consumer needs and consumer input.

I am just thinking out loud, wouldn't it be nice for our islands to have that where you probably do not need to have half a dozen service providers, Medicare cards, various private funding, you could just do it? You could just say for King Island we have our separate health system purely funded by the state. You design and you decide what service you need because it is very clear what the demand is. You have evidence in order to predict what the demand is; the data is already there; it should not be that hard, right? So, all the problems you experience on King Island where the population is very stable, you can predict the visitors, I would imagine, almost, would not that be something to consider as a natural experiment? What do you have to lose?

Ms THOMAS - Fabulous idea.

Ms MAURIC - It is a fabulous idea and earlier, I think it was Phil, was talking about engagement. Our community is very highly engaged in this and want that integration. They want to be able to have the whole integrated holistic approach for health services and we would very much welcome that.

Ms THOMAS - Absolutely, at the moment the lack of integration is disastrous. There is no clear accountability. If you go to a GP for a referral, the GP will then send a referral letter to the specialist's office. As the patient, it is really unclear, because you are given a copy of that letter, are you now meant to follow that up or is the GP going to follow that up or is the specialist going to get in touch with you? If it takes two months for the specialist to get in touch with you, do you just sit back and wait for that to happen or do you become that squeaky wheel? Once you have your appointment then you need to make sure you can actually get to it. Then you have to go back to your GP to get approval for your Patient Travel Assistance Scheme form to pay for those flights and accommodation to go to that appointment the day after tomorrow. The flight you have to get on is in three hours time, once you have sorted out your childcare and taken time off work and got somebody else to pick up your mum from the

hospital for her appointment. It is really complicated. If there was some level of communication between those departments listening to the previous witness give his evidence, imagine if, in our hospital on King Island, the GP who was also supporting hospital as well as the outsourced GP clinic, to get into a system that gives him access to the availability of specialists in another hospital in the Tasmanian Health Service. It would just be shocking.

CHAIR - We know IT and access has been a bit of an issue on King Island. It still is on many parts of the island for patients engaging digitally for health care. Is it getting better?

Ms THOMAS - There is the promise of it getting better in terms of the funding the island has been given through the Regional Connectivity Program grants. That will make quite a marked difference, but that is at least two years away from being finalised. It has not been started yet.

CHAIR - There are plenty of places on the island where mobile phone reception, even with Telstra, does not work.

Ms MAURIC - Correct. It can be in the main in Currie now and it is becoming a continuing issue.

Ms THOMAS -We have been given examples of cancer patients who are doing telehealth appointments with their specialist team literally having to leave their house and drive to a nearby hill so they can get enough phone reception to talk to them on the telephone. This is let alone actually have a face-to-face meeting on Zoom, Teams or the like and you do not really want to be parked on the side of the road when you are talking about your end-of-life plans.

CHAIR - Or finding one of those few hills there?

Ms MAURIC - Yes. And it is all that integrated - when the early childhood is going into school transition also - when you are doing those Zoom meetings, it is really hard to have that connection. As humans we want to connect and healthcare is one of those really primary things you want to be tactile and want to see that person. That can be really challenging for our community members because everything is like a speech therapist, as Helen was mentioning before, what we classify as specialists is anyone other than the GPs. You cannot just walk into an office and then go and see a specialist.

CHAIR - For end-of-life care, how is that managed on the island because obviously that person may get in the car - if someone has put them in the car and taken them to the nearest bit of reception for a phone call, but in terms of visiting them at home, what capacity does the hospital have? We know the hospital has had some nice refurbishments done which is great.

Ms MAURIC - Sure. Again, it depends really on resourcing and the ability to be able to work with that patient. You were mentioning earlier, like people do, there was a couple of community members who wanted to have the option to die at home, but it is really struggling. It just depends on what is the availability at the time for resourcing and that option for a technology issue is a real issue for our community members.

CHAIR - Bastion's suggestion about having a local service, how do you envisage you could trial something like that, but still meet the needs of the majority of the islanders?

Someone may have quite rare and unusual conditions and you cannot expect to have a specialist there for that. How would you do that?

Ms MAURIC -We have talked about maybe having a conduit. In terms of talking about an interdepartmental communication, we really see that as an opportunity to have someone to bring them together, and to streamline those opportunities. Maybe, it is about looking at what resources you have, but then working together to get that ability to then get them off island when required. At the moment

Turn 75

Ms MAURIC - (contd) …them off the island when required. At the moment it's the GP, then you have to go to see the Health Service who may not have talked to the GP that is two metres away, so it becomes very challenging and that advocacy piece comes in as well for those patients.

Ms THOMAS - Patient advocacy is a really big issue in that respect. Just having a patient advocate could get through a lot of those issues. Somebody who knows the system, who has the time to work their way through the system would make a huge difference and benefit, especially for those more at-risk members of the community, the more elderly and those who are in chronic pain. It's difficult enough to think straight when you have a bit of headache. If you're dealing with chronic pain and chronic illness, and now you're tasked with trying to navigate three different specialists, even just the logistics of how to get yourself from Wynyard Airport to the hospital in time for an appointment or from your accommodation to the hospital can be quite a lot to deal with.

I challenge anybody to work their way through a public transport timetable when they're feeling under the weather.

Dr SEIDEL - So what happened? Has it always been that fragmented? I think we heard earlier, it's team-based care that is so essential rather than having a healthcare worker doing something and then referring on once they've reached their ceiling which is to refer, refer, refer. Whereas if the team is there from the start, you can close the gap rather more efficiently.

What happened on King Island that, from what I'm hearing, we now have this fragmentation of care, poor communication, needs of patients not being met? I think it must be incredibly frustrating for a smaller community to pay the same rates, same taxes, same everything and just wants a decent service. I would imagine you don't expect anything outrageous.

Ms MAURIC - I think it is very complex and, like everyone else who has had the opportunity to speak here today, it's about various different things. It's about the integration, it's about being the patient-centred care and having that community consultation, our community being on the reference group. They talk about how they're not consulted or communicated with, they have lots of feedback and they want to have their say. They are really passionate about our community but I think it's also our ageing demographic and maybe it's also the service provision models have changed over time.

For example, when we talk about the NDIS and the different funding bodies, I think in the last six months we've probably had up to half a dozen ring us out of the blue or turn up on our doorstep, and then come to our community and say, 'We have this to provide.'. They know nothing about our community. They're not willing to look at our community and what their needs are but yet they're saying, 'We need to spend x amount of money. How can you make it happen for us?'

CHAIR - You're the council at this point?

Ms MAURIC - Yes, they're coming to us as the council. You ask them, 'What do you know about us as a community?', and they have blank faces. They've been given this mandate to come and provide whatever it is.

Dr SEIDEL - Tick the box and that's it, and let's move on from there. There's no genuine buy-in to make a difference for the community. It's just to meet their funding needs and they move on.

Ms MAURIC - No, exactly.

CHAIR - You have to understand the community's needs.

Ms MAURIC - That's right. It really stems a lot from there, I think.

Ms THOMAS - I've only been on the island for four and half years so I can't speak much to how it was beforehand. The information that we got back from the community when we went through this consultation process was that there used to be a funded position that was the community health nurse and it was her job to be that conduit between all the different services and to help patients navigate their way through it.

That position stopped being funded five or six years ago. Nothing has come in to replace it. The outsourcing of services to different private operators, for example, pathology on King Island is an outsourced service. The individual or the team that came over to do those pathology appointments has left the organisation. They don't have anybody who's particularly keen to do that on an ongoing basis at the moment it seems. Pathology may or may not happen on a Wednesday morning.

Dr SEIDEL - To take blood samples and transport them off - so even that's at risk now?

Ms MAURIC - Yes, last week it was cancelled. That's an ongoing thing that our community has to deal with.

Dr SEIDEL - You didn't have any pathology services last week on King Island?

Ms MAURIC - That's just one example. That's commonplace at the moment.

Dr SEIDEL - If somebody comes up and the doctor/nurse wants to do a heart test, a cancer-screening test, it's not going to happen then?

CHAIR - Just a basic full-blood count.

Ms MAURIC - Possibly not. They try to do the best they can and if they can filter them through the GPs but our GPs are heavily booked out and it's more pressure on them. We have 2.5 FTEs and they do a phenomenal job but they're expected to be everything to everyone at all times.

Dr SEIDEL - In the hospital, are there any point of care blood tests possibilities or for blood sugar and long-term blood sugar markers and heart testing?

Ms MAURIC - They sort of filter you to that one day which is generally a Wednesday morning for pathology. He's visiting from the north-west.

Dr SEIDEL - That's somebody who takes blood from a vein and the conventional stuff.

Ms MAURIC - Yes, and they do all the other tests - all the conventional stuff. Otherwise, if it's cancelled, it's cancelled for a week. That's it.

Ms THOMAS - They can't make the plane or the one staff member who was scheduled is sick or weather was bad and planes delayed.

Dr SEIDEL - And there is no backup then? It is outsourced by the organisation if there is no backup?

CHAIR - I know you are still trying to get your head around that.

Dr SEIDEL - It has been made quite clear how that is possible.

CHAIR - Your comment, Helen, about the community health nurse who acted as a bit of liaison person as well as the other roles that person fulfilled. It seemed that she probably also assisted with PTAS, or Patient Travel Assistance Scheme applications, and the management of that because I hardly had a complaint about PTAS. We had a very good manager in Burnie who used to assist greatly but that has all changed. When I read through this I thought, so many submissions about the lack of understanding of the island's needs with regard to patient travel. What needs to happen with PTAS and access? If you can make three key points about what needs to happen what would they be?

Ms MAURIC - One would be to have it GP-centric in so when they do the referral it happens then and there. At the moment we go in, we talk about having the required specialist. They give us a form. We then go to the Health Service component of the hospital. They then take it and then they have to see if they get approval. They have to call us later in the day or maybe in a couple of days.

It would be awesome if you were in the GP, it could go straight through, whichever way they could do that. Dr Shaw who came over and did that consultation recently, she was great, there was a lot of good feedback that people were talking about in our community. There is that one.

Ms THOMAS - The understanding that if you were going off the island for a medical appointment that is PTAS funded/eligible, why not let us go to a dentist as well? That isn't PTAS eligible. The flight doesn't cost more if you fly in the afternoon or the morning. You

are only paying for the one night's accommodation still but if you could get into the dentist on that day, that saves you the $450 to fly to Burnie to go to see a dentist because the chances of getting into a dentist on King Island are very slim.

Ms LOVELL - Can that not happen?

Ms THOMAS - It can but it takes argument.

CHAIR - Not as a right.

Ms THOMAS - God forbid you should try to do a personal appointment, go and do some Christmas shopping when you came over for a PTAS appointment.

Dr SEIDEL - So you have a referral to a service that is not available on King Island, let's say it is PTAS funded, you can only use it for this particular appointment? It can't be used for any other appointment that is also not available on King Island?

CHAIR - You can't go and get your eyes checked?

Ms MAURIC - It has to be directly related to that appointment.

Ms LOVELL - How do they know you are even going to do that?

Ms THOMAS - They will look at the time of your appointment and they will book flights that fit around that appointment. So, if there is availability on a morning flight, occasionally coming out of Launceston for example, there might be three flights in a day, so first thing in the morning, early afternoon, and later in the evening.

If your appointment is at 10 a.m. in the morning, you can come in on the morning flight, you could leave on the 1 p.m. flight and still meet that appointment and if you were to ask to make that flight home at the end of the day at no additional cost to PTAS so that you could go and get your eyes tested, go and have a hearing test, visit the dentist.

Ms LOVELL - Visit your mum.

Ms THOMAS - Exactly, sit down and have a coffee where nobody recognises your face, some of that mental health respite you need in a small community. You have to argue and fight to get it done and often it is rejected.

Ms MAURIC - Also, if you are going through cancer at the moment, we have had some community members where they have a long-term plan and they have to get PTAS every time. There is no continuation. Think of that on top of dealing with your family, leaving your family, all the money, all the care, everything that goes with managing health and wellbeing of an individual, on top of that they always have to go back to the GP.

Ms LOVELL - Do they ever take into account, if you are travelling for treatment that might knock you about a bit, do they take that into account? Or are you expected to get on the next plane and come home regardless of how you are feeling?

Ms THOMAS - Often expected to come home. We were given examples of people who have been sent off the island for hip surgery, knee surgery and the instruction is do not sit for longer than 10 minutes. You can stand up. You can lie down. Do not sit, but you do have to get on the scheduled flight home from Launceston via Burnie into King Island so you are two hours sitting down.

CHAIR - On the cigarette?

Ms MAURIC - Yes, on Sharp Airlines.

CHAIR - But you cannot stand up in the row.

Ms MAURIC - And the positioning.

Ms THOMAS - It is challenging. Examples of community members who have had to do that and then had to be referred back for extensive additional care because of the damage that was done just with that flight home.

Dr SEIDEL - I am asking again. For the cancer patient being referred to wherever for cancer treatment, typically a GP would need to do only one referral and not whenever they are going over.

Ms MAURIC - Yes, that's right.

Dr SEIDEL - It should be the same for PTAS, right?

Ms MAURIC - Absolutely. That is what I was saying we could do that one continuation of care. So you go to your GP understanding that this is the plan that you got from your specialist, so we have the PTAS coming through. You don't have to reapply -

Dr SEIDEL - It just happens automatically because the systems on the THS should link in anyway -

Ms MAURIC - Yes, that would be incredible.

Dr SEIDEL - the moment the appointment flags up, you would automatically get another flight voucher or whatever because it's THS-initiated; it is not the patient who won't come back. It's the THS that needs to come back.

Ms THOMAS - It is easier for that PTAS approval to roll on when you are operating within Tasmania. If a patient is referred north to Melbourne then it is every single appointment has to be a separate form. There is no exception made; every appointment, separate form.

Ms MAURIC - If that's for specialist care and specialists in the type of cancer that you have, and Melbourne might be our only option, it's a challenge for that person to get that through.

CHAIR - It is also the same for pregnant women. An episode of pregnancy care should extend to the six-week check but it doesn't, does it?

Ms MAURIC - Even the accommodation is challenging. I have had two kids since I moved to the island. Coming across for my first one was easier but for the second one you are not allowed to stay in the designated accommodation because you have a young toddler. So I had to leave my partner, my family, to come across. I had to find my own accommodation because they are not suitable for a younger child. It is commonplace for people on King Island, to have another sibling to come across to have another baby.

Ms LOVELL - Does PTAS cover a support person for a birth?

Ms MAURIC - No, for a period of time, for a couple of days when you have actually given birth.

Ms LOVELL - So you have got to be able to schedule that?

CHAIR - Like you know when that is going to be.

Ms MAURIC - Exactly.

Mr GAFFNEY - These are PTAS rules for the whole state, whoever it is?

Ms MAURIC -Yes.

Mr GAFFNEY - Because you are on the island, it is more prevalent and more painful as you don't have enough other services around?

Ms THOMAS - Exactly.

CHAIR - Because you have got to fly, Mike, you can't drive to it.

Ms THOMAS - That's right.

Mr GAFFNEY - So if someone's eligible for PTAS, they have to fly, drive or whatever?

Ms THOMAS - Yes.

Mr GAFFNEY - So your issue is that PTAS needs to be more flexible to make it easier because you do not have anybody there to help navigate?

Ms THOMAS - Just to make it practically possible. The things that you can and cannot claim for on PTAS just feel a bit odd. For example, if you are coming to Wynyard to go to Burnie Hospital, you can claim the taxi either from the airport to your accommodation, or from your accommodation to the hospital but not both.

You also have to be able to get one of the two taxis that are operating in Wynyard at any given time to make that happen. You can claim mileage for a car but you can't claim car rental. You can only claim a certain amount of money for accommodation. I think in our submission we are included an idea of the places that are available for the money that you are given under PTAS. It is not wonderful. There is not any consideration given, that we were able to identify through this process, to the capability and physical ability of the patient or their support person. Most of the places that you can stay are older style B&B properties, all great and very

comfortable, often with steps, often with narrow doorways, not generally accessible for somebody who has limited mobility in almost any way. So how do you make that work? It is very administration- and process-focused rather than patient-focused.

CHAIR - The other challenge if you would like to speak to it, is that sometimes, particularly with birthing, a family may want to book into a hospital that has family close by to look after the other children, rather than have to either leave them on the island or put them in a hotel that is more expensive. You can't put them in the one that is supposed to be used because it does not take children. There is a whole argument about rather than going to Burnie Hospital to birth, going to Launceston to hospital to birth because that's where your family is. So there is a whole new argument around that and whether or not they will fund it. Fund it to Wynyard but not to Launceston.

Ms MAURIC - Yes, that happens all the time.

Ms THOMAS - The decision seems to be based on which imaginary line you live within, rather than what's actually the best outcome for the patient.

Ms MAURIC - It is quite stressful coming across if you are on your own. You are having a baby and you have no other connections. You are filtered straight away to Burnie but you might need specialist care. Then it is a challenge to get to Launceston or Hobart. It is a lot of stress for that person.

Dr SEIDEL - The need for services on the island and the need for people to go off the island probably has not changed much, I would imagine, over the years. It is pretty static isn't it? You haven't had a massive increase of new people moving there all of a sudden. There hasn't been an outbreak of health conditions that needs specialist care? It is entirely predictable and plannable, isn't it?

Ms THOMAS - Even that isn't responded to. One of the things that you will see in the application is podiatry services to the island. One day a quarter, a podiatrist comes to the island. It is a day visit. They will fly in on the morning flight so they are really only accessible for appointments from 9.15 or 9.30 a.m. in the morning, assuming that the flight comes in on time and then they are flying out that afternoon at 4.30 or 4.50 p.m. so they finish their appointments at 3 p.m.

There is not enough time in that annual schedule just to see the patients on King Island who are taking preventative medicine for diabetes. That is taking out every other reason to see a podiatrist. There is not even enough time in the annual schedule to deal with people who we know are prescribed with drugs that they are taking for diabetes. It is mind-blowing. It's factually there. All of the information is there and yet the provision of service isn't provided to meet it.

Dr SEIDEL - The risk for the medical practitioner is quite extreme, isn't it? If I was the doctor on King Island and I refer this patient to a podiatrist, oops, he can't come in. So he has to wait for another four months. This week we had to wait another week for bloods. It is not the most attractive or safest place to work then, is it? Is that an issue in terms of what the doctor or what the nurse can do if some support services are like that?

Ms MAURIC - I think some are quite conservative. Rightly so, because they have a lot of risk. For that example, it would be interesting to have a look at our fly outs, or our call outs, in terms of the air ambulance in relation to that in terms of the stress level on that GP. Their job is really hard. They do such an amazing job. They are everything to everyone.

Mr GAFFNEY - One foot per person per trip.

Ms THOMAS - Pretty much.

In preparing for this visit, since we have put in our submission another family on the island have been sharing some horror stories where their mother is type two diabetic. She has had issues with circulation in her feet for some time. Long story short, she recently got herself down to Hobart to seek help with excessive pain. Shortly after that her foot was removed. She was moved from Hobart back to Latrobe for recovery. Four days later she had infection in the stump and so she was taken back down to Hobart for more of her leg to be removed. Now she's transferred back for respite.

This is just one example of somebody who hasn't been able to access the care they need. Now we are looking at how she can access the care she needs to live on King Island long term.

CHAIR - I look at example four on page 16, a tragic mental health challenge. I remember reading that one about this man who was seriously mentally unwell and couldn't get care and ended hanging himself over the weekend.

Ms MAURIC - That is still ricocheting through the community. We are currently going through the coroner hearings. We talk about it in our submission about that relationship and comms between the departments and also community services. It is so instrumental to our community's health and wellbeing to have that.

Mr GAFFNEY - The comings and goings of people has remained static except if it's one of your health professionals who may have to leave then that upsets the apple cart completely.

Ms MAURIC - The continuity is essential.

Mr GAFFNEY - If that person becomes ill or has to go away for a reason the flow-on effect would be humongous.

Ms MAURIC - Dr Anne is the only one at the moment who can do very basic level X-rays.

Ms THOMAS - And she is the only female doctor on the island. Up until she started on the island we had a couple of years where we had one full-time male doctor and then a series of locums filling the other one FTE and it was this huge rush. It was a public announcement - 'Female doctor coming to the island. Book in now for your female-related issues.' Everybody is in and the person is booked up within an hour of that notice being out because they are doing all of the pap tests and the other conversations that some female patients want to have with a female doctor.

Mr GAFFNEY - Do you have any nurse practitioners on the islands or you've got registered nurses or community nurses?

Ms MAURIC - A bit of both. We do have a few of each of those categories. With the community health nurse, I think we only have - like, home care, I mean, by community health nurses. They have multiple hats. The child health nurse is also in-home care. They are really stretched and the other issue for that is about accommodation and all the other issues that you -

Mr GAFFNEY - And paramedics?

Ms MAURIC - No. No paramedics.

Ms THOMAS - No, all volunteer.

Mr GAFFNEY - All volunteer.

Ms MAURIC - Yes.

Ms THOMAS - And huge stresses put on them.

CHAIR - There are no nurse practitioners on the island, though, are there, I don't think? You don't have a nurse practitioner. You've got registered nurses and midwives.

Ms THOMAS - We do have registered nurses and midwives.

Mr GAFFNEY - But no nurse practitioner.

CHAIR - But no nurse practitioners, no, unless that has changed.

Ms THOMAS - I don't think so; no.

Ms MAURIC - I don't think so.

CHAIR - If you were the minister for Health or he was sitting here, what would you say to him? What would be the first thing you would want to address in dealing with the island's health needs?

Ms THOMAS - I think the first thing that I would say is we're not putting our hands out for more money. We're not asking for special treatment. We're not expecting there to be every type of specialist available around the corner. We would just like there to be a little bit more joined-up thinking on how those services are accessed and a little bit more cooperation within the various departments and funded bodies to actually deliver care on the island.

It needs to stop being process and departmental-focused and become patient-focused. That's the reason for a healthcare system, to look after the people who need it.

Ms MAURIC - Yes and it's just that communication that is key. I think that's really instrumental to our community. They're really engaged and they really want their rural health service to be the best that it can be and they're realistic in their expectations. They just want that continuity so if they're going to the GP, to the Health Service, to wherever we have on the island, that they're all singing from the same hymn book so having that would be ideal.

CHAIR - In summary, PTAS, how would that look?

Ms MAURIC - I just think if we're able to, in terms of, again, like Helen was talking about, not throwing all the different money but looking at how that process is in terms of that approval process. Have it really streamlined within, say, from the GP visit, streaming it through. I know the recent consultation talked about that as maybe a possibility so I think we will be really keen to look at that as an option for King Island.

Ms THOMAS - One of the bits of feedback that Dr Shaw received during her visit was if PTAS is designed to be the financial facilitation of a medical recommendation, why do you have somebody in an office approving it? The doctor has said, 'This person needs an appointment and that appointment is best serviced somewhere else. Please now pay for that flight.' The only thing an office should need to be doing is confirming that you've got the correct information - the person's bank details, their Medicare number and their name and who it is they're seeing, perhaps. Everything else should be in the control of the medical practitioners because they're the people who have determined that the appointment is required.

Mr GAFFNEY - Going back to when you first started about having somebody there to help people navigate the various systems and whatever because of their degrees of capacity or the knowledge they have of people on the -

Ms MAURIC - Yes, education, age. Yes.

Mr GAFFNEY - Yes, all that sort of stuff.

Ms MAURIC - Yes, definitely.

Mr GAFFNEY - It would be in the island's situation to have a navigator, for want of a better word -

Ms MAURIC - Absolutely.

Mr GAFFNEY - which would circumvent a lot of that stuff because they would have a similar case or a similar PTAS situation or this is the - yes.

Ms MAURIC - Absolutely. It's like that squeaky wheel. Unless you are that squeaky wheel, you can get lost and a community member can drift off into - you know, and their health deteriorates because they're just not sure how to navigate it. It's as simple as that.

Ms THOMAS - Kate and I are good examples, I think, of mothers who have a voice and are not afraid to use it.

Ms MAURIC - Yes.

Ms THOMAS - It's hard enough for us to get through the different layers of what you need just to get your child into the school dentist or the school speech pathologist.

Ms MAURIC - Yes.

Ms THOMAS - It's a nightmare. And we are not afraid of speaking up. There are plenty of people in our community, in the whole of Tassie, who are not as willing to speak loudly as we are and they shouldn't be disadvantaged.

Ms LOVELL - Or just wouldn't know where to start, how to navigate that.

Ms MAURIC - That's right. They just don't know where to start.

Mr GAFFNEY - On the island it's learned behaviour. If they haven't said something 10 years ago - -

Ms LOVELL - Absolutely.

Mr GAFFNEY - they're not going to say it now.

Ms MAURIC - No. That's right.

CHAIR - Digital inclusion and access to telehealth. Some of this relies on the feds to step up, obviously, and I can promise him they are. We have the election particularly which will be coming up again soon.

Ms THOMAS - And Telstra.

CHAIR - In terms of the recommendation you would have regarding that?

Ms THOMAS - I think telehealth has a really important part to play on King Island for many specialists. Just having a telehealth appointment with a specialist can identify the next best course of action and can be a much quicker way of accessing the care that you need than getting PTAS approval and coming over for a face-to-face meeting.

For example, if you're talking to an oncologist or physio or someone else it may be that the best course of action is for you to be referred to another service provider before you go and have that face-to-face meeting with your specialist. Why wait six months to get that appointment just to be told that the first thing you need to do is see somebody who you could have seen four months earlier. So telehealth definitely has a part to play but it's not a reliable source of health care at the moment on King Island. It's something that can probably only be effectively delivered within the hospital, certainly not something that we should be relying on in home because there are just too many homes that don't have connectivity.

CHAIR - So, connectivity is one issue and digital literacy. How do you assess that on the island?

Ms MAURIC - Challenging.

CHAIR - So, that's another matter that needs support?

Ms MAURIC - Yes, it is, and we have to think about the demographics with the chronic health issues and the comorbidities. They are generally our older adults so sometimes technology is not their friend.

My parents are involved in that too so it can be quite challenging. There are benefits if you are seeing a specialist if you've broken your leg and you have that teleconference in between visits, maybe. That's always a really good benefit to King Islanders. That's always quite helpful.

CHAIR - That's usually a phone call rather than a telehealth face-to-face meeting?

Ms MAURIC - Yes. Again, it's having that initial connection.

CHAIR - Patients, all King Islanders, can come into the hospital and utilise those facilities to have a telehealth appointment?

Ms MAURIC - I think the majority can but also, again, it just really depends on what the hospital is planning and it's what we were talking about, the communication that might not be communicated through. So what you think is happening might not occur because they have something -

CHAIR - So, a person like the patient advocate, liaison person, whomever, could facilitate those sorts of things and help people to understand this is an option for them?

Ms MAURIC - Exactly, huge.

CHAIR - Is there a telehealth room in the new building? I think there was.

Ms MAURIC - There is. It is used for other things like Court and other things, bits and pieces, and training for their staff as well.

CHAIR - In the hospital?

Ms MAURIC - Yes.

CHAIR - Where is the hospital; remind me?

Ms MAURIC - The main part at the moment is where you go into the new reception area. To the left there's a room there that they are using.

CHAIR - Yes, that's right. We did have a look. I just couldn't remember where it was.

It was very helpful for members of the community to have a visit.

COMMITTEE MEMBERS - Yes, it was great.

Dr SEIDEL - Can I still come?

CHAIR - You can go and have a look.

Thank you again, so much, particularly for all those personal accounts and stories. They are quite tragic to read. As the elected member for that beautiful place it does break your heart to hear the hardship of some people, through no fault of their own.

Are there any closing remarks you would like to make or have you covered it off?

Ms THOMAS - I just have one on mental health. It was wonderful to hear from the previous witness that he sees there has been a lot of improvement in mental health care provided in the state. I haven't seen that evident on King Island. The example that you talk about in our submission about the individual who was discharged on a Friday, sent home, nobody on the island told that he was there and a very sad discovery on the Sunday. Those circumstances are not unusual. The outcome was quite extreme, obviously, but those circumstances are not unusual.

The nominated counsellor for the island has recently ceased her business and there is no communication or information available on the island about how that service is being replaced. So individuals who were provided with referrals in the week or two before she closed her business have nowhere to go.

CHAIR - How was her service funded prior to her closing her business?

Ms THOMAS - Through the state government.

Ms MAURIC - For a period of years but that just happened. It was a message that came on her personal Facebook saying: 'I'm leaving', that sort of attitude. The hospital wasn't even aware, it just came as quite a shock to the community.

Ms THOMAS - Now nobody knows what is happening next. The hospital doesn't know what is happening next, the GPs don't know what is happening next. There is no response coming from the individual's office because they have closed their business for their own mental health concerns. It isn't a criticism of them.

The system should have something in place. If there was a contract in place between state and that business, then how is that contract exited, how is that contract replaced, what process is put in place to look after the needs of the community meanwhile? There is no transparency on that.

CHAIR - Thanks very much. It was lovely to see you. I will be over in March for the show.

Ms THOMAS - I will update you on the things that are happening that week.

THE WITNESSES WITHDREW.

CHAIR - Thank you all for appearing. We have your submission. I will speak to Grant who is in the room with us. We will ask him to take the statutory declaration because he is giving evidence within Tasmania. Ms Evans and Ms Hobson-Powell don't need to do that because you're outside Tasmania.

I will explain the process that everything any of you say here is covered by parliamentary privilege while you are in front of the committee. It might not extend when you leave. If there was something you wanted to talk about of a confidential nature you could make that request and we would consider that but otherwise it is all public. It will be transcribed and put onto our website and used to inform our committee deliberations at a later time.

Does anyone have any question before we start?

Mr GRANT TODD, ESSA, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

Ms LEANNE EVANS and **Ms ANITA HOBSON-POWELL**, ESSA, WERE CALLED VIA WEBEX AND WERE EXAMINED.

CHAIR - We have read and received your extensive submission, thank you very much. I will get you to speak to that. The committee will have questions. It is something that is probably fairly new in terms of the health setting. I became most aware of it when Stephen Stone from SWIRL in Circular Head called me into his office one day to give me the lowdown on how important exercise physiologists are.

Mr TODD - I am glad he did.

CHAIR - He did. He was very forthright in his opinions as you would imagine Steve would be. I will let whichever order you want to introduce yourselves and who is going to speak first. I will let you manage that.

Mr TODD - I want Anita to go first.

Ms HOBSON-POWELL - I am Anita Hobson-Powell the CEO of ESSA. I have been with the organisation since 2006. I am also the chair of the National Alliance of Self-Regulating Health Professions and the deputy chair of the Allied Health Professions Australia. I am also an exercise physiologist but I have not practised for about 17 years. I work both in a clinical and a supporting setting.

Ms EVANS - Thanks, Anita. My name is Leanne Evans. I have worked with ESSA since 2017 in the Government and Policy Relations. I also did my undergraduate studies in exercise science. I am not a clinician so my comments are purely made from a policy perspective.

Mr TODD - I am Grant Todd. I am ESSA Accredited Exercise Physiologist. I am the treasurer with the ESSA state chapter and have been on the committee since 2018. I have been a practising EP since 2013, run my own private practice on the east coast of Tasmania and have run exercise programs in rural communities outside Launceston. I currently work for the Centre for Rural Health at UTAS.

Ms HOBSON-POWELL - I am going to start with some opening remarks. I would like to acknowledge the Traditional custodians of the land, seas and waters throughout Australia, particularly on the lands which I am speaking to today which is the lands of the Turrbal people and I pay my respects to the Elders past, present and future. I would like to acknowledge any Aboriginal or Torres Strait islanders who might listen to this inquiry or who are listening to today's proceedings.

Exercise and Sports Science Australia is the peak body for exercise in sport science professions in Australia and we have over 9000 members nationwide, including the exercise physiologists and exercise scientists. Exercise physiologists apply their skills broadly in the primary, secondary and tertiary healthcare, not limited to doing personal injury, workplace rehabilitation and chronic disease management, working in the aged care and the disability sectors. Exercise physiologists are recognised members of the allied health and we are required to complete a four-year degree or a master's post-graduate studies.

The exercise scientists have a three-year degree apply the Science of Exercise to the design and delivery of physical activity in an evidence-based practice and they will often work as an allied health assistant today.

Today, I guess, we are here to talk about the underutilisation and the lack of recognition of the exercise physiology workforce in rural Tasmania. As of 31 December 2020, there were 114 exercise physiologists across Tasmania. Many of the EPs are in the outer rural areas including Burnie, Wynyard, Devonport. Based on a survey done earlier this year, about 48 per cent were working in private practice and others were working in fitness centres, gyms, higher education or within the workers compensation space.

Currently there are no exercise physiologists working the Tasmanian health care sector or within the rural communities' health centres. The Northern Territory is the only other state or territory in Australia that does not currently employ an exercise physiologist in their public health system. This does leave patients with many conditions that will benefit from appropriate exercise interventions delivered by an exercise physiologist to seek services and will have to go privately, at their own cost, using Medicare or a Department of Veterans Affairs or compensations to access the services. There are some services being commissioned by Primary Health Tasmania, but they are sporadic and limited in their access.

Since we started this submission, we understand there has been a restructure at the School of Health Sciences at UTAS around the clinical exercise physiology degree and their last intake of students was in 2019 which means there is no longer an under-graduate pathway for an exercise physiologist in Tasmania.

They are considering whether they will do a masters program, but at this point, it is not. The difficulty has been in recruiting exercise physiologists into the program because there is a lack of employment opportunities.

As you are aware, the proportion of Tasmanians have a chronic condition including cardiovascular disease, arthritis, cancer, asthma, and a lot of these are related to overweight or having obesity, and exercise physiologists treat many of those conditions.

I guess we need to ask the committee to consider two main priorities for us. One is providing greater access to exercise physiologists in the community health sector, in this room,

partnerships with private/public system. Our other request is to expand the professions that can provide, who can apply for all positions in hospitals which will be just for OTs and physios. An exercise physiologist is another option who could play a role in that physical therapy space.

CHAIR - Thank you. Did you want to say anything, Leanne?

Ms EVANS - No. I am happy to answer questions.

Mr GAFFNEY - It's an overarching question, I suppose: Forty one recommendations, and we have about 40 minutes, so instead of going for one minute per recommendation, I will go to the four summary dot points that are in the submission. I thought it might be good to hear a little bit of background on each of those four. That would be on page 2 of the submission. You have touched briefly on some of that.

Ms EVANS - Do you want to highlight which recommendations that you want us to speak to?

Mr GAFFNEY - No. I said, instead of going to the individual recommendations at the moment, perhaps the four-dot-point summary in five minutes. You covered some of those but to me they are probably the most four important summaries of the submission. Instead of looking at the individual recommendations, just look at those four. It is on page 2 of the first submission we got. You have touched on some of those but if you sort of just spoke about those four, then that would give us an overview. Then you might highlight some of the recommendations that you think might be pertinent to us, if that is okay.

Ms EVANS - Sure. I guess Anita's touched briefly on the kinds of interventions that exercise physiologists can look to support. It's fair to say that our professionals support clients and patients with, in many cases, acute and/or chronic health conditions. Often those people have injuries. They may also have concurrent mental health conditions. That is basically the core business of what exercise physiologists do. That is point 1.

That comes back to our call for greater access to people in the community to see an exercise physiologist.

In terms of dot point 2, the theory is lots of evidence to support the fact that working with an Accredited Exercise Physiologist can both reduce the burden of chronic disease and it can also prevent chronic disease. Particularly in the case of Tasmania, we know that, as I'm sure are very familiar, with all the statistics that there are higher rates of chronic disease in Tasmania than in many other locations, compared to Australia.

In relation to the third point, we've also got evidence to suggest that an investment in exercise therapy in respect to providing treatment much earlier in the life cycle of a condition, is going to save both hospital admissions, time in hospital, and increased recovery time. That is the sort of brief response to that.

In terms of the fourth point, we've put forward some suggestions in Anita's opening statement, so we think there are two key areas that are worth considering, and one of those is in relation to partnerships. We have an example of one of those in Wynyard, the North West, and Burnie, where we understand that allied health professionals and other health professionals are being subsidised with rent in community hubs. We are also aware of other models in New

South Wales and we will be happy to pass on to you some research on the establishment of private/public partnerships. Is that enough?

Mr GAFFNEY - No, that's good. A specific question there. With some allied health professionals, it looks as though working as part of a team working out of the one venue, an exercise physiologist, plus somebody else, plus somebody else, for a core instead of independently. What is the most preferred model that has the best bang for your buck, sort of thing, from other jurisdictions that you know of or other areas? Is there a model we could look at that shows that this is where you get a better return for your investment in our public health system if there were exercise physiologists available or funded?

Ms HOBSON-POWELL - I can give you a quick example. What we were seeing around the outcomes, in particular the diabetic patients, if they are able to - I guess the big thing is commuting them into places sometimes. Where I live is a super-regional area, so people will come in, they will see the exercise physiologist to get their exercise program and then when they have finished that, they go next door and see the dietician and they look at their diet and the dietician will often look at their insulin. But the two professionals will then talk to each other. Because there is no funded thing around case conferencing they do this naturally. If the exercise physiologist is seeing improvements in the patient, they can say to the dietician, 'I think their blood glucose levels are changing', either we look at their diet or send them back to their GP to get things tested. If they have that core time spent looking at the multifaceted way of treating, they are getting better outcomes and a better monitoring of what the client is actually needing.

Mr GAFFNEY - Thank you.

Ms HOBSON-POWELL - Is that the sort of example you were looking for?

Mr GAFFNEY - Yes, that was good, thank you.

Ms LOVELL - Under Barriers to Access, you've said that there's no ESSA-accredited exercise professionals working in the Tasmanian Health Service. What is your understanding of why that is? What obstacles are there to that? Is it just not a recognition of the value of the profession or what would the obstacles be?

Ms HOBSON-POWELL - I think there are a lot of assumptions there. Unless you have seen it, it is often hard to introduce some things. A lot of the times we are seeing the natural rise because once they're introduced, just that first exercise physiologist, and they're seeing the outcomes, then another department will get them on board. Or you will see up here in Queensland, they'll see what is happening at the children's hospital around mental health and then they will introduce another mental health service up in far north Queensland. They'll learn from each other. So I think that's one of the barriers - until you've actually worked in a setting where you've seen them interacting. It is easy to bring in, I guess, to try and test it. I think the big barrier is getting one of the departments to make the call to bring in one, test it and show the benefits and then, hopefully, other departments will take it on board or other hospitals will take it on board.

Ms LOVELL - Have there been any discussions with the health department or the Government around that?

Ms EVANS - Yes, we have been engaging with the directors of allied health in the different health regions. We've made some progress. It's probaby fair to say, as Anita has said, it's a cultural change process because we're a relatively newer and younger profession than more established professions. Also noting that in the PHN submission, there was a reference to what was called professional protectivism. In other words the existing professionals that are within the system wanted to protect their positions. We're the new kids on the block trying to get a look into the system.

Ms LOVELL - Okay, thank you. On page nine there is a table of numbers per sector as of 31 December 2020. There are two AEPs according to this table working for a state government organisation. Are you able to tell us what organisation or what department?

Ms EVANS - We will take that on notice and come back to you.

Ms LOVELL - Thank you.

CHAIR - You don't know, Grant?

Mr TODD - No, I don't.

CHAIR - There are no EPs working in the state Department of Health. Can you explain to us, Grant, what you do and what someone like you could offer within our state's health service?

Mr TODD - I will preface that by saying in the business I was running in St Helens I was working a lot more in exercise physiology. I no longer do that because it wasn't viable any more. I had to unfortunately leave the community because of two hours travelling there and two hours travelling back to Launceston. A lot of the clients I saw were based through the Medicare system and other compensables so my income relied on that. Many times I would have people not turn up, so it became unviable.

What I can offer people in the state sector is to work with other allied health professionals to provide exercise programs for people who have chronic disease, musculoskeletal, cancer and many other areas. I also work in areas of preventive health and with people with obesity to prevent diabetes. We've heard today about diabetes on King Island. I am staggered by that unfortunate situation. If exercise physiologists had been on King Island as an ongoing part of the program, we may have had better outcomes for the people in those rural communities.

We can do individual exercise programs and consultations for people who want a one-on-one setting. We can work with groups and do group exercise programs for people with a condition or multiple conditions. We can also work with other allied health professionals to give a holistic approach to the community's health.

Dr SEIDEL - The evidence base for exercise physiology is solid. In cancer care you mention that it improves outcomes. We talked about some chronic pain as well. Using exercise physiologists can reduce opioid use. There was a Tasmanian study done in the Huon Valley not long ago. They have a role in aged care facilities as well. You mentioned UTAS no longer offers an undergraduate degree. That is pretty foolish, because you would argue for an all-hands-on-deck approach. We need to plan our workforce and need to offer a variety of allied health professions to the community and therefore need to train them. If we don't train them

here we have already heard they don't come, or they leave again. Is that short-sighted? Has the university been speaking with you as a professional organisation?

Mr TODD - They certainly haven't been speaking with us as a professional organisation about that. I think that it is a really unfortunate aspect of timing. I have spoken with the head of school previously and have been given assurances that it will be coming back, potentially as a master's program. UTAS is in the process of developing an allied health expansion program which is rolling out physiotherapy as a masters program next year along with speech pathology. That's the concept at the moment.

The next one to come on board would be occupational therapy but we're still unsure as to how exercise physiology will fit into this. I see your point and feel the same personally that it's unfortunate that we've lost exercise physiology when we did have students who were keen to get involved.

Dr SEIDEL - A decision was made without any input from the peak body?

Mr TODD - I believe so because -

Ms EVANS - We've only stumbled on this in the last week and a half in preparing for this. One of our colleagues is in discussion with the School of Health Sciences this week. As Grant said, we're optimistic that the masters course might resume. In the meantime, there's a gap so there are no new graduates coming out of the system.

If we go back a step, we think it's probably a chicken and egg situation. Enrolments have been low in some years, partly because of the job market. The viability of people transitioning into small private practices is difficult. Grant has given you the example of him trying to run a practice when it involves large distances and the majority of patients seeking services via Medicare and can't afford the gap payment.

You would be aware of the workforce incentive program that the federal government runs. We believe that's probably under-utilised in allied health. One thing we're advocating the federal government do is to allow allied health businesses to use that program to employ allied health professionals. At the moment that's restricted to GPs employing allied health professionals.

CHAIR - Mike's comment was about a number of recommendations. They all have merit in different ways. Can you either consolidate some or narrow down to five key areas what you think should be our focus when we look at the information you've provided and the way forward?

Ms EVANS - We are probably happy to narrow that down to three.

CHAIR - Sure.

Ms EVANS - Anita has mentioned two of those. The first one is funding away from the hospital system to support the employment of EPs in community health centres. We're not asking for new funding. We would recommend that funding be transferred out of the hospital system to allow for the employment of EPs within community health centres. That's probably our first priority.

The second one is expanding the number of roles within the public setting that already exist and allowing EPs to apply for some of those positions. As Anita said, to demonstrate to people what exercise physiologists can do within a hospital setting. Again, that's not going to cost anything. It's a cultural change process.

The third thing we flagged in consultation with the state chapter is the possibility of establishing pre-hab and rehab units for surgery patients within the two non-metro hospitals in Tasmania. This is partly to reduce hospital admissions. We have evidence to suggest that a very solid and comprehensive prehab program in some cases can help avoid surgery. A rehab program means people can live their lives more independently in a faster time frame. We're happy to leave that at three. We appreciate there are a whole lot of recommendations.

CHAIR - There are always ones that are more important to the organisation. It's sometimes hard for us to figure out which ones they are but that's really helpful. Other than the turf-war matter that was raised earlier for people not wanting to give up some of their space in the professions, are there any other barriers that you are aware of, or any clear reasons for pushback or non-engagement of EPs in our state health facilities - particularly in areas like rehab, and other areas where their value has been evidenced?

Ms EVANS - I think partly it is a lack of understanding in the scope of practice. That is something that, as an organisation, we are constantly working on. Not only the scope of practice for exercise physiologists, for some of the newer professions that are also allied health professions in Australia. That is an ongoing process, in terms of educating service planners on the scopes in practice, and the capacity and impact that various allied health professionals can bring to a particular service. Have either of you anything else to add?

Ms HOBSON-POWELL - The other barrier is challenging some of the models of care that have existed. For example, someone presents at hospital having a psychotic breakdown, they are put on medication and see the psychiatrist, whereas they could also be referred to exercise programs as part of their treatment. Or, someone turns up and has had a fall; sometimes they'll have to do surgery, and then they'll get someone into their home and look at what modifications need to be done - but they don't think, okay, they've had a fall, so they need muscle strengthening; let's refer them into a community exercise physiology program to make sure they don't have another fall.

It is challenging knowing that patients are presenting, thinking is there an exercise element that can be done instead of the status quo of surgery, medication? They don't know what they don't know, or they're afraid to try to do something differently sometimes. I don't know that there has been a lot of looking around the country to see where exercise physiologists are tapping into the healthcare system and the good work that they are doing.

One of the models Leanne presented was prehab orthopaedic surgery. There is a lot of work being done in Western Australia looking at that space. In Queensland at the moment, type two diabetics are a focus and mental health, putting more EPs in those mental health wards. There could be a bit of work seeing what is working in the various states, and what priority should be happening in Tasmania.

CHAIR - Have there been any direct approaches to our health minister or the department in terms of those areas, and if so, what has been the outcome of those meetings?

Ms EVANS - We have had a number of meetings, as I said, with several directors of allied health within three hospital systems, from memory.

CHAIR - It is supposed to be one system, but it is three or four hospitals. I was wondering what the outcome was. Have you made any progress?

Ms EVANS - We are at least having conversations. It is fair to say we have established contact. In some cases, there is a willingness to try to understand more about the impact that our members can have. It goes back to that cultural change. We are yet to have a breakthrough, and we are looking for champions to advance the cause within the system. In some cases, they may be leaders in orthopaedic surgery or a lot of other fields who can help influence change from within the system.

CHAIR - If you were sitting across the table from the minister, what would you ask him?

Ms EVANS - We would ask for a fair go. We know what the evidence says. We know what our people can do, so we would like to secure some opportunities for our people to get in, once people see the impact, as Anita said.

To give you another example, Metro South addiction services in Brisbane started with one, and now they're looking at employing six EPs in just one regional mental health service. They have actually seen the impact. They can see people are better able to cope with depression and anxiety and other mental health conditions.

As I said, it's a journey, and that's why we are here today. It's partly education, and it's also a request for help to see what the committee can do in terms of making some recommendations to the Government.

Mr TODD - Can I add something to that?

Ms HOBSON-POWELL - If we were in front of minister, it would be a commitment to employ at least one EP in each of those hospitals, whether it's all in the same unit, or in different units - but a commitment that there is at least one in each hospital.

Ms EVANS- And/or a community health centre. We're not fussy.

CHAIR - Grant wants to add something.

Mr TODD - I wanted to add to the concept that Leanne mentioned, about professional protectionism, and avoiding that entirely. If we were talking to the minister, we would be best suited to say, let's just avoid all of that and deal with things where we can be used.

You mentioned other allied health groups where exercise physiology would be really beneficial. It would be hugely beneficial for diabetes centres to receive exercise physiology as part of their service. If these services aren't currently being used, then why not have exercise physiologists go in there, and you don't have to worry about that professional protectionism?

CHAIR - So get your credibility there.

Mr TODD - Yes, get your credibility in other areas - in the Holman Clinics of the rural communities, in the diabetes centres where we currently have endocrinologists, diabetes nurse educators, dietitians and psychologists, but there's no exercise physiologist.

The biggest thing that the evidence suggests and people talk about for diabetes management is diet and exercise. Back in March last year, when we started to be locked down with COVID-19, I thought it was absolutely brilliant that our Premier was on the news saying we need to make sure that we exercise; this is part of our lockdown strategy. However, many people in our communities just do not know how to exercise. If there had been access to exercise physiology services in our communities, or at least through telehealth, like Phil was saying from Primary Health Tasmania, then we may be better placed to improve the health of our communities.

CHAIR - I think you are probably right, in that if you look for the gaps first - and there are gaps all through the health system - you will probably be less likely to have a battle to establish credibility.

Mr GAFFNEY - Anita, Leanne and Grant, in other states it seems as though the exercise physiologists are better regarded, because obviously there are jobs there now for them which there weren't before.

Anita, you are in Queensland?

Ms HOBSON-POWELL - Yes, we both are.

Mr GAFFNEY - What other medical organisations did you have to try to convince that there was a role for EPs in health recovery? Did you have to go through your local Australian Medical Association? What groups seem to have the ear of the health minister? Did you have to get some value-adding or credentials? Is Tasmania the only state that doesn't have EPs?

Ms HOBSON-POWELL - And the Northern Territory.

Mr GAFFNEY - So, what was the journey there, where you had to try to convince other professional groups that there was a place for EPs within the health system - and how long did that take?

Ms HOBSON-POWELL - To be honest, I don't think we went to any particular groups. As Leanne mentioned, it was more about championing the cause, having someone within a particular unit to drive something. We obviously go to a few conferences. A couple of years ago we went to the psychiatry college conference. That was our focus for the year. We saw people go back to their units and say, 'We need to make sure the next position we have available is an exercise physiologist. In the next two years we saw a huge growth in the number of exercise physiologists who were either employed into mental health units or as part of community programs through Headspace for example where there was a referral network. It was in-house people who were driving that. We did something similar up here in Queensland about 10 years ago, going to cardiovascular conferences. We then saw cardiologists trying to ensure that there were not only cardiology rehab facilities but also access to individual care when they went out into the community.

It was about targeting professionals rather than organisations to make a difference. In Queensland we are targeting the government specifically about type one diabetes in the diabetes clinics, showing the benefits. As Grant mentioned, they have clinics with dieticians, the diabetes educator, now let's get the exercise physiologists in there as part of the treatment.

That has been more of the model of what we've done. It's been a two-year journey in some areas, in others it's been a 10-year journey. The other angle we're taking is we're talking to directors of allied health within each of the health services area in Queensland. We've managed to get a meeting and have all the allied health directors come along to a meeting. We spoke to them for an hour about the benefits, what types of work we're trying to do and trying to get them to have a commitment that in the next 12 months they will try and get an exercise physiologist on board.

Mr GAFFNEY - Thank you. Last question. How many of the universities in Queensland would offer an EP course?

Ms HOBSON-POWELL - The training?

Mr GAFFNEY - The Tasmanian one, because it is not being offered, doesn't promote what we are trying to do. In Queensland how many of the universities offer a training course?

Ms HOBSON-POWELL - Every university has an EP program. Nationally there are 33 universities that will deliver either an exercise science or an exercise physiology program. I think there are 44 universities in total. I think there are about 25 that offer exercise physiology. Most of the universities are doing a program and a good percentage are either doing an undergraduate or postgraduate program.

Mr GAFFNEY - Okay, thank you.

Ms EVANS - We can take that on notice.

Ms HOBSON-POWELL - Yes, we will give you exact figures.

CHAIR - We are out of time. Are there any other questions from members, any other closing comments you would like to make?

Ms HOBSON-POWELL - No, but thank you for the opportunity.

Mr TODD - Thank you very much for the opportunity. We really need exercise physiology in the state health sector. That is the point of it all.

CHAIR - Thank you very much. Thank you for your time today.

The witnesses withdrew.