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THE PARLIAMENTARY JOINT SELECT COMMITTEE ON PREVENTATIVE HEALTH CARE MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART, ON THURSDAY, 7 MAY 2015.

PREVENTATIVE HEALTH CARE INQUIRY

Mr GRAEME LYNCH, CHIEF EXECUTIVE OFFICER, HEART FOUNDATION; **Ms CONNIE DIGOLIS**, EXECUTIVE OFFICER, STROKE FOUNDATION; **Ms JACKIE SLYP**, CHIEF EXECUTIVE OFFICER, ARTHRITIS TASMANIA; **Dr INGRID VAN DER MEI**, PUBLIC HEALTH ASSOCIATION; AND **Dr PAULINE MARSH,** AND **Ms MEG WEBB**, TASCOSS, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Ms Forrest) - Thank you all very much for coming. This is a public hearing and everything you say will be recorded on *Hansard* and will be transcribed and made publicly available through our website. You are protected by parliamentary privilege while you are before the committee but if you speak to the media afterwards then you are not protected. We have received your submissions to this inquiry, and also to the previous inquiry which has been taken into the evidence of this committee, so they are both relevant to this committee. If you want to raise any matters in camera you can ask the committee to consider that, and we would, otherwise it is all public. Graeme, would you like to make an overall statement and speak to your submission?

Mr LYNCH - I acknowledge the traditional owners at the beginning of this hearing, the mouheneenner people, and pay my respects to elders past and present as the custodians of the land on which we are meeting.

Chair, I congratulate you as the Chair in the role you played initially in getting this preventative health committee in place several years ago and then again in reconvening the committee. One of the things the Health in All Policies Collaboration is grateful for is the fact this committee has had the support of all three parties and independents in both Houses. It is great to be able to talk to you and add to the submissions we made a couple of years ago.

In relation to the work that has come out of this committee, when we were last here a lot of the conversation was around a single health network in Tasmania. We are delighted, in part, that this committee played a role in that because many people who submitted to the committee were able to get the focus on removing a barrier to move towards a statewide health system and being able to implement a health-in-all-policies approach, a social determinants approach, and a much better coordinated preventative health care plan.

CHAIR - There was certainly a consistent message in the last inquiry.

Mr LYNCH - It was very stolid and I think you, Chair, led that debate and got that good outcome. The other thing you just mentioned, being able to get all the previous submissions onto the public record and into the evidence for this committee is very

helpful as well. In our submission there are a lot of things we relied on that were in the previous evidence that are now in play and the public now has access to. The Government will also have access to all those submissions and the wealth of evidence that was in them.

I am here as the Chair of the Health in All Polices Collaboration. If you refer to appendix 2 at the back of our submission you will see the history of the collaboration, how it came together, who the members are, and what we represent. Unfortunately today Asthma and Diabetes are not with us, but I understand they have made a separate submission and will be presenting their addendums to the submission separately on another occasion.

With the committee's approval, I will set the scene very briefly and speak to our submission. We were then going to take the committee to our recommendations, the journey we have been on with the recommendations in the first committee and what we are recommending today in our current submission. I will then briefly talk about the model we have been advocating for many years now since we set up the collaboration about how a comprehensive approach to intersectoral action could operate in Tasmania and the mechanisms to drive that and make it accountable, and to move towards the goal the current Government has set for us to be the healthiest population by 2025. Then, Meg, who is acting CEO of TasCOSS, will talk about the role of the community sector. Connie, who is the executive officer of the Stroke Foundation will talk about a model for early detection. The Public Health Association, Ingrid, will talk about some examples of health impact assessments with some reference to what is happening in South Australia and why that has worked in part and not worked in other ways. Finally, I will speak to a couple of the suggested strategies that could be considered by a sector body if it was put in place from the Heart Foundation's perspective.

At the last hearing we spoke of a narrative around Bev to give a focus on what really preventative health is about, and that is about individuals in our community and how we can make life better for them. We have updated the narrative.

I will very briefly paraphrase what was taken into oral evidence back on 27 October 2013 where I told the story of Bev from the experience that I had had outside health, but as a lawyer, to illustrate that right across the community we interact with issues that are related to poor health and wellbeing and what that can lead to in the community. Bev lives on the outskirts of Hobart. She grew up in disadvantaged and intergenerational poverty. We talked about how her father died from a heart attack when she was quite young. Bev then had a number of partners, had a daughter at a very young age, smoked like her father and grandfather before her, and the difficulties Bev had about moving out of the situation in which she lived. She was living in isolation and she did not have easy access to the City of Hobart. She didn't have easy access to all of the things in an environment that would encourage health and wellbeing. There was a plethora of unhealthy shops, liquor stores, fast food stores and so on in her environment, and Bev inevitably had a number of chronic conditions, was depressed and socially isolated. That is a snapshot of the scenario we set for Bev.

What we have done collectively today is marked as exhibit B. We have looked at Bev and 18 months since we last heard about her things really have not improved in Bev's world. Whilst Bev finally had her knee operation six months ago, when she was

discharged from hospital her GP did not receive a discharge summary and did not even know she had had surgery. Due to her diabetes Bev's wound is not healing very well. The wound was red, rashy and a bit weepy. She tried using some of Michael's - her one-year-old grandson's - nappy rash cream for a while to see if that would help. But after three weeks it was getting pussy and she finally rang her GP to see what to do. Still without a car and limited public transport, she had to use the last of her fortnightly disability payment on a taxi to get her there and back. Luckily the GP bulk billed her but the antibiotics she needed for her infected wound had to be put on the credit card.

She had to get a pay day loan to make the overdue credit card payment or ask her daughter for some of her unemployment benefit. Bev is already seeing history repeat itself now in the way her daughter's life is panning out, and her beautiful grandson's life has already had a rocky start. But what would Bev's grandson Michael's story look like if these circumstances were different as a result of an integrated health system, a robust preventative health strategy, and if responsibility for the health of Tasmanians was taken by all sectors and all layers of government and the community?

What would Michael's story look like if an intersectoral action board had been established such as that proposed by a health-in-all-policies submission that provided the mechanism for a health-in-all-policies approach to be adopted in Tasmania? Possibly something like this: whilst Michael has started his life living in poverty and his family life is a bit dysfunctional, his mum, Jane, attended parenting support sessions through the peer education, Empowering Parents, Empowering Communities Program run at the Neighbourhood House.

Michael spent his pre-school years attending the Child and Family Centre with his mum where he had access to early year programs. When Michael was old enough to go to school, Jane saw how well he was going and decided she should go back to school too and finish year 12 and get a job. By now, the Education department has a policy that everyone goes to school until they have completed year 12 and receives support to do so. Michael also went on to complete year 12, which was good.

Our studies also show that those who have attained year 12 earn on average a higher level of income than those who do not complete school. It is also well documented that more educated individuals in turn have better health outcomes.

Michael does well at school and he even thinks he might go to uni or learn a trade. Because a state policy for healthy spaces and places is now well in place, there are now more options for Michael to be able to go on and do further study. The public transport system has improved considerably due to the increased population density due to the mixed-use and more sustainable, affordable, energy-efficient new housing that has taken place over the last few years. With the now much improved cycling infrastructure, Michael will often ride his bike. With some cheap bits and pieces off the internet, he made an electric bike with his mate. Even Jane likes to use it.

It is much easier now for Jane or Michael to take Bev to the Community Health Centre where she likes to go for weekly exercise classes. It has been helping her get some strength back since she had a knee replacement on her other knee a few months ago, and the friendships she has made have been invaluable.

Due to changes in liquor licensing laws, the high number of liquor stores in the area has been reduced, which has reduced drunkenness behaviour and makes the area safer and much more pleasant to live in.

Michael loves spending his time at the skateboard park, where he has fun with his mates while being physically active.

Instead of liquor shops, an extra fruit market has been established in the area with affordable, yet decent-quality vegetables. Jane start a cook group with her friends and she is now so proud of her meals that the whole family has to sit around the table. Just imagine what such small change makes to a family. Michael now loves meal times and makes sure he is home on time.

Poor Bev was beginning to think she was going to have to move into a nursing home if her knee was not put right. But when she was discharged from hospital this time, her electronic patient record was shared with her general practice so that her doctor was aware of what had taken place and had an up-to-date history of the other investigations they had done and the new medications Bev had been put on in hospital.

You can see what a different story this is to the story of Bev and her family we told the committee 18 months ago.

Last time we submitted exhibit B, this diagram which sums up the issue we have to address in Tasmania. That is, understanding the difference between equality and equity. If we start to address these issues, we will get to a stage where healthy choices will be the best choices people will make for themselves. Unless we address the inequities and the social disadvantage in Tasmania, we are not going to have a population that is able to make those best and healthy choices. That captures, in a very specific way, what we are talking about.

CHAIR - I spoke to the minister about health services on the coast.

Mr LYNCH - It is interesting when we talk about personal responsibility. We want to be at a stage where the healthy choice is the best choice people make for themselves. Unless we address the structural things that are going on in Bev's life, she is not going to be able to do that. In our submission we refer to the fact that, if you look at the bottom two quintiles of the population in Tasmania, that represents well over 200 000 people. That is not dissimilar to the number of people in the bottom quintiles in a state like Western Australia while Queensland is about three times more. A major proportion of our population is living in the circumstances that Bev was living in 18 months ago.

We don't intend to speak to the nature of the problem. Everybody sitting on this committee is fully aware, and there are many submissions from Medicare Local, the Health Advocacy Network, Menzies, and even the Minister for Health's submission to this committee that outline the problems that we are facing in Tasmania, so we don't intend to go over the high incidence of chronic disease and disadvantage in Tasmania.

I would like to briefly turn to the recommendations we made 18 months ago when we were last before the committee. There were three core recommendations. One was that we start to adopt a paradigm shift in the way we think about health. I think due to this

committee and activities that have been going on in Tasmania, if I take you to page 21 of our submission you will see where we have captured the comments of the three political leaders as they were at the time before the 2010 state election.

You can see that at that point in time - nearly five years ago - there was an agreement that we had to start to do something in Tasmania. We then extracted the statements and commitments that were made before last year's state election, and you can see there is an even stronger commitment from the then Premier Giddings, the then Liberal Leader, now Premier, Will Hodgman, and the Leader of the Greens, who were all really moving towards the sort of work that this committee is considering around how we address health in all policies and social determinants. We can almost, as we can with a single health organisation, tick off that that paradigm shift is taking place in Tasmania because of political awareness for this.

The second recommendation was that there should be a health in all policies taskforce and we have seen some good movement in that space. There was the Ministerial Health and Wellbeing Advisory Council that was established by the previous government, which handed down its report at the end of 2013. There has also been the recent establishment of the Healthy Tasmania Committee under the Health Council of Tasmania that is advising the minister around preventative health. This is showing the willingness of two governments, Labor and Liberal, to move towards taking some action in this space.

The final recommendation was that there should be an increase in investment in preventative health and the health in all policies and social determinants space. Unfortunately in that space there is really no evidence that we can point to but in our submission and the model we have, we have some strong suggestions about how we might be able to release some resources in the system to make more of an investment to address the problems we have been talking about.

Our three recommendations today in our current submission are really about the building blocks to working towards Tasmania being the healthiest state by 2025. First, we are advocating that this committee looks at and makes recommendations about how we implement a whole-of-government state plan to work towards that goal of being the healthiest population by 2025. Second, we are advocating for a health-in-all-policies approach to implement that state plan. Third, we look at statewide population health planning and resource allocation to be able to deliver against achieving the goals of the state plan.

Before I invite my colleagues to address you, I would just like to take you to page 16, which is really the core of our submission. This is the proposed model for a health-in-all-policies approach in Tasmania. We have been aware since the health-in-all-policies collaboration came together that unless there was a long-term approach to how we address these problems, we will not achieve anything. In discussing this around the community, there is often a push of governments to go towards small-'p' policy, but our experience in this sector is clearly that small-'p' policy comes and goes. Sometimes it is quite sustained. Often it is very well intentioned, but with changes of government and changes of circumstances, small-'p' policy is very vulnerable to those changes.

We have been looking at it and advocating for a legislative approach for a big-'p' policy. One of the ways we believe this can be achieved is by building on the existing strengths

that exist in the health system, particularly in population health services, with the paradigm shifts we are talking about and moving the responsibility for the care of the whole community into an intersectoral environment. We believe the best way to achieve this is through an act of Parliament that creates an intersectoral board or agency that is able to deliver long-term advice to government to drive long-term change.

We see that this act would do a number of things. It would firstly look to research information, tools, how we would go about evaluating the strategies that would be put in place. It would identify and recommend priorities to government, and we see this board reporting directly to the Premier because it is only in the Department of Premier and Cabinet that you can drive change across all of government. It will not happen in a silo, in the Health department, it needs to be across all of government.

The act needs to create performance indicators for government departments and government secretaries to perform against agreed outcomes to deliver long-term sustained addressing of these problems. We see that the board could be charged with looking at legislation. In Bev's story we have talked about education, planning and justice. There are many places where we could insert into existing legislation, rules, policies and guidelines interventions that would improve the health and wellbeing of Tasmanians.

Finally, the board could look at how we could use existing policies, instruments and powers that exist within a whole range of agencies of government and across the community to enhance them further. An example could be the Environmental Management and Pollution Control Act where there are many things that can be done there that currently are not used, either because they are not resourced or because government does not look at these through a health and wellbeing lens.

Ms O'CONNOR - Graeme, perhaps you might elaborate on that at some point when you get a chance because that is quite a specific piece of legislation when you talk about many things that could be done with EMPCA or looking at the EMPCA model. It features quite heavily, as such.

Mr LYNCH - Sure. Resource allocation is the key to being able to drive some of this change that is needed in Tasmania, particularly because of our population profile and those 200 000-odd people living in those two lower quintals.

Because we all work in this space we see that the way funding works often in this area is to force us into silos so that we cannot work collaboratively and compete with each other for resources but, as my colleagues will talk specifically to, many of the things we need to do are common. Whether someone has heart disease, diabetes or kidney disease, 95 per cent of their care is about the sort of things that Bev's concerned about. Only 5 per cent of their care is for the chronic condition, itself, whether it is taking the statins, the blood pressure medication or the insulin, whatever it might be. Ninety-five per cent of the care is in the system itself.

So why do we fund just heart disease, stroke, diabetes et cetera? Why don't we pull all those things together on the Premier's Physical Activity Council, which I chair? If we are talking about a state policy for healthy spaces and places my colleagues on the council say, 'We're the Physical Activity Council. We're not going to talk about

integrating food and nutrition which directly is related to planning or social inclusion', for example. Clearly we need somebody who can pull all these things together.

It is the same when we talk about community awareness and social marketing campaigns, again using the Premier's Physical Activity Council as an example. We have a website where we talk about physical activities, but we're talking to the same audience, while at the same time and through the same communication channels we should be talking about nutrition, sexual health, smoking, excess alcohol consumption and so on.

The way we are funded and the way we think about things is very much in silos. What the Premier's Physical Activity Council should be doing is giving advice to the intersectoral board to then look at whole-of-government solutions as to how we work collectively together to pool that expertise and deliver better outcomes. The way we suggest that can be done is by looking at different funding models where, through the intersectoral action board and its advice, we fund bodies to work together to achieve outcomes. It is a commissioning model based on outcomes - not just buying a physical activity solution but buying a healthier Tasmania solution. We can do that through local government, through state government, through organisations that are sitting here before you today and through the private sector, where we all work together and get funded to produce an outcome.

That is really the core message that we wanted to leave to the committee today. Meg would like to speak about the role of the community sector in this space, and we are happy of course to take any questions as we go through.

Mr VALENTINE - When I look at this, to me it seems fantastic. It is a great idea. How do you ensure that every party is committed to what is in this plan, and is there an opportunity for them to sign off on it in this model? I know that it all feeds back to the Premier. We want to reduce the opportunity for the areas of conflict, so how do we make sure that all parties are committed to this so that we don't get this every four years with change? Do you see the problem that I am seeing? The model is a great model, but it is reducing that field of conflict so that you get commitment from all parties. Where do you see that happening in this model? I'm not sure that it is there.

Ms O'CONNOR - There is a will on the part of all parties to agree on these core issues, so what is the best functional way of making that happen?

Mr VALENTINE - Over the long term.

Mr LYNCH - What we are proposing here is an act of parliament, so it becomes a legislated model. The Premier is accountable for the reporting. The act itself would incorporate in it outcomes. The act itself would also incorporate reporting against those outcomes. The act would make the government of the day accountable for the outcomes that are embedded in the legislation and for the reporting that is embedded in the legislation.

One of the problems with Tasmania Together, which was an admirable model, was that it had no drivers to ensure that outcomes were delivered. We set targets, but we didn't have any mechanism driving to achieve those targets.

Mr VALENTINE - It was only the government that was driving it too, it wasn't the Parliament.

CHAIR - The Parliament supported the establishment of it. It was an act that we repealed.

Mr VALENTINE - Yes. As far as committing to the outcomes, I don't know.

Mrs TAYLOR - It was an act of parliament.

Mr VALENTINE - It was repealed, which was a pity.

CHAIR - It was a pity, some of us didn't support that.

Mr LYNCH - Certainly we made submissions about that at the time. There was a small mechanism in the Tasmania Together Act that could have been a driving mechanism. We see this model as taking the Tasmania Together Act to a new level where it actually has within the act accountability to the Parliament, which should give it longevity over time if the act is supported in the first place.

In a way we are in a perfect storm, as I said in my very early remarks, the progress we have made in that paradigm shift across the whole political spectrum s everybody's problem, whatever the government of the day is. Now is the opportunity to get the buy-in from the Parliament for an act that builds in this accountability, and as part of that act could build in some of these joined-up funding mechanisms as objectives and principles of doing business in this new outcome-commissioning way.

Mr VALENTINE - Surviving in the long term is important. You need that long-term framework, of 20 years maybe.

Mr LYNCH - Yes.

Ms WHITE - We have been talking about an idea like this so to have a structure in front of us is really helpful, but this board sits outside of government, I am guessing. Could you clarify that? I am assuming if the board sits outside government, it is established through an act in Parliament, with independent members sitting on a board that then provide advice to the Premier. What mechanisms within the Premier's realm would need to be established to perfect and drive the recommendations that come from the board? There is still a missing part, as far as I can tell, whether it be in DPAC or whether it be in some other function of government that implements the recommendations from the board.

Mr LYNCH - That is a good point. It is the responsibility of the Department of Premier and Cabinet so there would need to be a commissioning agency within DPAC. The key to this model is very much the green arrow which is controlling the resources. The recommendations would go to the Premier, there would need to be a mechanism within DPAC to then fund the arranged partnerships so that Education did work with Justice or with Infrastructure, Health and did commission and work with the other contributors that could part of this joined-up model.

When we put this together five years ago, one of the things was that we were sensitive of the fact of the size of the Tasmanian economy and the resources within the Tasmanian

economy. Ideally you could set up a whole Victorian health agency which would do much of this work but in reality, in Tasmania the resources are scarce, the resources are limited so we have to work much more smartly. We do not see this as being a big bureaucracy within DPAC to deliver this but we do need the buy-in of secretaries. That is where the key is - in having within the act the accountabilities for the machinery arm of government to have this built in as part of what they are responsible for.

At the moment we always find that secretaries of departments can be very supportive of a lot of the work that we are advocating for but there is nothing that drives them, it is not in their KPIs. Unless they are accountable back to the government and the government's accountable back to the Parliament, they are the mechanisms that need to be built into the act itself.

Ms WHITE - To be clear then, you are saying DPAC would have a bucket of money that would fund the partnerships across other government agencies and the not-for-profit sector to do particular tasks that the taskforce had identified to be done. You would not be saying that DPAC would say to Justice and Education, 'The taskforce identified you need to work together to do this and to find it within your own internal budget to fund that.' Were you saying DPAC would have the resources to say, 'We have identified that we need to do this; we are going to provide you the funding so can you now perform the task?'?

Mr LYNCH - No, we do not see DPAC as holding a barrel of money, we see DPAC as joining up the budgets from other departments. For example, part of one of the submission is, if we wanted to fast-track better infrastructure for active travel, for public transport, for better pedestrian access, cycling access and so on, there could be a reallocation of money out of existing budgets to achieve that. There could, for example, be a reallocation of 5 per cent out of the Infrastructure budget, which is a relatively small amount to go into health and wellbeing and then joining that up with funding from the Education budget, for example, to have an impact on that active travel near, in and around schools out of existing budgets, and seeing that as a priority, and similarly out of the Health budget. It is releasing the resources that are there, finding the economies by taking the activities out of silos and looking at them as how you can achieve better health and wellbeing outcomes by using existing resources.

As more resources became available, if government decided to make a bigger investment, and we would certainly encourage that, the current investment in preventative health care in Tasmania is around about 1.5 per cent of the Health budget - it is insignificant. If that was doubled or tripled -

Mr JAENSCH - What was that figure?

Mr LYNCH - The preventative health spending out of the Health budget is about 1.5 per cent. Around Australia it is approximately 2.5 per cent.

Mr JAENSCH - But you also acknowledge the problem is in all policies and all portfolios, so there would be aspects of Human Services, public transport, Education and all those other things added together as well that you need to see to be able to say what the spend is on prevention now. You can't just take a fraction of the Health budget and say it is inadequate. You have to tot up all the other things we should be investing in and look at

what we are already investing there to see what the spend is now. With a view to driving the argument, we need to -

Mr LYNCH - We don't know what that is, and we've been asking for that for five or six years, so until we get that -

CHAIR - With due respect to our witness, he was saying it was 1.5 per cent of the Health budget. He wasn't claiming it was anything other than that.

Mr LYNCH - This model would start to go directly to Roger's question, because through this type of model we would start to do that evaluation of what we were doing and how we could then join all of that up. When you look at health budgets in other countries, in Canada, for example, it is up around 7 per cent, so our spend is much lower than it is in many other similar countries around the world. New Zealand, for example, is three or four times what we spend in comparative terms of the Health budget. What we are talking about here is releasing and finding where that preventative health spend is, joining it up and delivering it to achieve better outcomes.

Dr VAN DER MEI - A lot of this is also not about spending money but working differently. It is about making all the departments aware of the impact they can have on health and it's only done through collaboration, to learn each other's language, work out what is important for each and then work out the win-win situations. You can't change everything; you can't make the Department of Infrastructure spend all its money on cycle paths et cetera. It is about common ground and how you can work slightly differently. I have some examples of what South Australia has done and it will give you a bit of an idea of how that works in practice.

Ms O'CONNOR - I am interested in what the expertise make-up of the intersectoral board would be. Are we proposing to have people on there such as urban planners as well as people with health expertise and family support? What kind of expertise would be advising the Government to make sure it had that across-agency perspective? Would the Premier appoint them?

Mr LYNCH - That is a very good question. We see the board as being very much a strong governance model. We don't see the board as holding the expertise; we see the board as being able to get the expertise as it needs it. The board would need to be independent and conflicts would need to be managed. It's a high-level governance board that then draws on the expertise as it needs it. For example, you don't have to sit on the board to give consumer input to the board. You don't have to sit on the board to be a research expert. The board would just provide very sound governance to ensure it was able to get all the evidence and information from the experts. I mentioned the example of the Premier's Physical Activity Council. Around physical activity it would go to a body such as the Premier's Physical Activity Council and draw that expertise in. It would then draw in expertise about, say, social marketing and the state policy to provide that advice to Premier and Cabinet. That wouldn't be something DPAC would do. The board wouldn't be huge. It wouldn't be experts in the field, it would be experts in getting the experts together to draw the information.

Ms O'CONNOR - Do you see some value in making sure that in the KPIs of departmental secretaries there are health outcomes measures in there? We did something quite similar

when I was climate minister where we put a 10 per cent energy use reduction in the KPIs of the secretary of DHHS, for example. Do you think you can get those measurable outcomes through agencies unless we have a marker in the key performance indicators for secretaries of departments?

Mr LYNCH - That is exactly what we are proposing that would be part of this act, because if you're not accountable and you're not measured against it, you won't do it. It is the same in every aspect -

Ms O'CONNOR - Are we talking about all agency heads?

Mr LYNCH - Yes, across government.

Ms WEBB - A health-in-all-policies approach mandates that all policy across any department goes through a process in which the health and equity impacts are determined and are transparent and accountable.

Ms O'CONNOR - Yes, and at the end of the day secretaries are going to have to be measured for their success.

CHAIR - And reported in annual reports.

Mr LYNCH - And the Premier would have to be reporting in total the outcomes to Parliament.

CHAIR - In every department's annual report there is a reporting against that but the annual report of the Department of Premier and Cabinet would be the overall reporting.

Mr LYNCH - Also in the performance review of the secretary there would be KPIs that he or she would have to report. That is the way we can embed this way of working. If it is opt-in opt-out, everybody is well intentioned today, but what happens when the next crisis comes along?

Mr BARNETT - Regarding the percentage of health prevention at a federal level, you talked about Tasmania being 1.5 per cent and the other states being 2.5 per cent.

Mr LYNCH - I would have to get that figure for you but it is very small federally. One of the difficulties about prevention health funding out of health budgets is that the funding that goes to primary health care is the Commonwealth Government - the MBS, PBS, pharmaceuticals, GPs, the Commonwealth is responsible for that. Hospitals are shared jointly between the state and commonwealth and there are formulas for that and that is fully funded. Prevention is optional at both commonwealth and state level and it is very small.

Mr BARNETT - We will do some digging because we need to find that out, otherwise we are looking at silos just looking at the state and we need to look at federal as well and where the health prevention dollars are coming from.

CHAIR - Or not.

Mr BARNETT - Or not, exactly. That is my point so I appreciate that. We need to know the full lay of the land.

Mr LYNCH - That data is readily available, we just don't have it at our fingertips.

Mr BARNETT - You mentioned primary health care. I am of the view that there should be more focus in primary health care on health prevention and that could be a good start.

I draw your attention to PDAC, the Premier's Disability Advisory Council. They set out key performance indicators for each department. The department heads come to that entity, which I currently co-chair with the Premier, and they report on progress to those KPIs. It picks up Cassy's point of getting the departments to focus on where you want them to be against key performance indicators and it seems to work pretty well. The departments appreciate it and the disability sector appreciates it. I thought I would mention that to you because I think it picks up on where you are going.

How is your intersectoral board resourced? You talk about drawing resources from here and there. Is it going to be resourced in and of itself? At the federal level, the National Health Prevention Authority that was established under Labor got a little bit caught-out because it was a bit nebulous, did not have clear terms of reference, and basically has not been supported by the next government.

We have talked about having bipartisan and tripartisan approaches going forward, but we have issues there at the federal level. It has not worked. Now we are trying to do it in Tasmania so let's learn our lesson from the national scene. Can you share about how it would be resourced and how we keep clear the focus of this board?

Mr LYNCH - This board is a low-cost model and we recognise the realities of Tasmania in the scope and size. The main cost would be in the sitting fees for the board. We do not see this as being a 15-person expert board. It is tight governance about managing the process to draw together the resources externally. Under point A, when we are talking about gathering the information and the research and doing all those things, that would be sourced as and when it was needed from within Tasmania, but externally, nationally.

Mr BARNETT - They would have a budget for that?

Mr LYNCH - It would be a matter for the government of the day as to what needed to be directly funded or what would be resourced from existing mechanisms, for example, the Premier's Physical Activity Council which has some secretarial support from DPAC, but all the people who provide the input and advice to the Premier's Physical Activity Council are volunteers. Some of them are from within government and some of them are external to government. It would be drawing on all of those resources and drawing on the resources of the organisations that are part of the Health in All Policies Collaboration and others.

Mr BARNETT - And it would just have a few people to run the secretariat or something?

Mr LYNCH - Yes, it would have a few people to run the secretariat, and as we have shown as a dotted line here, that might come from Population Health Services where the epidemiology and the statistical capacity would sit. This board still has an interaction

with primary health care. The two things have to interface and talk to each other, otherwise we have a silo in primary health care and a silo in HiAP and social determinants of health.

Dr VAN DER MEI - I've had a little bit of interaction with South Australia on this as they went through their process and there's some good things to learn. What we have seen there is some really good work that started but because the governance structure wasn't strong enough it is slowly disappearing again, which is a real shame. They did not have legislation around it. They tried to make it sit outside the health department somehow, but it wasn't strong enough and as a result it hasn't survived strongly over time. It is still happening behind the scenes but not as well as it should.

The big issue is where you start because there are so many things, so they started with projects that were directly related to their strategic state plan's targets and outcomes and that was guiding them in their choice. Then they started with particular projects just to get wins on the board. I believe we can go way beyond just the number of projects.

To give you an idea of the type of things they did, there are some things that have already been done here in Tassie. For example, the Heart Foundation together with the Planning Institute developed different terminologies to get them to work together, and that wasn't driven by government, it was driven by the Heart Foundation who said, 'We need to start working together with Planning. Let's just come together and see where our common ground is and what we can do to develop a change in thinking.'. A lot of that is about the change in thinking. A lot of the change in thinking has happened within Population Health and you can clearly see that in a university report that they have done that very well. The change in thinking in all of those people has really resulted in some good outcomes. Now it is a matter of getting that outside of Health and getting all the non-Health people to start thinking about the impact they can have with their policy on health. It is a matter of getting that change in thinking.

You can put a health lens over the top of something or you can put an equity lens on top of that as well. I think the equity lens is probably as important as the health lens. In South Australia they looked at their water security plan. They had some real issues in terms of increased use of grey water, stormwater and rainwater that had health implications, so they put that health lens over the top and started to evaluate the positive and negative impacts and tried to think whether they should do business slightly differently. It clearly resulted in a different framing in their documents and hopefully this will also result in future policy development.

That is the type of thing you would like to see - different framing and different policy outcomes. You are not talking about massive differences. They still have to do business normally but you try to change that slightly to get that health aspect on the board as well. There was a lot done around active transport about how we build our environment, so if there was a new development in a particular area they would work together with local council to bring Health department and planning people together, talk to each other, understand each other, and put that health lens over the top of that new development. Then they would see to what extent they could positively influence that particular new development that was going on.

They are the obvious ones but there are also others where initially you would think, 'What does this have to do with health?', but when you look a little bit deeper you think, 'That's actually quite interesting'. One of the ones that stood out for me was about driver's licences. Initially you would not think that has much to do with health, but they had a particular focus on Aboriginal health. Many Aboriginal people would not have a driver's licence. They would steal cars and end up in jail. They would cause accidents. As a result, they started to put this health lens around Aboriginal road safety and driver's licensing and they started to change the policy in terms of assisting Aboriginal people in getting their driver's licences. It is an interesting one where initially you would not think there was a health impact there, but ultimately there was.

CHAIR - How long have some of these things been in place?

Dr VAN DER MEI - They had a period of time where they ran a number of these projects. They must have started around 2008 or 2009.

CHAIR - Improvements to health outcomes take a while sometimes to be able to be accurately measured and reported again. Have they been able to measure and report any significant change in terms of health outcomes?

Dr VAN DER MEI - Yes. I tried to get in contact with Kevin Buckley who has done a lot of this work but I was not able to in terms of the longer-term results queries about that as well. The way you would evaluate this involves three components. First of all, you can do the process evaluation where you examine the shared understanding, the goals and expectations, the barriers and enablers. That is when you go through that process of shared understanding. Then you have an impact evaluation to see to what extent it actually influenced policy or new knowledge, and then ultimately you have the outcome evaluation where you talk about the outcomes that you were talking about. Did this actually make a difference to health at the end of the day?

That is a lot more challenging to evaluate because often there are so many other things in play that might influence that health outcome as well. How can you attribute that part to ultimately the decrease in something? That is really hard to assess. The first two can be assessed quite well. For the last one, you can assess the outcome but whether that would be attributable -

CHAIR - What was the cause of the change - yes.

Dr VAN DER MEI - Yes, that is hard.

Ms O'CONNOR - You probably need longer timeframes too in which to even begin to be able to measure it -

Dr VAN DER MEI - Yes. With regional projects you might have a chance but some of those are even bigger than that, so it is challenging.

CHAIR - With South Australia you said it was not legislated and so things are starting to drift a bit now. Do you know why the decision was taken to make it a process that occurred outside legislation? Do you know if South Australia are considering perhaps putting in legislative framework to strengthen it?

Dr VAN DER MEI - I don't know. It would be great to have a talk to them and see where they're at right now.

CHAIR - See where the problems really are, yes.

Mr LYNCH - My understanding from my colleagues in South Australia is that this came out of a thinker-in-residence program that South Australia had over a number of years. It was driven by Amanda Kickbush, the thinker-in-residence who worked there for a year and developed the theory around this. We have drawn a lot of the intellectual work that has come out of that in informing Health in All Policies, but there was never a strong commitment from the South Australian Government to fund and resource it. It goes back to the question from Guy a moment ago about the resourcing and the bigger picture model. It's a small unit that sits in their Department of Premier and Cabinet but is not fully resourced. There are a few people there and it is very much opt-in. As the resources have gone there is nothing mandatory. If a minister or a department wants to refer something, they have somebody who can do it. As part of our model, what Ingrid is talking about, this is one of the tools we would be able to use and call upon. There are a number of universities and research institutions around Australia that do these impact assessments and some of them can be done very quickly. Others might be big inquiries - the investment in tobacco advertising, for example, might be something that was a bigger issue. Many of these things can be done quite quickly and if they are imbedded through the legislation they can then go through the recommendations, and often these things don't cost money.

CHAIR - In terms of a position the Government may take on this, whilst I can see the benefits and probably most of us can, in legislation there is the requirement that any decision government makes, whether it be in the area of health, infrastructure, education or justice, has to go through this extra filter that potentially slows things down. It is done for a Cabinet minute and you run the risk of it being, 'We've got to do this thing, so let's just tick and flick'.

Dr VAN DER MEI - There needs to be a genuine collaboration. Interestingly, we spoke to a number of people in those departments about their experiences, and they were all positive. The Health people were saying, 'Okay, we're going to make health your business. How good are we to do that?'. They were genuinely interested and it works. It's a time-consuming process.

CHAIR - That was in South Australia?

Dr VAN DER MEI - Yes. I don't believe in the tick-and-flick idea, that everybody needs to do a health assessment. That seems a bit like getting a consultant to do the health assessment and we walk out; that is not going to work. It is about that shared understanding and seeing where we can make changes and policy changes that will be positive.

Mr VALENTINE - Was there any community buy-in in South Australia that you're aware of? How much did the community get behind this?

Ms WEBB - I would imagine that community engagement with the concept would help stop it becoming a tick-and-flick exercise. If it is documented, transparent and open then those of us in the community and the broader community can hold people to account for that and the decisions that are made and the impact that is going to flow from it, which is why those lenses, although they may be slightly more time consuming and add steps into a process, ultimately are a valuable way of gaining community endorsement and involvement in the process and the outcomes of the decisions in the long run. The Tasmanian Women's Plan we have at the moment talks about a gender lens to go over policy, so this is a concept that can be looked at in different ways. We would endorse the health lens and particularly the equity lens in the Tasmanian context as being important.

Mr LYNCH - The model picks up what we're talking about. The bits in blue are legislative interventions. You will see in 'building on existing strengths' there is a new section in the Public Health Act. The commentary in our report talks about in Quebec in Canada. They have a section in their health act that specifies certain things that are particularly relevant to public health that could be mandatory to be looked at through a health lens. What we have with the body we're talking about is not a tick-and-flick. It's about making recommendations about actions to resource things in a better way. One of the tools you would use in determining what those actions would be would be the health impact assessment. So you could have over here on the left inserted in the Public Health Act, in looking at legislation, some particular classes of decisions that would require a health lens, but not every decision, for the very reason as you suggested, Chair, that you would not get anything happening and it would be very easy to delay things.

This is a place where you could look at some specific interventions that would be required to be met, and then over here, this is the advisory - making the bigger long-term changes.

CHAIR - You need a process that is going to always add value and not undermine the driver of it. Across every piece of legislation, trying as hard as you could, you could not really find a health outcome - a Repeal of Regulations Bill, for example.

Mr LYNCH - Yes.

CHAIR - There are some things that would be unnecessary so there needs to be some sort of balance that makes it valued and important, not just, 'We'll do that as well'.

Mr JAENSCH - I have a question and I want to be deliberately provocative because that is how we test ideas out. I will trust that Graeme and I have spent enough time around similar tables and debates that you know that I believe in solving these issues and we work through a lot of the same information together.

When I look at the solution that is proposed, I can see how much information and insight is invested into it. Here is the thing; it is very elaborate. It covers off extremely thoroughly, the particular lens and issue, and we have been talking about the mechanisms and all the pieces of this machine that are needed to make it happen. I think that those mechanisms are elegant but complex to build. Many parts involve a lot of energy in making legislation, setting up these structures and things. They can also make it vulnerable to weak links in that machinery.

I was interested in South Australia and how it is travelling where it has built something like this and the question whether the community sees it, understands it and demands it, or is it a thing that comes from the policy thinkers in the machine who need to engage the political here and the people here to make this thing work. Does that make it vulnerable? That is one assessment and there are some questions in that.

The provocation is looking at Bev's story, her daughter and grandson. The good alternative future for them tends to have a thread that runs through it which is about education for the little boy, his parents, and there is a life-long thing. Given the statistics that travel with educational attainment and the way that empowers people as well, could we do some comparative analysis, just for the exercise, of what if, instead of building all this stuff, we just doubled the education budget and told everybody in Tasmania this is the most important thing, which most people would be able to agree to. Then make everyone who came to school was fed, could get there on a bus and learnt to take care of themselves throughout their life. It would require fewer moving parts and it might be more engaging the public policy initiative than trying to explain this to the people it is meant to help.

Ms WEBB - I think that is a really interesting idea to put forward. In the first instance we would love to see a doubling of the education budget. There would be excellent outcomes to be gained by doubling the Education budget and it would be something very visible and straightforward for the broader community to understand and engage with. What I would say about that though is - and we have been talking about this from the Health perspective today but it fits with any of these human services and social policy areas - there is no straightforward, simple way to tackle things. The success within the education system and that silo of the Education department is contingent on so many other factors in people's lives as they are interacting with that siloed education system. Doubling the funding in that system will be beneficial for sure, but, for instance, the investment and impact that we make in the early years, the 0-6 years and even the antenatal years, the capacity-building for parents that happens in that time, the way that sets children up to then engage with the education system, are equally as important and foundational as what happens in the system.

What happens for children, while they travel through the school system, in their housing, their family support and those sorts of factors, the way we address violence in our community and in our families - all those things impact on the way a child is able to successfully travel through the school system.

The really interesting and exciting part of the school system is that virtually every single Tasmanian child will go through it. It is a fantastic central point, but we cannot just throw money into that one silo because we know that all those factors around it are absolutely crucial to success in that pathway. Again, we have to ask ourselves: how do we join it up? We come back to this idea of joining things up and that is what we are talking about with this model, and that is what we are talking about in the Human Services system at the moment, about joining up the different subsilos within that system.

While it might be easy to focus on education and year 12 retention rates and what we do in schools or what teachers have to do in a classroom, that is just one slice of what we need to be thinking about in terms of joining up. Attractive, but probably not -

Mr JAENSCH - We do also use schools - like with Move Well Eat Well -

Ms O'CONNOR - Which was de-funded by the Federal Government in the last Federal Budget.

Mr JAENSCH - as a Trojan Horse for those families of the students to be able to - under the cover of that we can do many other things. You are right, we have got to the point of engagement that might otherwise be very hard to find for so many interrelated, complex things to do with health education, to do with even the - we have nurses, counsellors, chaplains and others in schools who are able to detect where there is evidence of a need for an intervention or an additional delivery we see through the children.

Ms WEBB - I would very much like to see additional funds into schools for that sort of identification of issues and identification of families and children who might benefit from other sorts of support. I don't think we need to put all of the solutions into the school system because naturally there are solutions and supports that exist all around the school system connecting to other parts of people's and families' lives. I think the gap at the moment is the points of connection between the silo of education and the school system and those things that are existing around any other aspects of people's lives. By all means, it would be great to look at opportunities for that joining up and breaking down those silos. Joining up is really the theme of what we are talking about here. Health is a wonderful underpinning rationale for joining up because so many things affect health. Everything affects health.

Mr JAENSCH - It is taking a helicopter view, it is a holistic view.

CHAIR - Can I just challenge Roger's point here and get feedback on this from Meg or others? It is all right to focus on education. It might be the first child in the family who is presenting at the school and it is their first contact. I know, as a midwife, that many children are damaged during pregnancy through foetal alcohol syndrome and a range of other issues and end up with acquired brain injuries, and who knows what the hell ice is doing to people at the moment and unborn babies. It is too late by the time they get to school, the horse has bolted. There needs to be -

Mr JAENSCH - There is a generational challenge here.

CHAIR - Yes, but this is the first child who is going to school in this family. If you put all your resources in, double the Education budget and think you can fix it all from there, how do we deal with this and how do we link up the services here?

Mr JAENSCH - You are right, we will not double the Education budget.

CHAIR - I know you are not going to do that.

Ms WEBB - I mentioned early years before and that is an absolutely crucial area for investment. When we talk about early years, typically we might say nought to six, but it

is probably minus one to six, at least. The thing we see through the very effective programs that have been put in place in that space over the past five or six years is that, when you work with children in that age group, what you are really working with is families. The programs that empower parents and build capacity in parents as they engage through their child in Launch into Learning, with child and family centres, and with other programs, the capacity-building that happens there with parents is absolutely fundamental to changing that intergenerational effect. We are not just improving outcomes for children, we are improving outcomes for parents and families as well.

CHAIR - It is a pre-conception advice you need. I am not sure what the statistics are now as to the number of unplanned pregnancies. Unplanned does not mean unwanted, but there is a high percentage of unplanned pregnancies and women who have no intention of smoking and drinking alcohol or using other drugs, recreational or otherwise, during their pregnancy, find themselves pregnant unexpectedly even having used contraception. There is a whole area here where you can have a major impact which we seem to be missing in some way. How do we join these up? Where do you see that fitting into this approach?

Mr LYNCH - That would be the role of this advisory board, to pull these strands together to make the recommendations about what is the best investment and how we tackle an issue that Roger is talking about, but in that holistic way. The board would not make that decision, it would talk to Meg, it would talk broadly to the community and pull back together what the evidence says, looking at the local solutions in Tasmania and the best ways of delivering it, to then provide the joining up of the funding and the right partners to deliver the outcome we are looking for, which is better health and wellbeing for Tasmanians - if better health and wellbeing for Tasmanians is an object of government.

Mrs TAYLOR - Going back to Roger's idea, it seems to me there is a germ in there that is really important, and that is the focus on the individual, from which all other things stem. I don't think it matters whether you take education as the place, but Roger's point is, you get everybody there. It might be that you do it as soon as somebody goes to a doctor and says 'I am pregnant'. I don't know what the point is. If you get everybody somewhere at the point and then did a total health check in terms of environment and whatever, and then asked, 'Is this person fine or does this person have a need?', you would catch the problems before they arise. We are talking about his model here and I agree, it is far better than what we have. But you are talking about when problems actually present and often the problems have existed a long way back. If we want to prevent them from happening, it would be good to catch them.

CHAIR - Where is the point at which you prevent it?

Mrs TAYLOR - That is what I am saying and what Roger is saying: you catch a child at school. You are saying it happens earlier than that and that is fine, but there is a point at which we catch most people and if we did an assessment maybe at that point, then you would prevent a whole lot of things happening after that, say, this person is pregnant but she is not adequately housed or she is smoking or whatever, and this is going to affect the family and the child. If you can catch it at that point then you don't have the problems that present later.

Ms WEBB - This certainly comes back to the idea of being joined up. One of the things we emphasise in our submission is that we would like preventative health to be understood in the broadest possible sense. It's not just behavioural factors and individual choices, it's those social determinants of health and social correlates of health. A lot of the benefit of providing that sort of assessment - and it's probably at key transition points generally - across a person's life, where you can look at their whole circumstances and make appropriate referrals or support, is part of being joined up. That's where we need mechanisms in place to encourage that breaking down of silos and being able to say, 'You're here for an antenatal assessment but let's look at your circumstances around housing, income and employment', at that time.

Ms VAN DER MEI - In America, Rebecca Onie has basically asked, 'What if a GP could prescribe housing and food and other things?' She has created that - the GP basically directs them to the right areas where they can get those supports on the social determinants.

Ms WEBB - That's what happening in the Human Services system at the moment because even in the Human Services system there are little silos, where someone comes forward for housing support but they really need a bunch of other things, too. That is being tackled under a project in the Human Services space and it would be great to look at how that broadens out even more. The conversations so far as that project has been shaping up have always constantly thrown up the idea that this is all very well in Human Services but we know that Justice, Education and Health and many other things sit around that too, and are ripe for a joined-up approach.

Mr LYNCH - That's a very good example of Health in All Policies. Connie is going to talk about absolute risk assessments for picking up early interventions. That is where we should be injecting health in policies everywhere. Part of a major determinant as well as people's blood pressure, cholesterol et cetera, is their social circumstances and mental health. They should be things that are picked up, but there is no simple cure for everybody. In the area of cardiac rehabilitation, for example, there is not one model that suits everybody. These are difficult and complex problems and there's a different solution if you live in Smithton or Sandy Bay.

Ms O'CONNOR - Yesterday we had the Planning Institute in and there was discussion of the work the Planning Institute is doing with the Heart Foundation on a state policy on health and wellbeing. How might state policy fit within this structure that is described here? Have you had any interest or buy-in from the state Government on that work that is being done?

Mr LYNCH - The state policy is one of the legislative initiatives that could be taken. Ingrid said South Australia had a state strategic plan, as does Queensland, but in Tasmania we don't. I asked the rhetorical question a moment ago: do we value health and wellbeing in Tasmania? I don't know, but we don't have a state policy that says over a period of time this is an imperative. Maybe there are other things we value more. The opportunity for a state policy under legislation already exists. It was introduced in 1993 and there was a suite of 13 or 14 pieces of legislation that dealt with the new planning system. The State Policies and Special Projects Act was one of those pieces and all the others were really about the machinery of planning - planning directors, planning zones, permits and statewide planning.

CHAIR - The hoops you have to jump through.

Mr LYNCH - All of that. The reason that has got into such a mess since 1993 is because this gem of legislation over here on the left-hand side has not been implemented effectively. There have been a few cracks at it, but what has been done to try to address the stuff over here -

Mr JAENSCH - That's not what it's for.

Mr LYNCH - What it is for is to direct a state policy on any issue. We have been strongly advocating for a state policy around healthy spaces and places across government - intersectoral - using the planning system to direct for the Parliament and the people of Tasmania for the long term, going to Rob's point about how you embed something over a long period of time.

We could have a state policy for affordable housing which may sit within a state policy for healthy spaces and places. The policy as we see it would not be prescriptive, it would be about principles. The beauty of a state policy is that whilst it provides that direction so it has an impact on private developers and others in what they do with land use and so on, it binds state and local government. In that very simple, cost-effective mechanism we could have the beginnings of a statewide strategy around health and wellbeing.

Ms O'CONNOR - The state policy would sit over all other legislative mechanisms that are described in this diagram. Isn't the missing part of this diagram to have that state policy there sitting over the top of it all?

Mr LYNCH - In that diagram, yes, but in our submission we talk about a state plan as one of the mechanisms that can deliver that very easily. It is in legislation. It could be a state using that piece of legislation. The other very strong thing about the legislation is that it has to be referred by the Premier, so it is the Premier's responsibility to refer it to the Planning Commission and then within the act there are mechanisms for public consultation. We have done a lot of work with many stakeholders and we have drafted policy because we knew if it was left to government or the Planning Commission it may not happen with all the other priorities.

Over a period of over four or five years the Premier's Physical Activity Council has been working on this. There is a working group of the Premier's Physical Activity Council, which has recommended it to the previous premier and the current Premier as a way forward.

Ms O'CONNOR - Response?

Mr LYNCH - Before I tell you the response, I did speak about the silo before. The Premier's Physical Activity Council has taken the physical activity aspect and is now talking to all our stakeholders and it is part of the work of the Chronic Disease Prevention Alliance and this collaboration and many others about how in this state policy we can integrate access to healthier food and social inclusion. When you think about the sorts of principles around healthy spaces and places, you bring people into cities so how do you

keep them in cities because you bring them in and the prices go up, and that then brings in affordable housing, legislation and so on.

The answer to the direct question, Cassy, is that we have been consulting with the Government around this, both with the Premier but particularly with the Minister for Planning. The minister two or three weeks ago in the *Examiner* was reported as saying that he was aware of and interested in the idea of a state policy being promoted through the Heart Foundation. It is certainly being drawn to the attention of the new committee that the Government has set up and I think there is a real interest in government to look at this approach.

CHAIR - Can you provide the committee with a copy of that?

Mr LYNCH - We have mentioned the Heart Foundation agenda in the submission but we certainly welcome the opportunity to get this into a form to table it. I will undertake to do that.

Ms DIGOLIS - What I wanted to do today was to highlight the issues surrounding chronic disease and the travesty that will befall Tasmania and the Tasmanian health system if we continue to support a system where people have to get sick before they are treated and where steps aren't taken to prevent the preventable.

As you would have seen through our collective submissions, you know that we are the oldest state in Australia, but we are also the poorest and the least educated population. This creates a lot of challenges for our state and it creates a lot of challenges for our health system. What I am providing for you today is another example of how we are suggesting we can work together. As Graeme has suggested, rather than focusing on individual chronic diseases we are suggesting there are ways we can prevent a group of chronic diseases because we acknowledge we have common risk factors. We can address those together. The advantage being that we can ensure we are all providing the same message across Tasmania to Tasmanians, so we have consistency that may not have been there in the past as well.

Mr JAENSCH - And not competing with each other directly for scarce resources.

Ms DIGOLIS - Absolutely.

Heart, stroke, kidney disease and diabetes contribute significantly to the burden of disease of Tasmanians, and the economic implications of this are escalating. Tasmania has the highest prevalence of heart and vascular disease in Australia. In 2011-12 there were 114 000 Tasmanians living with heart and vascular disease, and over 22 000 Tasmanians living with type 2 diabetes. In addition to this, we know that we have one in six Tasmanians with diagnosed kidney disease. They are the people who we know are unwell.

What I would like to do is put that to one side for a moment and talk about the people who are at high risk, literally a heartbeat away from any or all of these conditions. If we again look at the population of Tasmania, we know that over 30 per cent of Tasmanians have a high blood pressure. We know that nearly 40 per cent of our population has high cholesterol, over 21 per cent smoke, and nearly 65 per cent are overweight or obese.

There are also estimated to be 10 000 Tasmanians living with diabetes that are as yet undiagnosed, and 45 000 with pre-diabetes. All of these indicators point to Tasmania having the poorest health outcomes in the country. We have the highest chance of developing a chronic disease, yet we have no system in place to make Tasmanians aware and empowering them to not only understand their level of risk, but what they can do about it. This does not have to be the case.

As we have said, poor intergenerational health is something that we don't have to accept and that we have to live with. We've already talked about Bev. If we had the right systems in place, the right measures, not just individuals in Tasmania but also their children and their grandchildren can take better control of their health, not because the system is doing it for them but because they understand where they can make different choices and how that will benefit them. The services and community surrounding Bev and her family can have the resources to help them know what they need to know and how to act upon that knowledge. We just need to commit to turning the health status of Tasmanians around and ensure the systems and supports are in place to make this happen.

How can we actually do this? As proposed in our submission, we encourage Government to stick to their goal of ensuring Tasmania is the healthiest population by 2025 by establishing targets, implementing systems to increase awareness, identifying people's risk, and to see that necessary interventions are in place to lower and manage an individual's risk of cardiovascular disease, diabetes or kidney disease.

There is a model with the paper that I have given to each of you. It will help provide a picture for you with the type of system and model that we are talking about. This model was developed in partnership with Tasmania Medicare Local, Heart Foundation, Kidney Health, Diabetes Tasmania and the National Stroke Foundation. It suggests we can have a significant impact on lowering the development of cardiovascular disease and kidney disease by establishing a pathway that will improve the detection of risk before an event happens.

The pathway begins with community health checks. We're going to go back to Bev, but we are not going to focus on Bev; we are going to focus on her daughter, Jane. This is how we would see this type of model working in reality. Bev's daughter, Jane, has gone to the supermarket on a day the local council is doing free health checks in the shopping centre. Jane is promised the check will only take 5 minutes so she agrees to have one. Jane is asked a few simple questions: 'How is your diet? Do you smoke? Have you had a diabetes check? What is your family history?' - and she also has her blood pressure taken. These answers are scored and it is found Jane is considered to be between intermediate and high risk, so she is recommended to see her doctor for more comprehensive testing. The person who takes the check has explained this in simple terms and given Jane a simple document to take to her GP. The person has been able to explain why it's important for her to take this to her GP, and with Jane's permission they can alert her doctor about her needing a further check and that can be arranged on Jane's behalf. So a letter goes to Jane's doctor. She gets a call from the practice nurse to make an appointment for an integrated health check. Jane already has some idea about what this is about because of the conversation she had with the community nurse, so she is prepared for what may be involved. She knows she is going to be receive some

preliminary information about the next steps and she makes the appointment to see her doctor.

CHAIR - Does she know she's going to be bulk-billed, because she won't go if she isn't?

Ms DIGOLIS - We will assume for this scenario that her doctor is able to bulk bill. She gets to the doctor and the results of the integrated health check are fairly good and it has allowed for some discussion with the practice nurse regarding diet. Jane is referred to a local cooking group that the local community health centre is running. Steps are taken to support her quitting smoking. There have been a few failed attempts, but now the discussion has started the primary care health services that interact with her are able to keep the conversation and her goal to quit going. Her e-health record is now flagged for her to have an integrated health check every two years to monitor her health.

Another valuable step in this scenario is about the practice recording her check and Jane becoming those statistics that can contribute towards the health targets we also recommended in our submission that the Tasmanian Government establish. These targets have ensured greater consistency in the methods that general practice is able to use to deliver integrated health checks. More importantly, they can provide the benchmark data for the Government to demonstrate the positive impact of providing a coordinated structured approach to identifying Tasmanians over the age of 45 and driving them towards an integrated health check.

Health targets, along with a coordinated model, will allow Tasmania for the first time to know the health status of a sector of the population that often aren't in the health system until it is too late. That is the scenario that is more costly. We are talking about those who are on a trajectory towards a cardiovascular event, diabetes or kidney disease and don't know it - the over-45s in particular who are old enough for their risk status to be increasing but young enough to make some changes that will lower their risk of a stroke or heart attack, or developing diabetes or kidney disease. All these conditions are avoidable, and the death and disability and the impact this has on Tasmanian families and communities are avoidable. We are talking about something that is preventable.

In summary, when you are looking at this diagram, it is a bit of a brag for the organisations involved in this. This is an Australian first. It hasn't been developed anywhere else. We have not been lucky enough to have these organisations sit together and say, 'Let's address our risk factors together and let's do it in a comprehensive way where we can say things are connected'.

Where this could fall down could be if, when Jane was at the supermarket, she was told her blood pressure wasn't great but she wasn't told what she needed to do about it. Or, she was told to go to her GP, and she contacted her GP and they said, 'We can give you a blood pressure check, but we are not really sure about the other things you might need'. So we actually have GPs who are prepared and resourced to be able to provide a comprehensive integrated health check. That is something that we can then track Jane's health against into the future.

Mr JAENSCH - GPs who are prepared to refer to people who are not doctors, like dieticians.

Ms DIGOLIS - Yes, I was about to go to that. It is the general practices, the practice nurses, who actually know the services that are sitting within Jane's community. It is about being able to empower Jane to understand there is a health system that is there to help her when she is unwell. It is also there to help keep her well. There is a community and community services, and things that Jane can actually be doing, because we are helping Jane understand what those things are for her to keep herself well.

CHAIR - It was not that long ago there was a federally funded project for the well-woman check, where you go to your GP and have all of these things done. You would be bulk billed. I was bulk billed for it. I went for a pap smear or whatever. There have been some attempts at doing some of this. Obviously they are not well promoted or well known and not perhaps in such a structured form. Is that the problem?

Ms DIGOLIS - That is part of the problem. What we also know is that when it comes to health checks as they are understood in the GP setting, what tends to happen now is people will actually be tested for singular things. It might be that once a year or once every couple of years they might get a blood sugar test, because their GP has got them in there and says, 'Let us do this while you are here', or the blood pressure gets taken. What we are actually advocating for is that on a regular basis they get an integrated health check so that snapshot of their health status is actually there and is covering all of those disease groups. It is saving the health system by not doing those one by one on various visits. It is also giving us the information we need to know about where that person's health is for a range of conditions and where their trajectory might be. The integrated health check will actually give an individual and their doctor a five-year scope. So this is where you are now. If you stay on this trajectory, this is where you are going to be in five years time. It enables some goal setting. It enables some conversation with that person about what they may be at risk of if they do not get the support to change things.

CHAIR - A lot of these things are happening in our rural communities, like at the King Island Show. They had a men's one and a women's one. It is all about having a check under the bonnet for the men and the plumbing and -

Ms DIGOLIS - That is the community health check.

CHAIR - The thing is trying to understand what has been out there already. There are things that are trying to do this, but it is about how you bring it all back together and actually get to that step 2.

Mr VALENTINE - So you do not throw away good work.

CHAIR - Yes.

Mr JAENSCH - Yesterday, and in part of today's conversation as well, we have talked about the need for data and population health surveys and things. Yesterday we talked about some of the inadequacies of a three-year landline telephone survey and questions about the future of that. It is valuable as it exists, but it has some problems with it. Have you had discussions in your group about the merit of these health diagnostic tests, screening and testing that might be done by a GP, while also being somehow de-identified and populating what would be an exquisitely detailed population health survey?

Ms DIGOLIS - Absolutely. We were even talking about it again this morning. Graeme is the expert on this one, given that he actually went to New Zealand and had a look at some of their data collection systems while he was there, didn't you, Graeme?

Mr LYNCH - Yes, there are gaps in the system and in the implementation of guidelines. That is what we are talking about here when we say things are happening, but they are not happening universally and it is how we resource them to be effective.

I remember before the last committee we were talking about more use of allied health professionals or practice nurses to be able to assist GPs in doing some of this work. There is a bigger issue I spoke about before how GPs are funded for and paid for through the MBS. In Australia we have six-minute medicine. We are hoping and advocating for some better payment mechanisms that will encourage GPs to treat to outcomes rather than treat to task.

That is a bigger collaborative effort at a national and state level. If we talk about the perfect scenario in Tasmania, in New Zealand they set goals so they have a goal that 95 per cent of their population will have an absolute risk assessment, which is stage 2, and we have the guideline in Australia. It is a desktop thing; when you go and see a GP in New Zealand he has a target, he gets funded to do these. He also gets funded to do brief interventions with any smoker and that is a target. The payment to the GP is tied to reaching these targets.

The elegant solution they have in New Zealand is that you see your GP who does the absolute risk assessment on his computer in front of you, shows you what your risk is, shows you, if you stop smoking if you are a smoker, what will happen to your risk, if you get your cholesterol down, if you lose weight - that is an interactive tool. The back end of that goes straight to the University of Auckland, I think it is, goes straight to the university where they get all the data de-identified and they have these huge data sets of hundreds of thousands on a seamless electronic system.

They have an advantage because they do not have three layers of government as we have.

CHAIR - And only one House.

Mr LYNCH - Finland has been doing this exquisitely for 40 or 50 years, where health in all policies started. They had the unhealthiest population in Europe based on dairy, saturated fats and so on. Now they have one of the healthiest because they had a totally integrated, really strong community engagement, and they have used agricultural policy to shift the way they produced food. They also have fantastic data sets on their whole population.

This is something we have to strive for in Tasmania. Having a single health organisation, and I spoke about the big influence this committee had had earlier, enables us to start to work on getting, first of all, our acute sets talking to each other - the computer systems do not necessarily do that. Then we need to start to look at how in primary health care we can work towards what they have in New Zealand which gathers the data.

The second point is, in our Heart Foundation submission we directly go to the point which I think Seana Gall may have spoken to you yesterday in her submission about: it is absolutely critical, if we are going to have a goal to be the healthiest population in 2025, how are we going to measure that? What does it mean? What is a healthy population? Elective surgery waiting lists and acute sector performance indicators are absolutely critical. We have to look after people who are sick. Of course we need all of those but they are not the measure of a healthy population.

CHAIR - It is an indication of the failure of preventative health, in many instances.

Mr LYNCH - Yes. We need those targets. If we want to be the best we need to be able to benchmark those targets, and we need to have the data regularly so that this board, if it was enacted, can evaluate, know and advise government appropriately about what the best investments are based on the evidence and based on the value for money.

To do that we need to collect data and one of the things that we do, again, I can refer back to some work we are doing at the [inaudible] council, which does great work. It has really joined up and it works across sectors but we talked about collecting data and we started to think about how to collect the physical activity data. I said, 'Well, hang on, if we are going to collect physical activity data, we should at the same time collect the smoking data, the health and nutrition data, not in silos, together.'

As Seana would have said yesterday, from reading her submission, we do need to be collecting longitudinal data on a regular basis. If there is one investment we should make upfront it would be the commitment to start to do that because the Australian Health Survey only comes out every three years and often we cannot drill down closely enough into the data to see what is happening in our particular communities. There should be an investment in that data to go towards hitting this goal, collecting both behavioural risk factors. It can be an omnibus survey and collected effectively because there are issues, as you would have heard yesterday, with comparing the data - the data that was collected in the Population Health Survey doesn't really match what is collected in the ABS survey and over time, because it is a telephone survey, we are comparing apples with apples but the orchard has changed.

Ms DIGOLIS - It is about being able to identify those gaps, too, and the mechanism for doing that. General practices that might be in the same community can be saying collectively we know that we don't have those public spaces such as bike tracks or walking tracks here for people, and there are not easily accessible gyms or the community health centres could be offering more on this. You start getting that picture of where the gaps are and then you get that collaborative approach through the model that we are proposing which is saying, 'Okay, we need to address these gaps,' whether they are regional or whether they are across the state. We actually need to start implementing things to make a change.

Mr VALENTINE - It is better for governments to be able to know what those gaps are and to be able to plan for that in the future with changes that go on. They might want to focus on certain gaps and a new government might want to focus on other gaps, but at least the gaps are being addressed over time; is that right?

Ms DIGOLIS - Yes, and there are some joint responsibilities. Roger referred to education, well Education shouldn't be the only ones who are accountable for the health of our communities and the health of our individuals. Again, coming back to this model, it is talking about having all those people there to be able to say it is more than just education, it is more than just the local government area that they are living in and it is more than what they are able to access through the health system.

Mrs TAYLOR - My question was in relation to Roger's question and your response, and you have kind of answered, I think Graeme, but just to make it clear: this integrated health check, whether it is done by the GP or the practice nurses or whoever, it has to be affordable, has to be free. Were you saying that in New Zealand that is free? Even if all of your other things are not, for the Bevs of the world, most of us go to the doctor if there is something wrong. People do not go for an integrated health check because it is also a big visit. It is not your six-minute thing, you have an extended visit and it costs you more than $100 or so and there are lots of people who cannot afford to do that. Unless that is free, that isn't going to work.

Mr LYNCH - Absolutely. The GP is the gatekeeper on this, so when I talk about practice nurses and so on, the GP is ultimately the person who provides the advice, but there are ways that we could look in our system of working more efficiently, effectively and letting GPs do the stuff that really requires their expertise and freeing them up. Yes, that is part of the whole equity issue that we are talking about. It is not equitable - I think the Chair said she would go and have a check-up irrespective of whether she had to pay for it or not because she knows -

CHAIR - I have the money to pay for it.

Mr LYNCH - Why should someone who can pay for it have the benefit of having their risk assessed when someone, through the circumstances in which they find themselves living - Bev's family, for example, and generations of Bev's family - not have it? That goes back to the diagram.

CHAIR - I don't have all the social determinants of health of those people who cannot pay for it.

Ms O'CONNOR - I have a question for Pauline and I don't know if you are comfortable being asked yet, but I receive your regular missives or news updates on changes in Commonwealth health policy. I am wondering if the elephant in the room here is: what role does the Commonwealth play in preventative health? What impact has the end of the National Partnership Agreement on Preventative Health had on any community and state endeavours to improve health and wellbeing? I am sure we would all agree that no state government can do all of this on its own. What is the role of the Commonwealth here?

Dr MARSH - Thank you, Cassy, it's a good question. There is one point that we made in our submission that we were hoping to speak to today. One point that was raised by some of our member organisations when we did our consultation around this preventative health submission and the submission to the One State, One Health, Better Outcomes health performance paper was that the community sector is already heavily involved in health care when we think about it in its broadest sense. In Aboriginal health services, child

health, men's health, mental health, nutrition, it is happening all over the community sector and it may not be happening out of a health centre but out of a Neighbourhood House. All those services received funding from a bucket load of sources, including federal, and there have been cuts across a whole range of those funding sources. They are already experiencing a squeeze in the different range of areas.

At the same time that tightness is happening, they are reporting that they are seeing an increase in the complexity of presentations, particularly around mental health. People are more unwell, there are more serious presentations and also a deterioration in people's social circumstances with people living in more extreme poverty.

Ms O'CONNOR - What time span are we talking about here?

Dr MARSH - I could not answer that accurately, sorry, but it is a current observation of what is happening in Tasmania. That came up because a lot of community organisations rely on a volunteer workforce and those volunteers, particularly community transport drivers, felt they were being asked to transport people or to be working with people who were in need of a more trained workforce in a health care capacity. They are still doing the same task but they are seeing more complex problems. They are transporting people home from hospital who are living in squalor and do not have any supports. These are current observations. I don't know how long the process has taken to get to this point.

Ms O'CONNOR - I want to talk about the impact of the cessation of funding for the National Partnership Agreement on Preventative Health, because we saw great programs defunded like Move Well, Eat Well, Glenorchy on the Go and the School Canteen Association. That must have a significant impact that is immeasurable at the moment in terms of actively bringing healthy choices across all age groups.

Dr MARSH - Yes.

Ms O'CONNOR - What is the role of the Commonwealth in preventative health? I don't mean to put you on the spot, Pauline, but I think it has to be part of our conversation as a committee because the state is not resourced to fully fund all that needs to be done.

Dr MARSH - That would be the point to make. As a state we can't look at this in isolation on our little island. These current services that have been providing preventative health measures in the broadest sense are impacted on by a decrease in funding from the Federal Government that is directly aligned with cessation of the National Partnership on Preventative Health.

CHAIR - Thank you all for your time. If there are any other pressing matters we can discuss them because we have other witnesses to hear including from the Government as well. We may even feel the need to call witnesses back in some cases, so there is always that opportunity. Thank you for your time and we are sorry about the delay we had and holding you up and making you late getting away.

THE WITNESSES WITHDREW.

Dr LEONARD ALFRED CROCOMBE, APHCRI (UTAS CENTRE FOR RURAL HEALTH), WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Ms Forrest) - Welcome, Len. You are protected by parliamentary privilege while you are before the committee. Everything you say is recorded on *Hansard* and will become part of the public record. It is a public hearing but if there is anything you want to say of a confidential nature you can make that request to the committee. We have received your submission and read it. We welcome your further comments to that submission and anything else you would like to say.

Dr CROCOMBE - I had better mention my conflicts of interest, which are many. I am employed by UTAS, the Centre for Research Excellence in Primary Oral Health Care, Adelaide, I consult for the voluntary dental graduate year program and am a federal and state councillor on the Australian Dental Association.

Ms O'CONNOR - I don't think they are conflicts of interest. It is your broad range of interests and expertise we are very interested in.

Dr CROCOMBE - Because oral health has tended to be siloed out from general health in many areas, I thought I had better mention the importance of oral health. It is extremely important for quality of life. It is very hard for a child to concentrate with a toothache. There are strong links with general health - diabetes, child birth weights, early births, cardiac disease et cetera. Big bucks are spent on oral health. According to AIHW it was approximately $8.3 billion in 2012, which was about 6 per cent of total health funding. The reason you don't hear a lot of about it is because 85 per cent of it is spent in the private sector and not the public sector, so you don't hear lots about it in budgets.

We have a massive worsening crisis in aged care oral health. The reason for that is that my parents' generation who went through the Second World War tended to have their teeth extracted and are now sitting in residential aged care facilities with lower dentures and plastic cups beside their beds. The biggest crisis they have is if the nurse loses the lower denture down the loo when cleaning it and we get a panic phone call.

CHAIR - Or loses hers.

Dr CROCOMBE - That's the other issue; that happens on a regular basis. They are in the plastic cups not because they don't particularly like their chin touching their nose when they close their mouths, it's because their salivary glands have degenerated and there is no lubrication. They have often had their teeth out in their 20s and the ridge on which the dentures sit is non-existent so it floats around in the mouth, which obviously affects their diet which then affects their health.

However, it is going to get a lot worse because when I hit the nursing home - although I hope to die at home - I am going to have teeth, and so will a vast majority of the people my age. A lot of these teeth have been saved by some very heroic dentistry; we have crowns, bridges, root fillings and implants. The issue is that these teeth can get infected. By the time you hit a residential aged care facility these days you are in high care, have multiple drugs and multiple diseases, and if you start getting infections around the mouth

that will be life-threatening. The particular thing that scares us is that when these implants fail you can't just pull them out, you have to surgically drill them out, so that's going to be life-threatening. So you have this massive crisis occurring in aged care oral health and it is going to get a lot worse.

Ms WHITE - So false teeth for everybody right now, then?

Dr CROCOMBE - That's a thought. Some people have actually said that when you enter the aged care facility we should take out all your teeth, but the trouble is it is too late then because you are going in because you have these multiple diseases. You have the health assessment of aged people and what care they need - I have forgotten the name of it -

CHAIR - You mean the ACAT assessment.

Dr CROCOMBE - Thank you. Part of it is using an oral health assessment tool. The problem with that is about 80 per cent of people who go through the oral health assessment tool need the health care. On top of that, there can be quite a long period between when the person has that ACAT assessment and an interview with a residential aged care facility, at which point another assessment is meant to be done but it is usually short and simple like asking if they have false teeth or not, and then they head into the residential aged care facility. We need a simplified assessment at that stage, which is what I am working on in my research, which involves a series of questions with the only outcome measure being whether you should be referred for dental care. The care we should supply should be palliative, in other words only doing what is affecting the quality of life of the resident or their general health. That is where that silver fluoride and non-traumatic dental technique came in.

CHAIR - Is that a treatment for older people as well? Is that something you do there?

Dr CROCOMBE - Exactly.

CHAIR - There are fissure sealants that they use on younger children - is this different from that?

Dr CROCOMBE - You have grooves on the top of the teeth. The grooves go right through to the dentine, bacteria get caught down the bottom and the decay spreads underneath the enamel so you can't see it. That is why we take x-rays basically. With fissure sealants the idea is that you seal the groove not long after the tooth erupts so the bugs can't get down there. The risk is that you can seal bugs in, which is not a problem if you keep it sealed because you starve the bugs of food, but if the fissure seal breaks in any way then you could have a problem.

The silver fluoride actually arrests the tooth decay. We're talking about residential aged care facilities, people with mental and physical disabilities, people with low SES who can't afford care, and the list goes on. I am looking at people in developed countries because I go to Papua New Guinea and Timor Leste on a regular basis and I can see this changing the whole world of dentistry, but that is my passion. By arresting it the question then is do we actually need to restore it afterwards? I would argue that in residential aged care facility, probably not. Why put them through all the trauma when you can't even get them out of bed?

Those two things go together: you need a simplified assessment followed by a palliative oral health care, and the ones I am looking at involve silver fluoride. We are doing a trial on the Tasmanian dental service for kids on the GA - general anaesthetic - waiting list who are usually on for about a year. My understanding is the GA waiting list is getting longer and longer. Whenever there are cuts to the GA waiting list, oral health is the one that always gets pushed aside as seemingly thought to be unimportant.

I will move on. The social determinants of oral health are exactly the same as the social determinants of general health. The one area of difference is fluoride exposure and this state has been a leader in the area of fluoride in water supplies. Hobart was the first capital city along with Sydney, the first place in Australia after Beechworth, to put fluoride in the water supplies.

Ms O'CONNOR - Has that been measurable in dental outcomes, do you think, in Tasmania? Does this Government have the space and scope or even the will to really investigate what the health outcomes from fluoridation would be?

Dr CROCOMBE - It is not limited to Tasmania. Our problem in Tasmania is that we are the most decentralised state and hence there are lots of little towns that don't have reticulated water supplies. That is the big issue in rural areas, in particular, and that is my area of expertise - rural health.

I did just have a paper accepted last month in the *Australian Dental Journal*. We looked at a whole mass of factors around the country for rural people, and rural oral health is poorer. We looked at all the usual social determinants: education, access to dental care, and found that it was still worse in rural areas. When we put in lifetime fluoridation exposure, that difference disappeared completely. It is the one simplest, cheapest factor and it would be the one that I would really push, but I cannot see that you could much more. That hassle we have is the National Oral Health Plan. We haven't come up with a solution about what you do with people in the rural areas who are on tanks, like I am.

CHAIR - We used to be given little white fluoride tablets when I was a child.

Dr CROCOMBE - That's right and you cannot get them now. That was what was in the National Health Plan, which is still current but the new one is coming out in a couple of months time. The trouble with the fluoride tablets is that kids can swallow them like lollies and you could end up with an overdose. What it says in the plan is that you should put it in a jug of water and have the water in the fridge and when you drink you drink from that. A complicating issue is that there is this halo effect. If you are in a town that is fluoridated and you are producing food from that town and manufacturing the food, people who are outside the fluoride area are still getting some benefit from it because they are eating the food which has been produced using the fluoride.

CHAIR - That would be a sub-therapeutic level, wouldn't it?

Dr CROCOMBE - It would.

CHAIR - Is anything better than nothing?

Dr CROCOMBE - That's right. We have some in-surgery fluoride applications as well. In answer to your question there is a minimum of 50 per cent reduction in tooth decay in fluoridated areas to non-fluoridated areas.

Mr VALENTINE - I am living proof. I spent the first 20 years in the country and I had 13 fillings and four extractions when I got to high school, and have had about four since.

Dr CROCOMBE - My parent's generation, teeth extracted - this is a generalisation - my generation, lots of fillings, and as the teeth collapsed it re-decayed, and as the fillings collapsed had it redone, redone and redone. You went small filling, big filling, bigger filling, crown, extraction, denture, implant-type of stuff. It is good for money. In private practice the target generation is the baby boomers because you have lots of disposable income and you're the ones with all the caries.

Then our child's generation are the fluoride generation, and they have not been getting the tooth decay as our generation has. The Commonwealth Government in its usual method, just as we are getting to that stage of getting on top of the caries, increases the number of dental schools from five to nine, increases the number of placements, increases the number of dentists coming from overseas. The last HWA Dental Workforce report that came out in December said we are heading for a massive oversupply in the dental workforce. They use seven scenarios in the process. The issue of supplying dental care is now not a dental workforce issue, but it would have been 10 years ago. If this state had a billion dollars to throw to dental care, we didn't have the workforce to supply the care. It is now not a workforce issue; it is now purely a money issue. Even the Commonwealth probably doesn't have enough money to supply universal dental care, let alone the state of Tasmania.

CHAIR - Maybe if they increased the Medicare levy.

Dr CROCOMBE - Even that would have to be more than 1 per cent.

Mr JAENSCH - I want to understand more about the links that you have mentioned between oral health and other disease - things like diabetes, heart risk et cetera. I understand why self-esteem, speech, sleep et cetera are directly, but what are these other disease relationships with oral health?

Dr CROCOMBE - Diabetes is the number one that has been proven over time to show that people who have diabetes have worse gum disease. On the other side of the coin, people with worse gum disease have worse diabetes, and it has also been shown that if you treat the gum disease, the blood sugar level reduces. So there are strong links between the two.

Mr JAENSCH - Do we understand the links or is it circumstantial?

Dr CROCOMBE - They have done studies taking account of all the risk factors and there is still a link between the two - not 100 per cent. If you were to take the inflammation that is associated with gum disease and if you, say, had it on the back of your arm it, would something like about 10 centimetres around. If you had that inflammation on your arm you would be treated as quickly as possible.

CHAIR - And your diabetes would be out of control.

Dr CROCOMBE - Yes, you can see the big link. One other area is heart disease. The links there are not quite as strong but again they think it is the same inflammatory factors. Around the tooth there is a micro film which is the inflammation, and they think the same type of thing occurs on the inside of arteries and that there is a direct link between those two. Another big one is with inhalation, pneumonia and basically strong links there. They think that what is occurring there is that people are swallowing oral bacteria which then get into the lungs and create massive diseases in that area.

Mr JAENSCH - Ruth, the other night in Devonport the Health minister quoted you on links with premature birth.

CHAIR - And the poor outcomes.

Dr CROCOMBE - That is exactly right - low birth weight babies and treatment of gum disease in pregnant women. Of course with all the hormonal changes, as you would know, you have swollen gums and they bleed very easily, which then goes away when you have the baby, or hopefully it does. Again, treatment of the gum disease does play a role with low birth weight babies and premature birth.

CHAIR - My submission to the Health minister was to prioritise all pregnant women in the north-west to have access to dental care when they first present and try to reduce the rate of premature birth, because if you could save two or three premature babies you would pay for it.

Dr CROCOMBE - Exactly.

Ms WHITE - Some of the other submissions we have had say we should be moving away from our policy of fluoridating because there is apparently a greater prevalence of chronic disease, including asthma, arthritis, thyroid disease, diabetes and heart disease in fluoridated water.

Dr CROCOMBE - You have not thrown in a bit of a cancer.

Ms WHITE - I am wondering if you could respond to that and indicate whether you are aware of any instances where fluoridated water has increased the risk of other chronic diseases.

Dr CROCOMBE - The World Health Organisation put fluoridation in water supplies as one of the 10 major preventative mechanisms that has ever been done in the world. There has not been any study that has shown that any disease is worse in fluoridated areas. As a matter of fact with osteoporosis they might be going the other way. The way science works is that we cannot disprove anything. I cannot disprove that the sun won't rise in the morning tomorrow, however the balance of probability is, as it has for the last four billion years, that it probably will rise tomorrow. It is fairly easy to throw in a whole mass of diseases and say they haven't proven that it can't occur. In epidemiology all we can say is that in areas that are fluoridated there isn't a higher incidence of any disease than in areas which are fluoridated. Do you see what I'm getting at?

Ms O'CONNOR - That contention is disputed in this submission. She looks at the Republic of Ireland which is fluoridated and Northern Ireland which is non-fluoridated, and this submission states that there is a much greater prevalence of chronic disease, including asthma, arthritis, thyroid disease, diabetes and heart disease, in the fluoridated population.

Dr CROCOMBE - I would like to see that balanced by sex and age. I would like to see the actual article and rip it to shreds.

Ms WHITE - It is something we have received in submissions. I was just curious to understand your view on that.

Dr CROCOMBE - We have had in Queensland, unfortunately - I will not go into the politics of it all, but two premiers ago fluoride was going to be compulsory but with the last government in Queensland, it was left to councils which have been taking fluoride out of the water supply. Queensland has pretty poor oral health and I am really concerned about what is going to happen in that state. Please don't take it out, guys, unless you want to give us a couple of billion bucks and I will go back into private practice and earn big money and retire.

Ms WHITE - There was one other question I had which comes from hearing you talk about it, Chair, and that is the link between good dental health and pregnant women having healthy weight babies. Could you explain how that link has been identified?

Dr CROCOMBE - Again, by epidemiological surveys. From the point of view of a biological plausible mechanism, I'm not 100 per cent certain. We're still at the stage of hypotheses on that.

Ms WHITE - But it is assumed that if someone has good oral health they have a healthier weight baby. Is that correct?

Dr CROCOMBE - It is all part of separating the body into separate parts. It goes back 400 years ago with the way we have set up our health system. It should not be a surprise that if you have infections in one part of the body you're not going to have problems in other parts. You can't just cut out the mouth and say it is not going to affect the rest of the body.

Mr JAENSCH - It has to do with the immune system and the body responding to infection and invasion. Because you have got a mouth there and it is wet and you're putting lots of nutrients through it, it is sort of a constant open wound and that is why it is -

Dr CROCOMBE - Yes.

CHAIR - You were talking about heart disease. As I understand it, there is a risk of inflammation of the membranes around a baby and a risk of rupture of the membranes and -

Mr JAENSCH - That is that membrane relationship you were talking about. The membrane around the tooth, the membrane inside the artery and membrane around the baby, so

somewhere if there is an attack on the membranes, they might all be compromised. Is that what you are sort of saying?

Dr CROCOMBE - Yes. I think 'potentially' is the right word. I would not write in a scientific journal and say it is definite, but the evidence is beginning to point that way, yes.

CHAIR - The problem in this case is that women with poor dental health also often have a range of other social issues, such as living in poverty and poor educational standards. Which is the one that causes the problem? It is trying to take a holistic approach to this individual woman who is pregnant or an individual who has heart disease or whatever.

Mr JAENSCH - Yes. Do you fix the teeth or do you take the Coke out of the fridge?

CHAIR - You take the Coke out first.

Dr CROCOMBE - That is part of the problem in oral health. For some reason there seems to be this idea that if you've got poor oral health it's your problem, you've done something wrong - you have a poor diet, you haven't been cleaning your teeth or something along these lines. The strongest link is the socioeconomic determinants. It's a blame-the-victim type of situation and in most cases it doesn't hold true. I think that is part of the reason we have been looked at separately from other areas of health, because people naturally think, 'Well, it's your own fault so why should we be funding it?'.

CHAIR - If you did dentistry under the same training platform as medicine, maybe it would be different and be treated as part of the whole body.

Dr CROCOMBE - Yes. That only happened because the Yanks set up a research situation. Prior to that production of sugar was part of the slave trade. It was very expensive to do and was done on small farms. They set up a research institution in America and set up big factories to produce sugars. That had a big role to play with the slave trade back in those days. We are talking about the 1900s, which was when dental caries exploded because they cost of sugar dropped through the floor. Prior to that only the rich could afford sugar. It was probably also a time of blowout in diabetes and a whole mass of other things. You will notice the first dental schools in Australia all opened up in the early 1900s. We couldn't afford to have physicians treating dental disease because there was a massive epidemic in oral disease. It reduced during the Second World War because no-one could get sugar but after the war it went rampant again and hit the baby boomers.

We set up a dental school and the dental therapists program as a result. Now we are going through the cycle of the fluoride in the water supply - Tasmania was the first state in Australia to do so - so the next generation aren't getting the caries the baby boomer generation had. Right at the stage where the baby boomers are beginning to retire we have a massive increase in the workforce, so it is going to be an interesting time. I wonder whether in another 50 years' time historians will look back at our era and say, 'That was a strange time when we had this massive explosion of dental disease and now hopefully it is gone.'. We are now producing people just at the time the incidence of dental disease is going down.

Mr JAENSCH - We're going to need them for forced extractions at some stage.

Dr CROCOMBE - Just before you put them in aged-care facilities.

Ms O'CONNOR - Len, could you describe, so we can personalise, the story of an individual Tasmanian who is living in an area of socioeconomic disadvantage, who has grown up in a family with poor oral health. What impact is that having on that individual's health and wellbeing and their prospects through life, from birth through to adulthood?

Dr CROCOMBE - I guess people with low SES have trouble with access to care. We have linked it to those other diseases so if you have any of those diseases you are much more likely to be poorer. Your employment prospects are lower because it is part of your social outlook on life. You are going to have a greater possibility of those diseases we were talking about. It locks them into that stereotype of not being as good as people from higher socioeconomic areas and it locks you into that whole cycle, if you understand what I am getting at.

Ms O'CONNOR - Yes, I do. Have you personally seen a person's health, social and economic prospects transformed by timely access to dental therapy or orthodontics?

Dr CROCOMBE - Yes, definitely.

Ms O'CONNOR - A case study.

Dr CROCOMBE - I used to be head of the Tasmanian Dental Service and our research is now with them. We had a young chap who had no employment prospects. He had terrible teeth and it was affecting his health. We were able to put him through the whole lot of dental treatment, which is always difficult in the public sector, as you can imagine. We were able to in his case because he was going through a charity organisation that was willing to pay for any extra dental treatment. That increased his confidence and he was then able to gain employment and that transformed his life. It does make those types of transformative differences.

It is very hard for the Oral Health Services Tasmania to do that type of stuff. They get approximately $23 million a year. About a third to a half of that comes from the Commonwealth Government, not just from the state Government. It will be interesting to see what happens next week in the Federal Budget. If there is any decrease in the main source of funding, they will have massive problems. All children are eligible for access to public dental care in this state. About 40 per cent use it. Adults with healthcare cards are eligible for access to dental care but only a small percentage can get access.

Ms O'CONNOR - That is about the capacity of the Oral Health Services to deliver the services and there are quite long waiting lists, aren't there?

Dr CROCOMBE - Yes, there can be.

Ms O'CONNOR - I take onboard what you were saying before that it is possible that we have slightly healthier teeth and that over time we will see an improvement in oral health. Do you support regulatory mechanisms like a ban on junk food advertising or

other regulatory mechanisms or legislation for driving a population towards improved oral health and therefore overall health?

Dr CROCOMBE - First, the poor oral health is in certain sections of the community. You are looking at lower socioeconomic status groups who are the ones with the worst oral health. That is number one and I have to press that home.

The regulation - I prefer to go down the track of education from regulation. That is a very difficult track to go down. Usually the way that it has tended to go is more along the lines of increasing taxes and stuff on those things which are not as healthy for you and you try to combine it with education in the process. There are strong links between your education level and your oral health, as there is with general health. Here are talking about generational change, in that anything we can do to improve the education levels of people in Tasmania will have flow-on effects for both general and oral health. I expect that would be like a two-generation type of thing. It will be long after you and I are pushing up daisies. Maybe I should not have said that. Maybe long after you and I have retired it will start having flow-on effects.

Mr VALENTINE - I did have a quick one, but I think it could be an important one. That is with your work on fluoride, water out of the plastic bottles, the community is absolutely dedicated to getting their water out of plastic bottles out of fridges in shops. Is this damaging the exposure to fluoride and/or is it increasing the exposure to things like antimony which might have an adverse effect? Do you have any comment on that?

Dr CROCOMBE - With the last question I don't know, so I won't try. With the fluoride, up until the past couple of years it was illegal for the companies that were bottling the water to add fluoride to them. That has now been changed, under pressure from the Australian Dental Association, which was good, so you can buy water with fluoride in it. Interestingly enough, frequently when they do get the water it comes from springs and stuff like this, there is quite often a high concentration of fluoride in it.

CHAIR - Naturally.

Dr CROCOMBE - Naturally, yes. The amount I am never certain, it would change from brand to brand. We have noted an increase out of the other place I am employed, the University of Adelaide, with ARCPOH there, we have noticed with the children who go to school dental services around the country that there has been an increase in dental caries. After going from an extreme high in the 1970s it was just a constant downward trend until the past five years, where it started to go up again. We are not certain of the cause, but one of the hypotheses is increased use of bottled water rather than tap water. We always suggest to people why pay money why not use the tap water and it is particularly good.

We think it is a factor and it is a bit of a concern that we are not 100 per cent certain on that increase in caries.

Mr VALENTINE - Antimony you don't know about?

Dr CROCOMBE - No, I know nothing about that, it is over my head.

CHAIR - We had better wrap it up as we have another witness waiting and one to get on the telephone. Thanks for your time, we appreciate your input. It is an area that people don't tend to focus on so it is good to have your expertise in that area.

Dr CROCOMBE - Thank you.

THE WITNESS WITHDREW.

PUBLIC

Ms NATASHA MEERDING, VICE-CHAIR, DIETITIANS ASSOCIATION OF AUSTRALIA WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED, AND **Ms ANNETTE BYRON**, DIETITIANS ASSOCIATION OF AUSTRALIA, WAS CALLED BY TELEPHONE.

CHAIR - In terms of the proceedings of this public hearing, it is being recorded by *Hansard* and will be transcribed and form part of the public record. Essentially what you say here is covered by parliamentary privilege while you are before the committee but if you speak to the media or someone outside you will not be and you need to keep that in mind. If you want to give evidence in confidence to the committee, you can make that request and we would consider that, otherwise it is all public.

I know your organisation put a submission into the inquiry in 2013 and then we had the election and re-established. Most members have had a chance to have a look at that and that it is all been taken into the evidence of this committee again so that still stands. I would ask you speak to that submission to update us and anything further you would like to add and then we will have questions from the committee.

Ms BYRON - We are very encouraged by the Tasmanian Parliament's interest in preventative health care. I think you are showing quite a high level of leadership with this because we can see that in other jurisdictions there is not the same interest and certainly not the same willingness to put some of your findings into practice, so we are very encouraged by that.

There are three key areas we would like to elaborate on today which extend the submission we made a little while ago. One of those is that nutrition is an important contributor to preventative health care and we can see that echoed in some of the other submissions to this committee. We also know that collaboration is needed to ensure that people can access and afford safe and healthy food. The third point is that we need a workforce here, and dieticians have particular skills and knowledge they can use to lead programs and work collaboratively with others.

Those are the points we would like to elaborate on a little. We know there has been some further slide, if you like, in the workforce so we would like to talk a little bit more about that as well.

CHAIR - Thanks for that. Did you want to make some opening comments too, Natasha?

Ms MEERDING - Annette has covered our key points but to build on what was originally put in, as Annette is alluding to, we have probably a reduction in numbers of dieticians from what was originally submitted in the submission. We do not have those figures factually but over the past 12 months there has been a big cut from public health and we are seeing some cuts coming now from the clinical sector as well to dieticians.

CHAIR - In terms of the collaboration, how do you see this working? I am not sure which other submissions you have read but we have had submissions from the Health in All Policies Collaboration which is a group of key stakeholders in wellbeing and chronic illness who talked about a joined-up service. How do you see dieticians fitting into that sort of framework?

Ms BYRON - The key thing is that nutrition is impacting people across lifestyles and there are a number of areas we can be collaborating on. We know, for example, that Tasmania keeps really good figures about the initiation rate of breastfeeding at the time of discharge of women from the time they have delivered their babies. In Tasmania we can see that there is a drop from 82 per cent of mothers breastfeeding to 75 per cent.

CHAIR - That is on discharge from hospital, isn't it?

Ms MEERDING - Yes, that has happened over the past five years.

Ms BYRON - There is a strong social gradient with that. Natasha might want to elaborate a little more on how we see dieticians, for example, working in that space.

Ms MEERDING - Yes, there is a huge social gradient with breastfeeding rates where in our higher socioeconomic groups there are much higher rates of breastfeeding than in the lower socioeconomic groups. It's very counterintuitive because they don't have money to be able to afford infant formula but it's really around the social norms of breastfeeding and the support of communities in place to help the women breastfeed. In terms of solutions for that, it is a very complex area that would need many different health professionals working together to change the environment that the women are going home to.

CHAIR - One of the issues I see is that it is becoming accepted practice, and not inappropriately, that women leave hospital sooner after giving birth, and with the Kate Middleton effect we are going to see it even more. That is okay when you have good support. She would have gone home to every service known to humankind, whereas women in these lower socioeconomic groups go home to inadequate housing at times and a whole range of other factors there. These figures of 82 down to 75 per cent of women breastfeeding on discharge could be six hours after the birth. The baby may have only had one feed. The real issue here is what is happening in two weeks, four weeks, six weeks and six months' time.

Ms MEERDING - Yes, and that's when we see an even more dramatic drop-off from 75 per cent to 60 per cent, and after four months it drops even more to 45-50 per cent. Particularly in the lower socioeconomic areas you can really see that shift rather than in more affluent areas.

I was talking about health professionals needing to work together, so that would be dieticians, lactation consultants and child health nurses. There is the change to the maternity practices at public hospitals, with the early discharge Ruth was talking about. Although that is happening, there is a follow-up at home with the midwife, who often has lactation experience, but it is still that extended support from family members and neighbours and everyone else who is maybe not breastfeeding within that community. There is a lot of research going on nationally and at a state level about what we can do for these more disadvantaged groups to try to help with the breastfeeding rates, but real solutions are very complex and it is to do with the social situation.

Mr VALENTINE - Has there been any correlation with them not wanting to breastfeed because they want to start smoking again, for instance, and they don't want to harm their child? Do you know whether that is happening?

Ms MEERDING - I have not read anything specifically that says that, Rob, but there are all sorts of postulations. If you see that the discharge rate is going down it is early on that it is happening.

Ms BYRON - We know breastfeeding is so important because it has implications for health later in lifestyle. That is clear in some of the research that has been done. If we move on to programs for children, if you look at primary school-aged children, two in 10 are already overweight or obese, and by the time they reach adulthood, we are looking at five in 10 children being overweight or obese as adults.

Ms MEERDING - An additional five in 10, so seven out of 10 will be overweight or obese adults.

Ms O'CONNOR - Is that in Tasmania or a national measure?

Ms MEERDING - That is a prediction of where we have two out of 10 kids who are overweight or obese and what they will be as adults. That is what the predicted figures will be nationally. The figures would be worse in Tasmania, given our population is more of a regional rural population.

Ms BYRON - Some of the work that is being done to address that is looking at some of the school programs and other programs. Natasha might like to expand on some of those.

Ms MEERDING - A lot of the work being done is really on preventing those five children becoming overweight as adults, trying to embed some healthy behaviours and giving them a healthy environment in the settings where they are learning, playing and growing up. An example is the schools-based program called Move Well, Eat Well, which has active play and drinking water and eating fruit and vegetables and healthy school canteens and -

CHAIR - And it has been de-funded.

Ms MEERDING - It hasn't been completely de-funded. It lost its Commonwealth funding but still has some state funding. It has been remodelled and re-looked at how it is going to operate. That is a really important model that happens in many other states around Australia. We are also looking at the fundraising, making that more healthy, and just making it a whole health-promoting environment for the kids around physical activity and nutrition.

Mr VALENTINE - Just picking up on one thing you mentioned there with regard to healthy school canteens, have you, as a dietitian association, had much active involvement in trying to promote that?

Ms BYRON - As an organisation we have not had a lot to do individually with canteens. We have certainly responded to the development of national guidelines and so on, but not as

an individual activity. It is really our members who have been working on the ground in those programs.

Ms MEERDING - With my other hat on that is one of my work areas, so I am well versed on healthy school canteens. That is not from a DAA point of view as such.

Mr VALENTINE - In respect to that work, are you finding resistance to change?

Ms MEERDING - I have been back in Tasmania for about nine years and over that time, and even if you go back 15 years, we have seen a real cultural shift within schools and school canteens. Back 10 or 15 years ago there was soft drink sold in all school canteens, hot chips, lollies. There is a real cultural shift where things are changing. There is resistance. It comes from all different areas. That resistance might not come from whom you might think it might come from. It might not come from the canteen manager; it might come from the parent body, it might come from the teachers, and so it is different for each school. The model that we use in Tasmania is an accreditation program where a non-government organisation, Tasmanian School Canteen Association, supports the schools to try to make changes and get around these barriers or whatever they are for that particular school.

Mr VALENTINE - That association was specifically formed to try to improve that?

Ms MEERDING - That is one of their main mandates. They are also supposed to be looking after the rights and being advocates for school canteen managers as well. That is formed. They have also lost some Commonwealth funding from the National Partnership Agreement on Preventative Health last year, so that is going to come into play for them midway through this year.

Ms O'CONNOR - I have a couple of questions. The first is about locally produced food and the role that might play and we are seeing a shift to community gardens. There is the 24-Carrot schools program that happens out in the northern suburbs. Do you think as the community moves towards more locally produced foods and the ownership of food spaces that this could have a significant improvement on public health?

Ms MEERDING - I hope it would have a significant improvement. People have to have access to affordable healthy food for them to be well nourished. We know that in our more disadvantaged areas often there is less access to fruit and vegetables and more access to takeaway stores and unhealthy foods. It is great to see this movement starting to happen, but that needs to be affordable and accessible and become the social norm in that community as well. That is starting to happen. An example is the Waterbridge Project out in the Gagebrook-Brighton area, where there is a food co-op in a more disadvantaged community. Often we see these farmers' markets and food co-ops in the more affluent areas. It is about getting them in all of the other areas and having community involvement from earlier on so that the community owns it and really wants to be part of it and wants to buy their things from there or obtain them from there for swapping work or whatever the arrangements are.

Ms O'CONNOR - They were doing it in Devonport Neighbourhood House. It is happening; it is just not as widespread as it needs to be. There was a briefing here last week from HACSU, and some dietitians from the Royal Hobart Hospital were there. I asked them

why the food in our public hospitals is so poor and why does it meet so few nutritional standards. I was wondering if you had any thoughts on cups full of red and green jelly and custard, white bread sandwiches that have unidentifiable substances in them.

Ms MEERDING - I don't work in the clinical setting at the moment, but I previously have. It is a very complicated space, and if change is going to happen, like school canteens it is going to be very gradual and happen incrementally with changes that will have a lot of resistance, I imagine.

Ms O'CONNOR - Why the resistance? Not from patients.

Ms MEERDING - From some patients. You will find that some older patients really like that food and that is what they are used to. I would have to agree with you that that is not what I look forward to eating if I am in hospital.

Ms O'CONNOR - I have never heard a rave a review of the food at the Royal.

Ms MEERDING - The other resistance really comes from the food service department. There are often a lot of financial constraints, there are skill level constraints.

Ms O'CONNOR - The dieticians who were present were extremely frustrated about the situation, particularly at the Royal. They felt their inability to influence healthy purchasing and food supply.

Ms MEERDING - There are have been some projects that have tried to look at making it healthier at the Royal Hobart, I am not so sure in the other regional hospitals, but there is a lot of resistance with them. Yes, there should not be but it does not just happen in Tasmania as well.

Ms BYRON - My last clinical position was at the Royal Adelaide Hospital and we were feeding 600 or 700 people at a time. There are ongoing challenges to satisfy what people expect to eat. At one time, for example, I was in one of the orthopaedic wards talking to a young chap who was telling me that he was very unhappy about the food and described his [inaudible] response quite graphically. I was around in the kitchen two minutes later and there was somebody who had been in the process of leaving the hospital, they were discharged and they wanted to pop around to the kitchen to say how much they had enjoyed the food.

Sometimes food services do patient surveys and that is sometimes a way to get a gauge on meeting patient expectations. I agree that over many years I have had a number of frustrating experiences trying to ensure that you have the general needs of patients met but also the specific nutrition needs. Nutrition needs to be seen as therapy for people.

Ms O'CONNOR - That was my point.

Ms BYRON - One of the overriding issues here is cost. I am sure if you talk to any food service manager, and I know this is true in aged care and other situations, cost is a driver. Unless administrators and funders recognise the role of food as nutrition therapy it is very difficult also, for them, to get the changes that they would like to make. That is certainly one of the things that limits their capacity to change.

CHAIR - You would think this is an ideal opportunity to influence people's choice. I know when you are in hospital you are there for some reason of ill health and you may prefer to have comfort food, if I could call it that, which is what we are hearing a little of, but this is an ideal opportunity to say, 'We understand you like white bread and raspberry jam sandwiches, but let's talk about why you are here'. I was in the supermarket the other day and there was a mum and a little boy in front of me. He was grabbing a couple on Kinda Surprises and she had the big bottle of coke and he was deciding which order he was going to consume them. I did not feel it was my place to stand in the supermarket checkout and say, 'I don't think you should be eating either'.

Ms MEERDING - I try to avoid the supermarket, Ruth. Going back to your previous point, the dieticians that are working on the ground would be trying to help people with their choices they are making, so they would be trying to get in there for that opportunity. There is the setting and the food provided needs to give that message as well, like we are trying to do within schools and school canteens. The Department of Health facilities need to be health-promoting as well.

Ms BYRON - One of the flip sides of this is that, if you look at the Australian study, around 35 per cent or so of people who are inpatients are malnourished. While we accept there is a proportion of people who are not in for very long and who might not have very particular needs, there is also a group who are malnourished. It is a matter of attending to those issues. People come in because they are malnourished at admission. That is where it started and it reflects what is happening in the community. There needs to be work going on in hospitals and you cannot do that without the workforce. You can't change - your brief hospital stay and the average length of stay might be six days, I am not sure, at the Royal Hobart Hospital, but you must have the programs in the community to address that.

Ms MEERDING - Also to keep people out of the hospitals.

Ms BYRON - Yes, that is right. The estimates are that about 45 000 Tasmanians are at high risk of developing diabetes. We know that you can intervene, you can delay or prevent the onset of type 2 diabetes by diet and lifestyle activities. That is dietitians, exercise and sport physiologists working together but it is also working with other community workers and GPs to effect that change and stop the increased rates of diabetes.

Ms MEERDING - Or the complications for the people who already have diabetes.

Ms WHITE - I have a clinical question, so I am not sure whether you can help me. From that same HACSU briefing we received last week in Parliament, I was speaking to a dietician who works at the hospital with children aged two to 18, in the paediatric dietician's area. She was saying they have received a 50 per cent cut to their budget. Are you aware that is the case? There has been a 25 per cent to the budget overall in the hospital for dietitians, I understand, and a 50 per cent cut to the budget for those working in the two to 18-year-old group. She said that the waiting time for an appointment is now six months.

Ms MEERDING - And that would be for an outpatient appointment.

Ms WHITE - Yes. She said for children who have growth problems, who are not eating, who might have Crohn's, they are now being told they can't make an appointment to see anybody until October. Have you been told of those concerns?

Ms MEERDING - I haven't personally, as I have alluded to, I work in community and preventative health and we have received very similar cuts. I am not surprised they have received those cuts. I used to be a paediatric dietician at the Royal Hobart Hospital. They already had long waiting lists for outpatient appointments. You can imagine if there is any sort of cut, that is only going to blow out those waiting lists. It is complicated though because you will have a clinic booked and then a number of people will not come. People will not necessarily have the motivation to come which they should if they realised the imperative of their situation and also of how long the waiting list is. The dietitians at the Royal Hobart Hospital do a number of things to try to address that and they do a number of phone catch-ups with people to try to follow them up if they are booked in and cannot come to the session.

Ms WHITE - She said that exact same thing, that someone had made an appointment for their child, had to ring and say they could not make it, could they reschedule and they were told it would be October before they could get another appointment. They are struggling at the moment.

Ms MEERDING - Annette might be going to talk about this more, but that carries on really well to a point I wanted to make, which is that we have child health nurses working out in the community and dietitians in Tasmania have traditionally supported them with a lot of information, training, resources and all sorts of things to help with their clients but we do not have dietitians out in the community, sitting with those child health nurses who could be seeing some of those people rather than coming into a clinical setting.

Ms WHITE - We would possibly use our child and family centres better to do that as well as the community health centres.

Ms MEERDING - We have dietitians working in preventative health in programs like the schools program and the school canteens, which is really important, but we have received a cut for those dietitians. We need to maintain those levels. We have them working in the clinical setting but it is very few who are working out in the community. It is about half an FTE in Clarence and then half an FTE in the nursing homes for the south and I am not sure of the figures around the rest of the state. They were the figures before the cuts. I am not across what has happened since the cuts.

Ms BYRON - And that is against a background where there are very few dietitians in private practice. Even if people could afford or chose to see somebody as a private patient, their options are limited. We know the figures for Tasmania, going on our membership base, we can see that there are 13.5 dietitians per 100 000 people in Tasmania compared to 20 per the same population nationally. Tasmanians are not getting the access they need to keep themselves healthy.

Mr JAENSCH - I want to pick up on some discussion we had a little while ago about access to better quality fresh food in particular. I am aware of the analysis of that. One of the examples we talked about was of a shopping centre in a neighbourhood in my electorate where there is a TML-funded project which has set up a pop-up fresh food grocery. It

sits in a little shopping centre which also has a supermarket that has very little in the way of fresh food, yet the same chain of supermarkets a kilometre away has lots of fruit and vegetables. In my discussions with those businesses they say they supply what people buy. We are solving supply problems. We have supply solutions to demand problems. Are you aware of somewhere where we are working on the demand side? If people in that neighbourhood wanted to buy more vegetables, someone could sell them to them. We will have a project which is funded for 18 months.

Ms MEERDING - The TML one is funded for 18 months.

Mr JAENSCH - Something like that - it's truncated, it's going to finish.

Ms MEERDING - I'm not aware of a project that has increased demand but I would say that changing people's daily habits is a very slow thing to do. It is very hard even to change one small habit, particularly about your diet or activity. It is slow and hard. Having dietitians on the ground within the communities who are there for a long time and supporting people with projects but also giving them counselling or running groups would go a bit of the way to helping them change those habits. We need the supportive environment and some education but behaviour change is still a very hard thing to achieve a change.

Ms BYRON - There has just been a study published in Melbourne from work done by dietitians and others about the influence of price discounts and skill-building strategies on the purchase and consumption of healthy foods and beverages. It showed that if you give people the opportunity, they will increase their fruit and vegetable intake. There are signs people will take it if you can organise within the community to improve that access. It is about having the food available at a price they can afford, but it is also about building their skills and food and nutrition literacy.

Mr JAENSCH - There is another argument we have in our broader community that we don't value food enough and that we have a duopoly in our supermarkets that is constantly arguing to suppliers that it needs to minimise and minimise the costs of the food, whereas maybe good food does cost, should be valued and is something we learn to place value on if we look at that nutrition and nutritional therapy thinking. Annette, you just said there is research that says if you make good food available and make it cheaper that people respond, but will they learn to value food then and seek it out, and grow it or buy it later on after the one-off project is finished?

Ms BYRON - It is hard to know the answer to that. I know there is research that says it does cost more to eat healthily, and that is partly because of the price of fruit and vegetables. You can certainly teach people to make the most of their food dollar and in the context of the social determinants of health, when they are struggling to pay for housing and so on it is hard to find the money for food as well.

You can build those skills. People do want to do it. I think this underlines the importance, though, that when you have programs short-term funding is not enough, you need long-term strategies. I do not think we know the answer in terms of whether will people continue, but they certainly respond to short-term projects. I just think it needs to be taken to following level where you are continuing that support for people. It is also looking at the other community issues. It is about the transport they have and whether

they can get to supermarkets which provide the range of products at a price they can afford.

Ms MEERDING - And the cooking equipment they have at home. What do they have at home?

Ms BYRON - Yes, their housing situation - do they have somewhere to store their food? If they wanted to cook, do they have the material, the implements and so on?

Mr JAENSCH - In some programs I have been involved with one of the devices for education that has been used is a board that shows some familiar snack foods and things that appear in kids' lunchboxes and next them a little bag with equivalent cubes or teaspoons of sugar to try to bring that out. Have we ever done something which compares a packet of cigarettes to a basket of vegetables and makes a comparison of your buying power, because there are choices being made and values assigned to things? I understand the scarce thing but we need to confront some of the demand sides and the choices that are made because there is spending happening in these communities on things that are part of our social determinants.

Ms MEERDING - I think you are getting at the heart of some of the underlying issues of the social determinants of health.

Mr JAENSCH - Yes, we have to.

Ms MEERDING - Yes, we are too, but people make their choices and we can't make them make alternative choices. We have to create the environment that makes it as easy as possible for them to make the right choice, but people are addicted to smoking and putting the price up is one thing that will hopefully reduce the rates. I know we can say, 'You shouldn't be buying this', but I feel that would be very judgmental and not really helping. I agree with you but I don't think it is a good strategy that we could go out and do.

Ms O'CONNOR - Is it more about health literacy and informing people about what is healthy and the risks?

Ms MEERDING - Yes, the risks and benefits and having it as a possibility for them that if they have paid for their housing they can still have money aside to pay for fruit and vegetables and that it is there and they can access it.

CHAIR - We probably need to wrap this up. Is there anything else you would like to add in closing comments that we haven't covered through our questions?

Ms BYRON - No, I think we have covered our key points that nutrition is really important. We need to be collaborative but we need a diabetic workforce to address the issues as well.

Ms MEERDING - And that it is most important to start with the kids but obviously we need the whole life span as well. We do not want to be taking services out from other areas but we need the biggest push with the kids to try to keep them healthy. That is where habits are formed and that is where we learn a lot about food and nutrition.

CHAIR - Thank you very much, both of you, and again apologies for the delay in starting.

Ms MEERDING - Thank you.

THE WITNESSES WITHDREW.

Dr ROBYN WALLACE AND **Ms ANNE SAKARIS**, SHAID CLINIC, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Thank you both for coming. This is a public hearing and everything that is said is recorded on *Hansard* and will be transcribed, made part of the public record and published on our website along with the others. You are covered by parliamentary privilege while you are before the committee, but it does not extend beyond that. If you speak to the media or anybody else afterwards you don't have that cover at that time. If you want to give us any information in confidence you can make that request of the committee, otherwise it is all public evidence. We have received and read your submission so we invite you to speak to it and then members of the committee will have questions flowing from that.

Dr WALLACE - Thanks very much for the opportunity to meet and speak with you. I'm a physician specialising in internal medicine and I work at Calvary Hospital. Among the things I do is perioperative medicine, but one of my main interests and the one I'm here today for is health care for adults with an intellectual disability.

There is a significant minority of people with intellectual disability in Tasmania, I suppose between 1 per cent to 3 per cent, so up to 15 000 people here with an intellectual disability. They have a cluster of negative social determinants of health. By nature of their cognitive impairment they have lower educational levels, lower opportunities for employment, high rates of sexual, physical, financial and emotional abuse. They have less opportunity, again by way of their cognitive impairment, to present to the doctor and give their story. They have more requirements for support for usual activities of healthy living, such as choosing healthy foods and exercising. They have lower incomes and much more difficulty in accessing the health service. The health service is in turn not friendly to people with an intellectual disability, it is not accommodating, and the disability sector as well frequently lets down people with intellectual disability from the health side of things. There is no talk between the health and disability sectors.

As a result, people with intellectual disability die much earlier, up to 20 to 30 years younger than peers of their own age. They die not of the intellectual disability per se; a person doesn't necessarily die of cerebral palsy but they may die, once it is identified, of an untreatable oesophageal cancer which, if identified earlier as reflux and treated, may well have been prevented. They may die of under-nutrition. They may die because of palliative care instead of active treatment from their clinicians. They may die because the disability sector didn't support them in the hospital setting and no-one knew what was going on.

This group, as well as the cluster of negative social determinants of health, has a greater number of medical problems per person. On average young adults and older adults have up to five or six medical problems each compared to peers without disability.

CHAIR - Why is that?

Dr WALLACE - Part of it is syndrome-related, part of it is not getting access and things get out of control, like some constipation gets out of control and gets a bowel perforation. Diabetes gets more complications because it is not treated.

In part, some of the medical problems are the social determinants of health per se, which a risk factor for health disease. The poor access and ability to early stages of disease, syndrome-related conditions and poor health care, so things get out of control. I would like to highlight that many of these things are treatable and preventable.

In terms of prevention, I mean two aspects of preventative health care. One being the traditional dental care, immunisations, mammograms, vision and hearing, exercise, healthy diet. A cluster of those normally considered primary care issues of health care are poorly managed in people with intellectual disability. The other aspect of preventative care is recognition of diseases early on and adequate of them - for example, epilepsy, diabetes, spasticity, oesophageal reflux. These together contribute to the excessive mortality and morbidity in this group.

In terms of treatment that is required, the first thing is that we need the disability and health sectors to come together and talk and a formal way and in a sustained way. We do not get on with each other very well. I admit the health system has a lot to answer for, the terrible times that people endured, those poor people with intellectual disability, dressed up in pyjamas and housed in hospitals simply because they had intellectual disability. We have a lot to answer for and we have to improve ourselves a fair bit.

The disability sector has swung a bit the other way almost to the point of denying the presence of intellectual disability. I was talking to Anne today about a patient, yesterday, with Down Syndrome and aged 32. She is now morbidly obese since she has moved into care, with the carers, I believe, having a misguided sense of choice. She is allowed to have a date night with her boyfriend at McDonald's where she has six hamburgers and two thick shakes. That is her choice and they feel uncomfortable with imposing some regulation of her behaviour. They feel that is unfair and restrictive and they cannot do it. I feel that is a very misguided, unhealthy and dangerous approach and it can be modified if we talk to one another.

There is a problem with health care for people with intellectual disability everywhere in getting access to health care. I provide a specialised service. It is called SHAID: Specialist Healthcare for Adults with Intellectual Disability. It is a fantastic clinic but it is one clinic a week at Calvary Hospital. Calvary pay the administration costs and I bulk bill the patients. There is no public service in the public system. We have fantastic paediatricians getting kids through to young adulthood in a marvellously well, health state, get to the age of 18, leaving the education system which has also been contributing to their health via the dental, vision and hearing assessments. They get to age of 18 and not only is there a whole range of social black holes but there is a health black hole.

I read in the paper of the deaths of my patients whom I have seen at the SHAID Clinic and going well and all of a sudden I read the death notice at age 30, 40 or 50 in the *Mercury* and I think, what happened here? Often it followed a repeated bouncing back to the hospital where it might have been a relief carer who was with them. All the work we had done at the SHAID Clinic, and the notes and preparation of medical background was not shared, despite efforts of doing that. There were multiple problems. It is very preventable - partly logistics.

Mr VALENTINE - So you're not informed?

Dr WALLACE - No, so that's another silly thing. E-health would be good but it is very difficult to get any information from the Royal if you are not working there.

CHAIR - On this whole data issue, it is a problem for people without intellectual disability, so for someone with an intellectual disability who can't read their own records or instructions it is a much bigger issue. In trying to address this issue of electronic records, as long as they are able to manage getting the information into the system, is that the most effective way or are there other things that need to be done to facilitate this sharing of data where it is important and necessary?

Dr WALLACE - I think you are quite right; the e-health system would help a great deal. Electronic records are an essential source that are now starting to be taken up and used, but not frequently used. I can send my notes to the Royal's medical records, which I do, but the logistics need a manager. You can have records but you also need a person. As a clinician we need a history of what has gone on, we need to examine the patient, we need to do tests, and we make diagnoses and management plans. A patient with an intellectual disability often can't give a history, so we rely on the support worker to help and if they're not well organised and well prepared we can't get anywhere. We might need assistance with the examination to settle the patient - and we have strategies in the SHAID Clinic whereby we do that - and usually it is successful in managing to examine the patient. Tests can be a problem. We have a system at the Royal where we can organise sedation. It is a big deal and we need a support worker there to help. We need the consent of the person responsible. Then we need to make a diagnosis, which can be difficult - behaviour problems can interfere. We then need to treat the management plan, and that again relies on the support workers at home. At their team meetings do they talk about the health -

Ms O'CONNOR - They should.

Dr WALLACE - or did the hospital send a discharge summary with the carer? Part of the SHAID Clinic is talking about managing hospital but it is so limited - one clinic a week. We need to be able to talk in a formal way with Health and Disability Services about organising how we get going with our health and how the Health people learn more about disability principles. I have learned so much from the disability sector. For example, someone has tooth caries, the treatment is not to remove all the teeth. It is first to clean the teeth to prevent disease.

Ms SAKARIS - I have a son who has Prader-Willi Syndrome and attends the clinic. Our son has had some significant health issues in the transition from childhood to adulthood. They were quite extreme and had the potential of shortening his life to his early 20s. Our experience has seen his health improve and the main reason for that is the SHAID Clinic. Communication, as Robyn was just saying, across the levels is a vital and important component of managing health care. The e-health records would open up a value but I think even beyond that a sense of protocol of communication that is formally there for medical staff to be sharing the information. In our situation our son was extremely keen for independence and had relatively high verbal communication skills that made things perhaps seem what they weren't if you take it at face value. That's not uncommon in the disability sector that somebody can present, have the conversations and divulging what they want to divulge but not the other things. Some young people and adults are happy

for parents to be involved and to cover those things but there are a lot of people who are wanting to make their life, wanting to go forward and many of them are doing that within the disability support organisations.

Without something being formalised and put into place that is a consistent method of support for these people, their quality of life, their length of life and their function in the community, the grief they are going to go through - of no choice of their own but by virtue of their circumstances - can be minimised through steps that are put into place within the systems. This means that if a person is in care, as Robyn has been saying, that disability, that health, opportunities like the Shaid Clinic work together and flow, minimising much of the cost that goes into covering crisis situations and suffering.

Ms O'CONNOR - Is your son in the National Disability Insurance Scheme, or is he a little bit old for that now?

Ms SAKARIS - He was above the cohort. Through the crisis we went through, he achieved an individual support package and his whole situation is a very good model in the way that it is happening now. Things like the Shaid Clinic brought his health needs into a place that work with the disability support organisation well, and his health needs have improved. The risks that he had -

Dr WALLACE - He can just get on with his life. Health is there in his life, it is always an issue but it is not where it used to be.

Ms SAKARIS - That is right, it is not the dominating factor in his life, the expectancy now is open.

CHAIR - As I understand, your clinic is the only one in the state?

Dr WALLACE - In Australia, run in a hospital setting by Internal Medicine. Our brief is people with complicated and multiple problems of any age.

CHAIR - Who established the clinic?

Dr WALLACE - I did.

CHAIR - With the backing of Calvary?

Dr WALLACE - I approached Calvary after I set up the perioperative service there and their Calvary community fund pays for the one clinic a week, which is $350 a week administration; next year it is $450 a week. The clinic is booked out for months and I have worked out that we need four clinics a week, three additional ones. I need some time as well to play a role outside the clinics to talk to people to get it away from me as well. At the moment, it is dependent on me and that is not a good thing. It would be lovely if we didn't need a Shaid Clinic in due course and if it was embedded in as much a normal system as possible.

We still need a core - like I have written here in this very highly regarded article that was published. You still need a baseline service that is available for the psychiatrists, it is available for the gastro's, it is available for the people having surgery, a physician who is

there and does not take over but can lend a hand to other physicians, for people who come in with pneumonia or diabetes, or whatever issues and disability that I can help with particularly.

CHAIR - That is like a coordinator role, is that what you are talking about?

Dr WALLACE - A backup, not necessarily a coordinator. If somebody comes in with cerebral palsy and pneumonia, they cannot talk, for example; they can communicate but cannot speak words so I might come in and say we need the carers involved, we need them there to meet with the doctors on ward rounds, they need help with their nutrition and medications, then the plans come back - that is literally how we do it.

Other associated features with cerebral palsy are their epilepsies, in addition their vision and hearing impairment that is contributing to the disability. Is there and intellectual disability or just simply a motor problem? Even things like that, the enhancement of all the issues that are uniquely involved with someone with physical or intellectual disability - not to take over but to support them becoming better themselves. Next time they have a patient with intellectual disability they are aware of it a bit more, the support workers have also learned a bit more and they will be more helpful.

CHAIR - Did you want to say any more before we go to questions?

Dr WALLACE - We really owe people in Tasmania with intellectual disabilities a lot. There is the terrible history of Willow Court. I see some of these people, they are 50 years old and no one knows anything about them - nothing. I am seeing them for the first time and the carers know nothing about them and it is terrible. I find lots of things wrong with them medically. We do what we can and we work with the carers, and we make things a little bit better, but we have to catch up. We owe this community a lot. That is one thing but we owe our young children with intellectual disability a good life as well. The paediatrics are well organised, they are fantastic in Tassie.

Mr JAENSCH - When you say you know nothing about Willow Court, what do you mean, in terms of the records?

Dr WALLACE - That's right, we know nothing about their life -their family, who they are -

CHAIR - Family history and that sort of stuff.

Dr WALLACE - Any brothers and sisters and their health backgrounds, we know nothing, it is archived.

Ms O'CONNOR - The interesting thing - sorry to interrupt - the Department of Health and Human Services was, I understood, undertook an audit of people who were former clients of Willow Court in 2009. I was assured that work was done, so there should be some record in the agency somewhere because they were directed by the minister of the day to at least find out where the former patients' or clients' records were. There should be because that's what they said there was. What a shame that it's not shared.

Dr WALLACE - Even now, the SHAID Clinic has been going for a couple of years, and I have patients who come in - they are clients of the service provider but they are my

patients - and they may have had a hospital admission. I ask them, 'Did you take the Shaid notes in because we would have an appointment specifically on organising the hospital stuff?' In the meantime, there has been a rotation and change of carers, the notes have been archived again, they have been filed away somewhere in the main office of the service provider and it's gone again. I get used to -

Mr JAENSCH - Do you think the notes are destroyed or do you think they are somewhere?

Dr WALLACE - They are put away in the office somewhere.

Mr JAENSCH - Do you think they are available?

Dr WALLACE - They're probably available, but no-one knows. They come to me and they think, 'What are you, are you a psychologist?' They are not organised - some support workers.

Mr JAENSCH - They are not joined up. No joined-up service.

Dr WALLACE - That's right, not all of them are like that though.

Mr JAENSCH - We have an issue if you think they've been destroyed or they are totally unavailable.

Dr WALLACE - They are practically inaccessible and not used. We've gone through a couple of hours' work to go through this background and do a very thorough baseline review of where we are now with the health, what we have to do and what the GP has to do, what I have to do and what the support worker has to do. Understanding what goes on in the group home - there are some very good support workers and service providers, but there is a turnover. The organisation of the health part of someone's life - it is much more than health - does require some organisation within the service provider by the caregivers and that's not there.

Ms O'CONNOR - What's the solution to that, is it a memorandum of understanding, is it a directive from Disability and Community Services, how do you make what should be quite straightforward common practice?

Dr WALLACE - At the moment, within the limited clinic I have, we talk about it when they come. There is one appointment dedicated to health logistics. We organise it, write it down and send letters to everyone and the GP, et cetera, of what is whose role - the carer's role, the GP's role, my role, allied health roles - but because of that turnover it gets lost. As I said, it is filed in the office, the main office -

CHAIR - Electronic health records would deal with this.

Dr WALLACE - The carers on the ground need to know about the health treatments here and now, so they need to have them in, read them and it needs to be at their team meeting. This is the health of Julie today, we went to the Shaid Clinic, or we visited Dr Saul today and these were the health issues and everyone needs to know about them.

CHAIR - But you could have that as a portal on an iPad. You have limited access to the relevant information in terms of patient privacy. Surely it can't be that hard? I mean, in technical terms.

Dr WALLACE - First of all, there needs to be time spent with people. In my own spare time I have gone out to some service providers at their invitation and had a talk. I'm not a do-gooder, I'm a professional and this is professional stuff. It is big stuff that needs to be supported and formalised.

If I look at the NDIS and think I will look at this quality assurance safeguard's working arrangements and see what they have about health, if I go to the last page of the appendices there is no appendix 2 anywhere on the computer. I write to someone and get no answer. I said, 'Look, have you got any standards of what the service provider has to do with regard to health?' There is nothing on there. Who do I ring? There are no names there. I can't even get a foot in the door.

CHAIR - People are working in silos.

Dr WALLACE - There are no names. There is a number but it's always, 'He's out to lunch,' or 'He's not there.' It's such a barrier everywhere I go - 'I'm on side, I'm keen, I'm enthusiastic', but I'm knocking at the door and there is no-one there.

Mr VALENTINE - You have talked about disjointed services and obviously there is a real issue there. I know what has happened in the past and I know there are records that may have been misplaced or not available to you. What about today? What are the showstoppers today? For instance, on one occasion I had some X-rays done at the Royal. My osteopath needed to know what my problem was, but we could not get the X-rays because they belonged to the Royal. Do you have these sorts of problems?

Dr WALLACE - Absolutely. I ring up and if someone answers it's always, 'I'm the wrong person', or, 'We're not supposed to do this.' I get annoyed.

Mr VALENTINE - So ownership of materials is causing an issue?

Dr WALLACE - It is a big issue for people with and without disability. It is silly in Tassie because we are just three kilometres away. I think eHealth would be of dramatic positive assistance.

Mr VALENTINE - It could be if the records were available and if the other records were available that go with it, the X-rays or whatever.

Dr WALLACE - Yes, and someone has to write the report. For example, after two years of running the SHAID Clinic and talking to the people at the Royal, some people need MRIs or tests and won't lie still and Calvary doesn't have a sedation service. After quite a lot of conflict but in the end a great resolution, we got a sedation or GA service at the Royal. I have a system. I fill out the forms and write a letter, send all the background notes to a coordinator nurse and she fantastically organises all the tests to be done. Then they are supposed to come back to me before the patient comes back to me but the results do not come back to me. The system does not work if they are not sent back to me because I am not in the Royal or it might be that someone does not do it.

I had another example of a fantastic link in the private sector. I examined a patient, 55 years old with an intellectual disability - he cannot speak, but communicates by other ways. I noted that he could not see very well and when I examined him I thought there may be cataracts. There is something called the 'red reflex' that I could not see using my ophthalmoscope. So when he was having a dental review at Tony Eldridge's special needs private dentist I had written to the Hobart eye surgeons and they kindly went across when he was asleep, looked in his eyes, found two cataracts, spoke to the team, and he is going to have his cataracts removed. He'd probably had them for a few years, no-one knew, but I have also had ophthalmologists say, 'Why does he need them removed because he can't read anyway?'. I have had that attitude, which is not good. It's only some colleagues, not everyone's like that.

Mr VALENTINE - Quality of life comes into it a bit, doesn't it?

Dr WALLACE - Yes. Young people are given palliative care for treatable conditions. Doctors make an opinion on their quality of life within 30 seconds of seeing a patient. They don't know that the patient is loved and cherished by their family and contributes to the community. Anne's son does a lot of community work. He contributes greatly but he shouldn't have to justify his life anyway. He's alive and that's enough.

CHAIR - In an ideal world, then, which we don't have but let's live in Utopia for a couple of minutes here, how would you fix it? What would you do?

Dr WALLACE - First of all we need a clinical service that provides and sets the example of what is required.

CHAIR - Statewide?

Dr WALLACE - Statewide. I have people come down from Smithton and Launceston at the moment but it needs to be a statewide service. Potentially every adult with intellectual disability could have a specialised review and dedicated plan if hospital is required, and they are high hospital users with their profile of diseases - epilepsy, constipation and surgery. We need a clinical service and, as part of that, a dedicated focus on the logistics of health care management as opposed to giving health care management.

We need the health people to learn from the disability sector about disability principles and normalisation. We need to be informed and our medical treatment enhanced by awareness of disability principles. The disability sector needs to know more about health, what we require, how we work and what we need to do our job for that patient. They need to know how to manage health in the home. They need to know that it is not giving a person choice to let them eat anything they like. It is a responsibility to say 'no' and enclose things sometimes by nature of the intellectual disability.

It extends as well to another issue. We need some sort of quality assurance mechanism of not only my treatment but for any person with an intellectual disability in the hospital setting, any death or adverse events needs a formal quality assurance assessment. We have started that at Calvary off our own bats in our spare time. There are not many people with an intellectual disability who attend Calvary as an inpatient but we have

written that up, we send the doctors feedback, and are working on developing a quality assurance program.

I am trying to make links with the Coroners Court about deaths of people with an intellectual disability being reportable. We can learn from those.

Ms O'CONNOR - Can you elaborate on that a little? Is it the coroner's role to report or inquire into a death that is unexplained? There is some ambiguity at times over the deaths of people with intellectual disabilities.

Dr WALLACE - Yes, definitely. In other states all deaths of people with an intellectual disability are reportable.

Ms O'CONNOR - In all other states?

Dr WALLACE - No, in some states - Queensland, for example.

CHAIR - If you were the treating physician or the nurse on the ward and the death certificate was written and off they went, if I had concerns I could refer it to the coroner.

Dr WALLACE - Of course you can but my colleagues don't do that. They think, 'People with intellectual disability die young', so it is not a reportable case.

Ms O'CONNOR - It is laden with assumptions.

Dr WALLACE - Exactly, everything is minimised and nihilistic - not everything but there is a general nihilism in the adult world anyway - and palliative for what are actually very treatable and reversible conditions. It is not malicious necessarily at all but people think this is a blessing in disguise, and when the family see their love member treated so uncomfortably in hospital, so they don't want to put them under any more strain and see them held down for poorly organised tests. They get talked into it and they thank the doctors. I have seen that so often and I think, 'Gosh, even the families have been duped by my colleagues'.

Ms O'CONNOR - Australia is a signatory to the UN Convention on the Rights of People with Disability. In your view, are those rights breached on a daily basis in Tasmania?

Dr WALLACE - Yes, they are breached but no-one says anything, no-one speaks up.

Mr BARNETT - In your view, across the country?

Dr WALLACE - It is across the country as well. On numerous times I have knocked on the door of Royal Hobart Hospital to get into the adult system and I can't, but the door is open for anyone from the Royal Hobart Hospital to come to the SHAID Clinic and I will help. My door is open for any adult with intellectual disability or any service that needs a hand.

Mr BARNETT - Is there any Australian or state law that is being breached apart from the international convention, to your knowledge?

Dr WALLACE - In the last few months of last year I saw three of my SHAID patients in the *Mercury*'s death notices. One was my eldest patient of 75 who had ischemic cardiomyopathy. He had been seen by a cardiologist and it was untreatable. I don't know why the other two died. One was 35 and one was 55. One had a bowel obstruction and was having some investigations planned and the other was well. Those deaths, as far as I am aware, were not looked into.

Mr BARNETT - Were they patients?

Dr WALLACE - They were my patients at Calvary and I saw their death notices in the paper.

Mr BARNETT - You are not able to follow up on that and find out why and how?

Dr WALLACE - No. I wasn't formally informed of the death by the hospital. I read the death notices in the paper.

Mr BARNETT - So do we have a system error where you are not informed?

Dr WALLACE - I was not informed when the patient was in hospital or when the patient was deceased.

Mr BARNETT - Do you believe that is a system error? Do you believe you should have been informed?

Dr WALLACE - Yes, I do. It may have been the patient was admitted to hospital and the carers did not bring the notes or inform them that I had been part of their care.

Mr BARNETT - You would be registered as their clinician, wouldn't you?

Dr WALLACE - Where?

Mr BARNETT - With the Royal Hobart Hospital, you would think?

Dr WALLACE - Not necessarily. If the carers don't bring in my notes and letters, of which they have copies, the hospital may not know, even though we have spent time at my clinic talking about the logistics of hospital management.

Mr BARNETT - They wouldn't have had your notes and details of your patients?

Dr WALLACE - I don't know. They may or may not have.

Mr BARNETT - But if they didn't, they clearly did not provide the optimal care or it is unlikely they provided -

Dr WALLACE - I don't know what happened, but it was a surprise.

Mr BARNETT - But if they didn't have the notes it is unlikely they would have provided the optimal care. Is that a fair assessment?

Dr WALLACE - I would rather say if they had the notes there may have been less delays in any crisis situation that may have facilitated their care.

CHAIR - Particularly for someone who cannot describe their own condition. There would be some who are non-verbal.

Dr WALLACE - Many people are - they communicate but not necessarily with words.

CHAIR - Those of us who are verbal are not good at understanding that.

Mr JAENSCH - Do you know how your patients came to be in the hospital, how they were referred or under what circumstances they were admitted?

Dr WALLACE - No. There is poor communication and perhaps e-health or central access would help. I have started, as a matter of course, sending all my letters to the digital medical record at the Royal but I don't know if they are put on there. I don't know the Royal very well, I have never worked there.

CHAIR - It is a question for the Royal of how they deal with those things. You wouldn't be the only person who sends them things.

Dr WALLACE - It would be important to talk to the Royal. I went to the paediatricians at the end of last year to talk about a transition clinic and they are very keen and we have a bit of a program going. It is a big issue and I have this one three-and-a-half hour clinic a week getting transition referrals and all these other people to see as well. I would really like a dedicated transition clinic but there is no funding. I wouldn't make enough money from the bulk billing to pay for the clinic.

Mr JAENSCH - Are all your patients referred to you by GPs? Are the main referrers to your clinic GPs?

Dr WALLACE - Mainly GPs, but for the transition it is mainly paediatricians.

Mr JAENSCH - Are any of your patients just walk-ups direct to you, or do they all come via other people?

Dr WALLACE - As a specialist I require a referral from either a GP or another specialist.

Mr JAENSCH - Would those patients of yours who passed away in hospital have had some other doctors involved in that string?

Dr WALLACE - They may have had an emergency situation at home and were brought to the Emergency Department at the Royal Hobart, bypassing their GP. It may have been an emergency or crisis, so the GP might not even be aware.

CHAIR - The GP might not have got a notification either, potentially, in this circumstance.

Mr JAENSCH - That's right. I am interested in everything you have to say and I thank you very much for your submission, how well it is written and how well it articulates the case. As someone with adult family members with intellectual disability, one who died

in care and one who lives independently now - living the life of Riley I have to say; he's having a ball - I value what you have to say. When you talked about some cases and your suggestion that there has been some sort of failure there, I want to try to understand as a government member of this committee if there is something there or could it be that someone had an accident, were taken by ambulance to hospital and something went wrong, and there has not been a failure of a chain of communication?

Dr WALLACE - I think that the literature supports everywhere - both in the stuff I've done in Tassie and Queensland - nationally and internationally, that the care of people with intellectual disability in the hospital setting is substandard in general. I suppose I just assume that there is probably something that is reversible and that person should not have died at the age of 55 or 35. It may not have been easy, it could have been difficult medicine, but I am sure that a communication problem probably played a role, there was probably a delay in diagnosis and the situation escalated before a diagnosis was made, the patient was probably very distressed and may have been agitated and that played a role in the difficulty for the doctor doing the job, the carer was probably told to stay away from the patient because of privacy issues, which is another bad approach. We could find multiple areas.

Mr JAENSCH - In your experience of these circumstances in Tasmania and elsewhere there is a possibility that if someone has found themselves in an emergency situation and has been brought to hospital there is a whole lot of health history and possibly a lot of undiagnosed health history, but that person is not in a position to transmit to whoever has custody of them and a carer might not either and there is no chain of record-keeping. They are all more possible than they might be for someone who is not an adult with an intellectual disability -

Dr WALLACE - Exactly.

Mr JAENSCH - which could contribute to complication and misadventure in that situation.

Dr WALLACE - Absolutely, yes.

Mr JAENSCH - I understand.

Dr WALLACE - There was a patient in Queensland I not directly involved with, but she had cerebral palsy with a peg tube feeding the nutrition through a tube in her tummy. It was a weekend and the tube fell out. The carer was a relief carer and didn't know how to put the peg back in. The patient didn't speak and communicated with some signs. The patient was sent to the hospital on her own by ambulance with a note, and the tube fell out. She went to the ED, in the back corner of the hospital. She wanted to go to the loo and was using a sign for the toilet but no-one understood it. She wet herself, screamed and pushed away. The junior doctor came to look at her and the tube fell out so they put a urinary catheter in her and sent her home. She was in the ED for 11 hours and had not had her medication so she had some seizures when she got home. She went back to hospital and they finally worked out what was going on. By then the tube had closed up and she needed a formal endoscopy a day or so later to fix it up. Suffering for that patient, potential death, costly, stressful, terrible and 100 per cent preventable.

Ms O'CONNOR - Obviously there are issues for people who have physical disabilities as well if you go into hospital [inaudible] are non-verbal. How much do you think, Robyn, the challenge we clearly have here is because of a cultural values-based medical model towards people with intellectual disabilities?

Dr WALLACE - Take a history, examine, test, diagnosis, management - that's what I call the medical model. From the disability sector, the medical model means medicalising and making intellectual disability an illness.

Ms O'CONNOR - What I meant is in practice in our public health settings, do you think there are decisions being made on a set of values that may not necessarily place the same value on the life of a person with an intellectual disability?

Dr WALLACE - Absolutely. The attribution of lower social worth is rampant in the health system, and that is where we have a lot to learn from the disability sector. We have to see people like Anne's son dramatically flourishing in health. It is always there lurking, it needs constant attention, but it is not threatening his life.

Ms O'CONNOR - We also probably have a lot to learn from people with an intellectual disability about their experience of the health system.

Dr WALLACE - I have had people with intellectual disability tell me about the fog of the years in institutions with Mellaril and the Largactil and the injections to suppress them. No mental illness but behaviour problems as an expression of they didn't like where they were, but given antipsychotics. Antipsychotic use for behavioural problems is still rife.

Mr JAENSCH - We have talked a bit about the failure of the hospital in the case you gave us of the lady with the tube. She was in the custody of a carer who sent her in an ambulance alone with a note if the tube fell out, not 'this person is non-verbal and is epileptic'. What happened there?

Dr WALLACE - It was a relief carer. There may have been other people at the house. Part of the service of the SHAID Clinic or any other service for people with intellectual disabilities, especially adults, is this logistics issue. We go through the scenario: before it happens, I have some paperwork we go through. What if Angela has a seizure that goes for more than five minutes and we have to get to the hospital, but there are three other residents and you are on your own. What is your plan? I do not necessarily tell them the plan but it is something for their service provider to get organised on because that carer cannot leave and leave the other residents on their own.

Mr JAENSCH - How can that person be a service provider for vulnerable people, dependant people, without those systems in place? Who is paying them?

Dr WALLACE - This is what I am trying to see if there was anything on the accreditation of service providers. It is very difficult to find if there is such a thing.

CHAIR - It may be that they have to have someone on call where they had to call them in. There are a range of things.

Dr WALLACE - Yes, that is right; they have to have a plan.

Mr JAENSCH - In a lot of workplaces, under today's laws you cannot hold a meeting like this unless you know what is going to happen if there is a fire.

CHAIR - Thank you, both of you. The personal side of it has a much greater weight in many ways and we appreciate your taking the time to come in and share that. I think you are the only person that has really addressed this in the submissions that we have received, so we really do appreciate it because these are some of the forgotten areas that can be overlooked at times - being able to have a look at a big issue and a big problem that has many aspects to it.

Dr WALLACE - Thanks for having me. This is a preventative health care committee but a lot of the issues are preventable.

Mr VALENTINE - When I asked you whether you could get X-rays and things like that, in my case I could have got them but it would have cost. They were available but they would have cost. Is that the problem here?

Dr WALLACE - No, it is just that someone doesn't send them.

THE WITNESSES WITHDREW.

MR ROBERT WATERMAN, CEO, RURAL HEALTH TASMANIA, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Ms Forrest) - Welcome. You are protected by parliamentary privilege while you are before the committee. Everything you say is recorded on *Hansard* and will become part of the public record. It is a public hearing but if there is anything you want to say of a confidential nature you can make that request to the committee.

Mr WATERMAN - I started off in managing drug and alcohol residential rehabilitation services and then I went across to Salvation Army in program development and implementation to help get the Salvation Army Bridge program in the north-west off the ground. Then I went across to the Department of Justice with the court-mandated drug diversion program there. Then from there I went across as CEO for Rural Health Tasmania. My last two positions I have worked in a statewide capacity or senior management positions.

As I have become older I suppose age has given me a little bit of wisdom around social determinants of health because I've been able to watch the trends of health over generations. If I was to go back, say, three generations I think the level of disadvantage in our community, although it has always been there, it was fairly contained. It didn't seem to fluctuate that much. Over the last three generations we are seeing a really significant acceleration in that disadvantage because you have disadvantaged families having children and then they are staying in that cycle of disadvantage, and then they're having children. If you, for instance, have three children and then those three children have three children, it only takes two generations to go from a couple to nine people living in a disadvantaged situation. It is becoming more serious. I think the more serious it becomes the harder it is to address. From that perspective we are losing the battle a little bit. It is still something that we can address and it's still something that we can very much change the nature of, but I find there is a serious lack of understanding of social determinants of health right across the board, from government and through service providers.

I will give an example. I went to the ATDC conference yesterday and people's understandings of social determinants of health varies, so there is an obvious need there for some training from a service level. An example of how well that can work is that the Bridges Out Of Poverty training was really, really helpful. I think something similar developed for services around social determinants of health would be equally as helpful and not very expensive to roll out either.

There are definitely some broken areas there - a poor understanding by government of social determinants of health. There is a poor understanding of how socially and economically beneficial intervening at an early stage in a person's life can be in comparison to waiting until they have been through 20, 30 years of pain and suffering and then the massive social, emotional and financial costs to that person to have to go through that longevity of pain and suffering, when we could act early. There is an ethical issue around that as well. If a doctor or a GP knows that a person comes to see him and they have an illness that they can prevent if they treat it now, they have an ethical obligation to, if not treat that patient then inform them of the availability of that treatment and what can be done to prevent that illness. The same with services. If

somebody comes to us and we understand how to treat that person and prevent illness we have an ethical obligation to at least make that person aware and offer that service to them if it is available for us to do that.

From a societal level, we are aware that there is a lot of preventative disease and we don't act on it, we don't put in place preventative measures to stop that burden to health. Substance abuse is a good example, and mental illness, are probably the two that I see as really big issues for us at Rural Health. One in four youth are now experiencing mental illness. It is preventable. We know what the key indicators for future mental illness are. We know how to change those at a young age and we know how to prevent or significantly reduce the occurrence of mental illness. We do see some roll out of preventative mental health services, but nowhere near to the level that is going to affect us as a state and that is going to have a significant impact on the savings in health. They are saying you save around $7 for every $1 spent preventatively. Financially I don't understand the logic of why you wouldn't take up that opportunity. If somebody offered me $7 for giving them $1 I'd jump at it and yet we don't.

CHAIR - It is that a lack of understanding or a lack of funding, even though you can argue that with $7 for every $1 spent?

Mr WATERMAN - I guess it's a lack of understanding and I can give you an example of that. In Queensland, to keep an offender in prison costs around $120 000 a year or thereabouts. The drug treatment program costs $18 000 per person per year, so the Queensland Government was saving around $104 000 per person per year. They saw the cost of $18 000 per person, so they cancelled the program. They didn't see the saving of $104 000 per person that was going back into government. They just saw the cost of $18 000 and cancelled the program, so those offenders who would have been able to get into a therapeutic environment are now back in custody. Decisions like that have a serious impact on preventative health. I hope that answers your question about a lack of understanding of how that works.

From a substance abuse and mental health perspective, we've come a long way in the past 10 to 20 years around our understanding of substance abuse in particular and mental health and we now know that those key indicators for mental health and substance abuse are present in just about every case.

Ms O'CONNOR - Do you want to talk through those key indicators?

Mr WATERMAN - Things like poor emotional regulation. If I talk about the protective and risk factors, there are secondary or external risk factors and then there are primary protective factors and they are the internal ones we have. That is emotional intelligence, social and emotional competencies, is a person has good emotional regulation, can take responsibility, is objective-resilient, those types of behaviours. We are generationally losing that because parents have lost that now. We have lost one generation, so now the parents are unable to pass that emotional intelligence education onto their children. They might be having two, three or four children so we are getting that explosion of poor emotional intelligence in families.

Ms O'CONNOR - Why is it being lost, do you think?

Mr WATERMAN - Because we didn't address it. We didn't pick up on it in a large enough scale to have an impact and reverse that trend.

Ms O'CONNOR - How much do socioeconomic factors have to do with that loss of capacity on the parent's part to be emotionally intelligent and pass those skills on to the children? You talked about young people who are resilient, who have confidence, who are able to work through complexities and challenges in their lives, and you talked about the loss of parenting capacity to pass that on. I'm trying to get to the bottom of how it came to be that parents would lose that capacity and how much poverty, disadvantage, homelessness, violence and addiction have to do with the loss of that skill being passed through generations.

Mr WATERMAN - A significant amount. Family violence, mental health, all of those. There are so many social determinants of health. Diabetes and self-esteem are linked, if you look hard enough. People with low self-esteem, through eating foods that give them pleasure that are not necessarily good for them, might become obese and then they are at risk of diabetes. There is that link, but it all goes back to children and families.

When you ask how that came about, how parents lost those skills, they might have lost all of them, and this is why we are seeing that creep. They might have lost one or two. A child might grow up in a family where two parents might not do a bad job but just missed one or two things, but that child is then going to grow up and not have those couple of skills. That child might then get married or get into a relationship and have children. For example, if you said there were five skills, that child has grown up and only has three, so he has lost those two emotional and social competencies to pass onto his or her children. Those children might miss one from that parent so those children will grow up and have children and they only have two of those five left, so they are losing those coping strategies. It might be emotional regulation so they have anger management problems and that starts to cause other problems such as relationship problems.

Generationally you don't go from having 100 per cent competencies to none in one generation. There is that creep and they might just lose one or it might even be part of one of those competencies. They might just be not quite as good at explaining, maybe it is communication skills they're not very good at, so they're not at communicating with their children. We know more about this now but there is a serious lack of dissemination of that information. We are now getting to a stage where our communities are in serious need of this information, we have it but we are not disseminating it properly to our communities to reverse that trend for the rebuilding of those social and emotional competencies.

If I ask a lot of people in the drug and alcohol sectors, even the mental health sector, what the risk factors are for substance abuse or mental illness, they would say a lot of the time that it is neglect, sexual, physical or emotional abuse. Yet I know a lot of people who have experienced sexual, physical or emotional abuse who do not have mental illness or substance abuse problems because they had strong internal protective factors. They were very emotionally intelligent, had very strong education around that when they were children, so when it came to those dramatic experiences in their lives they were able to navigate them and say, 'That's not my responsibility. That's somebody else doing something wrong to me. That's not mine. It doesn't mean there is something wrong with

me; I'm okay', and they navigate those risk factors quite successfully. Those internal protective factors are very important for our children and families.

CHAIR - Children with acquired brain injury from alcohol abuse during pregnancy and perhaps other drugs have permanent damage; it is not reversible. Even if they had good role models or early intervention strategies, the chance of having a huge impact on those children is limited. Is that a fair comment?

Mr WATERMAN - I would say you are going to improve their life. They are definitely going to find life easier. They still might find life difficult but not as difficult as it was without any of those. Imagine a child with acquired brain injury who has some level of emotional intelligence and regulation and has the capacity to make informed decisions and weigh up the pros and cons and compare that to the same child with all those as deficits - no emotional regulation or capacity to make informed decisions.

CHAIR - But they don't have a brain injury.

Mr WATERMAN - No, I am saying the same child with a brain injury. Even for children with an acquired brain injury having those competencies, their life may not be as easy or as fruitful as somebody without an acquired brain injury but it is definitely going to be better for them to have some of those protective factors in place. They have enough to deal with, they have an acquired brain injury and enough going on in their lives, and we have an obligation to provide as much support for them as possible to make their life as meaningful as we can given the circumstances.

CHAIR - So it is early intervention you're talking about?

Mr WATERMAN - Yes. I had a lady ring me the other day with a seven-year-old child who was self-harming and attacking her. She was told by a paediatrician to get an assessment done.

CHAIR - For herself or the child?

Mr WATERMAN - For the child. I said to her, 'You need more than an assessment. You need to get your child onto a mental health care plan and have some long-term contact with a psychologist to see if you can work out some strategies to help you as a mother and to help your child'. We now have children in our society of seven years old self-harming. A lot of that can come from poor parenting and those poor social and emotional competencies. Most children are born with such potential and yet they don't choose to have substance abuse issues, they don't choose to have mental illness and yet something goes wrong in those early years and they just find themselves in all sorts of trouble.

We have the skills and the knowledge now to do something about that and we don't. That is why I refer back to what I said before about GPs and services. We are accountable for not providing those services if we know that failing to do so is going to lead to harm for a person. Don't we have that same obligation as a state and as a nation if we now have the information we need to prevent serious illness to actually implement that? We don't. There is a big breakdown in communication, I think, from the top down and from the bottom up there is poor understanding of social determinants of health

across the sectors. There is confusion about what they actually are. Some people have a very good understanding, but they cannot get funding to put programs in place. I think there are quite a few people in Government who do understand social determinants of health, but I also find that there are quite a few people in Government who don't understand it. I think we need a national approach so everyone is on the same page about what the social determinants of health are and how impactful early intervention and prevention can be for children of families, and how significant it can be in turning around those statistics and we start to see a decrease in disadvantage rather than an ongoing increase.

CHAIR - In the way forward here and the way to address this, obviously it is across the board, it is not just Tasmania, not just Australia, it is not just rural communities, it is across the board. In enhancing the understanding of social determinants of health, is it a nationwide approach, where do you start with this? It has obviously been let go a little while and if you want to make a difference in as short a time as possible, what would be your ideal way of dealing with this?

Mr WATERMAN - There are two approaches to this. Some people would argue in an ideal environment you would roll out a national program, right across the country, because I think the earlier you do it and the larger the scale - you cannot overeducate a person. You cannot provide families with more than they need in the way of resources, but you can certainly underdo it. That would be the ideal environment. Then you have the -

CHAIR - We will address it in the issues and one of your key points was a lack of understanding of social determinants of health. Let us put aside for a moment that the families and children are out there adversely impacted by this. You have to have this greater and shared understand at a policy-making level to identify and put processes in place. How do we do that, what needs to happen there?

Mr WATERMAN - We need this nationally as it is happening everywhere, it is not just Tasmania, and remote or regional communities in Tasmania. It is happening right across the nation so I think we need a national approach. To start with, you cannot expect services to provide those resources to a community if they don't understand them and they don't have funding to implement them. Generally, services will default back to old models when they don't understand the training. I will give an example of that. DEN provides a lot of education around early intervention and prevention to services, but services don't implement them because they don't know how and they don't have the funding to do it.

We need a national framework around how to implement social determinants of health and what they are - some training that can be disseminated out through communities. It is not just services that need to understand social determinants of health; if families understood social determinants of health, they would make some seriously different choices to do with how they raise their children and how they live their lives. Maybe not all families, but I think it would have an impact.

That communication is really broken right through. In the services we have the middle group of people who understand it to a degree; we need to make that so all services are on the same page - a national framework around training and education for services. I think there is a big gap between government and services, and services and community.

Services aren't rolling it out to communities because they are not getting funding, and the reason they are not getting funding is because, I feel, governments do not understand social determinants of health and the generational benefits of the impact that they can have by intervening at an early age.

Mr JAENSCH - Robert, thank you very much for coming here to talk to us. We have many submissions on social determinants of health and many people have quite intellectualised the determinants and number them and we have talked about them in a few different ways. You are the first person I have heard articulating this issue of absence of learned emotional intelligence as a factor in the way you have. Thank you for doing that. To me, in this raft of social determinants, some of which are about geography, income, access to transport and education et cetera, to some extent you can take a person out of that situation and put them here but if they still don't know about good decisions and they don't have those personal tools, those other determinants are quite academic to their situation. What have you seen that is available or has worked by way of interventions around those issues of the person's learned emotional intelligence and their ability to make decisions? What can we do about that in your community and in my electorate that makes a difference?

Mr WATERMAN - I think a program and we are nearly where we have a program that we can roll out as a train-the-trainer model. If you looked at those social and emotional competencies, there is a list - you could have a list of 40 or 50 of them. The ones that are really significant and very common, they present over and over again, in substance abuse and mental illness are things like resilience, self-esteem, honesty, taking responsibility, good emotional regulation and those things.

I guess if you want to know what we can do, we need to formalise that and put it into a training package but it has to be disseminated to communities, that is the hardest part. The issue has always been -

Mr JAENSCH - How do you put it where we learned it in our safe home as we grew up.

Mr WATERMAN - Yes. I have always found the biggest issue that we have in social determinants of health is engaging the people that we need to engage and they are always the least likely to want to engage. I notice when we run preventative -

Mr JAENSCH - They are not going to turn up to say, 'Look, I've run out of emotional intelligence.'

Mr WATERMAN - No, because they don't know. Having different careers in justice and mandated programs and non-mandated programs, people will generally move for one or two reasons. That is for an incentive or a disincentive: it is too uncomfortable to stay where they are or it is more attractive to go somewhere else. It is about providing programs with either an incentive to get people into programs or a disincentive to not go into programs. An example of that could have been something like the 'baby bonus', if we had rolled out a parenting program with a baby bonus and said, 'Yes, you can have the baby bonus but you must complete a parenting program to be able to have the baby bonus', that is an incentive, I guess.

There are a lot of different approaches like that. We will eventually end up somewhere like that where we are going to have to provide incentives or disincentives to get the disengaged people engaged because they just won't.

CHAIR - Modify people's decisions and behaviours.

Mr JAENSCH - That is the problem, we cannot ask people to go through a course before they have a baby.

CHAIR - You did, didn't you?

Ms O'CONNOR - You can, we did at school.

Mr JAENSCH - What we cannot do is say, 'I'm sorry, you are not allowed to have babies'.

Ms O'CONNOR - That would be silly because people will just have babies.

Mr JAENSCH - We need to create an incentive and a disincentive but the people who need this most may not respond to either.

Mr WATERMAN - It would be nice to get the parents and the children. We try to get to children through parents because you're breaking that cycle of disadvantage then because the parents become the trainer again. They become the teacher again and are teaching the things they have lost. That is an ideal scenario. The worst-case scenario is if you can't get to the parents, we have to get to the children early. I have found in all the conversations I have with parents around their children that they would be very happy with an academically mediocre child who is a good mum or dad.

Ms O'CONNOR - Or a good person.

Mr WATERMAN - Yes. We focus so heavily on the academic but emotional intelligence is more important than academic intelligence. I think we need to start not just culturally passing that on in our teaching methods but actually start teaching it as a subject.

Our curriculum has changed a lot since I was in primary school, for instance. I think you can role-model behaviours as a teacher in the way you talk and interact with a child. To give an example of that, the old drug and alcohol education we used to provide as a service in schools was around the harms of drugs and alcohol. We have changed that in Circular Head where we are getting the kids now to do research projects on the harms, so they are researching their own potential futures and seeing the harms that can come from drugs and alcohol and they think, 'That's interesting', and will look into that a bit more. Other kids might find something else to do that is a little bit more interesting and then they start thinking, 'Well, how did that happen to that person and not happen to that person?'. They get really engaged with the whole research process.

We know from experience and from an evidence base that children who are motivated and seek the information themselves, who feel like they have done it and it has not been imparted on them but they discovered this information for themselves, are much more likely to do something with it. I think we need to go back to that whole education model because teachers over the years have always thought it was the job of the parents to

provide social and emotional competencies to children and we can't say that anymore because they just don't have the capacity to do it anymore. The people who have those children in their care for a large percentage of their life are the educators. I think we would have a significant case -

CHAIR - Roger wants to double the funding for education, he said earlier.

Mr JAENSCH - It is important. Every witness has touched on this somewhere.

CHAIR - Absolutely, it is an integral part of everything.

Mr WATERMAN - Yes, I think we have to build those social and emotional competence in kids at a young age. We know that by the time a child is seven they have very ingrained patterns of behaviour and as they get older they become more and more difficult to change. I have a three-year-old who is nearly four and he understands responsibility. He will say, 'That was my fault, I won't do that again, I'm sorry'. That is a fantastic behaviour to see in a three-year-old but it's pretty uncommon today, I guess, to have children with that level of emotional intelligence. You can get to kids early, you can get to them at three and four years old and he is not even at school yet. Primary school is a perfect time to start that social and emotional intelligence education and build it into a curriculum-type model. Okay, we're not going to get to all of the parents but eventually, generationally, we will see a reversal of that trend because those children will be emotionally intelligent and are going to be able to pass that information on.

If it is at school we have a system where what they are being taught at school is being reinforced at home because you have emotionally intelligent parents because those kids are going to grow up emotionally intelligent and have children of their own and become parents. That is where I find all the teachers that I talk to are saying they get frustrated because they do everything they can at school and then the kids go back to a dysfunctional environment and are back to the same behaviour when they come in the next morning.

CHAIR - We need to provide some sort of intervention, for want of a better word - I think it is a bad word - in the lives of the families before they get to school. Engage with them when the baby is born. Most women give birth in a hospital in Tasmania. There are not many who don't. They may not present for antenatal care, and the ones who really need the help are more likely to fit into that category, but they usually all rock up to a hospital when they are in labour. They may only be there for six hours, 10 hours or whatever and then they are gone.

Mr WATERMAN - The relationship with the child starts before it is born. You would be aware of the antenatal classes they run at Mersey and Burnie. We just took over those and now provide a mums and dads group as part of those antenatal classes. I know one of the classes in Launceston was taken offline. It is my understanding they are not provided in Launceston. The mums and dads group part of it definitely isn't. That's a really good opportunity because we are getting new parents and providing them with the simple things such coping with sleep deprivation and the stress it puts on a relationship, the financial pressure of having a child and how to plan better for that, how dads can feel disengaged because mum has become fixated on the baby and dad feels ignored. We go through all those things with new parents so they understand when that happens and

don't take it personally. We also go through the pre-indicators for post-natal depression and those types of things and how to support your partner through those processes. That is the best time to get to new mums and dads.

In an ideal environment all the disadvantaged people in our society would all come to these programs and learn these skills and we would all go home happy, but unfortunately there are very difficult to engage. There are opportunities around incentives and disincentives and we need to explore what they are to make people go to those programs - maybe a cash incentive. With our community kids program we noticed we quadrupled the number of parents and children at that just by providing a sausage sizzle for the after-school program, because that meant mum and dad didn't have to cook that night and the kids were fed. The role modelling and the environment they are introduced to included other parents and children from non-disadvantaged backgrounds to interact with, so you are trying to break that cycle and give them other people from outside of that disadvantaged community to interact with so they're getting exposure to stronger role models.

CHAIR - We could probably talk much longer about this but I think we have the general idea of what the key points are. Thank you for coming down from Smithton, Robert, to talk to the committee. We appreciate the work you do up there in an area that has some challenging health problems.

THE WITNESS WITHDREW.

PROFESSOR GREG JOHNSON, CHIEF EXECUTIVE OFFICER, DIABETES AUSTRALIA, AND **Ms MINKE HOEKSTRA**, ACCREDITED PRACTICING DIETITIAN, DIABETES TASMANIA, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Welcome to the committee hearing. This is a public hearing. You are covered by parliamentary privilege while you are in front of the committee. It doesn't extend beyond that. Everything you say is recorded, transcribed and then part of our public record and put on the website. If you wanted to give us any information in confidence you can make that request to the committee and we will do that, otherwise it will be the public hearing.

Prof. JOHNSON - I'm the CEO of Diabetes Australia, the national body. Caroline Wells, CEO of Diabetes Tasmania, sends her apologies. There was a submission put in by Diabetes Tasmania, which is informed by many of Diabetes Australia's policy documents as well as Tasmanian data, which you have.

I am from a clinical background originally. I was a pharmacist, my first profession, and then I was a hospital CEO and I built the private hospital in Burnie. My two daughters were born in Tasmania in Burnie and I have a fond affection for the place. I live in Melbourne now and my third career has been in diabetes. I have been 12 years with Diabetes Australia in various roles. I spend a lot of my time in Canberra talking to international parliament about diabetes, so I understand the processes.

The first comment about your terms of reference relates to inequality and social determinants. The bottom line for diabetes is that poorer people and disadvantaged people get more diabetes. They are more at risk, they get more affected in terms of prevalence, by type 2 diabetes in particular. They get more of the complications - blindness, amputations, heart attacks, strokes and others - and they have poorer access to treatments and things that might prevent and manage diabetes. There is clear evidence all around the world for that. Right now, the latest international statistics say there are 381 million people in the world with diabetes.

Ms O'CONNOR - Diagnosed?

Prof. JOHNSON - Not all diagnosed. Country by country, there are different rates. There is a problem with undiagnosed, silent, type 2 diabetes. We need earlier diagnosis. The prevalence rates are all available worldwide in a thing called the Global Atlas of Diabetes. It is online and web-based and you can look at that. It shows that four out of five cases of diabetes in the world are in the poor and developing nations. The big myth has been that diabetes and the explosion of type 2 diabetes is a disease of the affluent nations - America, Britain et cetera. In fact, the USA has about 27 million people with diabetes, China has 100 million people with diabetes, and India has 68 million people with diabetes -

Ms WHITE - They also have more people, so as a proportion of population -

Prof JOHNSON - No. The prevalence rate in China is higher than the US. On a population-adjusted prevalence rate basis, poorer countries have higher rates than wealthy countries. The evidence is very clear.

The same is in Australia. We have done analyses by post code across the cities. The poorer socio-economic suburbs of Melbourne and Sydney have more type 2 diabetes, more complications. Rural and regional people throughout Australia have higher prevalence rates in rural and regional centres and cities and towns. Our Aboriginal and Torres Strait Islander people all over Australia and various disadvantaged communities suffer diabetes at higher rates. It all goes to a strong picture that if you are disadvantages, if you are at the lower end of the socio-economic scale, diabetes is a diabolical problem and has a huge impact.

I know your terms of reference specifically address mental health. The diabetes-mental health connection is very important and very significant. One third of all people with diabetes in Australia suffer moderate to severe anxiety and depression in their daily life. Currently the diagnosed population in Australia, registered and known at the moment, is 1.2 million. That means that 400 000 Australians right now, who know they have diabetes, experience moderate to severe anxiety and depression in their daily lives and 10 per cent have clinical depression. That is only at the extreme end. If you then take it back to distress, rather than clinical depression, the numbers are even higher. Diabetes causes distress in families. It has a huge burden and there is clear evidence that people's psycho-social wellbeing, by whatever measure, is much poorer when they have diabetes.

It is a big problem and poorly resourced and poorly identified. Mostly, in our health system doctors and primary carers don't even think about mental health when they are thinking about diabetes, but they should. It should be an integral part. Our view is that every diabetes assessment should include a mental health assessment. That is a bit of a comment on inequality.

The challenges and benefits of integration and collaboration is a big challenge but have big benefits. Where it has been addressed in terms of achieving integration and collaboration, it shows you can get big benefits. At the moment, across Australia and in Tasmania, we still generally have a disconnected siloed, hospital-focused health system. We don't have anything that approximates a prevention system anywhere. It doesn't exist. Every time an election comes around, with all due respect to politicians, what the election is about is hospital beds, waiting lists and capital spends on fixing perceived issues with infrastructure mostly.

CHAIR - When I went to the health forum the minister held in Devonport on Tuesday night there was not one word about [inaudible]. It was all about acute services, waiting lists and access to the hospital. I wanted to say something but I didn't think it was my time, it was for the people to say.

Prof. JOHNSON - That problem is all over Australia. We pay lip service to prevention. It is not still real, so that requires leadership. I think there is great opportunity for governments and states and territories to take leads on things and show the way. It is disconnected, siloed, hospital-focused, and we don't have anything approximately a prevention system and people taking responsibility. There is poor investment in prevention and building capability. We keep restructuring the primary care system. The

Australian General Practice Network has a structure to coordinate primary care in general practice, morphing to Medical Locals, with 61 of them, and now morphing from 1 July into primary health networks with 30 of them, and really nothing has changed or improved. We have just spent a couple of years reorganising people and having new boards and new people appointed.

Mr VALENTINE - And a few millions dollars to boot.

Prof. JOHNSON - We spend the money on reorganising the system, not making a difference. It is time we got serious about that. Primarily it is still clinician-focused, so there is too much emphasis, with due respect, to the views of medical specialists and doctors. There really isn't a serious focus on how communities and consumers can have input to things and support and make change happen for the better, which can be very powerful and very low cost if it's supported and understood, but it's not.

We are making progress in some places with that integration and coordination. I will talk a little later about the COACH program and the Life program in Victoria and others. They are examples where you shift the focus away from clinician-driven, thinking GPs can prevent diabetes. Most GPs can't prevent diabetes; they have not had any training in behaviour change. There are very few drugs available to prevent type 2 diabetes. The one that is probably the best is not allowed to be used for prevention - Metformin. We have a very quaint system. Metformin is not approved through the PBS.

CHAIR - But you could use it for prevention if it was approved?

Prof. JOHNSON - Yes, that's right. Metformin has the best evidence but the strongest evidence of all for prevention in the high-risk group is structured behaviour change, which is what the Life program is based on. That is not delivered by doctors. It can be delivered by health professionals. More and more evidence is that peers can do it. You could have Aboriginal health workers doing it, and that is what the Life program has done. It has built that prevention workforce. The doctors have a role, which is clear, but we stop pretending that an 8-minute visit twice or three times a year to a GP is going to prevent diabetes development; it isn't. They are not trained or resourced.

CHAIR - Can I come back to the Metformin discussion? Obviously there is a whole process through the TGA et cetera. Are you saying there is plenty of research and evidence to support the preventative role that Metformin could play? Why isn't this happening? What is the barrier here?

Prof. JOHNSON - It's a complicated one. It is not cost. Metformin has been around a long time and it is the most widely used drug for the management of type 2 diabetes, but it is not approved for prevention. So you have to have diagnosed diabetes to use Metformin. If you have pre-diabetes, it is not approved for that purpose through the PBS. Because it has been around so long, to now submit and get it approved for prevention is a complex process. It can be fixed. We have put this to the federal Health minister and it is in this NHMRC case for action. It would be an easy thing to do and would make a difference. It would give clinicians a tool. There is a good evidence base for it, but the strongest evidence is for structured behaviour change programs such as the Life program, which can be delivered in groups, over the phone, which we will talk about with the COACH Program and indeed we are working on web-based delivery. You can have multiple

ways to deliver and build a workforce that can do that but ultimately you can operate online, on the telephone and face to face. Then you start to get serious about using the best evidence-based thing that is available.

Ms WHITE - If behaviour change is the best way to prevent diabetes, you do not want to have a quick fix to prescribe a pill, but are there instances where people's behaviour changes aren't ever going to help them prevent diabetes and a pill could actually prevent the onset?

Prof. JOHNSON - The case for action, which I have co-authored, says that of course not everyone can do a behaviour change program, for different reasons. Some people's mental health status is not good enough, if you like. Mental health assessment is now an integral part of these prevention programs because if people are so affected by anxiety and depression, they cannot apply the motivational techniques and goal setting.

It is a commonsense criterion and if they fall into that category, that is where a pill would be good, notwithstanding the fact that their compliance in taking the pill might be just as problematic. Everyone forgets that but that is okay. We are not saying lifestyle and behaviour change is for everyone but the evidence base is incredibly strong around the world. The US has been building a program there; the Life program - I will give you the stats in a moment - has shown very good results. The new Queensland Government has made a commitment for $27 million over a number of years for a program based on the Life program.

We are talking to the Federal Government but with their fiscal problems they are not that interested in spending money at the moment, and we understand that.

CHAIR - There is another reason to saving money if you apply the principle right through on this.

Prof. JOHNSON - That's right.

Ms O'CONNOR - How much of the challenge in reaching hard-to-get-at populations or particularly at-risk populations is a misunderstanding of what diabetes is and how it impacts on your life? For many people it is just a word and they know that in their minds diabetes isn't a life sentence - well, it is a life sentence but it is not a terminal condition. Do you think there is a complacency about the risk factors and how it impacts on people's lives?

Prof. JOHNSON - It is not complacency, it's that we haven't applied. What the Life! program has done very successfully is start to address that through structured social marketing. If you look at the campaigns in detail, we modelled them on the Quit campaigns, we did a very successful television campaign with a woman with an amputated leg. That was based on good research that showed this is new news for people. We have all this research now that shows that the messages need to be different for different subsets - if you were sending a message to a middle-aged man about their risk, do you know what is going to scare them and make them do something and change their behaviour?

CHAIR - Impotence.

Prof. JOHNSON - Impotence, erectile dysfunction and blindness - it scares the life out of them, but not heart attacks. If you tell them they might have a heart attack - everyone has a heart attack.

Ms WHITE - Everyone has a heart attack.

Prof. JOHNSON - Exactly, but if you are sending the message to women in a different age group, it is entirely different. You are right, there is so much evidence. Australia is good at this; we led the world in the use of social marketing and messaging in tobacco control, we have done it very successfully in other health issues, so why not do it for diabetes? We have a new campaign coming out in July that is doing just that.

It is an integral part of what we are talking about, it is not something separate or different. It comes to the point of motivation. The evidence is strong: you cannot just give content and train people to change their behaviour that is going to be sustainable, you have to have the motivational component as well. People have to want to do it. Sometimes the drive for that does not come from the person, it comes from their spouse or other family member.

Diabetes UK ran a very successful campaign last year based on the family where it was then messages like a young woman saying she made her mother or father change because she did not want to lose them. She realised this was a killer disease and that it would kill them through various things. It is that use of not thinking this is just about educational content for someone, it is far more complex but we have all the tools, we just need to apply them properly.

Ms O'CONNOR - And the investment too.

Prof. JOHNSON - Yes. A brief comment about structural stuff. I mentioned the primary health network. I think there is a great opportunity - you have to see things positively - with the new primary health networks. There is one health network in Tasmania, so you do not have that problem Melbourne or Sydney has where they are carving up the territory and they draw a line somewhere and it does not make sense.

Ms O'CONNOR - We do actually, but we are just overcoming it. It is still in place at the moment.

Prof. JOHNSON - Yes.

CHAIR - In the TML?

Ms O'CONNOR - No, not the TML.

Prof. JOHNSON - The idea should be that that is where you can have some clear responsibility for plans that actually state: what is our plan to prevent type 2 diabetes? How do we measure achievement and report that to the public transparently so we know how we are going? How do we join up all these disconnected parts and resources that we have that could make a difference? How do we make sure we are involving the public and the private sector and the charitable sector that can all bring things to it?

All of those things can be done. We can have a very integrated collaborative thing that uses all the possible resources in a concerted effort. We just need to put the plan in place and have someone taking accountability for it. That does not exist at the moment. We ran around and looked at the 61 Medicare Locals, and only a handful of the 61 Medicare Locals over there - at the end of five years only a handful of Medicare Locals had plans for prevention of type 2 diabetes across the Medicare Local. A lot of them have little projects, maybe 5 per cent of their plan - it is not serving the community well.

Of course, prevention, prevention, prevention have to be the three leading words for all of that. Otherwise, you will just keep having elections based on trying to fix up hospital capacity and treating all of these problems. Remember, diabetes is responsible for between a quarter and a third of all hospital attendances. If you audited a hospital system across Australia today, you would find between a quarter and a third of all the hospital beds are for cases of diabetes and its complications.

Ms WHITE - That is huge.

Prof. JOHNSON - That is huge - about 32 per cent.

Ms O'CONNOR - Where did that data come from?

Prof. JOHNSON - It is all in there. It actually was released by Nicola Roxon when she was health minister first from - I cannot remember the source. There have been various subaudits done. There has been a recent audit done in Melbourne at the teaching hospitals. The same numbers come out. Western Australian audits - about a quarter to a third.

CHAIR - They don't not always present for a specific diabetes-related issue, but they have got diabetes when they get there.

Prof. JOHNSON - That is right. The key thing about that - you are absolutely right. They are there because they have had a heart attack. They are there because they have kidney failure and they need dialysis. One of the big problems is that they get treated for that and in the worst case they die early, which many do. Then we write on the death certificate they had a heart attack or we write their kidneys failed. What we do not say is: that happened 10 or 15 years earlier than it should have because of diabetes. We go out and say this is a tragic story about kids in Indigenous populations getting kidney failure at the age of 20. What we do not say is that it was because of diabetes. The biggest dialysis unit in the Southern Hemisphere is in Alice Springs, mostly treating people with diabetes. What are we doing?

CHAIR - Treating their kidney failure.

Prof. JOHNSON - They are treating the failure. The bottom line is there is great opportunity. We need clearer and better leadership. We need to just put plans in place and actually implement them with the tools we have. A lot of it does not need big, new investment. I am not saying we need to stop funding hospitals and stop building hospitals. But if you shifted a few per cent of that each year, or 1 per cent even each year

for five years, from acute to prevention, it would have a huge impact. It is happening in other parts of the world.

The final two bits. There is a question in the terms of reference about the extent to which expertise in social determinants is engaged in committees and advisory panels. My comment on that would be: generally that is a problem. The public health people, the people who actually work in prevention and understand this do not get involved enough in it. Mostly we still listen too much to individual clinical experts who might be fantastic cardiologists and put stents in people's hearts or they might be fantastic kidney specialists who can do a kidney transplant but they don't know about public health and prevention and most of them do not believe in behaviour change.

Ms WHITE - They don't believe it? What do you mean?

Prof. JOHNSON - No, because they have never been trained in it and they think it is soft science. It is a common problem. I constantly come up against very eminent medical specialists who, despite the fact that it is the National Health and Medical Research Council process that I was involved with that had lots of medical specialists on it and documents all the evidence, they do not want to listen to that evidence. Why is that? It is because the medical system hasn't trained doctors in behaviour change and motivational; it doesn't do that. In recent years it started to on a small scale - that is a small step and that is good.

Most of the people who are involved in committees and give evidence have never been trained in it, do not understand it, do not have time for it and do not think it will work. We're not saying they should do it, we're just saying that they shouldn't stand in the way and block it because it can be done. You can have dieticians, diabetes educators, Aboriginal health workers, peers - there are programs done in India and elsewhere where they are getting people with diabetes to run the behaviour change for prevention because they are actually champions. They have diabetes and they say, 'We don't want anyone else to get it', and they can be trained to run peer-based prevention programs.

That is how we should look at the workforce. It is not about doctors and not necessarily about GP clinics and practices. They are important but that is not where the answer is. The answer is in broadening our approach to prevention in a community setting and using all the resources we can. We run a two-day training program for prevention. In Victoria we now have 400 people, mostly health professionals but some not, and it makes a huge difference. They are not employed by Diabetes Victoria, they are employed in lots of places - 110 different organisations - but they are champions for prevention, they know about it and that starts to make a big difference.

Ms O'CONNOR - Is there a charge for that training for an organisation to cover costs?

Prof. JOHNSON - No, that is funded by the Victorian Government so there is no charge for that. It is funded through the Life program.

Mr BARNETT - Greg, I am wondering if you can outline an overview of the Life program and how it works. Can you convince us that it actually does work because I know the research shows that?

Prof. JOHNSON - The research is all in that document which was recently the outcome of an NH&MRC case for action. The Life program is based on very strong evidence that started coming out in 2003 after three big randomised controlled trials around the world - one in the US, one in China and one in Finland - that all came out with the same result. It was startling and it surprised the world. It said that if you invest in a strong dose of behaviour change - which is helping people change their diet and what they eat, change their physical activity - and sustain that through building sustainable skill change, goal-setting, motivational techniques, then you get a strong prevention effect - 58 per cent.

That was found in two of those big studies with thousands of people in the US, China and Finland. The Finns then said, 'How are we going to do this on a broad scale?', and they went to the next stage of the same groups. It's more cost-effective if it is done in groups rather than individuals. It can be done in an individual setting with a die titian one-on-one, but it requires five or six sessions or more of 90 minutes to two hours, and that is not cost effective if it is one-on-one and face-to-face.

So they went to groups which were shown to be very effective in Finland, which is what is in the detail of your paper from Diabetes Tasmania and that other one. There were five goals set for the program. You do not have to achieve every one but if you achieve most of them and you do it once well, the effect lasts a long time. You do not have to do it again next year and the year after. They have shown a seven- to 10-year prevention effect from doing it once.

Mr VALENTINE - What do they use as a motivator in that?

Prof. JOHNSON - Lots of motivators. The motivator has to be worked out with the person. It is about understanding the motivators in the process, and people can be trained in understanding that, and then finding the right techniques that work for that person. That can be done in groups.

In Australia that got put in place with our initial program based in Warrnambool and then the Victorian Government started funding this Life program in 2007-08. I was just going to give you the updated numbers. I think there are numbers in your submission from Diabetes Tasmania, but the latest numbers are these. The Victorian Life program now has had 61 000 Victorians referred to the program since it started. Over 44 000 of those went to what is referred to as the first session. They have a one-on-one first session, which can be done on the phone or face-to-face and that is how they explore what is going to work for that person. A total of 34 500 people have gone into the group courses. They go into groups of eight to 15, have five to six sessions over a period of three to six months with a trained facilitator and they work in groups. Nearly 35 000 people have now gone through those groups and 6 700 have gone into a telephone line of delivery.

What you do is triage. You start with an initial interview and then you either go to the group one or the telephone one and now we are developing a web-based one, which is not there yet but is not far away. It is not one size fits all. Some people are going to work well in the group thing, some people need the telephone thing and there are different reasons why. It maybe time, cost or lots of things. The web one we think will be without borders in terms of being able to bring people together in a webinar, and there

are limits to size. You need multiple channels of delivery and this is now one of the biggest in the world.

Ms WHITE - Do you know why nearly 20 000 of them who were referred didn't go to their first session?

Prof. JOHNSON - Some of those who have been referred but there is a waiting list.

Ms WHITE - It is not that they just decided not to engage?

Prof. JOHNSON - Some don't. Some get referred and don't go and there will always be a number of those. That might be because their mental health assessment means they are not suitable, so they were referred but they just don't get there. Some of that mental health assessment can be done through the telephone service that talks to them and assesses that. Some will not be suitable and some will talk about it, go to a first session and if they're not sufficiently motivated they don't go on. There is always a drop-off in numbers as you go through.

The principles are to use social marketing and get as many people interested in prevention as possible and then you have multiple pathways for them to achieve prevention based on the evidence.

Mr VALENTINE - These people haven't necessarily been diagnosed with diabetes?

Prof. JOHNSON - None of these people have diabetes.

Mr VALENTINE - So they don't have diabetes or they don't have the potential to have diabetes particularly.

Prof. JOHNSON - No, they're all high-risk. The definition for this is all high-risk people and that is where you need to understand -

Mr VALENTINE - This is the 45 000 Tasmanians.

Prof. JOHNSON - You have 45 000 Tasmanians right now who if you went out and did a blood test you would find they have abnormal glucose metabolism, a condition called impaired glucose tolerance, or impaired fasting glucose, and are at high risk of getting type 2 diabetes in the next five to 10 years. All of this evidence is in that group. This is where a sensible public health policy says if we are going to put scarce dollars into this, focus on that high-risk group, because the ones who are low-risk firstly don't need that. What they need is sensible public health policy. They just need the food environment and the food that is available to be a bit healthier. They need to have public education about healthier choices. They need better labelling of food. That should be done for everyone. These are the high-risk people where we know if we do this well we can stop the progression to type 2 diabetes in 60 per cent of them.

That's how it works. I should stop talking and let Minke say a few words about the COACH Program and what it is now.

Ms HOEKSTRA - I am a die titian and work as a coach at Diabetes Tasmania. I have been in the COACH Program and was the very first coach employed when the program rolled out years ago, so that was kind of exciting. The COACH Program is an evidence-based program for the prevention of chronic disease, not just for diabetes. It can be used for heart failure, chronic obstructive pulmonary disease or a range of things, but at Diabetes Tasmania we just use it for type 2 diabetes, people with pre-diabetes and people at high risk. It covers primary prevention, but the vast majority of our clients are people with diagnosed type 2 diabetes.

It is just over the phone, it goes for six months, and the idea is that over a six-month period clients will have access to a trained health professional. We are all dieticians at Diabetes Tasmania but elsewhere in Australia they use physiotherapists, nurses, anybody in allied health basically, and the client works with the coach over a six-month period to improve their risk factor levels for type 2 diabetes towards the national guideline recommended levels. We know there is a big treatment gap, especially in Tasmania but everywhere, between what is evidence-based, what people's risk factor level should be in order to best prevent or best manage their conditions, and what happens in doctors' surgeries day to day. The COACH Program aims to reduce that treatment gap. All through the coaching the patient is encouraged to continue working with their usual doctor. It is not a replacement for usual care, it is coaching the patient to be proactive in their health care, to learn about their risk factor levels and about lifestyle, diet and exercise, and through medication to improve their risk factor levels and better manage their conditions and/or prevent complications.

Patients are called once every four weeks over a six-month period, so there is a total of three-and-a-half hours of contact time with a trained health professional who just addresses that person's needs and wants and fills in their knowledge gaps and motivates them to do what they need to improve risk factor levels. If you compare that to the annual diabetes checkup at the local doctor, it is a lot of time. For a lot of people that's where they get their confidence from and learn to figure out what it means for them, how serious it is, and what their motivators might be. That is a big benefit of the program.

In a session the coach would typically find out what the patient's blood test results are. A key component of the COACH Program is to encourage the patients to go to their doctor, get their blood test done and find out the results. A lot of people don't know how to interpret blood tests, how to read the results or to read their medication, so a strong part of the program is teaching people to find out what their results are and how to interpret them. The coach will then work with the patient to figure out what they can do in terms of lifestyle and medication to improve their risk factors, set some goals and then that process is repeated at every session. At the end of every session the coaching over the phone is followed up with a structured written report that is sent to the patient and their local doctor. The doctors are kept in the loop, they know what is going on and the patient knows that if they forget what they have to ask the doctor the doctor has a copy of the letter. Often patients will take the letter to their doctor and say, 'The coach has asked me to talk to you about my medication'.

Ms WHITE - When you said there is three-and-a-half hours of phone contact, is that over the six months?

Ms HOEKSTRA - Yes. The first session is typically up to an hour and the other five are about half an hour.

Prof. JOHNSON - At the moment this is primarily people who have diabetes, around secondary prevention. The outcome of this will be you will stop blindness, kidney damage and heart attack and strokes because you are enhancing the management of the diabetes. The lifestyle risk factor stuff with physical activity and nutrition advice in that is very similar to what you need in the prevention stage of the high-risk people going to diabetes who don't have diabetes yet. The COACH Program on the telephone can do both. You can deliver it to a person with type 2 diabetes [inaudible] to secondary prevention, you can deliver it to a person with pre-diabetes to stop it going to type 2 diabetes. That is where we need to, in our view, scale up the COACH Program. It is already there so you just need to scale up the numbers to do more of the prevention of high risk going to type 2 diabetes. The capability is already there, it doesn't need much new; it just needs to be able to scale up those numbers.

Ms HOEKSTRA - The COACH Program has been running since 2009 at Diabetes Tasmania. Before we were talking about training, and it only takes a week of training to train up health professionals, so it is very easy for us to take on greater numbers to move more into the prevention field to take on more people with type 2 diabetes because there are 10 000 people in Tasmania who don't know they have it.

The COACH program has been shown to work. Two randomised control trials have shown that, yes, six months of coaching significantly improves people's risk factors for their modifiable risk factors. A follow-up at 18 months, following graduation from the program, showed that people maintained that improvement. It is not just the six-month benefit, it is a long-term benefit.

In Victoria, where the COACH program started, an independent audit of the program, conducted by the Department of Human Services, showed that over four years, following people going through the COACH program, that group of people, compared to usual care, had 16 per cent fewer hospital admissions and 20 per cent fewer bed days, which financially works out to a massive saving.

The same thing has been shown in Tasmania. Professor Andrew Palmer from the Menzies Research Institute did a cost-benefit analysis of the first three years of the COACH program at Diabetes Tasmania and he showed that in the first three years of that program the coaching delivered increased life expectancy, delayed complications, and an average saving of about $3 000 per client over their lifetime. They looked at estimated health care costs for usual care compared to people who went through the COACH program. Using those cost projections they figured out that those people who went through the COACH program would have saved the Government $3 000 of health care costs.

Prof. JOHNSON - The health economic are now clear that you don't have to absolutely prevent forever. The value of substantially delaying the progression from pre-diabetes to type 2 diabetes through a life program is an incredible value if it delays that for five to 10 years. It does not have to be absolute.

CHAIR - If the measures you take to delay the onset, if you cannot prevent its onset, won't that also reduce the risk of getting some of the debilitating complications as well?

Prof. JOHNSON - Absolutely.

CHAIR - You might still get it but you are probably not going to get the degree of complications.

Prof. JOHNSON - Correct. Even when you get it, the evidence is very clear. When you get type 2 diabetes - and we are focusing on type 2 - the complications are the same for type 1 and type 2 - kidney, eyes, amputations, all of these things. The evidence for all of those is clear that if you do these programs, and this one is evidently working very well, and get the management better early on, it is not just early detection but optimising the management early.

CHAIR - Controlling their blood sugar levels.

Prof. JOHNSON - Yes. If you do that early, you might not absolutely prevent. They might still have kidney damage but you might delay it by 10 years, and the effect of that, in an economic sense, is powerful.

The other thing we should mention is the productivity impact of what we are talking about. We recently jointly endorsed a Deloitte Access Economics report on just the eye damage - a $2 billion economic impact on productivity just from eye complications of diabetes in Australia per annum. The overall productivity impact was in another report last year -

Mr BARNETT - $14.6 billion?

Prof JOHNSON - No. That is the overall cost. That cost includes productivity plus, health system costs, plus others - $14.6 billion is the total cost. But if you are talking of productivity alone, the eye impact is $2 billion and the other impacts take it up to about $5.7 billion to $6 billion. The economic productivity impacts are huge.

CHAIR - Why aren't we seeing governments invest in this?

Prof. JOHNSON - It is a big change to re-orient the system and take money from the acute sector and the Royal Hobart Hospital and put it upstream. All the evidence is there. People all around the world are saying that is what we should do, but it is hard. We don't pretend it is easy. But you don't have to do it in an absolute sense. Set a task and shift 1 per cent - grow it by 1 per cent a year. That would have a huge impact.

Ms WHITE - I have two questions about the COACH program. How much funding has been provided by the Department of Health and Human Services for that three-year period you did the analysis?

Ms HOEKSTRA - I would have to get back to you about that one, I would have to check with Caroline.

Ms WHITE - If it is possible. For that three-year period that the analysis was conducted, how much funding was provided and how many people went through your program?

Ms HOEKSTRA - That was 527 people over the three years. The cost saving is above and beyond the cost of coaching and medical cost, so it is a $3 000 saving per client even when you take into -

Ms WHITE - Return on the investment?

Ms HOEKSTRA - That's right, exactly. It's above and beyond, so $3 000 saved.

Prof. JOHNSON - There is quite a lot of economic evidence now. There is ACE Economics Report out of Deakin University that looks at a whole range of prevention intervention, so there is a very strong evidence base for these prevention things gives. Sometimes they are cost-saving to the system and other times they are cost-effective; either way they're good.

CHAIR - The challenge is that, because this has been neglected for so long, we now have such demand on our acute health services; the burgeoning waiting lists are a result of the failure of preventative health. It would be a brave government that says, 'Right, the Royal is going to have 1 per cent taken off their budget and every other hospital around the state, and we're going to put it into these programs', when you're not going to see the economic returns. Let us talk of purely economic, not human, cost here, because that is a whole different situation too, but in terms of economics alone we're not going to see a return on that for a number of years.

Prof. JOHNSON - Yes, but can I paint that differently. You do not have to take the money away from the Royal Hobart Hospital. Why not just set a budget target for the Royal Hobart Hospital that they should spend and be transparent about spending money themselves from their budget on stopping people coming into the hospital. Then you get over the political hurdle of cutting their budget. They still have control of the budget.

CHAIR - They have to provide the service, not someone else?

Prof. JOHNSON - This is happening. That is what integration and collaboration is about. If you look around Australia I can point to many places where the smarter services have said - the Royal Melbourne did this with the local community health service and the local GP network. They took budget from the Royal Melbourne's budget and they spent it on preventing foot problems. They were getting a lot of amputations from diabetes. They had great outcomes. They substantially cut the numbers of amputations coming to the hospitals and requiring that, so they then didn't have to provide another operating room, they didn't have to do all that.

CHAIR - Capital expenditure can be less, so let us use the capital expenditure on it.

Prof. JOHNSON - That's right. They had a benefit within a year. It was a two- to three-year project and they got the benefit. It is not necessarily long term. The benefit can be for the hospital. The budget can stay with the hospital; that is just integrating things so we don't have a fight. It is not a competition here.

CHAIR - We should all be looking at the same ends.

Prof. JOHNSON - We should be. The way we can address that is through the structural change to the system that gets the incentives there and gives some responsibility. We can do that in a smart way that isn't cutting budgets here and giving it there; join them up.

Ms HOEKSTRA - It is about joining them up - even a simple referral process from the Royal Hobart Diabetes Centre to the COACH program. So many things I see are not quite acute, but they would be if I hadn't said, 'By the way you should have eyes checked and your doctor should check your medication'. I'm only a dietitian, but I can see according to the evidence-based guidelines that if your three-monthly average blood sugar reading is sitting at 10 per cent you are going to be running into problems, and you will be at the Royal unless you do something about it. If we can just catch those people a little bit earlier to get them liaising with their GP, which is cost-effective and something they should be doing anyway, but they just have not, then they [inaudible].

Prof. JOHNSON - Getting to the specifics of what we would recommend you should focus on as outcomes here, one is to build on what you have. One of the big problems we have is people keep chopping and changing. They start and they do something good, it runs out of money and we don't get any sustainable benefit. Where you've already invested in something and it's working, keep it going. The COACH program is a good base. This is not diabetes-centric. The Life program is not diabetes-centric. The Life program is about preventing type 2 diabetes, cardiovascular disease, heart attacks and strokes, and it has a mental health component as well.

CHAIR - There must be a renal component also.

Prof. JOHNSON - Yes, and those benefits extend to renal health. These changes work through all of that. It is not a competition between diseases, and it shouldn't be. There should be collaboration in that and there is in the Life program. The Heart Foundation and the Stroke Foundation have been engaged. They endorse the program, they agree that it works, so it is not an argument and a contest. It works beyond diabetes, but the evidence base in diabetes is the strongest. Keep the COACH Program going and expand the element of preventing people going from high risk to pre-diabetes to type 2 diabetes and you will get a substantive gain building on the infrastructure you have. That is with telephone delivery, using the telephones program that has been set up.

Secondly, add to that the two additional pathways. One is in groups, face to face in rooms. Remember, this is not in doctors' clinics, this can happen in a workplace. You can get employers involved and you say to them they could contribute to the costs.

CHAIR - It is in their interest to do so.

Prof. JOHNSON - It is in their interest to do so. You can have it employment based and run the program. What the program does though is make sure there is a facilitator trained to do it who can go to that workplace down the road and run a program over three to six months. You can then engage the employers in a co-contribution. It is all possible - engage the private health insurers in it as well, they should be playing their part but they are not at the moment.

Those things should be done to grow that group element and then we will shortly complete the first stage development of an online delivery which will then be available to Diabetes Tasmania to add to that. Then you will have three avenues of prevention.

Finally, that is really specific to do but at the same time, don't forget you have great powerful levers in your hands as legislators and MPs to make better public policy in Tasmania and that is up to you. There are many things you can do in encouraging and promoting healthier food, access to healthier food, more physical activity in people's lives - all those public policy things that need to be there for everyone, not just the people at high risk .

Finally, support the screening programs. What the COACH Program does is enable you to say, 'This person might be at high risk of getting complications because they are not doing it'. They have not been educated or given the right messages, they do not even know what their blood tests are, and they have no capacity to self-manage. If you give that to them - and this can be screened, you don't have to necessarily have to do the same intensity for everyone but if you can identify high-risk people going on to get complications, screen them and deliver that accordingly. You will get great benefits in the short term out of preventing blindness and preventing all those things that are filling up the hospitals. Give the hospitals a role in the accountability in doing that as well as the primary health network.

CHAIR - Then we can close some wards.

Prof. JOHNSON - Yes, there are some powerful levers. I wanted to have the discussion but we will follow up with a further submission if that is possible, just to set that out, but I thought it was good to have the discussion first.

CHAIR - I am sorry we are short of time. We will leave it at that and look forward to further input from you and we appreciate your coming over from Victoria.

Prof. JOHNSON - Thank you. I've really appreciated the opportunity to talk to you.

THE WITNESSES WITHDREW.

Ms SUSAN LEITCH, CHIEF EXECUTIVE OFFICER, AND **Ms DEBRA LEWIS**, OPERATIONS MANAGER, COUNCIL OF THE AGEING, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Welcome, Sue and Deb, to our hearing. Thank you for waiting. Everything here is being recorded by Hansard and will be part of the public record. This is a public hearing. You are protected by parliamentary privilege while you are before the committee, but not once you are outside if you speak to people outside about it, so keep that in mind. We have got your submission, and thank you for that. You also made a submission to the previous committee. That has all been taken into evidence at this committee as well. We have read your submission. I would ask you to introduce yourselves briefly and speak to the submission - the last one and this one if necessary, any updates. We will ask you questions from there.

Ms LEITCH - I am Sue Leitch, CEO of COTA Tasmania. I am a registered health professional in that I am a pharmacist by profession. I take preventative health sincerely to heart because it has been something that I have been working with most of my professional life. Now I bring the consumer voice to the table with respect to older Tasmanians. I feel quite strongly that it is important that we still remember that older people do have a right to preventative health as well. Just because they have reached a certain age does not mean that preventative health cannot have an appropriate place in their life.

That is a key message I want to put across. We have really good data on where older Tasmanians are and the sorts of conditions they are facing because of the research that we have done in this space through our demographic profile on older Tasmanians facing the future. We are a little concerned about anecdotal reports that we get that there may be some form of age discrimination in the health profession about how older people are treated within the health system. So from a preventative health point of view we feel that older people should be listened to and they should be considered as parts of the health process. They have very strong feelings about how they want to be treated within the health system and they also have the right to be fully included in the health process. We are talking here about the principles of co-design and co-production about systems and development policy, and that they should have a voice at the table.

Government should try to think laterally about health and not just think within the health budget. One of the things that COTA is very strong on is development of an aged-friendly community in Tasmania, and a number of councils are already working towards that aim. Clarence is our first aged-friendly community in Tasmania. That is looking at putting things in place that can help older people's health by creating safe communities where older people are valued and considered in the planning for their own communities.

I note that the Heart Foundation have put forward a proposal to get a state policy on healthy places and spaces. We feel that that would go a long way to creating environments that are safe and accessible for older people to get out and do some of the simple lifestyle measures that can make a lot of difference towards preventative health. If they can have a more active lifestyle then naturally you can go a long way to reduce a lot of the things - such as Diabetes Australia were talking about before. We know that simple lifestyle measures such as getting out and doing some gentle exercise such as

walking, and if people have a safe environments to be able to do that in, then you can have some significant inroads into preventative health for things such as diabetes, hypertension and heart disease.

Another thing that I would like to point out from our submission is some of the work that we would like to do regarding falls prevention. We have made several budget submissions based on our peer education model. This about involving older people directly in spreading healthy messages about what you can do for preventative health. We know that there is really good material developed by Population Health in the area of falls prevention. We had some initial discussions with the department under the previous government. We wish to take those resources that are well developed in falls prevention. Again, simple messages about good levels of exercise and doing a little bit of strength training and some simple messages that can be delivered through a peer education model to prevent falls. We do know that if you can keep people out of hospital, you save a lot of money.

Mr VALENTINE - And lives, no doubt.

Mrs TAYLOR - And pain and suffering.

Ms LEITCH - Yes, exactly right. There are some fantastic resources that have already been developed but how accessible are they, especially to that age group where we know that we do not necessarily have a lot of engagement online, so we use peer education in a number of forums. We have used it in a health forum before with partnerships with the National Prescribing Service, so it is a proven delivery method for information services.

Mr VALENTINE - You have public programs too, don't you?

Ms LEITCH - Yes.

Mr VALENTINE - You have advertisements in lifts and all those sorts of things. I have seen them.

Ms LEITCH - Yes. With peer education we tend to go out to established groups in the community rather than calling public meetings because we find them to be more effective. People are in their comfort zone; they are with their friends, they are out on a social event and they are more likely to try and hear those sorts of messages. We have used it in a number of formats before. We use it for elder abuse. They have used falls prevention; in the past it has been funded as a peer education model. In the other states and territories we have peer education around programs such as Strength for Life, or another version of this called Living Longer Living Stronger, which is about a simple weight training that can help to prevent falls.

Ms LEWIS - My role in the organisation is around operational management and overseeing some of the projects we do in peer education and consultation with older people in the community. I have hands-on experience from that role that can perhaps help the discussion today. One of the things we had identified in the regard to falls prevention is some data about the proportion of hospitalisations, nationally, not Tasmania-specific information, that relate to falls prevention that are quite compelling. While there are a number of areas that we could be working in in preventative health, that is the pointing

end of where we are seeing a lot of hospitalisations and a lot of cost. Also a lot of implications for people's emotional wellbeing and capacity to be included in society after a fall.

CHAIR - That confidence.

Ms LEWIS - Exactly. It has significant flow-on impacts in the community. We have some data here from the Australian Institute of Health and Welfare that says, 'One in every 10 days spent in hospital by people over 65 years of age was directly attributable to an injurious fall'. This was 2010-11 data. That calculates out at about 1.4 million patient days over the year. The actual cost, which is a consistent message that I am sure you are hearing through these hearings, is that there is a huge downstream cost in acute care and a big opportunity. It is one to be focused on.

Mrs TAYLOR - It is a very interesting area demographically at the moment in the world and in Australia, in that it is the top edge of the baby boomers who are coming into the older Australian category. We know there is a huge bulge of those in the population. I don't know how huge but it is big. The generations on either side are very different. The voting power of this group is big.

Ms LEITCH - Yes.

Mrs TAYLOR - You are representing a group that over the next 20 years will be really great. I am not against this; it is an observation. We are seeing that quite a lot of research money is being spent on prevention and cure of diseases for older Australians, and I am included in that, because it is the voting block. I also know that the baby boomer generation is different to the generation before. You were saying about online, how your 80-year-olds are generally not doing online stuff but your 65-year-olds are who are at the beginning of that baby boomer and for the next 20 years. Do you see the method of delivery or that kind of thing changing dramatically and are you preparing for that?

Ms LEITCH - Yes and we do. We are about to release a report, which is another part of the inclusive ageing strategy, specifically about how older people like to receive their information and some of their barriers as to access to information. It is at the printer now. We were happy to submit that as part of our submission. We know that the baby boomers are more likely to go online and access their information through the internet. But in the older age groups, the prime sources of trusted information tend to be their GPs or local pharmacy. They tend to get it either through the TV or through newspapers. We had a fairly good size data pool when they did this research work. We got about 800 responses to the survey we sent out.

Mrs TAYLOR - Did you divide those into age groups?

Ms LEITCH - Yes, we did.

Mrs TAYLOR - My age group would Google it as well. You go with information or if the doctor prescribes something you check out the side effects. The 75-plus don't do that.

Ms LEITCH - No, we have shown they are more likely to get that type of information from either their GP, local pharmacy or family members. That would be their greatest source of information - or from friends, and that's where we find peer education is good. We don't train our peer educators to be experts - we don't ever extol that - but they are trained in a particular area of their subject matter to be more knowledgeable in that area and they have clear referral pathways if there is information they don't know. It is a safer, more trusted environment where they can discuss things and the message is more likely to get through.

Mrs TAYLOR - Is that changing as baby boomers move through?

Ms LEITCH - Yes, it is changing. We are finding more engagement on social media as it is coming through. Susan Ryan, the Age Discrimination Commissioner, has said that if that older group cannot access information easily then it is a form of discrimination.

Mrs TAYLOR - I am not suggesting you don't do that for that age group; I am just asking if there will be a transition. Even that isolation in the home, which is very critical for older people, is not the same for baby boomers because they do the social media thing. They are online, so the social isolation is changing.

Ms LEWIS - You will see on the Facing the Future fact sheet and in all the documentation that we break the older group down into three main areas: the 60-70 group, the mid group, and then older old - so, young old, mid-old and older old. There are significant differences in the uptake of information. In the Finding Out report there is an interesting graph that shows that up to 75 the use of landline, television and those things is alongside the web and the other digital opportunities, but at 75 the digital drops right off. If you want to reach that group with a certain amount of information, you need to have two different approaches.

Mrs TAYLOR - Do you need difference approaches, because you have very different generations there?

Ms LEWIS - Yes, and peer education works in different ways for the different age groups as well. You might have a group who go to meet at a senior citizens group in an older group, but you might go with a walking group with a younger group, so there are different opportunities to engage.

Mr VALENTINE - Can you provide us with that research?

Ms LEITCH - Yes, we can. It is called the Finding Out report and is about to be officially released. We can do a submission on that when it has gone up to the Premier.

Ms WHITE - I want to speak about the Living Longer Living Stronger program. Thinking about the evidence we've just heard, the COACH program - services delivered over the telephone or in groups, depending on what the person felt most comfortable with. Do you think there could be something that could be used to also reach your target cohort? The Coach Program, in particular, sounded like it was around nutrition, but also around exercise. If we are looking at falls prevention - and we found out also that older people have a greater propensity for malnutrition and dental issues. Thinking about all of those co-morbidities and how you might help someone who might be living at home by

themselves or not mobile, a phone coaching service - I've never really been excited by it, but perhaps it is one way you can reach people in home and talk to them and coach them.

Ms LEITCH - It may. My only concern with that would be there is a lot of benefit if you can get people out of their own homes because of the social inclusion factor. I personally would prefer that it happened more around that group environment if possible for the social inclusion component of it. We know that it has a lot of benefit for health and wellbeing anyway, but if there was no other alternative I would say, yes, a coaching program may work. You would probably need to have a preliminary step in that process where there is some face-to-face interaction so there is a bond and rapport achieved with that person.

Ms WHITE - It might be more like the Life Program, which is another one we heard of just prior, where people are referred into a service by their GP, or a community health worker or your organisation. They have an initial assessment and then they either get referred to the group or the phone coaching. Fewer people took up the phone coaching in that scenario. They would prefer to be in a group environment where you can do a lot of that life skills enhancement. Social inclusion is a biggie, isn't it? That engagement with community that improves people's life expectancy. The Living Longer Learning Stronger Program ran for six years. I assume you have done some qualitative and quantitative analysis with that?

Ms LEITCH - Yes, and we could send you some information on that. It is still currently running. There is a version still running in Western Australia, and there is a version running in Victoria and also in South Australia. The South Australian one is called Strength for Life. They are very similar models and based on some good principles of simple strength training. It does not have to be really gung-ho gym work or anything like that, but just some simple weight training.

Ms WHITE - Yes, my Grandma told me how she went down to the community hall and walked from end to end and that was very exhausting.

Ms LEITCH - But there is some good evidence about these sorts of group activities anyway. The Heart Foundation do it with their walking groups, and that is fantastic for community engagement. In fact, when I was involved with the Pharmacy Guild and in the ACT a lot of the community pharmacies used to do walking groups in their local communities. It was swinging off the Heart Foundation work, but based around the local pharmacy.

Ms WHITE - That does still happen not with pharmacies, but with local GP practices.

Ms LEITCH - It is a fantastic idea. It all lends itself to that principle of age-friendly communities as well, so being involved in their community and using the networks that are already in existence in communities.

Ms WHITE - One of the problems we have and you would probably agree is that there are different things happening, but if you wanted to refer someone who ran COTA to your service in their community how would you find out what was available? Do we have a problem with information sharing?

Ms LEITCH - Yes. We try to be very ears to the ground about what is happening in the community. We do get a lot of cold calling to the office about what is available. We try to share as much information about that as possible. Our networks within the organisation dealing with other organisations and we talk and have professional relationships, for example, with the Heart Foundation on work that we are doing together. They have a representative on our working group for the inclusive-aging strategy on age-friendly communities for exactly that reason because it is quite integral. That leads me to thinking outside the health budget, because you are shifting then to other areas of government policy, but they all lead in to health. It is about planning and what is in place in the planning systems to be able to enable environments where you can actually be active. We are talking simple activities here. We are talking about having parks that are safe for older people to take the grandkids to where they can get a little bit of exercise. That would benefit their health and wellbeing.

Ms LEWIS - It is also important to think of older people not just as recipients of healthcare, but think about their role as volunteers and mentors in the system, and the opportunities that are open. The Peer Education program is just one example of that. I really think there is a lot of opportunity for intergenerational work as well, with older people contributing their skills and knowledge in a volunteer capacity to those sort of programs.

Ms LEITCH - I would like to bring to your attention some work that has been done in the UK, which goes to the point of co-design and co-production. This has been some work that has been done. Helen Anderson and Associates in the UK do a lot of work on co-design and co-production. They produced a series of postcards specifically around this issue about talking to older people about what is important to it. Just some simple quotes, 'Do not just listen to me, listen to us all. We need to talk about our issues, not yours.' Another really poignant one, 'I need to feel safe before I can share my concerns and ideas with you.'

So some of the ideas, yes, COTA is happy to come to submissions like this. Being able to provide environments where people feel safe, that they can talk about their concerns and issues - these are quite powerful, especially when you are talking about people's health. We do get that fed back to us quite a lot, that people feel things are being done to them, not with them or for them. That is a really powerful message that we need to take into consideration. I will just pass that over.

CHAIR - Tasmania has such a dispersed population. A lot of our older members of the community live in rural, remote areas, regional areas. Many of them are on the land and they did not use hearing protection when they drove tractors and used chainsaws and the whole bit. Phone connections with them is very difficult, when they might indicate they can hear, but they probably cannot at times. It is a pride thing as much as anything. For them to actually get out and engage in a service that may be some distance away, and none of them were able to drive, creates a whole lot of challenges. Does COTA have a role in trying to look at options for these people? How would we actually assist the people in these situations? There are many of them, especially in my electorate.

Ms LEITCH - We do. That is one of the reasons we actively try to engage with our partner organisations that are out there regarding community transport, for example. The transport systems are integral to people who are not able to drive. The network of community transport across the state is quite crucial to making these things happen, and

also to that point of social inclusion. If people cannot get out and about then it is an issue for them.

Mr VALENTINE - Very isolated.

Ms LEITCH - Yes. That is where we need to be able to keep the local communities vibrant and have these services at grassroots level as much as possible.

CHAIR - How do you see the role in that? We have heard a lot today about linked up integrated - or joined up, however you want to describe it - health services and health systems. This is stretching it as far as you can to the edge of the west coast, edge of the east coast, King Island, Flinders Island. How do we create a linked-up service that actually does reach these people?

Ms LEITCH - Transport is key to it. You need to have a coordinated transport system, which in itself is a challenge. They have been reviewed to death as well. There has been a number of state-based reviews and also some federal reviews on how that is going to work. There will be changes in that space. The old HACC system is going to change. Come July there will be changes to the fee structure. It may be a little bit delayed because they are falling a little bit behind on the work. We are not quite sure what the first structure is going to be yet, and that will have impact on whether people have the capacity to pay. It is one of the reasons why we were very concerned about what was happening with the potential changes of pension indexation. Not only do the services have to be there but they need to be affordable for the people as well. That needs to be a key consideration.

They are trying to be clever about hooking in between how can you link up the community transport system but also the public transport system as well and the bus systems that are in place at the moment. I know they did a trial on the east coast with the Swansea system. Unfortunately, our bus systems are very integrally based around what is happening with the schools, so quite often the timetables do not suit older people. To get from Swansea into Hobart is a 6.30 a.m. bus in the morning and that can be a big challenge for an older person.

Ms WHITE - For anyone, I would say.

Ms LEITCH - Yes, anybody.

Mr VALENTINE - There is that one example we heard the other day where someone was let out of the LGH and had to get a taxi to Scottsdale because there is no bus service and there was no community transport available, apparently.

Mrs TAYLOR - Are you doing anything in the area of confidence-building in older people? I say this because all of us, I guess, often go to meetings where there are older people. I always say to them, 'You're not finished. I'm sorry but you're a really important part of society because you are the holders of the wisdom. You guys have been there, done that'.

CHAIR - Seen it all.

Mrs TAYLOR - Yes, 'You can't sit back now and say, 'Oh well, I'm old'. That is the feeling they get often that people think, 'Well, you're old, you're useless so, yes, we will look after you and, yes, we will do this', as if they have no value any more. It seems to me we need to be doing something about restoring pride in older people, or continuing that. Are you doing anything in that area?

Ms LEITCH - We are. It is a constant battle trying to combat ageism that is everywhere in the community.

Mrs TAYLOR - Discrimination, ageism, whatever you like to call it. I think it is on that border.

Ms LEITCH - Yes, it is.

Mrs TAYLOR - So what do you do?

Ms LEITCH - We are constantly trying to portray positive images of older people and bat away the negatives that are always appearing in the press. In fact, I have just been reading the proposed population growth strategy. Even the language that is in the opening document of that talks about the 'burden' of an ageing population.

Mrs TAYLOR - Yes, rather than the value of it. There is value as well.

Ms LEITCH - Yes. This negative language comes through all the time. There are significant changes happening with the concept of consumer directed care in the home care space, so the shift is moving away now from provider to consumer rights and what the consumer can do. That is a lot of the principle about co-design and co-production that we are talking about.

Part of the problem is that there is going to be a huge cultural shift that is going to be needed from a provider's point of view in the aged care space, so providers for not only residential aged care but home care as well. The majority of them are still in the space that we need to do things for older people rather than including them in the process. We have a long way to go, definitely.

Mrs TAYLOR - There are societies that value their older people a lot more than we, in Australia, do.

Ms LEITCH - Yes, unfortunately Australia has gone backwards in that space but we will continue to try to combat that. One of the key principles of age-friendly communities is that older people are respected and valued in the community, and are consulted on what happens in the community. So rather than necessarily just designing things that a council would consider to be safe for an older person, they are actually involved in that process, they are asked about what is important to them and that is considered as an integral path.

Mrs TAYLOR - My second question was around dental care. I was quite shocked today because I had not thought about. We had another witness talk about the fact that when older people go into nursing homes or higher care there is a significant shift then to their dental care, and that succeeding generations now - they talked about pre-fluoride and how people now are not having teeth removed but are getting implants and crowns. In a

sense that need in dental care is continuing. When you are in a nursing home there seems to be some doubt about whether that is available any more. If you get disease, say, on a tooth that has been implanted, how difficult it is to remove that? You can't just pull it out as you do with a diseased, rotten tooth.

Ms LEITCH - I am not aware of that.

CHAIR - I encourage you to talk to them because it is a big issue for COTA to look at. The evidence was that it is an emerging problem we are looking down the barrel at.

Ms LEITCH - We can check what is happening in our national policy council. I am sure there would be some work that has been done on that.

Mr VALENTINE - There are more and more people going into nursing homes who don't have false teeth.

CHAIR - False teeth are also a problem because often they had they teeth taken out when they were quite young and the gum deterioration that has gone on means their false teeth don't fit any more.

Mr VALENTINE - Emergency buttons - I read in your submission about depression and anxiety. One of the things that seems to concern older people in their homes is that something is going to happen to them and they are not going to be found for a day or two. The button is a facility but even then they feel there is a possibility they may not be found in time. Have you addressed any of those anxieties with the people you are dealing with, support networks and things like that? Is there some way that people who don't have family, for instance, might be able to work with others to somehow assist them in this time in their life where they are more vulnerable?

Ms LEITCH - There are systems in place that are fully-paid systems. Most of the alarms are user-pays. I have a concern about the cost -

Mr VALENTINE - And what they achieve.

Ms LEITCH - Yes, that might be one aspect of it. There is one state or territory, and I am trying to recall which it is - it may be Queensland, but I would need to check on that - where the government has made a contribution towards funding these alarms. I have been having some discussions with CSIRO on these types of monitors and alarms. The people I have been talking to feel that, with the newer technology that is coming out now on tracking devices that people generally wear, you could do a far more cost-effective model by modifying the existing technology that has come down significantly in price to improve that type of service.

CHAIR - More and more people are going to have tracking devices on them, and this is one of them.

Ms LEITCH - Yes. We know there is still a bit of hesitation with older people using mobile phones. They quite often have them, but they have them turned off to save the battery. This type of technology may have some merits for integration into an alarm-type of system as well. We are talking with an investigator at CSIRO about the potential of

using that type of technology. He has investigated costs of some of the alarm systems and has been alarmed about the cost of them. I think there is better technology these days.

Mr VALENTINE - An effective alarm system can really take away a lot of anxiety.

Ms LEITCH - Yes, definitely.

Mrs TAYLOR - Technology should be able to do that very cost effectively in the future.

CHAIR - We probably need to wrap it up unless there are any burning questions. Thank you so much for your time and your submission. It was very comprehensive with the information you have given. We would appreciate copies of those other documents when they are available.

Ms LEITCH - Thank you.

THE WITNESSES WITHDREW