THE LEGISLATIVE COUNCIL SESSIONAL COMMITTEE, GOVERNMENT ADMINISTRATION 'A' SUB-COMMITTEE INQUIRY INTO RURAL HEALTH SERVICES IN TASMANIA MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE, HOBART ON FRIDAY, 26 NOVEMBER 2021

CHAIR (Ms Forrest) - Welcome to another day of our rural health inquiry hearings, and apologies for previous cancellations. I think you are fairly familiar with the process, but this is a public hearing. Everything you say is protected by parliamentary privilege. It is being recorded and broadcast. If there is anything of a confidential nature you would like to share with the committee, you can make that request; otherwise, it is all public.

We do thank you for your very extensive submission, including the submission you made to the government process. That has been very helpful. I will get you to take the statutory declaration, then speak to your submission and make any other additional comments relating to that. Members will then have questions.

I think you know everyone at the table. We do not need introductions. Thank you.

Ms ADRIENNE PICONE, CHIEF EXECUTIVE OFFICER and **Dr CHARLIE BURTON**, MANAGER, POLICY, TasCOSS, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Over to you, Adrienne.

Ms PICONE - Thank you for having us along today. TasCOSS talks to a lot of Tasmanians, particularly Tasmanians on low incomes and those in rural and regional areas. When we ask them what they need for a good life, what we hear over and over again is health. Health is everything; health is number one.

As an organisation, we are very supportive of that and agree with that statement. Our goal is really around Tasmanians having the support that they need to live healthy lives. In support of this goal, we have two key targets. The first is that Tasmanians can get affordable, timely, high-quality, whole-of-life-oriented primary, secondary and allied health care - and that includes physical, mental and dental health. That is about having the care where and when you need it. It is also about all Tasmanians being supported to prevent ill health, and to promote good health and wellbeing.

As you mentioned, Ruth, TasCOSS made a submission to the Our Healthcare Future process. In our submission we noted that Tasmanians living in rural and remote communities face compounding inequities in access to healthcare services which, in turn, has an impact on rural health outcomes. For example, Tasmanians in outer regional areas have far worse self-assessed health than their urban counterparts. We know that across Tasmania, around 29 per cent reported fair or poor health in 2019, but on the west coast, for example, 45 per cent of people self-reported that they had fair or poor health. In the Derwent Valley, 38 per cent, and George Town, 31 per cent. As a state, we should never accept these kinds of disparities.

We also know that some population groups experience more difficulties accessing health care in rural areas - particularly women, young people and LGBTIQ+ Tasmanians. These disparities in health outcomes partly stem from inequities in health access. Tasmania's rural areas have the nation's second-lowest rate of GPs per 100 000 residents. Our ambulance

response times are significantly longer in areas outside Hobart. We welcome the attention to the rural health workforce in the recently released Health Workforce Strategy.

Digital inclusion is an area that TasCOSS has quite a strong focus on more generally across our work, but specifically in health, because we know that increased use of digital technology will improve access and outcomes for many Tasmanians - but for many others, the shift to online or digital services will only exacerbate their exclusion. This, of course, is worse in rural areas with the challenge of connection, affordability, and digital skills being exacerbated.

A TasCOSS health literacy report produced in 2021 found that while digital technology could improve access to health care for many Tasmanians, for many others it was actually a barrier to getting care. That report found five areas of challenge -

- cost of devices
- data access
- digital literacy skills and literacy skills
- being able to navigate services
- the user experience.

So, there are a number of challenges, which I know you are aware of, but we also think there are some opportunities at the moment. I guess key to that is the Tasmania Statement. We were really pleased that the Tasmania Statement, after the review being updated this year, acknowledges the impact of poverty on health and wellbeing, for current and future generations.

This, I think, provides us with an authorising environment to embed a better health and antipoverty lens across all government activity, and in the context of the current inquiry, particularly in rural areas.

Other opportunities we see are the Healthy Tasmania Five Year Strategic Plan, and the Our Healthcare Future reform process. Both of these initiatives have the scope to include a focus on rural health, which we would encourage. We are quite keen to hear from you about how these pieces of work in this space are going to be connected up, or aligned, so that we are actually all moving in the same direction.

Finally, our recovery from COVID-19 presents an opportunity to invest in the health and wellbeing of our population so that we can better withstand future disruptions, whether these are health, economic, natural disasters, or some combination.

Of course, we should not have needed COVID-19 to bring our attention to this, but COVID-19 has actually shone a spotlight on this, and PESRAC has also acknowledged it. We really think it is incumbent on us all to be doing something about it and lifting some of the health outcomes for Tasmanians - specifically rural Tasmanians.

CHAIR - You listed a range of barriers to digital literacy. Was there any breakdown into age groups? In some respects, we imagine older people may have more barriers, but it may not necessarily be. Was there any breakdown of data, because different approaches are needed to address each of the barriers, I would think?

Ms PICONE - Older Tasmanians are definitely disproportionately impacted, as well as Tasmanians with low levels of education, and Tasmanians on low incomes. These specific groups were the ones most impacted, particularly during COVID-19.

In Tasmania, we have the lowest rates of digital inclusion in the country, and that gap between Tasmania and the mainland is actually getting wider. So, we really need to do more in that space. As I said in my statement, if we do not start to invest and set some targets in digital inclusion, it will actually have a real impact on people being able to access health services.

CHAIR - When you say to set targets, I think targets are sometimes often used as a way of avoiding making a decision.

We have a federal election coming up and the state Government is also doing reviews of various areas. If you had a wish list of three things you could do to make the biggest difference to the factors you have identified, what would they be?

Ms PICONE -I guess it is around the challenges. One is actually having access to a device. We saw during COVID-19 that a lot of families, for example, were all trying to use the same smartphone because it was their only internet-connected device. It is about having a device. It is about having data, and it is also having the literacy skills. We would like to see a greater investment in those areas. We have made suggestions around things like telco concessions for eligible Tasmanians, so that they are actually able to afford data, and to boost community-based digital literacy initiatives, and grants for community services organisations to allow service users to access devices and data. They are some of the recommendations.

Dr BURTON - Another suggestion that would be worth considering is based on a Smith Family model, and also what is happening in the ACT, where all government school students get a device, and those students who need it get access to data.

CHAIR - At home?

Dr BURTON - Yes, they take it home. We know from the Smith Family program that grandparent carers can have access to the student's device. There is also tech help so if the child comes home and needs to do their homework online and the grandparent has no clue, they can call someone up and have that talked through. That is extremely valuable.

One of the things the program has demonstrated and why you get quite a bang for your buck is the ripple effect. It's not just the student who is able to learn from home, the family also has access to a device and they have the support to be able to use it. That, to us, is a terrific model. We have advocated for investment for all Government school students to have a device, ideally from upper primary levels, but certainly from high school and for those students who need it to get a data allowance.

Ms LOVELL - Charlie, where did you say the Smith Family has that program? Is it here?

Dr BURTON - In Tasmania.

Ms LOVELL - They do, great, thank you.

CHAIR - Have you done any modelling as to the cost?

Dr BURTON - We did. We put in a budget submission, I think, last year. It has been a long year so off the top of my head I can't remember. I can get that figure for you.

CHAIR - It would be helpful to have some idea of what the cost would be. Have you done a cost benefit analysis in terms of the improvement in digital and health literacy or literacy generally?

Mr BURTON - It's more self-reported, so not in terms of how they've increased on the digital index, for example. The Smith Family has reports showing self-reported improvements in confidence, skills and access.

Mr DUIGAN - I am interested in that. What aged kids would you be providing a device to?

Dr BURTON - If it was high school only, 12-13 years old, through the high school and college years.

Mr DUIGAN - Do most of that cohort of kids have devices? In my experience, they all do and they're all glued to them. My experience may not be -

Dr BURTON - My children have at least two or three devices, but in many Tasmanian households the only device is a parent's mobile phone and maybe a child's mobile phone, which is pretty impossible to navigate school work on.

I've been speaking with the Department of Education to try to get a sense of how widespread the problem is. On a typical year, maybe around 3500 school students have a device loaned to them. During COVID-19 that increased by about another 2500 students.

Mr DUIGAN - Loaned to them from?

Dr BURTON - From the Department of Education. That tells us that there's at least a couple of thousand school students who, on a normal day, wouldn't have a device capable of doing online learning at home. While the department says schools design learning programs based on what their students have a capacity to do, it is very worrying that, for example, Friends School has a one-to-one ratio of student to device but other schools have a five-to-one ratio, for example. This means that digital divide within Tasmania is just going to increase as Friends and other schools' students accelerate their digital skills no end and others are crowding around a single device. That is a concern.

CHAIR - What I heard from Montello Primary School, and I know it's a primary school not a high school, but during our lockdown everything had to be put into hard copy in packs. Even then a lot of it didn't get through.

Ms PICONE - The ACT model is just high school, so years 7 to 12. What they're recommending is that it probably would be better to start at upper primary, from grades 5 and 6 through.

Dr BURTON - The other thing the research showed is that we know that the No Interest Loan Scheme provided loans for devices for learning throughout COVID-19. We know that digital technology is an essential service nowadays. If it is essential to learning then families should not be taking out loans to access what should be a basic educational right.

Ms LOVELL - I know that through COVID-19 the Mental Health Council used some funding that wasn't tied to buy devices or to buy data so people who needed to access mental health support online, who wouldn't ordinarily be able to do that, could.

Dr BURTON - Yes, TasCOSS also facilitated what we call essential technology funding. Getting back to the health topic, we knew that greatly assisted providers in our sector to get devices for their staff to quickly provide services online, train the staff in how to use it, and also, in some cases, lend devices to their service users who needed them to access the services that weren't being provided face to face. With digital health, to ensure access is equitable there should be a permanent technology fund for health and social care providers - because we know social care is essential to health outcomes - to be able to provide devices to their service users.

Ms PICONE - I agree. It is two sides of the coin. It is one thing about the individuals having the devices or having the capacity to utilise the services, but it is also about the services being appropriate and being assessible for people. Having that dual funding during COVID-19 was almost like two sides of the coin. It was one about the individuals but also about the service providers being able to provide services.

CHAIR - One thing you have not touched on yet is dental care. Do you want to make any comments? Dental services is one of our terms of reference, in terms of the availability and timeliness and barriers. Would you like to make some comments around that and the impact as well?

Dr BURTON - Yes, sure. We know that access to dental care is a massive issue in Tasmania because of the out-of-pocket expenses that are involved, particularly in rural and remote areas. I think you heard from John Kirwan only a few weeks ago around their activities in that space. They have recently been expanded to deliver more oral health care.

Part of the problem with that, though, is that while the RFDS model is no out-of-pocket costs, because this is a state-funded expansion, they are asking a $45 co-payment fee. The people we are talking about are sometimes missing out on buying food in order to put a roof over their heads and pay the energy bill. They don't have $45 so they put off dental costs. It becomes intergenerational to the extent that we hear of some young people going to Oral Health Services asking for all their teeth to be removed because that happened to mum and dad and they were fine.

CHAIR - When you say young, how young are we talking about?

Dr BURTON - Teens.

Mr DUIGAN - How common is that?

Dr BURTON - It is not uncommon. I couldn't give a figure on it. I am not sure if the Oral Health Services made a submission to the inquiry but they would be very happy to talk to you, I'm sure.

Dr SEIDEL - Specific youth fund available as well, specifically used for dental care in teenagers, in particular teenage girls. It is a confidence thing.

CHAIR - Social inclusion.

Dr SEIDEL - Social inclusion.

Dr BURTON - Yes and we know The Link health service in Hobart was for a while providing some funds for people to get braces, orthodontic care. They have had to stop that and there have been some efforts to bring in some pro bono providers to do orthodontic work for young people because we know that has ripple effects. People are ashamed of their teeth so they don't seek employment and that kind of thing. That would be a terrific investment.

CHAIR - There is also the impact on the increased rate of premature birth with poor dental health, so you are starting behind the eight ball as a little kid, a baby. How do you see a more equitable and inclusive dental service in Tasmania, acknowledging that it is not covered by Medicare and it really is a federal government responsibility in that respect? What is the solution? In an ideal world, blue sky stuff.

Dr BURTON - I know St Lukes Health is interested in this issue in particular, finding ways to make some inroads into the affordability of dental care in Tasmania. Again, no solutions but -

CHAIR - Increasing access, is that what they are focusing on?

Dr BURTON - Yes and possibly lower cost services. I'm not exactly sure how that would work but it would be a combination, perhaps a co-funding arrangement, where the state Government provides some possibly health funds, maybe a co-payment.

Ms LOVELL - What we always know is that children and young people often go to the dentist because it's free through the department but for adults and with the waiting lists, people are going for long periods without going to the dentist.

What we're also hearing is, because the waiting lists really blew out over COVID-19 and there's still that backlog, it's also about having skilled dentists in Tasmania, being able to attract skilled workers here to be able to keep up or knock off that backlog and start to address it. It's similar to what's happening, I think, perhaps more generally in health. It's one thing about people being able to access but you have to have the services there where people can access them.

CHAIR - Dental co-payments are still a thing here, aren't they? We did try and get rid of that a few years ago.

Dr SEIDEL - Can I stay with the co-payment and cost theme? When you made your introductory comments and also in your submission, you said it's important that all Tasmanians can get affordable primary and secondary health care. You don't say free but 'affordable'.

Let's try and be a bit more specific because it's quite an issue, isn't it? We know in primary general practice, out-of-pocket costs are a thing and we know they're rising. If you

look at statistics we have six per cent of all Tasmanians who are avoiding going to the GP because of cost. You could argue that is only six per cent, it doesn't really matter.

We see that even in community nursing, when patients attend community nursing, they are now being asked to pay for dressings, for dispensing fees as well in case they need some medication.

So how do you define 'affordable'? What sort of work has TasCOSS done or is aware of that potentially says it doesn't have to be free but it has to be affordable, if that's the view of TasCOSS? What does it mean for health services in rural areas?

Dr BURTON - There should be much more bulk-billing at doctors. But you would know it's a combination of decisions of private practice and Commonwealth Medicare rebates, so we recognise that there are limited levers, as a state, that we can pull there. If we could encourage more bulk-billing doctors, particularly in rural and regional areas but across the state, that would be ideal. Ideally, again, no co-payments for dressings and that sort of thing, or minimising it. Perhaps subsidies for patients on concession cards, that kind of thing.

Ms PICONE - Six per cent might not seem like a big figure but when you think about the flow-on effect of what that means, that if people are not going to the doctor in those early stages of a condition, then what we know is they often end up in the emergency department and we all know the flow-on effect that then has. I think it is quite a significant issue.

I don't know if we have a dollar figure on what 'affordable' means but I agree, the more we can have as free so that people can see going to the doctor as something they're not trying to put off and trying to avoid because they are too worried about the cost, and where they have to make that choice about whether they eat tonight or get their condition seen to.

Dr SEIDEL - You mentioned, Charlie, I think when you said $45 for dental care, that's too much. I think that's probably a firm view yet that's the amount that's out there. Are you aware of any research that calculates or suggests reasonable out-of-pocket contributions for people who have limited income?

Dr BURTON - I'm not aware but I would suggest that this is one of the areas where initiatives like Our Healthcare Future can speak to Tasmanians themselves and understand from them what they are able to afford in relation to health care and a better understanding of some of the trade-offs they make when prioritise their health care. For example, over rent or energy costs and that kind of thing.

Dr SEIDEL - There is sort of a myth out there, for example, just talking about general practice that general practice is just a federal thing that the state can't be involved with. It is actually not true; the state can be involved if they want to, and can fund it in any way or form. Private general practitioners really do not care where the income is coming from. Really couldn't care less. It just has to come from a lever and the lever is either the patient, whether that is through Medicare rebates or other contributions; the Commonwealth whether that's through Medicare rebates again or incentive payments, literally; or the state, or other things.

Is there a view that general practice or primary care, in particular, would need to access all those levers because otherwise we have an obvious gap?

Dr BURTON - We know, for example, there are lots of levers that aren't being accessed. In our Budget submission we made previously, and through work with Primary Health Tasmania - they have done some great digging of data for us - the estimate is that only about 17 per cent of eligible adult Tasmanians have a chronic disease management plan.

A rough estimate only looking at those untapped plans, that is $38 million a year of Commonwealth funding and health funding that isn't coming into Tasmania. Those Tasmanians who need various services to look after their chronic diseases are drawing on state funds or possibly paying out of pocket.

We think there is an opportunity to look much more closely and encourage service users, patients, as well as health professionals and allied health professionals, to understand the kinds of Commonwealth payments that are available which are not currently being used.

Ms PICONE - Can I just go back to the co-payment, too, to contextualise that $45 might not seem like a lot of money but if you are living on JobSeeker, that is one day of your money that you receive from the government, so that you need to go without and that is already stretched very thinly. It is actually a significant amount.

Dr SEIDEL - Sometimes I read letters in the Tasmanian newspapers about that we should just charge a co-payment in emergency departments because of the problem of people attending. What is TasCOSS's view on that, if we started charging?

Dr BURTON - People are arriving at the emergency department because they are in dire need, so if they are turned off from going because of the co-payment, then the mind boggles to think of the state of health of the population as a result.

Dr SEIDEL - Wouldn't make sense, would it? Is there a view of charging a co-payment for ambulance call-outs or having a private transforming of the ambulance system from Tasmanian-style to Victorian-style, where it is insurance-based?

Dr BURTON - No.

Ms PICONE -. The previous Labor treasurer tried to do that.

Dr SEIDEL - Can I ask you why you think it would not work? Why is that nonsensical to start charging a fee for those that say 'urgent and critical for our services'?

Dr BURTON - It 's like a regressive tax. A fee like that, where everyone pays the same regardless of their income, is regressive. We already know that Tasmanians put off seeing the doctor. While they might go to the doctor, we know that many do not follow through with the care that the doctor prescribes, whether it is getting a prescription or seeing a physiotherapist or an occupational therapist. We know that those costs stop Tasmanians accessing the health care they need. That is why we have some of the highest rates of preventable hospitalisations in the country. Adding yet another barrier, a cost barrier, will decrease our health outcomes even further.

Dr SEIDEL - You also mentioned in your submission, and when you made introductory comments, about the timeliness of services. You gave the example of ambulance services where we have quite appalling response times in regional areas. Now the current (inaudible)

is that people know where they live, they just need to put up with that, if it takes longer, it just takes longer. We just can't ensure that ambulance times are consistent throughout Tasmania. Is that something you believe is just the way it is?

Ms PICONE - No. It comes down to human rights and our right to access effective, accessible, appropriate health care no matter where you come from. We talk a lot about Tasmania being a compassionate society. It is not very compassionate to actually expect a group of people not to be able to have affordable and accessible health care.

Dr SEIDEL - So you would say ambulance response times for call-outs in Queenstown or Zeehan should be the same as they would be for Sandy Bay?

Ms PICONE - Yes.

Dr SEIDEL - Do you think that is realistic?

Dr BURTON - Depends on how we prioritise health care.

Dr SEIDEL - Do you think it should be prioritised? Do you think it should be the same? I am just saying that because there are countries out there where that is the case. In Switzerland, with lots of mountains, the response time is seven minutes. Germany, if you are living on an island, response time is seven minutes. They just make it work, not because they decided that's a priority for them; it is just the same response times, no questions asked. It is free, too. Is that something TasCOSS would believe in for those essential emergency services - that it doesn't matter where you live, you should have the same access to emergency services when you actually have an emergency?

Ms PICONE - Yes, we would. As Charlie said, it comes down to choices. It's about how we invest our resources and what we prioritise. While it is about having a good response approach, it also comes down to preventive health - how we actually get into communities in the first place so that fewer people are ending up needing to call ambulances or ending up at emergency. The OECD recommends 5 per cent of the health budget should be invested into preventive health. We are a fair way off that right now -

Dr BURTON - 1.7 per cent

Ms PICONE - Yes.

Dr SEIDEL - And that includes roads and walkways.

Dr BURTON - Yes, and possibly parks and playgrounds, which also are a part of preventive health. We are yet to get a full breakdown of what that preventive spend is.

Ms PICONE - We do know it hasn't increased for a number of years.

Mr GAFFNEY - Charlie, it was interesting when you said about accessing buckets of money, like that $38 million, and how to get that out there. If you can send the committee some more information about the buckets of money that Tasmanian health services are not accessing, I think that would be of interest?

Dr BURTON - Yes.

Mr GAFFNEY - If you can put that on your job list, it would be helpful for us to have more information.

CHAIR - Just tell Jen. Make sure she has that one.

Mr GAFFNEY - You talk about rural areas having fewer services, such as one general practice, two general practices. I have had people tell me that they haven't been able to get into the general practices because they are not taking on new clients - especially people relocating from the mainland, or somebody from a migrant background who may not have the networks. You know how Tasmania works - if your grandfather or grandmother goes to a doctor, you can get in to see that doctor.

CHAIR - Not always.

Mr GAFFNEY - Have you any comment about services for new clients, or new people, or migrant backgrounds?

Dr BURTON - We know from research we were doing for the hospitalisations submission that across Tasmania, not just in rural areas, many clinics are not taking new patients - or they are taking new patients, but not bulk-billing them which, as we know, excludes a lot of people. You would literally need to ring the different rural clinics to get that figure.

Mr GAFFNEY - If we step down from that, instead of person A having to ring around five different places to get in, surely we could design a one-stop shop where you contact one, and then they can say, 'Well, look, there's an opening here, here or here'? So, a hotline service that is not just a 1800 number that puts you on hold, but more of a personalised service? Has TasCOSS thought about, discussed or have any ideas on that?

Ms PICONE - Health Consumers Tasmania has made some recommendations around that. I'm not sure of the title, but it is almost like a navigator program, and I think it is about that human-to-human connection. We know we have a whole group of people who need to be able to access services online or go to the doctor easily. Some people are going to need some support to be able to access those services, and it really does come down to having the human touch and putting people in touch with each other, making those connections.

Dr BURTON - Yes. Health Consumers Tasmania was funded in the most recent state budget to set up community health and wellbeing networks, and they will be designed in communities according to what those communities need, which is fantastic. We have advocated for this for a long time. Everyone says 'place-based', but communities know what their health needs are and where their gaps are, so this program, which will kick off next year, will ideally do some of that navigating.

There's another kind of element to that, particularly in rural areas where there are thin markets in terms of health and allied health and other support services. We're great fans of models that recognise the social determinants of health. Ill health doesn't happen in a social vacuum. So, someone can have a health navigator, as well as a physio or OT, as well as their

GP, and maybe a specialist in the one area. We know transport is an issue, with people trying to travel around from provider to provider; it is just too hard in many cases.

Ms PICONE - As much as possible, we're advocating for taking health care to the community - very much that place-based approach. Navigators is an area that I think is really growing. There are youth navigators at the moment. Three navigators have been established across the state, with three more to come. COTA Tasmania have some navigators who support people to navigate the healthcare system for older people, so they can actually engage in it.

Mr GAFFNEY - Looking at what Bastian was talking about regarding the ambulances and the Swiss, and how they've just decided to do that, I sometimes get frustrated that there's something put into the system that seems to be working, but the funding is for two or three years and then it just drops out. There's no long-term sustainability of those programs that are working well. I'd be interested in a comment on that from TasCOSS.

CHAIR - Are you talking about review of those programs, to assess whether they should continue or not?

Mr GAFFNEY - Have you seen programs that you think have been working, and then suddenly there's no funding, or we get a new government and they want to rebrand it as something else? It happens all the time. Do you have any comment?

Ms PICONE - I don't know of specific programs; Charlie might. I guess it's fantastic that we're having this conversation and other conversations across the state about health, but what we really need to be doing is making the choices, putting the investment in and actually starting to get some action.

Dr BURTON - There was an anticipatory care project that was recently reviewed by UTAS and another evaluating organisation. Projects like that identify or target people at risk with chronic diseases, and tryto make sure their care doesn't deteriorate. These are the sorts of things where we learn a lot about what works well and what doesn't, and then people move on, or priorities change at the government level or whatever, and nothing ever happens.

We've had review after review. We know what the problems are, we know what many of the solutions are, it's just a matter of will to put the solutions in place.

Dr SEIDEL - Specifically on this, do you think it's just the political will to make it work? Do you believe we have all the evidence, the knowledge base is not really going to change or make a difference, so we should just get on with the job now?

Dr BURTON - Consumer voices always have to be upfront and are key. The needs of health consumers will change, and do change, over time. The demographics of a small area, small town or whatever, will change, and so the focus on the health needs of older people might need to shift to health needs of younger people or minority populations, for example.

Having said that, there are innumerable national and international reviews of how we can provide better care, and better preventive care. It's ultimately a matter of political will and where you choose to put your dollars.

Dr SEIDEL - What do you think are the barriers? Do you think there are certain special interest groups who are part of the problem, who would oppose change? Is that an issue, or is it just all too hard, too complex, it's health, let's not touch it? Or something else?

Ms PICONE - It is complex. It is an entrenched problem here in Tasmania, because we know that we're pretty much sitting at the bottom in most areas. We know what we need to do, and it is really just a matter of starting.

CHAIR - Touching on the navigators. I had a personal experience assisting my elderly father to navigate the health system. In doing that I spoke with lots of other people and other family members who were doing similar things. It became apparent to me that, particularly with older people or people with low literacy levels generally, they find it very difficult to comprehend all the messages they are often given in a medical appointment. There is often a lot of information given to them. Sometimes it is provided in writing. That is fine and good, because at least it is written down, but if you can't understand it that is just another barrier.

I acted like the advocate. During the appointments I would translate from doctor-speak to parent-speak, which was a really effective way to do it. I thought, how does everyone else get on? The navigator system is a different thing. This is a direct, individual advocacy role with a person who will struggle to understand - which is just about everyone who does not have a health background - the messages they are getting from their GP, their specialist. Is there any value in a model like that and how would you do it?

Ms PICONE - I have also had to navigate aged care and it is very complex and difficult to navigate.

CHAIR - Yes, and NDIS is a whole new beast.

Ms PICONE - Absolutely. Many people would not have the support person like yourself. We need to build in lots of different ways we can help people to navigate these kinds of systems. It might even be an investment we make; it's almost an extension of the navigator program, potentially. Or make it an advocacy role.

Dr BURTON - There is also, I am not sure who is sponsoring it, an initiative called Teach-Back, where GPs in particular are being encouraged to not just deliver the health information but then actively ask their patient, 'Tell me what you have understood of what I have just said', whether they can get the right pills in the right order or whatever. They might need to communicate in a slightly different way. It potentially takes more time, but it is about educating, it's a health literacy issue for health providers to better ensure the people receiving their care understand what is being asked of them.

CHAIR - If you don't understand why you are doing this, people are unlikely to do it. It doesn't make sense to them. Teach-Back obviously takes more time in a consultation. Medicare is pretty ordinary in terms of, how long is a regular appointment, three minutes? How long is a regular appointment, as opposed to a long appointment?

Dr SEIDEL - I can tell you what the average appointment is. The national average appointment time for GP consultations is 11.9 minutes. It is actually quite long. The idea there is six-minute medicine out there is a myth. The question is, what is financially viable for a

bulk-billing practice? That would be six minutes. You have to get people in and out within six minutes, otherwise it is just not viable.

CHAIR - That is what I am saying, you can't really do an effective Teach-Back, for example, in six minutes if you have a patient with a number of complex health issues.

Dr SEIDEL - Impossible.

Ms PICONE - Even in 11 minutes.

CHAIR - What would you recommend to address that very real challenge for GPs and the patients they care for?

Dr BURTON - It could be a follow-up. We are not experts in health provision. We think a lot about person-centred care in various settings. It may be that there is someone employed by a practice who does the follow-up once the patient leaves the clinician's office and can talk through the instructions for the medication, this is who you need to see next.

CHAIR - Currently, that is not a Medicare-funded service.

Dr BURTON - No.

CHAIR - So, it has to be fitted into the operations of a GP and funded through their own business.

Dr BURTON - Funded from somewhere.

CHAIR - So, there is an avenue. That is where the state could, perhaps, come in and assist.

Mr GAFFNEY - We've all seen when we've gone into a general practice the staff are flat out behind the desk taking payment and organising. When someone has come out from the doctor they should be able to sit and talk to somebody who asks, 'Do you fully understand, are there any other questions?'. Somebody to debrief from the GP if the GP does not have time.

There has been a lot of talk recently in the media about allowing professionals to do their full scope of practice, whether they are a nurse practitioner or a paramedic or -

CHAIR - A pharmacist.

Mr GAFFNEY - Pharmacist, yes, those sort of things. Is there any comment from TasCOSS? Have you done any studies or have you any feedback for us about that type of model of care?

Dr BURTON - Yes. Health Consumers Tasmania recently did a kitchen table session in the Tasman and heard from residents there that they would really value nurse practitioners, for example, and access to other providers when they can't see a GP. A pharmacist too. Again, that's not our area of expertise but there are certain ways to provide additional care without necessarily needing more GPs.

Mr GAFFNEY - Any feedback regarding the different roles that pharmacists have been able to play during COVID-19, such as more injections, they have been hands-on?

Dr BURTON - Only a personal reflection that I went to a pharmacist for my flu shot and it was easy. Normally I go to the doctor. No, I haven't come across it.

Ms PICONE - No.

CHAIR - It's the national immunisation program vaccines that they can't give and that's the problem.

Mr GAFFNEY - That's the problem.

Ms PICONE - The mobile vans for the COVID-19 vaccinations have had a significant impact. That's about taking services to the community.

Mr GAFFNEY - It would be interesting to find out because I think there's more community confidence now in allowing other health professionals to have access to your body. That has changed in conversations I have had, especially with older people. Instead of waiting for a long time in the doctor's surgery they are more than happy to just go and grab a shot and get out.

CHAIR - Thank you very much, Adrienne and Charlie. We appreciate your submission and input today. All the best.

Ms PICONE - Yes. Thanks.

Dr BURTON - Thank you.

THE WITNESSES WITHDREW.

CHAIR - I will do the broader introductions. This is a public hearing. It is being transcribed by *Hansard* and also being broadcast. Everything you say in front of the committee today is covered by parliamentary privilege but that may not extend when you leave this room. If you have anything of a confidential nature you wish to share with the committee, you can make that request and the committee will consider it but, otherwise, everything will be on the public record and will inform our later report. Do you have any questions before we start about any of that?

I will just introduce the members of the committee: Nick Duigan, Sarah Lovell, myself, Ruth Forrest, Bastian Seidel, Mike Gaffney, and our secretary, Jenny, down the end and *Hansard* and assistant secretary. We would ask you first to take the statutory declaration. If both of you are going to speak, I would ask you both to take it and then you can speak further to your submission. We appreciate the submission, and we will have questions for you after you make some opening comments.

Ms TAMARA MICHELLE DICKSON, MANAGER, TASMANIAN STATE OFFICE and **Mr PETER ALAN MOORE**, CHAIR, RACS, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - I invite you to speak to your submission.

Mr MOORE - I am Peter Moore and I have taken over as the chair of the Royal Australasian College of Surgeons state committee from David Penn since the submission of this. That's why it was prepared by David and not by me. Thanks for reading it. There is some good evidence in the attachments there as well that I think are definitely worth reading. One is from the College of Surgeons, the definition of 'rural', because in some ways Hobart itself can qualify as outer metropolitan, it doesn't have the full slate of surgical services which we rely on in Melbourne. Then everything from Launceston to Burnie to the islands are a prime example of what we look after in the north. You could, in one way, lump all of Tasmania into 'rural' from the college's perspective. But, primarily, outside of Hobart, we'd consider what we would call rural, lumping everything from remote, regional into that one thing.

Clearly, the biggest problem we find is access to services. That can be a combination of the availability of services, like spinal services, which we used to provide in the north of the state. Unfortunately, as a single operator, it can be very, very difficult. That gentleman, David Edis, has now moved back to Melbourne.

The same with vascular surgeons. We used to have vascular surgery performed in the north, which would provide services, obviously, to Burnie. Unfortunately, as a sole operator in conflict with the Government, with the Tasmanian Health Service, as I am sure you are aware, he has moved on to another state. So, now we have rotating services coming up from Hobart but that doesn't provide us the 24-hour cover we necessarily always need.

With impending shortages of ENT as well as urology services, we currently have one ENT surgeon in the north west, in Burnie, who doesn't really do on-call. We have four practising ENT surgeons in Launceston General. Two are fellows of the college, one is a specialist international medical graduate who hasn't completed his exams yet and one is going through the assessment process. Gavin Earles retired last week, so now we're down to four. One of our surgeons broke his foot last week, so now we're down to three.

The college recommends, for lifestyle as well as the longevity and sustainability of the services, that anyone participating in an on-call service should regularly do no more than one in four. That's going to provide a significant impact on the services we are able to provide up there.

Long waiting periods are obviously a big problem. As you have seen in COVID-19, two years ago, unfortunately, Launceston General was having lists restricted due to funding. Lists were being rotatingly closed between specialties. Now we've had a pandemic, which put external pressures on, and we haven't been able to catch up on the waiting lists at all.

The wait times, if you look at it, are very sub-specialty-dependent. I know, I was at the State-Wide Surgical Services meeting a few weeks ago, there has been report of a drop in the overall number of people on the waiting list. However, if you look at some specialties like orthopaedic waiting lists, our bi-monthly audit last week showed that our waiting periods and the number of people on our waiting lists are increasing.

CHAIR - Which sub-specialties have dropped? This is my argument a lot of the time - you do the quick and easy ones, so which sub-specialties have improved?

Mr MOORE - Well, it will be things like plastics or ophthalmology, where you can get a very high turnover of cases and you can do it quickly. You can attack -

CHAIR - You can even have an ophthalmology blitz with a heap of cataracts. I have done those back in the day.

Mr MOORE - At the Australian Orthopaedic Association annual meeting, they looked at the number of people on our waiting lists across all three health services for joint replacements: equal, it would take three years to do that number of joint replacements.

CHAIR - Just the ones on the list now?

Mr MOORE - Yes. Say, there are 1000 people on the waiting list, we're doing 300 or so a year in the public system, so you have to do three years of work just to clear the backlog, not to mention the increasing numbers coming through. That's a bit of a problem.

The other thing that dramatically affects surgeons, not necessarily in this report, is access to anaesthetists. Some of these hospitals, Burnie, Launceston, have kind of a critical number. It only takes one or two to retire or get sick and not be able to work. It provides an extraordinary amount of pressure. So, yesterday I was writing a letter to try to get support for an IMG to be accessed to be able to do work in private. He's an SIMG who is still under his moratorium.

CHAIR - Tell us what it is for the purpose of the record.

Mr MOORE - An SIMG is a specialist international medical graduate who obtained their qualifications overseas.

Medicare considers that Launceston isn't an area of need for anaesthetics. If you look at the number who live in Launceston, we should have enough per head of population. But that doesn't always account for the population that we provide services to. From the Government's

perspective, if you guys can liaise with Medicare for more flexibility so that it's not such a drawn-out process when we do need people to be able to provide extra care.

Dr SEIDEL - Can I chip in there, Madam Chair, specifically. That's an important point you make because we said we are not looking at Launceston or Hobart, specifically, in this inquiry. But as you pointed out, you are serving this huge area in the north, in particular for specialist surgical services. So, although Launceston is not an area of need for specialist surgeons, considering that the area you serve includes Latrobe, Devonport, Burnie, St Helens and the islands.

CHAIR - Circular Head and the west coast.

Dr SEIDEL - That's right. That's all part of what you do because there just is no specialist surgery service in Burnie nor at the Mersey Hospital. The classification and the work for classification is nonsense, isn't it?

Mr MOORE - It can be for certain areas, yes.

Ms LOVELL - I just can't get my head around why that is because, essentially, I presume that they would do the same for Hobart - define Hobart as a particular area. Most of the population of Tasmania is just not taken into any account in terms of the services they're accessing at those hospitals.

Dr SEIDEL - They need more hospitals up in the north. That's why it doesn't make any sense. It's a nominal hospital with the same service. They are withdrawing the doctors there though, shift them off. You need to transfer the workforce shortage classification and that's not being done.

CHAIR - Let's move back to rural health. Is there anything else you want to add? I want you to focus in on a bit about what this means for our rural health services. You clearly identified some of the barriers to throughput to deal with the patients who are on the waiting list and need surgery in our major hospitals, Launceston and Hobart. What's the impact in terms of your practice?

Mr MOORE - In what regard do you mean the impact?

CHAIR - If patients are having to wait longer, what does that mean for them and what does that mean for the rural health services, the GPs and such looking after your patients that you haven't got to yet?

Mr MOORE - One example is the impact on general practitioners, that they now have to manage people who are in chronic pain, when it takes them years to get to their surgery date for their joint replacement. For example, it'll take them a year before they're seen in clinic. My waitlist is probably about 600 days so they'll wait 600 days before they get that joint replacement. That will mean repeated admissions or presentations to the general practitioners, looking for scripts for pain relief, ongoing use of physiotherapists and other ancillary services to try to manage their symptoms until they're able to be treated.

CHAIR - If those people, as a general cohort, access the surgery within a reasonable time frame which, if it was me, I'd want it straight away, but within three, four or five months. I

think people accept that they have to wait a period in the public system. What would that mean in terms of the conditions of the patients you see, like their general health and wellbeing, and what impact do you think that would have on the flowback effect to GPs and other services?

Mr MOORE - It would have a huge impact, I think. People, they do decondition; especially with a lot of surgical services, they become surgical pathologies, they become debilitated, they lose their capacity to work for a variety of different functions.

CHAIR - Tell me what you know about this.

Mr MOORE - A lot of people lose their capacity to work. They have to be cared for by other family members who may also be pulled out of the workforce. Regular GP presentations. They also have repeated clinic appointments, so then they have to keep coming back to the GP every week, or get numerous letters from GPs to upgrade the person on the waiting list. It is incredibly difficult to say one person is more important than the other 200 people in the exact same condition.

Ms LOVELL - Is that harder or is that impact greater in what you see for people in rural areas, than say somebody who might be living on the Eastern Shore of Hobart, or in the middle of Launceston?

Dr MOORE - Definitely in the rural areas, because I think the more rural they are the later they are to present to the GP with their pathology. It takes them longer to get there. It is quite a long way to come into Launceston or down to Hobart. It definitely has a greater impact in that sense.

One of the problems we have in the rural areas is that we do not have the capacity to have these surges of funding blitzes and outsourcing. We just do not have the capacity because we are already at maximum capacity.

Dr SEIDEL - The Mersey Hospital is meant to be the elective surgery hub. How is that going from your perspective?

Dr MOORE - Because of COVID-19 and multiple other reasons, there have been times when it had to be downgraded because they did not have the 24-hour services and on-call doctors. But really, that is a lower acuity hospital because they do not have the full services of intensive care.

CHAIR - They get a lot of colonoscopy and endoscopies done.

Dr SEIDEL - But they do not do any elective surgery? They just do scopes. There is nothing like hernia repairs, for example. Are they being done there?

Dr MOORE - Because I do not work at Latrobe I am not sure of the scope of practice. I do know that it is reduced practice. They are not doing orthopaedic work there at all.

CHAIR - They were doing arthroscopies at one stage, I thought. But not anymore?

Dr MOORE - No. So, the majority will funnel to Burnie, but then Burnie has limited -

Ms DICKSON - The renovations currently going on are impacting some services.

CHAIR - That is the impact of the outpatient area where they are building the antenatal clinic. Is that the one you are talking about in Burnie?

Ms DICKSON - They are doing very extensive renovations from what we're aware of.

Dr MOORE - I think it is also impacting the utilisation of the theatres. I spoke to Jonathan Fong, the chair of the general surgeons section, yesterday. They are outsourcing some of their stuff, obviously to the private sector. The obstetrics is being done in the private, when that comes back that will mean that they will lose -

CHAIR - Not necessarily. Spencer Clinic will be gone. That is an area to be repurposed.

Dr MOORE - It has an impact.

Mr GAFFNEY - You made the comment about, you call them SIMGs? Also, the program to try to get more SET trainees. Are we still relying heavily on international doctors? What is the issue here, Australia-wide, about trying to get more doctors and surgeons from Australia? Why are we still behind the eight-ball? Are we not attracting so many people? Are we making it too difficult for people to get into the training? You guys looked at this.

Dr MOORE - There is a great paper here written by Bridgette Clancy which is 'Retention of Positions in Surgeons in Rural Areas' in the *Journal of Public Health*, published last year. Bridgette Clancy is an ENT surgeon in Warrnambool, Victoria, and they have look at all of that. There are multiple elements. That is why the College of Surgeons has come up with this rural workforce.

Ms DICKSON - Rural pathways to retain and attract specifically to rural areas.

Dr MOORE - You have to look it across the whole spectrum. We have to select people. We need to make sure that people from rural areas get into medical school from day one. They are more likely to go back because they've grown up and had a positive experience in an area. Then, when they're in medical school, they need to have experiences, we've been through that system. I was a rural-bonded scholar. I spent two years in a rural health program at the University of Sydney, so I spent two years in Orange and Broken Hill. That interaction with rural junior training is really important.

Then, you need to have pathways when you're an intern and resident. One of the problems in Tasmania is that we don't provide enough support for our junior doctors in the north and north west region. Burnie is a very popular place for medical students. This year in Launceston, they had more rural medical students who wanted to come than they had places. They are turning medical students -

CHAIR - That's been the case with the north west clinical school, too.

Dr MOORE - Yes, people love going there because when they interact with the doctors they have a great experience of medicine as a medical student. When they get into the work force as an intern or a resident, they flock away. Launceston is their second choice, everybody wants to go to Hobart. If they intern, then the next year they'll leave, which has us relying very

heavily on international medical graduates. These are medical graduates who have trained overseas and have their medical degree but aren't a specialist, so they want to come. The North West Regional Hospital is very reliant on IMGs to provide the junior medical work force. There are not clear pathways to get into surgical training.

Bridget Clancy has done an extensive review of the literature across the entire country of the strategies that work. Having people with positive experiences of rural life as well as rural practice means they're more likely to go back.

Mr GAFFNEY - You said they have to turn people away. I heard there were 54 places in the north west Rural Clinical School. Why do we have to turn people away? I don't understand that. Is that a funding issue or quality control aspect?

Dr MOORE - You've got to look at it as all of those elements. Cost comes into that. Your experience is impaired by the increasing numbers. The more medical students I have on the ward round, the less well I can get to know them and interact with them and give them a positive experience.

CHAIR - The competition, as an obstetrics rotation, to participate in births, you have student midwives -

Dr MOORE - Your experience is impaired by the numbers -

Mr GAFFNEY - It is a bit of a catch-22, isn't it?

Dr MOORE - Absolutely, that is a definite problem.

CHAIR - You talked about the rural-bonded scholarship. My son got one, too. I understand there is no requirement now, or they can't take his Medicare provider number from him any more. That was the power.

Dr MOORE - It has been a troubled system, I think, and they've had a bunch of issues.

CHAIR - What has happened to that system? That was particularly designed so that when you do your specialist training, whichever pathway you go down you're still bonded back to a rural area. He is working at the Albert in Melbourne, so that's not rural but he has not finished yet. Has that completely fallen over?

Dr MOORE - I think there are multiple arms to that program. There was the scholarship where people were offered money, then there was a bonded place where they had to return service -

CHAIR - To a particular place, rather than to a rural setting?

Dr MOORE - To an area of need. I always had the intention of working in a rural practice. During medical school, I had a very positive experience with it. They sent me to rural surgeons conferences, that interaction. Once I got into the workforce, I forgot about it because the return of service didn't really mean anything to me because I was going to do it anyway. I can't really give evidence on the finer details of that.

CHAIR - What do you think would be an effective model? We know how popular the north-west clinical school is because of that experience. How do you encourage that translation into not just surgeons, but GPs and others looking to stay in rural communities?

Dr MOORE - Talking to the junior medical officers may be worthwhile, to see what it is that drives them to have such a great time as a medical student and then leave. Ours is really just that anecdotal evidence that students love it, but then I know some of our interns come through and then they leave after one year.

CHAIR - So the problem is not in the rural clinical school, I am hearing you say?

Dr MOORE - The rural clinical school gives a great -

CHAIR - Yes, and then you get sucked into the vortex of the intern year, the residence year - and then we know how poorly doctors are treated in the hours worked, expectations, working with fatigue, that sort of stuff. Does there need to be more focus there in the intern and residency years, to make that a better experience? Because I don't think it is.

Dr MOORE - Yes, absolutely. What is in your control from the government's perspective is ensuring that the culture at the hospitals, and the treatment of the junior medical officers -

CHAIR - Let's focus on the Burnie and Mersey hospitals, because they're the ones we are looking at. They are the ones we particularly want people to come back to. What do you think the state government could do to actually make that experience better for them, and make them think, this is a really good place, I want to come back, I feel well supported, or whatever it is? Because they still have to go away and do their training.

Dr MOORE - Yes. I think we would make sure that they're well looked after in the sense that they are working in a culture where they feel that they can work, and the hours they're being paid are not contested. You know, it's a regular experience where people feel that their overtime isn't kind of paid -

CHAIR - So their working hours are not being paid for?

Dr MOORE - That's the perception from the interns in residence. That's how they feel. I haven't spoken to the residents there but, as a whole, it's an issue that is raised by juniors.

Then, also, trying to really focus on recruiting the best people in giving great teams, because one of the issues with IMGs is they can be highly variable. They can be absolutely exceptional, or they can be coming into a system where English is their second language, and the health system and how it functions is completely foreign to them, so they're learning not just how to communicate from a medical perspective, but also how to deal with the Tasmanian/Australian health system. That can be a whole challenge in itself. Then if you are a Tasmanian intern who is up there -

CHAIR - As a former nurse and midwife, I used to dread the beginning of the year when you get this whole new cohort, but I also took the approach that if I don't invest in these people, then we won't have good doctors coming out the other end. Do you hear feedback about that?

I know midwives can be pretty notorious for eating our young, as well as making it hard for interns or residents. Is there work there that needs to be done?

Dr MOORE - From the surgical perspective, orthopaedics and general surgery are the services they provide at Burnie and in the north-west, and they are both really supportive units that people like working in, in that sense.

CHAIR - Okay. So that's not such a problem? I'm just trying to understand what the barriers are here.

Dr MOORE - I think sometimes it's in the middle. If you look at, say, Burnie and Latrobe, the north-west health service, I think you would see that interns don't stay; they tend to kind of travel. Or, if you looked at preferences - understanding that a lot of people come from Hobart who get into medical school, or from interstate - I think that would be a lower preference. People don't want to go there, and it may be worth looking at the conditions, but I don't have strong evidence about that.

Then, once they get in, they need a pathway. They need to feel that they can then get a junior job -

CHAIR - They need to see where they're going.

Dr MOORE - Yes. What RACS is trying to do is to find better ways of selecting people who have rural experience, and more momentum to get back to rural, whether they grew up in a rural area or they went to school there.

CHAIR - RACS is specifically looking at that in their applications to get on the pathway?

Dr MOORE - Correct. We now have two specialties, particularly ENT, where starting next year you'll get bonus points in the application if you grew up in a rural area, or spent a certain number of years there.

CHAIR - Is that being effective in terms of people applying?

Dr MOORE - Internationally it has, but this is one of RACS' current flagship programs at the moment, trying to get what we call 'rural health equity'.

Ms DICKSON - We're in year one of a 10-year program. As Peter said, we're looking to build on that. If you have established links and relationships with an area, you're more likely to return to that area.

CHAIR - And you specifically identify an area of need, like ENT, urology or neuro.

Mr GAFFNEY - I'd be interested to know about a variety of experiences for doctors, interns or residents. Is there a program where a person can do six months in a rural school, and then six months in a city school, because I would imagine that sometimes in a smaller hospital, they don't have the flowthrough and the variety of cases they might be involved with in a larger organisation? Do you have programs where somebody can experience both of those - like a larger Sydney hospital linked up with a little hospital in Orange, so there's more flowthrough?

Dr MOORE - Do you want to focus specifically on the surgical trained pathways?

Mr GAFFNEY - Yes, that would be good.

Dr MOORE - From the college perspective, it's kind of an expectation that for the majority of specialties you'll go and spend some time in a rural area. It's not mandated, but it is definitely built into the program. For example, in orthopaedics, our two accredited trainees come from the Victorian training program. Both of them worked in Melbourne last year and will spend a year here, and then they'll go back. One is going back to Melbourne and the other one will come down to Hobart.

Mr GAFFNEY - Excuse my ignorance here. When they come here, do they have a supervisor here, or do you have somebody here of the standard who can supervise them?

Dr MOORE - Correct.

Mr GAFFNEY - If we don't have it at that level, then we can't offer that program?

Dr MOORE - Yes, correct.

Ms DICKSON - Some of the specialities don't have anyone attached to them, based on purely that exact reason.

Mr GAFFNEY - If you're looking at the next five or six years in Tasmania, if somebody retires or breaks their ankle, are we susceptible to losing some of those things, because we don't have the right training, or enough of the training?

Dr MOORE - Focusing on Burnie, one exciting point is that they've been accredited for an orthopaedic trainee next year. It's the first time they'll have one who is on the accredited training program. You have four orthopaedic surgeons there, but Scott Fletcher is towards retirement age - so when he retires, if we don't have someone else to fill in for him, eventually they'll drop below their accreditation standards of a minimum number of surgeons.

CHAIR - It is really important to have the accreditation in the rural hospitals to enable registrars to train there.

Dr MOORE - For example, I don't think you could ever get an ENT in Burnie. You could potentially get one in Launceston, who may go up and do lists in Burnie for the day, or something like that.

CHAIR - Mr Carter [tbc] can't be far from retiring either, I'd say.

Dr MOORE - Correct. Now we have four, and only two of them are fellows, and I think you need three fellows. One of our issues has been support for the IMGs in passing their exams. We know that SIMGs - specialists who have obtained qualifications overseas - definitely have a higher rate of failing the exam, especially on the first go. That's probably again because of the system. We are probably uniquely trained from medical school in how to pass our exams, but they have to learn a whole new system. It doesn't mean they're not capable of providing excellent-quality care.

CHAIR - It doesn't mean they're not competent.

Dr MOORE - Yes.

CHAIR - Going to the telehealth aspect of the submission, obviously you can't do orthopaedic surgery by telehealth. Regarding the value of telehealth through COVID-19 in attracting surgeons to our regions and progressing through lists of people waiting, what role does telehealth play, could it be improved and what are the barriers to using it?

Dr MOORE - From a public perspective, focusing on the Tasmanian health service, it definitely plays a role in minimising people's travel. There are surgical specialties where being able to examine a patient can be an issue. As far as attracting people, I don't think telehealth is going to make a huge difference. I think it's going to make a big difference to the patients, whether they can travel or not. The other is trying to find the dedicated time in clinic. Our outpatient clinics are already overrun with people coming in. I think that can be a bit rushed at times. You have to spend time as well as when you have 40 people in your outpatient clinic.

CHAIR - They could be scheduled in as an appointment. What sort of things can you do, maybe post-operative follow-ups? You may still want to look at the wound, for example, because most surgeons leave a wound of some sort.

Dr MOORE - That's an example of services. We treat people from Flinders Island regularly. It's a big deal for them to come all the way for us to have a look at a wound. A lot of the time we liaise with general practitioners who do a wound check.

CHAIR - Does there need to be an investment in higher quality telehealth facilities, so that you can look at the wound from a distance via telehealth?

Dr MOORE - It's probably creating a robust system involving general practitioners as well as allied health. Accessing allied health, physiotherapists and things like that, is another issue. They probably have a very strong ability to use good telehealth services, so they can watch someone do exercises and have a consult. I consulted someone on Flinders Island yesterday. It was in the private setting but extremely difficult because it's hard for someone who runs a farm to say when they can come over. The physio was there once a fortnight and she said, 'I forgot he was there', because they get busy. I think telehealth from that perspective is going to be extremely useful. If you have people you trust, you can look at a wound, take the stitches out and communicate that with the surgeon if there's a problem.

CHAIR - We're talking about a collaborative model there. What role do you see for other allied health, like nurse practitioners, pharmacists, paramedics being involved in some of this, like wound care, removal of sutures and things like that?

Dr MOORE - I think it provides an incredible opportunity, especially in more rural and remote areas. Orthopaedics has practitioner physiotherapists specialising in orthopaedics, nurse practitioners to be able to assess them.

CHAIR - So, you don't see that as a threat to the turf you occupy?

Dr MOORE - Personally, no. We are so overrun with work, any kind of support… The key is integrating them into the system, so that they're part of the team as opposed to operating solo. Launceston has demonstrated some areas where we are doing that quite well.

CHAIR - In what particular regard?

Dr MOORE - There are nurse practitioners and advanced care physiotherapists working in the emergency department. We have a physiotherapist in our outpatient clinic. We operate a virtual fracture clinic. A consultant goes through all the referrals from overnight and the physiotherapist then liaises with them and diverts people away from clinic. We get a lot of people from St Helens now, with the mountain bikes. There's quite a lot of trauma coming in or Flinders Island, people having injuries there, and Scottsdale. They don't have to come into Launceston because they can be managed by telehealth through an advanced care physiotherapist. We have just graduated a nurse practitioner in orthopaedics who then provides education services to people prior to their joint replacements as well as attends clinic.

CHAIR - How does she or he deliver that care?

Dr MOORE - At the moment it's face to face.

CHAIR - In the hospital or does he or she go out in -

Dr MOORE - In the hospital. It's a him. They are all opportunities and I think -

CHAIR - So you would support the expansion of nurse practitioners in those areas?

Dr MOORE - Yes. I haven't spoken to him but I can speak to him about whether there's a role for doing that for telehealth. It's a long way if you live in St Helens to come two hours for a one-hour session and then drive back.

CHAIR - Does anyone else have any other questions? Finish up? If you were the minister, what would you do first?

Dr MOORE - Ensure sustainable long-term funding for surgical services in rural settings or probably across all Tasmania. Four-year funding makes a huge difference as opposed to year-on-year. We can plan.

CHAIR - To focus on that assured four-year funding, we often see around election times they are going to focus on an elective surgery blitz in a particular area. Do those things help or do they disrupt the flow? You said consistent four-year funding ensures you knew what you had. I am sure no one says, 'No, we don't want money', but is that blitz funding helpful or would it be better to have an overall increase over a period rather than bang, we're going to give you another half a million dollars to do something.

Dr MOORE - You'll get different answers depending on who you speak to. Everybody wants the wait list to be reduced and accepts that we have to do something about it. It is incredibly frustrating and demoralising as a surgeon to have your list closed because there's no funding and then 12 months later being told you've got to do more cases. As you said, people want the funding in place and if there's room to do extra we're trying to find ways. These blips definitely have a negative impact -

Ms LOVELL - You just catch up again.

CHAIR - Yes.

Dr MOORE - When they're sent over to Melbourne and then the complications that come back - every surgeon has complications - are incredibly frustrating to the system.

CHAIR - If there was certainty of funding over a longer period, would it be easier then to attract an ENT surgeon or a urologist or even another orthopaedic surgeon in the North West Regional for when Scott retires?

Dr MOORE - Yes because I think it builds on the culture. You want to have a place where there's a strong culture that people like to work in. When you go to the public system it's an enjoyable time versus the frustration that builds up when you ask, 'Are we on the go-slow this year or are we being pushed to speed up?'

CHAIR - So a consistent flow?

Dr MOORE - Yes.

Mr GAFFNEY - To have the consistency there and then if they want to throw a bucket of money in a certain area, that's fine too?

Dr MOORE - Yes.

Mr GAFFNEY - You can attract that sort of specialist for a short term if you need to.

Dr MOORE - Yes. Correct. There has to be a role for locums to give flexibility. This is an example in Launceston. Surgeons need to have a break and that's really important for the sustainability of the service. In orthopaedics we have had a number of well curated hand-picked locums come in. So, they come down here and are able to do wait list cases. Instead of the theatre sitting idle during school holidays we get a break and the patients are getting looked after by someone we know and trust. That money for locums is something that can also be looked at.

CHAIR - It is when you rely on locums all the time that you have a continuity of care issue.

Dr MOORE - Yes, correct, but if they're integrated into the system in a sense that can be a sustainable model. Dana Shurani [TBC] came for a six-week locum and is still there 20 years later. That's how you attract people.

CHAIR - Have you ever asked him why he stayed?

Dr MOORE - I think again it's just that you come and you have a very positive experience at the hospital. Culture has to be part of, it's not just money and fun.

CHAIR - To name some of these things, you say culture. Peer support?

Dr MOORE - Yes.

CHAIR - A one-in-four roster?

Dr MOORE - Minimum, yes.

CHAIR - Minimum, yes. Anything else?

Mr GAFFNEY - Sustainable funding.

Dr MOORE - Yes, sustainable funding. Pathways. We are working on our elements of creating better pathways for people. The Government, I think, has that control over the JMO space because -

CHAIR - JMO?

Dr MOORE - Junior medical officer.

CHAIR - Thank you. That has been really helpful. I appreciate your insights.

Dr MOORE - Thank you. If you need anything else, please let us know.

CHAIR - Thank you. I'll look up that report. Thanks very much.

The witnesses withdrew.

The Committee suspended from 10.31 a.m. to 10.57 a.m.

PUBLIC

Mr ROBERT CASSIDY, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Robert, welcome to the committee inquiry. This is a public hearing and it is being broadcast and transcribed by our Hansard reporter. The members in the room are Nick Duigan, Sarah Lovell, myself, Ruth Forrest, Bastian Seidel and Mike Gaffney. Everything that you say will be covered by parliamentary privilege. If you have anything of a confidential nature you want to tell us, you could ask the committee to consider that in confidence and then we would stop the broadcast and that sort of thing. Otherwise it's all part of the public hearing.

The parliamentary privilege doesn't necessarily extend beyond the hearing, just while you're appearing before the committee. I know you would have received the information for appearing before an inquiry. Do you have any questions following reading that?

Mr CASSIDY - I don't have any questions about it.

CHAIR - Thank you, Robert. We appreciate your submission and you taking the time to talk further to the committee. We invite you to introduce yourself and to speak further to the committee, and to raise any other particular matters you want to, then members will have follow up questions.

Mr CASSIDY - Good morning committee members. I am Robert Cassidy. I live in Bothwell, Tasmania. I am an Australian citizen despite my foreign accent. I have been in Australia since 2000. First lived in South Australia. I have been in Tasmania since November 2009. I purchased my property in Bothwell. Just a humble place, one acre with a Cape Cod style home. I worked as a pilot. I spent 36 years as a military and civilian pilot, flew army helicopters and became a captain flying those jumbo jets. Now that I have said all that, I am ready for you.

CHAIR - Did you want to speak to your submission or raise anything else beyond what you have written?

Mr CASSIDY - No. I think my submission is reasonably succinct in the three pages. I tried to express my beliefs, my observations, my personal experience.

CHAIR - We know that Bothwell is in a regional part of Tasmania. It is not close to any major centre. In terms of the expectations you had when you moved there, what did you believe would be a level of healthcare service that you would be able to have in Bothwell? Has that worked out as you expected? And how do you feel about the access to services for a person living in rural Tasmania, and what barriers there might be to getting care that you may have felt you should have had but have not?

Mr CASSIDY - Well, if you would like to start the morning with a laugh, I did not know anything about Bothwell before I moved here, really. I agreed to buy my house sight unseen. I found it on the internet. I was looking at a couple of places, one up in Oatlands and the one here in Bothwell. I did not know very much about Tasmania except for a beautiful photo by Peter Dombrovskis, so I had no real expectations what I might find here.

For example, you probably know that it is about 77 kilometres from Bothwell down the Highland Lakes Road, then down the Midland Highway and Brooker Highway to the Royal

Hobart Hospital. Seventy-seven kilometres - it is really not a heck of a lot. Normally it should take, if everybody is doing the right thing and travelling at the speed limit, you could conceivably make it there in 45 to 56 minutes. The problem is, it might be somewhat off the topic or for another committee, but the drive to Hobart is troublesome. It has become a bother. I have actually considered relocating from here, if I could afford to, and spend $600 000 or $1 million for a home in Hobart or close by.

That is one aspect I did not anticipate. I have commuted pretty much all of my adult life, especially as a pilot. In fact, I would commute across country or halfway around the world to meet an aircraft to go fly it somewhere else. So, commuting is not uncommon to me. But if you have got a posted speed limit of 110 km/h and someone is doing 83 km/h for no darn good reason on a clear day, dry road, you cannot predict how long it is going to take you to get there.

Let's say, for example, you are an ambulance driver and you have a critically ill patient on board - someone with a life-threatening issue. Can you imagine getting stuck behind somebody on a single-lane stretch of road who will not pull over? That's a concern for me.

CHAIR - The law requires people to pull over when lights and sirens are being deployed. I know there are some sections of the road where it wouldn't be safe to do that immediately, but that's only small sections of the road. Do you think a public awareness campaign needs to be put out there to remind people of their obligations?

Mr CASSIDY - Absolutely. I think a public awareness campaign would help. Again, that's probably a discussion for another committee, maybe a road safety inquiry. I see a lot of traffic. I drive to Hobart twice a day, three to five days a week. My wife is a registered nurse at the Royal, so I take her there and I come back home and I have been busy writing a book and magazine articles and whatever else I'm doing, like council. So, I come back home to do my own thing, then go back down and pick her up at the end of her shift.

So, I see a lot of traffic. I see a lot of bad behaviour, stupid behaviour - and not pulling over for emergency vehicles is one of them. I cannot understand people who just sit there. Now, I can say I have been in the wrong lane looking in my rear-view mirror and seeing flashing red and blue lights behind me, but I would immediately pull over. I find that people aren't doing that. They're not getting out of the way; they should get out of the way. When I drive past them, they don't look like they're from elsewhere. They look like they're Australians and they should know better.

CHAIR - If you've seen this occur, do you think that could have an impact on response times? In another committee I sit on, we've looked at ambulance response times, and people not pulling over is not an issue that's been raised with us.

Mr CASSIDY - Of course, it all adds up. For example, my drive to town can vary from 56 minutes if I catch all the lights on green all the way down, to 1 hour 15 minutes if I end up stopping at every traffic light. You could use the same analogy that the ambulance or emergency services vehicle is stuck, invariably, behind this or that vehicle that just won't get out of the way. Maybe they can't get out of the way because of so much traffic, or maybe they're crossing the Bridgewater Bridge, as an example, and the only place to pull over is that stretch on the mid span of the causeway there. That's about the only place. You wouldn't be able to fit ten vehicles in there, that's for sure.

In a situation like that, you could easily lose a few minutes. Those few minutes, sometimes patients don't have that long. So yes, that would certainly adversely affect response times. I couldn't quantify it, but on a drive from Bothwell to the Royal, that could easily add another 10 minutes or so.

I have had both of my AstraZeneca vaccinations, being 67. I have to tell you God's honest truth that I was initially reluctant to get the AstraZeneca vaccine. I would have preferred anything else, but my main concern was that I could never get any reply from anybody official that I wrote to or phoned, including the Therapeutic Goods Administration. Because I live rurally, my concern was, if I get a blood clot - especially a blood clot on the brain - how long do I have? Especially if I have to go by ambulance - if an ambulance is available to take me from Bothwell all the way to the Royal, because I live so far out. I'd be some kind cabbage by the time I got to the emergency room.

That was my concern. I never did get an answer, but I ended up getting the AstraZeneca and I'm talking to you right now, so I guess my concerns were maybe not realistic. I'm just saying the commute in getting there by ambulance is an issue for a lot of medical conditions.

Mr DUIGAN - Robert, you alluded to potentially moving from Bothwell to Hobart. The cost of doing that aside, I am interested to know whether that decision is being instructed by the health services that are currently available to you in Bothwell, or is it a more general thing that you're thinking about, because of the commute into town, or something like that? Are the health services that are available to you, driving you in that direction?

Mr CASSIDY - All of this is part of the equation. Let's say, for example, there is no Woolworths here. I like to shop at Woolworths. In fact, I like to shop at the Woolworths in New Town because I love the people there. They're great people at that particular store. I've been going there almost since I've been here in Tasmania. There are no facilities, there's no BP petrol station here, you can't get the NBN fibre to the node, but this is all part of living in rural Australia - rural anywhere. You don't have all the facilities and amenities and things you like to have.

There are so many issues living in rural Tasmania or rural Australia that people like me never considered before buying a home. For someone who's born here and grew up with it, I guess they just learn to accept or work around it or put up with it.

Insofar as the medical aspects of it go, I would love to be able to get hearing checks, eye checks, dental checks as needed without having to drive 78 kilometres to do so, and make a specialist doctor's appointment - dermatology, skin cancer checks, stuff like that. None of that stuff is available here, and it all takes away time from your life doing other things that you need to do - mowing your lawn, sitting down reading a newspaper or whatever.

In some small part, I would say it contributes to the decision, but mostly it's the inconvenience of the commute to Hobart. I probably would not live right in Hobart. There are many places that I like in Hobart, like Glebe, for example. I love it. It's beautiful and you have beautiful views. Could I afford to live in Glebe? No. I hope I answered your question.

Mr DUIGAN - You did mention that you had been vaxxed. Did that happen locally?

Mr CASSIDY - Yes, it happened locally. That's the funny thing. There's a lovely medical receptionist by the name of Jane Rogers. I had to call her for something else and she said, 'Oh, we're having a vax clinic today, are you interested?' Well, why not? That's the first I knew of it. There was no other announcement that I was aware of - and I should be aware, because I'm a council man in the municipality on my second term, but I didn't know.

Anyway, I said, sure, why not? I'm here'. I was walking back home from the clinic, it was only a few minutes, five minutes or so. I talked to our new neighbours. They had just moved here from Victoria and I saw them outside with their moving van and I told them that, hey, they're having a vax clinic if you guys are interested. They hadn't been vaccinated and they were interested, I expect they probably went down there after me. That's how it occurred.

There was an older nurse down there, I can't remember her name now offhand. I tell you what, that's the lady who should be talking about the vaccinations because she was just so knowledgeable. She basically put my concerns at rest, so I decided to go ahead. When I got my second dose, I decided to do a Peter Gutwein and I had my photo taken with my sleeve rolled up - sans tattoo, I don't have any tattoos. I decided to have that published in the local paper and actually submitted it to the *Mercury*, who rejected it. The others published it and I thought that was good because I think Central Highlands municipality still has the second-lowest vaccination rates, so I thought it was my duty to encourage others to get vaccinated, lead by example, set an example.

CHAIR - Robert, there are obviously a range of services you can access in Bothwell. Can you take us through what services are available there to the community? We know there is no acute hospital there but what can you access in Bothwell?

Mr CASSIDY - Basically, general GP services and I believe there is physiotherapy by appointment, a vaccination place. We do have a pharmacy here in town. There's an ambulance that's driven and staffed by volunteers.

CHAIR - There is a volunteer ambulance based in Bothwell?

Mr CASSIDY - Yes.

CHAIR - Are there things you believe should be available in Bothwell that aren't? We are being realistic about where you live. What sort of things do you think should be there that aren't?

Mr CASSIDY - Well, a barber shop.

CHAIR - That's a health and wellbeing matter, I agree.

Mr CASSIDY - There are some very basic things that should be here. A real general store. We're paying prices that would be incomparable to prices at Woolies in New Town. There should be a Woolworths here or a Coles, or an IGA. There are facilities that should be here that would contribute to the health and wellbeing, and the mental health and wellbeing of residents.

Insofar as the medical facilities, the problem is that here in town there are probably only about 350 to 400 people and most of them are older. Would it pay to have a dentist out here,

an ophthalmologist or an optometrist? I think they could be here on a once-a-month or once-every-three-months basis: 'Hey, we are having a clinic for optometry', or hearing checks, or maybe have roving vans that would take a group of dentists and their dental equipment and chairs and so forth, have a van set up that could go through all the rural communities. Or an optometrist in a van that has got all the supplies, equipment and so forth. Why not? Yes.

CHAIR - You are talking about outreach services then. You are talking about visiting services from a central hub somewhere? Is that what you are suggesting?

Mr CASSIDY - Yes, I'm suggesting that only because I think the patient load here, I don't know if it will pay somebody if they have a practice here, like an optometry clinic every day of the week, for example, or a dental service. I don't know if there would be enough patients to pay for it, to make it viable. That's why I said maybe an outreach, something like that, would probably better serve in rural places like Bothwell. Also, I would like to see the Bothwell medical clinic open five days out of the week. It is just not.

CHAIR - How much is it open at the minute?

Mr CASSIDY - I think it is open three days a week, if I recall correctly. Sometimes it's hard to get an appointment. You might have to wait two weeks, I've been told. In the past I've had to wait two weeks. If there's an opening or somebody cancels, please give me a call.

Mr GAFFNEY - Robert, it's interesting you speak about lack of health services to, say, Bothwell, and you and I both know there are lots of little regional centres throughout Tasmania of similar size, and probably even smaller, that don't have those services. Do you think there could be a role for the state Government to have mobile vans or something that would go around to those different little service areas to provide some of the services you need?

Mr CASSIDY - Absolutely. Let's say, for example, I took a drive some years ago up to the east of Launnie, to Avoca, Mangana and Rossarden. Those places are really rural. Imagine somebody having to commute all the way down to Launceston from those places. I can't imagine it. It would certainly help.

Up on the north west coast, for example, some years ago my wife was going for professional experience training as a nurse. She was up in Smithton. While she was there, I would go out along the west coast, the north west coast and so forth exploring, driving around, and, again, there's a rural community belt there that, wow, you know what I mean. And their only facility would be to drive all the way into Smithton. Smithton is nice, it's a beautiful little town. It has got a district hospital there and aged-care facility but it's not like Hobart or Launnie.

Mr GAFFNEY - Thanks for that. What I'm hearing is that there are a lot of places that don't have the number of people around to support a private service.

Mr CASSIDY - That's right.

Mr GAFFNEY - But collectively there might be a role for a rotational sort of service supported by government, which would actually be both cost-effective and save people a lot of time and effort to take it to the area.

Mr CASSIDY - I agree with you on that. It's always the issue of funding - who is going to pay for it? If you look at Tasmania with the older population and, even myself, I'm never shy to ask any service or any facility, or if I go and buy a grease gun, like I did yesterday, 'Do you offer a senior discount?'. The fact of the matter is there are a lot of Tasmanians with not a lot of money. They put off dental checks, hearing checks, GP visits.

There could be women living with endometriosis as an example, that would be undiagnosed or possibly even untreated for many years because there are no facilities. No outreach to them. And they can't afford it.

It is really a complex issue. I think both the state and the federal governments need to kick in some serious money to healthcare. If they improve the health of the populous it can only be a long-term benefit and make it a more productive society.

Dr SEIDEL - You made some reference to paramedics in your submission. You stated paramedics should be salaried and not expect a volunteer to be traumatised, verbally abused and assaulted.

Is that something committee members have talked to you about, that volunteer ambulance officers are being abused and assaulted? Is that an issue?

Mr CASSIDY - It's there in the paper, it's there in the media. It happens in the emergency department at the Royal Hobart Hospital. It happens on the wards. I think it is a silly notion to have volunteers stacking ambulances. Paramedics, ambulance drivers, and ambulance attendants, they should be paid positions. There is a lot of training involved.

CHAIR - I hear what you're saying about the volunteers, but some people volunteer because they want to be a volunteer. They want to be able to say 'no' if they are not available. They also see it as a service to community. Do you think we should do away with volunteers entirely acknowledging that fact?

Mr CASSIDY - It's a tough question. I see somebody who is a doctor, or a nurse, or a paramedic, or military pilot, airline pilot. They do it because they have a passion for it. They love it. They are dedicated professionals. Just to become a commercial helicopter pilot as an example in Australia costs about $80 000. That is just the beginning of it.

I cannot imagine the cost to become a general practitioner, as an example. I have some idea about becoming a registered nurse because I was side-by-side with my wife who has become a registered nurse. There are costs taking these university courses that the universities just don't advertise. There are a lot of costs that are not covered by HECS.

The people who take this training should be appropriately compensated so they can survive and be comfortable in their profession. I don't think it is appropriate for them to be a volunteer. For example, as a pilot, I would not fly for free. I have seen in my previous life advertisements for pilots to fly for free to gain experience. Or they might say, fly for food or lodging. I would always call them and tell them they are diminishing the entire industry. It's not necessarily a union that is directing like that, but I think you get what you pay for.

CHAIR - One last question, are you aware of the medical services in Ouse? I am not sure of the travel time between Bothwell and Ouse. There have been some recent changes and I understand there are walk-in clinics on Monday.

Mr CASSIDY - I probably shouldn't get into that because I'm a councilman here in the Central Highlands municipality, I'm aware of it, let's put it that way. It's about 30 minutes to get to Hamilton and probably another 10 to 12 minutes to get to Ouse from here. Ouse used to have a hospital. I remember when Michael Ferguson first came to Ouse Town Hall and announced the closure of it, I think that was a mistake.

CHAIR - Okay, thanks very much for your time today, Robert. We appreciate your submission and speaking with the committee today.

Mr CASSIDY - Thanks for your time. Have a good day.

THE WITNESS WITHDREW.

PUBLIC

Ms BRIGID DALY, CO-FOUNDER, TANA, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED, AND **Ms SUE HEART**, CO-FOUNDER, TANA, WAS CALLED AND EXAMINED.

CHAIR - Welcome to both of you and thank you for putting your submission to the committee. This is a public hearing, all the evidence provided by you today will form part of the public record. It is being transcribed by Hansard. You are covered by parliamentary privilege while you are before the committee. I assume you got the information regarding appearing before the committee? I will ask you to speak to your submission, which was very informative. Members will have questions for you.

Ms HEART - We have prepared background information for you. I am Sue Heart, one of the co-founders and the current president of TANA - Trauma Awareness Network Australia, co-founded with Brigid Daly and Mike Lizotte in 2018.

We are about upstream prevention of complex trauma from the grassroots. What we want to widely disseminate is an understanding of adverse childhood experiences and their impacts, which now can often be diagnosed as complex PTSD or complex trauma. As we have identified this as a root cause to so many of our health and social problems, I have written a piece here called Root Causes Need Grassroots Solutions.

We are about trauma awareness, and we want an Australia-wide public mental health promotion campaign, with a pilot in Tasmania.

Mental illness and substance use disorders are ranked equal second in the Australian Burden of Disease Study 2018 key findings, published in August 2021. A burgeoning global evidence base reveals that adverse childhood experiences, or ACEs, contribute to most of our major chronic health, mental health, economic health and social health issues.

The higher a person's ACE score, the greater the risk of chronic disease and mental illness. For example, compared to a person who has an ACE score of zero, a person with an ACE score of four or more is twice as likely to have heart disease, seven times more likely to be alcoholic, and 12 times more likely to attempt suicide.

Exposure to chronic stress in childhood has been known to have a detrimental effect on the immune system and on neurological development. It impacts on how information is processed, and the processes for decision-making which, in turn, obviously impact on socialisation and social interaction.

The life-course impacts associated with ACEs are not limited to, but include, the adoption of health-harming behaviours such as misuse of alcohol; antisocial behaviour, such as violence perpetration; poor physical and mental health; the earlier development of diseases; and increased use of mental health services.

We are really addressing part of the solution to the burden of disease that we experience in Australia, and Tasmania in particular.

Australia's burden of disease highlights a barely fathomable concept that 5 million years of healthy life were lost in Australia in 2018. This came from the Australian Institute of Health and Welfare's Burden of Disease key findings, released in August this year. To consider

5 million hours of healthy life is barely fathomable, but trauma awareness is part of the solution. It can really address this problem on a wide-impacting scale.

Risk factors attributable to our health burdens include tobacco use and being overweight, including obesity. Both of these health burdens have been proven to be associated with adverse childhood experiences or early life stress. The leading cause of death in Australia for Australians aged 15-44 years is suicide. The state of psychological distress in what should be our most thriving and contributing working population is a grave concern for our health services and for their economic implications.

TANA's mission is to propose a solution. We want to lead a widespread public health campaign to raise awareness of the effects of trauma on the individual brain as it is developing - as it is literally being built early in life - and the pervasive effects, because what happens in those early years when brain architecture is being built is always evident years later in the adult stages of life, and it manifests as disease.

Extensive research reveals that approximately 70 per cent of any given population is likely to have one or more ACEs, and this compounds intergenerationally. It is now obvious to anyone who works with people that we have another global pandemic permeating our societies everywhere that is deeply rooted in this state of personal distress.

Professor Ben Mathews from the Queensland University of Technology, who we met with in 2018, is currently leading Australia's first child maltreatment study. He says he is doing it because of its massive significance for individuals, families, communities, governments, society, and the economy.

The single year cost for 2016-17 was $5 billion or more. That is just from child protection, out of home care and intensive family support services. It doesn't count downstream costs.

TANA's proposal is to alleviate this burden from the grassroots. TANA wants to lead this campaign for upstream prevention of complex trauma from the grassroots, beginning with a statewide pilot in Tasmania commencing in 2022.

Our objective is to prove that widespread trauma awareness at the community level, not just at the level of service providers, will significantly impact and alleviate our burden of disease. We have first-hand experience of addressing this with people. More than 70 per cent of the population has an ACE score of one or more - and the people who suffer most from ACEs always find a revelation, instant relief and almost an instantaneous desire to do things differently. We have seen this time and time again in our training of the public so far.

We have conducted an extensive literature review of peer-reviewed scientific studies and meta-analyses over four years. We've read Government reports, as well as interviewing the locals and the coalface service providers - as well as our own experiences in education on the north-west coast in Tasmania over 16 years. That gives us a snapshot and a slice of the whole community and how they're interacting, and an insight into the future.

We have reason to be concerned. One profoundly significant effect of trauma awareness is that immediate capacity to start making pro-social decisions, starting with their own children.

As soon as people understand that it's not their fault, they're not faulty - it is what happened to them - it's like a light bulb goes on, and it is transformative.

In 2018, the World Health Organization included, for the first time, complex PTSD as a diagnosable condition in the International Classification of Diseases, version 11 - the ICD-11.

Complex PTSD is defined as a disorder that may develop following exposure to an event, or series of events, of an extremely threatening or horrific nature, most commonly prolonged repetitive events from which escape is difficult or impossible - for example, torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse.

This is the definition as published in the ICD-11. This is a direct quote -

> Complex PTSD is characterised by severe and persistent -
>
> (1) problems in affect regulation or emotional regulation;
>
> (2) beliefs about oneself as diminished, defeated or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic event;
>
> (3) difficulties in sustaining relationships and in feeling close to others.
>
> These symptoms cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Working in schools, we see a slice of the community, and every one of these symptoms is actually increasing in young people. We are talking high school, mostly 15-18 years old. This is our future. More and more people can be diagnosed with complex PTSD, and I don't think we can handle the health burden and the economic burden if we can claim disability for something like complex PTSD.

We're talking about widespread information at the grassroots level, based on peer-accepted, validated science, and in alignment with the United Nations advice that, quote -

> Necessary services are only part of the solution. Just as public health responses to COVID-19 have been crucial to protect Australia's physical health, public mental health initiatives will be essential for full social and economic recovery.
>
> Indeed, the first of the three UN recommendations for post-COVID-19 recovery is to apply a whole-of-society approach to promote, protect and care for mental health.

That came from Hammerberg and others in 2021. It's critical that we take this action now to reduce the health burden on our governments and service providers through enabling greater levels of self-help and informed help seeking. We've come across a lot of people who

have seen counsellors and don't want to any more. They turn to addiction and other things instead because they don't have the basic information they need.

We can help people become informed help seekers and use the services to greatest effect. The health services can't do this alone, with the increasing numbers of people who need help. We can support their great work with this foundational underpinning that truly sets people on a new trajectory that is about healing, it's about recovery, it's about aspiration, it's about contribution and thriving.

We proposed Tasmania as a pilot to help alleviate the health burden, educate the general public in the science of complex trauma, adverse experiences and their impact as well as the science of benevolent childhood experiences, positive childhood experiences. As a community, we can provide those with community-wide awareness. This inoculates against toxic stress. This inoculates against the development of future illness related to toxic stress and is what builds resilience in a community. This is all based on science.

CHAIR - Thank you. Did you want to add anything, Brigid?

Ms DALY - We were going to talk a little bit about our program called Building Strong Brains. That's been produced with a private-public partnership in America. It's been approved by Harvard and Yale and the Alberta Family Wellbeing Initiative, which is a philanthropic organisation in Canada that started from the objective of helping people who are drug addicted.

They started to think, what's the philosophy and understanding behind drug addiction? If you look at the history of how we treat people who are addicted to drugs, it went from the thinking that there's something wrong with them, there's something morally wrong, well, they have a disease, so it's the disease model. What the Alberta Family Wellbeing Initiative did is they said, well, it's actually based on the brain, on neuroscience, on neuroplasticity, on adaptations to early childhood.

They helped co-produce the Building Strong Brains program that we now have access to. It was produced in conjunction with the FrameWorks Institute. The FrameWorks Institute's function is to ask what are the misconceptions and biases people hold that hold them back from understanding the root causes of ill health? Instead of the shame and the blame, asking why can't they pull themselves together, and what's wrong with them, anyway, it's ridiculous, this sort of decision-making, they did 10 years of research to pick out the best possible metaphors to get this information across to people, so they can understand neuroplasticity, building strong brains, resilience, the effect of toxic stress and what we can do about it.

We have been gifted with that program to roll out in Australia. That's why we can do this much cheaper. It's been tested and it's been approved and it's all based on science. It will clarify for people what's going on with them and it's based on the science of human thriving, benevolent childhood experiences and building resilience in the face of adversity. That's why we feel we've got something we can use to help the upstream prevention of a lot of these conditions of distress and suffering.

CHAIR - Thank you both for that. I noticed in your submission you've talked about a trauma-informed community of care and the wellbeing centres. Can you talk the committee through a little more about how you would see that rolling out? Are these the things you're intending to be a pilot, Sue? I am interested in those programs and what exactly you wanted

to pilot in Tasmania. Once you've talked about what that is, I'd be interested to know what discussions you've had with the Government, about the willingness of the Government to take on board such a program.

Ms HEART - We have had a huge picture around this since the beginning. Our first step, the proposal that we are now putting forward to get started, is really just about getting this information to people. We have referenced the USA because they are ahead of us on this journey, mostly with service providers but also at the grassroots level.

We are the only grassroots organisation for the upstream prevention of complex trauma that we know exists anywhere. We haven't found another. It started in Tasmania. We are proposing first information. We are discovering that when people, especially those suffering most from ACEs, get this information it motivates them to come up with their own solutions. That's always what we've been about.

We're interested in addressing trauma only because it's in the way, it's the root cause of the problem. As soon as people have the awareness they want to know what to do about it. What we're proposing is to get out there and offer community forums, go into prisons, go to peak bodies. We have a session with the Alcohol, Tobacco and other Drugs Council Tasmania early next year.

We've just written a business case, which is partly what I read from because it's our most recent iteration. We have sent that off to Bridget Archer who has offered to take it to the Health minister. She completely understood our concept and she said that she will push our project with the federal Health minister.

From the very beginning we've had the support of Mike Gaffney, who sponsored our first public forum. We had local, state and federal members of parliament attend that event in January 2019. We haven't had a single person - and we have spoken to thousands of people - disagree with our concept.

Everybody nods because anybody who works with people knows that it's a viable solution and that the problem we're talking about exists but is uncomfortable for some people to have a conversation about. Not people who are suffering. Most people who are suffering have the most interesting shift in body language, attentiveness, nodding, realisations, and then can't help but talk about it, agree and want to share their story.

CHAIR - Sue, what I'm hearing you say is you're wanting to introduce a program where it's more a community awareness raising, making people aware of the issue. I agree with you, it's little understood. Beyond that you raise awareness and we realise we need to provide much more support for women who are pregnant, who are in stressful circumstances, living with family violence.

We have children being traumatised through the absence of loving parents in some of our communities. You raise awareness of what trauma is, what it looks like, how it impacts on our overall health and wellbeing through a process. Then what?

Ms HEART - We've thought this all the way through to how do we bring about a culture change? In the first instance we're not clinicians, so we can offer information but not advice. We're creating, in the first instance, a more empowered general public. We would like to

trauma-inform the politicians, the service providers, teachers. Teachers are critical and the Education Department has taken a lot of initiative in that area, but it's information that motivates people to come up with their own solutions. We would need to collaborate with others on the 'where to next' but we can support building capacity.

Ms DALY - I was just going to say that collective impact is gaining wider and wider attention. However, research is showing that trauma awareness underpins collective impacts. That lack of information, that lack of self-awareness, that lack of understanding that 'It's actually what has happened to me causes me to make these decisions, to behave the way I do, to be in situations that aren't the healthiest for me'. The trauma awareness is the very bottom layer. Above that, we believe the collective impact is something that people can, with more self-awareness, pride and understanding of what they've been through, go from there.

We would firmly recommend that funding is put into a collective impact where they have that voice, something like Burnie Works. We talked to Burnie Works as well about trauma and informing the Burnie community. Then, in turn, participants being involved in collective impact decision-making.

Ms HEART - Another thing is giving people the language. A lot of people don't know how to talk about what it is that they want. Part of our capacity to build the capacity of others is to help them appreciate being part of a community, appreciate finding their purpose and their sense of what they can contribute. Often it begins at the most fundamental level of family. So parents who say, 'Wow, this happened to me and I'll pass it onto my kids', have that realisation, first of all. I can think of an example given to me recently of a man in prison who when he learned about ACEs the first thing he wanted to do was ask his kids how they felt about him being in prison.

He did that at the next opportunity he had and they said, 'Well, I'm really angry', and probably used some more expletives. They were able to start that conversation and start their own healing process.

The other thing that TANA is really about is respect for hierarchy. Not in a dictatorship sense. I think we've gone a little bit too far the other way. I think there's safety in boundaries, understanding how to set boundaries in a healthy way, how to accept other people's boundaries. We have a whole range of evidence-based programs for parents that we could recommend based on the prevention scientist Anthony Biglan's work in the USA. He speaks about every branch of the human sciences, including economics and political science, have come to their own conclusion that a nurturing community is the only solution. It's what we need for thriving. It sounds really basic but there's a whole lot of scientific studies that we can draw upon to share with people on that front.

In Tasmania, if everyone in the local community is trauma-informed, if a child who is dysregulated emotionally and has an overreaction to something that's not explained and has a big angry reaction, then the nearby shop keeper, the average person walking on the street, the police officer, the teacher in the classroom can say, 'Hey, are you okay?' as a first thing rather than something aggressive or making a judgment. It honestly changes behaviour almost instantly.

Trauma awareness is a process. Once people have the awareness, they become more sensitive. Trauma sensitive is the second stage, then trauma responsive. They become more

responsive to the person and start changing policies and practices. Organisations can start changing their policies, families can start changing their practices, and they do. Then become a trauma-informed community when our behaviour change is our new way of operating and we all have policies and practices in place that have an awareness of complex trauma.

Dr SEIDEL - You mention it is critical to take action now. I think Ruth asked about what contact have you had with politicians. Going back to the state level, have you had contact with the state Education minister, Health minister and Corrections minister.

Ms HEART - Yes.

Dr SEIDEL - What reception have you received from them. Is there interest to talk with you about pilots?

Ms HEART - Yes, 100 per cent. I met with Mr Rockliff on 31 July last year. All the work we've been doing has been in our unpaid hours. I pitched to him that the public awareness campaign is something the Government needs to do, but I didn't say to him that we can do it. I have realised since then that we've put the work in, we have the background, we have the vision, we have the big picture, we have the resources - except the financial resources - so he has been 100 per cent supportive the whole time.

We had a strategic planning meeting after our initial forum on January 2019. Jeremy Rockliff sent his adviser, so that was before we met with him a year later. The police commissioner sent a delegate to that meeting as well. We haven't followed up with the Justice minister, but I have been in touch with the executive director of the Justice Reform Initiative and I am meeting with her on the phone on Monday to talk about what we can do there. She is definitely interested in us going into prisons.

Ms DALY - The Department of Education.

Ms HEART - I wrote to Tim Bullard last year and got a reply within three days and he set up a meeting. We've had two meetings with the director of Child and Student Wellbeing, Ruth Davidson, and the head of support for teaching staff. Every single person, without exception, is agreeing this is what we need to do. We really have been building our capacity to finally realise that we have to do the implementation because it's our project. Everybody supports the idea.

Dr SEIDEL - You just need a funding commitment now. You would expect it's not only going to be one minister, one department, it probably would be Education, Health, Communities, Corrections, right? It's a broad preventive program, isn't it?

Ms HEART - Yes. When we were speaking to the minister last year, he said at one point in the conversation, 'I came here with my Minister for Education hat on but I am also the Minister for Mental Health and Wellbeing and now I'm thinking this has to be a whole-of-government approach'. They were his words.

Ms DALY - We've also been gifted the Building Strong Brains program recently, which is a really important program. It's important that we have a common language rolled out, so that everyone who is doing trauma awareness has the same metaphors and we all use the same

language, so we all have a common understanding of exactly what we're talking about. That's been a very important aspect of this journey for TANA.

Ms HEART - Yes, it's really critical. For people who are heavily addicted, for example, or have unresolved childhood trauma, there's a spectrum and cognitive impairment is one of the manifestations of that. We know a lot of people who have been affected are working with a whole range of service providers, so this idea of common language is really important for helping people in their recovery journey because they will hear the same metaphors used from the psychologist to the counsellor to the nurse to the teacher to the shopkeeper. We all understand brain architecture, toxic stress, resilience and self-regulation, emotional regulation, we can teach people how to co-regulate. My brother, who is a police officer, talks about talking people down, de-escalating a situation. It really will equip the community to do all of those things.

We really are all in this together, we're all affected because it affects so many people. That was what drove me in the first place, watching a child when the penny really dropped. Other teachers were saying that he just needs to be expelled and I thought, but he lives in my community. I might go home from work but he is in my community and what are all these kids who are not going to school doing? We have some idea of what they're doing but I'm all about supporting the Education Department's values of aspiration, growth, courage and respect, but without trauma awareness, we will not get there.

Ms DALY- Can I add to that about the Department of Education? When we met the head of student support, and told him of our desire to inform the public with a public information campaign, he fully agreed with us. He said, 'You know, I would do this if I could; I think it is fantastic'. He said, 'Please include people in the south of the state, not just the north-west coast'. We explained that service providers can only do so much, but if we cannot get into the community and pass this information to the grandparents, parents, aunties and uncles, there is only much teachers can do in their capacity as teachers.

If we can get this message through to the wider community, that is the level of support that can rise up for our present young people, and the subsequent generations.

With epigenetics now, they have shown that life-threatening experiences change the expression of genes in at least the next two generations. They are born more hypervigilant. They are impacted. Those epigenetic changes can be switched on and off with information, with the right environment, with a sense of psychological safety. So, epigenetics has shown that we have to take this on board. It is passed on through our gene expression into the next subsequent generation.

CHAIR - Which is a real concern when you look at non-fatal strangulation and other aspects of family violence.

The Government here has listened to a degree. They have put some funding into trauma-informed services or awareness in education, and I commend them for what they have done to date, but obviously, it is much broader than that. Have you put forward a bigger budget submission, in terms of taking a more holistic approach, to the state Government?

Ms HEART - We just submitted to Bridget Archer to take it federally, but we can submit to state now, as well. I have literally just done that this week. Because we realised it was

broader and because I am on the mainland now, we thought we would go bigger, but we are happy to do that. It is important that we do, so we will.

We propose a two or three-generations approach. I would like to be working in a three-generation approach. I have personally worked as an educator, really from birth - because I am mother - to 75 as a coach. Brigid and I have both worked in school classrooms from K-12. I have also been a literacy coach for teachers.

We really are across a whole spectrum of society. We are skilled at being able to connect with people and have these real conversations in a way that absolutely has no shame, no blame. It is like, this happened to you. It is not your parents' fault. It happened to them, too. This is just about healing.

Mr GAFFNEY - You spoke about Tasmania being a pilot project, and it is community-based, so therefore you are working with all different groups creating awareness.

How are you going to implement this to get it out to all of the regions, where initially it was the north-west coast, and then you have realised this could go bigger because it needs to go bigger, and there is a need for it. How do you see that working in Tasmania? How are you going to implement it across the state?

Ms HEART - We have a committee. We are an incorporated association in Tasmania at the moment. We have a dedicated group of supporters. One of our strategic objectives focus areas is events, because we have Mike Lizotte's music event.

It is about getting people out. We are running awareness-raising events in the first instance. A wonderful movie called *The Wisdom of Trauma* is being shown in Ulverstone in February. One of our committee members has led that initiative. This is just an illustrative example, but we have received a small grant from CatholicCare, so at that event we will be following up by inviting the people who come to the film - a soft approach - to a community forum, and from there into some workshops. That will be with people who are working with 0-12 children.

Another approach that we have in mind, an intention, is to contact all of the local councils. We've been in touch with all the local councils on the north-west coast, but we propose going into every local government area in Tasmania and working with the councils, perhaps. We will always be looking for key influential people in every community. If we need to, we will organise a pizza evening for a group of 10 people where they might need that sort of level of safety, and they are on couches.

We want to get this information to people who probably wouldn't normally come to forums, as well as those who would, so we'd be finding out from the local communities who the local influencers are. We put in a proposal for a music event, and invited some people who have some influence in their own little sphere and asked them to bring two or three people along who wouldn't normally come out. There are those sorts of approaches about getting to those 'hard to reach' people.

Ms DALY - Can I just add that we did talk to a mum's group in the Acton Child and Family Centre? It was really interesting, because when we showed them the video about

nurturing and bonding, there was a drop in the energy in the room. It was a bit like, 'Here we go again, what we're doing wrong or what we should be doing.'

We then gave them a little animation on ACEs. They sat up straight, they paid attention, they started whispering to each other like, 'My goodness, did you see the kid has a black eye?' When that four-minute video finished, every woman in that room wanted to talk. It had a huge, profound change. One lady was organising a self-help group for drug-using parents and she said, 'I want to photocopy everything you've got today. I want to share this with my group.'

It caused a profound change, it really did. They just wanted more and more of this information, and that was just one small group.

Mr GAFFNEY - Thank you. For members here, one of the things I picked up when we had the initial forum in Ulverstone as a kick-off was the wide representation of the people at the forum. It showed that the network has to be run by somebody, not under a department. I think this is better serviced by a Tasmania-wide group that can reach into all these places.

From that, say you guys start this up, then you connect with your youth groups and councils and service groups, how do you train people? What is the progress there? You need to have other people out there being trained in the ACEs delivery, so how do you deliver the model that you are thinking about, statewide? Sue, you're in Canberra now, and Brigid you're on the north-west, so how do you connect with and train a group in the Huon to help spread the word?

Ms DALY - Good question. Sue and I have both qualified as Train the Trainers in the Building Strong Brains program from Tennessee, and they also said that anybody who we train can also use their base camp as a way of organising new trainers, who then have free access to use the Building Strong Brains program - and they, in turn, can deliver that.

So, there is that model of using this program, and using it in a safe way, this information based on science. We have that organisation thanks to the people in Tennessee who said we can use the technology and we can use their base camp. I set one up for Tasmania, for Australia, and that's all the organisation necessary behind this.

Ms HEART - We also have permission to contextualise, so we're using what's relevant, but we bring in our own data. We're using the essence of their messaging, but making it relevant to our context.

Mr GAFFNEY - Once people get trained or have this information -

CHAIR - It has to be short, Mike. We're running out of time.

Mr GAFFNEY - So, you guys are a peak group or a network.

Ms DALY - Yes.

Mr GAFFNEY - For further advice and support, they would then link into you, and you would then start this networking link throughout Tasmania.

Ms DALY - Yes.

Ms HEART - We have already, but small scale. We kept it small deliberately while we figured out all the details. So, at every event we will always ask people to become a supporter and join the network, and with funding we will also be posting regularly.

I just started a podcast so they can witness people having conversations about this. There's access to lots of information that we've sifted through and sorted, and will continue to find. There will always be more and more information that people can access, to keep building their own awareness and have conversations.

Ms DALY - Always working in a network of people with the same goal of trauma-informing, and then taking their clients to a further level of healing and functioning - so, being part of that network with the same goal.

Ms HEART - It has changed the lives of our community already, and it will just get bigger. We know its scale now.

CHAIR - Thank you very much. We have run out of time, but it's a very relevant and important contribution to the committee, so thank you very much for your time and your submission. If there is anything you wanted to pass onto the committee following this, feel free to do that through Jenny Mannering, the secretary. Otherwise, we thank you very much for your time today.

Ms HEART - Thank you for your time, too. We really appreciate it.

THE WITNESSES WITHDREW.

The Committee suspended from 12.17 p.m. to 1.03 p.m.

Mr LUCAS DIGNEY, ASSISTANT SECRETARY, HACSU, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Welcome to the hearing for the rural health inquiry. We appreciate HACSU's submission and the time taken to put that in. This is a public hearing, everything is being transcribed and will be used to inform our report and the transcript will be published on our website. Everything you say while you are before the committee will be covered by parliamentary privilege. That doesn't necessarily extend when you leave the room. We will ask you to take the statutory declaration in just a moment, but do you have any questions before we start?

Mr DIGNEY - No.

CHAIR - If there is anything you wanted to discuss of a private or confidential nature, you could make that request to the committee and we would consider that, otherwise it is all public. I ask you to take the statutory declaration and introducte yourself and speak to your submission.

Mr DIGNEY - I am Lucas Digney. I am the assistant state secretary of the Health and Community Services Union and I thank the committee for their time today, Ruth.

As outlined in our submissions, we have some serious concerns in relation to the delivery of health services, particularly in rural and regional Tasmania. They relate, broadly, to underinvestment and governance issues.

As outlined in our submission, the reality is that Primary Health Tasmania is run as a separate organisation from the primary health sites. In essence, they compete with one another for resources. That creates an issue that the committee is well aware of, I assume, and has probably heard from other witnesses. The underinvestment in preventative and primary health leads to Tasmanians becoming sicker, they present at our major hospitals and those major hospitals, you've seen the pressure that they're under, you see the demand pressures that can't be met on a daily basis. Some of the drive for that is because of the underinvestment in, particularly, primary health services in rural areas.

CHAIR - Do you have a view, Lucas, on what level of investment, in terms of a percentage of the Budget, should be invested in primary health?

Mr DIGNEY - Not by number but I could certainly take that question on notice and have a look at the Budget and the proportion that goes to it now. Certainly, there would be benefit in quarantining some of the Budget, in our view, for that investment.

CHAIR - I know you understand this, but you have a component of primary care and preventative health that's funded by the Commonwealth then there's other components funded by the state. Do you have a view on how that works or doesn't work? Then I'll get you, maybe as part of that conversation, to talk more broadly about what you said was an issue with governance and how that all fits together.

Mr DIGNEY - I think that the funding partnerships, if you like, or the funding arrangements are shambolic, they're ad hoc. The federal government will fund a particular program, the state will manage it on their behalf. Then the federal government will decide that

they're not going to fund that particular program. You've got permanent employees and service delivery wrapped up in that funding. Then they have to move, get money from their own state coffers to try to deliver the same service because the community expects that service to be delivered. Then, the federal government will focus on some other area that they want to invest in and the state health service simply has to respond and provide that service. There doesn't seem to be any strategic planning in how it's rolled out.

Again, you have these weird corporate models where the state is the purchaser of services but then it's also the provider of services, which isn't consistent with the federal funding model, if you have a look at it. It's in no way well thought out, planned or strategic. It's just done in a way to grab as much funding as can be had and deliver what services can be delivered with that funding.

CHAIR - Some of the programs that may fall into that category, where they are funded for a while by the federal government, either under a National Partnership Agreement or some other one-off funding, related to an election usually, are you aware of whether before the federal government stop funding them or even state-based programs that are for a time period, are you aware of any work that's done around the outcomes of those programs before the decisions are made regarding no longer funding the programs?

Mr DIGNEY - No, and any work done in that regard, Ruth, is minimal. Generally, it's subsequent to the service being ended when those assessments are done. Sometimes they have a look at the numbers of people accessing the service and compare it to other jurisdictions in terms of value for money and make decisions based on that, but in terms of assessing the actual outcomes that are provided by the program and making a decision on that basis, we've never seen any evidence of that.

CHAIR - It is a matter for governments, both federal and state, perhaps, but if you're not going to focus on patient outcomes, how do you know? You can count as many things as you like but if everything's bad -

Mr DIGNEY - Yes, and if you couple that with the fact that you may be able to push them off, for want of a better term, into the acute settings or the major hospitals. Then you don't have to count that adverse outcome because that's off being dealt with in another service delivery area now.

CHAIR - Under a different funding model.

Mr DIGNEY - Yes. So it probably looks better than it actually does because a lot of the adverse outcomes are hidden, as they're not recorded at the rural or primary health level. That individual ends up in the acute care setting and that assessment about the deficiencies that led to that occurrence are never assessed because it's assessed as part of the acute care setting.

Ms LOVELL - I have a question about that competition and the way the different funding models work: does HASCU have a view on how that could be done differently, particularly with that tension between Commonwealth and state funding, and different parts of the system?

Mr DIGNEY - The issue for us, Sarah - and this is in no way a criticism of the wonderful people who run primary health for the Tasmanian Heath Service - is it is split into three regions.

You already have competition among the different regions of Tasmania. As you've heard, no doubt, there are very significant market pressures on particularly senior nurses, allied health professionals, paramedics. What happens is that the larger acute care settings are more able to offer permanent full-time stable employment; for a lot of clinicians, they offer a wider range of experience and clinical intervention. Whereas in rural and regional, or primary health, as we like to call it, there is a lot of fixed-term employment, there are a lot of part-time contracts.

What you're essentially doing is asking people who live closer to the major centres to travel out to the rural or regional areas to work and the reality is there's no incentive to do that. People won't do that on a sustained basis if they can get work closer to home.

Part of the problem is that it's run as three separate entities and then the THS broadly sits over the top of it. There's no overall nursing director for primary health in Tasmania - there's three of them. There's no overall medical director - there's three of them. There's no allied health director at all in any region.

CHAIR - Even though we have one primary health network.

Mr DIGNEY - Yes, that's Commonwealth. This is the difference. Our view is that there needs to be an alignment and it needs to be governed as a whole, rather than silos.

Ms LOVELL - There's a lot of disconnect.

Mr DIGNEY - Yes, and what that leads to is the outcomes outlined in our submission, that people are forced into those more acute healthcare settings and that costs the Government 10 times more than if they hadn't have turned up there.

Mr DUIGAN - You mentioned earlier underfunding around that primary health space. I am just wondering, your members are aware when the rubber hits the road, if you were investing in that area, what are your top three spots that you'd be putting your dough?

Mr DIGNEY - Allied health, number one, Nick. I understand you've heard evidence from the College of Paramedic Practitioners. We're going to pursue a generalist classification for AHPs in the upcoming bargaining round. We've already had initial discussions with the State Service Management Office about that. Physician's assistants are another option for expanding the scope of current health professionals. That's one major investment the Government could make.

CHAIR - They are usually RNs who go from there to physician's assistants, not allied health.

Mr DIGNEY - Yes, or someone who's already got a degree in health care. My understanding of it, and it's limited, Ruth, to be honest with you, but my understanding is it's a master's degree qualification, but you have to have an undergraduate degree in nursing, allied health or paramedicine to get access to it.

Mr DUIGAN - That's an investment in training.

Mr DIGNEY - Absolutely, and an investment in providing the clinical framework for them to perform duties and deliver services in that space. That doesn't exist at the moment either. There's that investment.

We need further investment in ambulance. I know there has been significant investment in ambulance but you'll read in our submission and you can read in the Budget papers, the wait times just continue to increase. That is, again, because of the demand on ambulance services. The demand on ambulance services is because people become so unwell they need emergency intervention.

Mr DUIGAN - I heard yesterday that there has been reasonable recruitment, reasonable numbers.

Mr DIGNEY - They put on 30 more in the last month or so. We've not seeing any reduction in wait times just yet and we've not seeing any reduction in them being ramped at the hospital either. Until we see those things, you're not going to see any significant change in the outcomes for ambulance.

CHAIR - The Public Accounts Committee tabled a report yesterday that reviews the Auditor-General's recommendations from a couple of years ago. It would be interesting reading for you. We tabled it yesterday, so it's only brand-new.

Mr DIGNEY - I will definitely be reading that. So, an expansion of extended scopes of practice, particularly for other health professionals, would deliver so much value to the primary health space that it's not up for argument, to be quite frank with you.

Ambulance, as I said. And the other area is around incentivising people to stay and build a career in rural and regional Tasmania, and that simply does not exist.

CHAIR - How would you do that?

Mr DIGNEY - There would be a number of ways you could do it. Certainly, training partnerships; frameworks around support in terms of professional support and professional development; pay is always one thing and we'll sit that over there, that's only part of the story, particularly for health professionals.

There are certain junctures in our current instruments where our people in Tasmania are significantly underpaid compared to other jurisdictions, but it's only at certain junctures. For health professionals, collegial professionalism, support from their employer in developing their own career that may or may not be connected to service delivery, those things are very important to retaining health professionals in rural and regional areas. The reason they leave is that they can't access those things, not necessarily because there's low pay.

We had a social worker, for example, who had worked in Beaconsfield and she used to be supported because they had another social worker in Scottsdale-George Town. They defunded the position in Scottsdale-George Town, then the social worker in Beaconsfield left because she didn't have that collegial support.

CHAIR - When you say 'they', who was funding those?

Mr DIGNEY - That was a THS position; that was part of managing positions in the State Service arrangements.

Mr DUIGAN - Is that something that has substantially changed over time, that collegial support?

Mr DIGNEY - It's changed markedly in rural and regional areas simply because of the numbers of certain cohorts that are employed. For example, the example I just gave, there used to be a robust allied health service run for regional areas out of Launceston in a hub-and-spoke type model. They then deployed them to different rural sites to be based there by themselves and, over time, they have resigned or found another job. They cannot fill those positions so those positions remain vacant. Some of them they have been advertised for three years and they cannot fill them.

CHAIR - Does that come down to the fact that there aren't enough trained, is that why they can't attract people?

Mr DIGNEY - That depends on the cohort, Ruth. If you're talking about occupational therapists or psychologists, then it's market pressure. There's just not enough of them on the market. When you are talking about social workers or speech pathologists there really is no market pressure, particularly at a graduate level. They still can't fill those positions.

Dr SEIDEL - One of the key sentences you mentioned just now was stay and build a career, particularly in rural areas. That's impossible to do with short-term funding leading to short-term contracts, right?

Mr DIGNEY - Yes.

Dr SEIDEL - So, it fails the people who actually want to build a career in rural areas. Is that a fair assumption?

Mr DIGNEY - That's absolutely a fair assumption.

Dr SEIDEL - It's interesting, isn't it, because most of your members, I would imagine, would be looking for permanent employment.

Mr DIGNEY - About 99.9 per cent of them.

Dr SEIDEL - So 99.9 per cent of members you represent - and you are the largest allied health union covering occupational therapists, paramedics - would look for permanent employment but the funding in the system doesn't allow them to actually do that.

Mr DIGNEY - Particularly in those areas where it's funded for a limited time. They only employ for the funding period, and that's it.

Dr SEIDEL - Do members feel then that they actually can't commit to an area because the system doesn't commit to them?

Mr DIGNEY - Absolutely. What we find is that even if they do commit to a rural area, if there's a permanent job available in another jurisdiction - Queensland, Western Australia - they will go.

Dr SEIDEL - They would go off.

Mr DIGNEY - They will go.

Dr SEIDEL - They would move interstate.

Mr DIGNEY - Absolutely.

Dr SEIDEL - The main driver is to have a permanent position, permanent employment at what they do so they can stay and build a career, as you said, just in a different area.

Mr DIGNEY - Yes.

Dr SEIDEL - The reason why I'm asking that is we talked about the TAFE legislation yesterday. We talked about flexibility as well. In that area, flexibility seems to be the main driver, we were told. In health, it doesn't apply. Flexibility in health and funding flexibility and employment flexibility doesn't seem to be a big deal as a driver.

Mr DIGNEY - No, it's not a big deal. If you are a health professional and you only want to work three days a week, then the service will accommodate that. The real issue around flexibility is that the way it is rolled out is with fixed-term contracts.

Dr SEIDEL - For three days a week, yes.

Mr DIGNEY - That's right, yes. It's flexibility but only on one side of the ledger.

Ms LOVELL - You can be permanent in a three day a week job, for example?

Mr DIGNEY - Correct, yes. If the funding was there.

Dr SEIDEL - The principle of continuity of care and the benefits for it are so obvious. You can't really access that aspect of continuity of care and the benefits if you're not allowed to actually work for any length of time.

Mr DIGNEY - That's correct, Bastian. Also, if services are spasmodic in the area in which you live, people who suffer from chronic or underlying conditions need regular and systematic care or their condition will just worsen.

If they're seeing a physiotherapist on a schedule of once a month but the reality is they see them maybe once a month because on the Wednesday the physiotherapist was meant to come, the physiotherapist had to take personal leave because she was ill. They don't send somebody else because they don't have the capacity to. There's no contingency built into the system for things that they know are going to happen. They know people are going to take sick leave.

CHAIR - Particularly this time of the year.

Dr SEIDEL - We heard evidence before that the health system is quite complex, services come and go and the solution is to employ a self-care navigator so they can make sense of what's out there. But if you have permanent funding, permanent employment, you will have very stable backbones. It would be less confusing for health consumers and patients then to access services that they know will exist for a length of time.

Mr DIGNEY - If I'm a 65-year-old man and I live in the Tamar Valley, I live at Beasconsfield or I live at George Town and I'm able to access a health service in my town for an underlying but not chronic health condition and my care can be stable and consistent in that town, well, the likelihood is that I will never need to be in an acute setting, at least for a decade.

What is happening is that 65-year-old man who lives in the Tamar Valley has more hope of going to the moon than he has of accessing consistent health services in his own town. He will be forced into a major centre - a major centre that cannot afford that additional pressure.

CHAIR - To access services?

Mr DIGNEY - Yes. They will still be there.

Ms LOVELL - I wanted to go back to what you were talking about earlier when you were talking about increasing resources for ambulance. You mentioned that there has been an increase but it has not impacted on demand and it has not impacted on ramping at the hospital.

There are two ways of trying to address that. One would be to deal with the bed block that is causing the ramping and that is increasing resources and infrastructure at the hospital end. The other end would be to work on the demand end, and look at primary and preventive care, or a bit of both.

What do you think would be the best way, from an economic point of view and from a health outcome point of view?

Mr DIGNEY - The LGH and the Royal Hobart Hospital need additional bed capacity. Not massive numbers, but a small increase. We are seeing that at the LGH now. They are about to open some new beds and they should be commended for doing that.

We can't continue to just build more massive acute care settings. That investment delivers far less value for money than the investment on the other end. The investment in primary and preventive health, the last time I checked, was 10 to 1 on investment in acute health. So, it's a no-brainer where the majority of it needs to go, that's in the preventive side of it.

Dr SEIDEL - Why do you think it does not happen? Everybody says that. You are the largest health union in Tasmania. You have ongoing discussions with the Government on that. The evidence is crystal clear. Nobody is disputing the evidence. What do you think is the barrier for the thinking to change and for the funding to follow the evidence?

Mr DIGNEY - It is a complicated question, but largely it is related to the political nature of health. You have Health ministers who are, for want of a better term, jammed in the

headlights and they become reactive because of the pressure that is put on them by the community.

As we outlined in our submissions, the Giddings government savaged health in 2011, tore the guts out of it. Since then, there has been a 'finger in the hole in the dyke' arrangement where they have tried to do the best they can to keep everything going as best they can. Then it becomes more political because there are pictures of the ramp on the front page of the paper. I am on the radio saying how bad things are, and all the things of that nature. Then the minister becomes less inclined to engage with stakeholders because they know that it is a problem and it is difficult to fix it within that election-cycle framework.

We need a bipartisan approach to it. We need to put down the swords, and we need to say, 'This is how we are all going to fix it'. If we don't, I fear that I will be here in 10 years telling you and other MLCs who replace you largely the same things as I am telling you today.

Dr SEIDEL - Do you agree that politicising health would lead to worse patient outcomes?

Mr DIGNEY - Absolutely.

CHAIR - I have sat on a number of health inquiries in my 16 years here. Preventive health, acute health. We see the same thing. Some of the submissions we have received to this committee, I could have picked them up from previous submissions. It is not like the problems are not understood.

We continue to have this tension between the federal funding and the state funding and the political pork-barrelling that goes on around that. Perhaps, reactive solutions are put in place rather than the proactive ones.

If you were Health minister for a month, you have a little bit of time, not just for a day, a day is a bit too short, and you were looking at the whole shooting match - Nick asked for those three things you would do. In terms of the big picture, when you look at federal and state intersect, or lack of, what would be your priorities at the very high level to start addressing this?'

Mr DIGNEY - My priority would be to deal with the federal health department, if I was the Health minister.

CHAIR - When you say deal with it, what do you mean?

Mr DIGNEY - I mean come up with a sustainable funding arrangement that means we're not running cap in hand to Canberra however often we have to, doing media or community campaigns because the federal government's proposing to pull funding on this particular service because they only put two years' worth of funding in the bucket. I would seek funding arrangements based on decades, rather than based on two years.

CHAIR - Okay, funding is one part of it. Surely, another crucial part of it is a long-term strategy for what health care should look like. Funding will flow to that if you've got a well-articulated and non-partisan approach to a strategy. How do you see that?

Mr DIGNEY - I see that as the health executive, for our purposes the secretary of the department, seeing health as whole. So, rather than running it as different businesses based on this funding model, that funding model, 'we've got these aged-care beds in that regional hospital, we do this over there, we do this there', it needs to be viewed as a whole health system, where the rural and regional multi-purpose centres, whatever they are turned into, are the first port of call for the people who live in rural and regional areas, rather than, 'I might go there if they offer the service I need'.

CHAIR - In terms of the cost shifting that goes on, if you have some pathology or radiology done through the doctor's surgery, that's funded by Medicare. If the same tests are done when you're an inpatient, it's funded by the state. Federal funding, state funding; same thing. Do you suggest that the whole health funding should come from the Commonwealth? A comment I often hear when people from the community, say, ring into the ABC is that the Commonwealth should just be running the hospitals and the health system.

Mr DIGNEY - That would not have good outcomes for Tasmania. It's that simple.

CHAIR - Why wouldn't it?

Mr DIGNEY - Because you've seen as recently as the last year or so, redistribution of GST receipts based on pressure that politicians from Western Australia put on the federal government.

CHAIR - Mathias Cormann, before he left.

Mr DIGNEY - Correct. While federal funding is always going to be important and we'll always need it, if you think things are concerning now in how the health system is run, in our view it would be 10 times worse if they were as remote as Canberra running it. There is no way that we, the union, want health handed over to the feds.

CHAIR - If you could get a non-partisan approach to a strategic direction for health - ideally a 10- or 20-year rolling strategic direction to that, with dual-funding models with an agreed approach to where the funding from the feds goes and where the funding from the state goes, could that work?

Mr DIGNEY - I think so. It would work better than the current arrangements.

Dr SEIDEL - A follow-up from what the Chair mentioned, you mentioned X-rays and pathology done by the Commonwealth, whereas here in Tasmanian hospitals it is done by the state.

CHAIR - Paid for by the state.

Dr SEIDEL - It doesn't really apply to the regional hospitals, such as North West Regional, the Mersey and all the smaller district hospitals because pathology is outsourced to a private provider and so is radiology.

CHAIR - But if you're an inpatient and you're sent to the private radiology, you don't get charged.

Dr SEIDEL - It's a Medicare funding arrangement.

CHAIR - Yes.

Dr SEIDEL - So there's no cost to the state. It's the Commonwealth that takes it over.

As a union, what's your view on outsourcing those services from a state obligation to a Commonwealth obligation? Is there a concern there or is it something you would encourage and let the market decide?

Mr DIGNEY - We'd much prefer the services to be delivered by the state, Bastian, and that's simply because of the remoteness of control. In terms of services where there is already a large private-sector footprint, in particularly pathology and radiology, those arrangements already exist and if it's going to save the state money then we'd be happy to have those discussions.

We're a little bit concerned about the spectre of outsourcing large parts of health that are currently in-house. That's more around support services for health delivery rather than health delivery. If you think about corporate services at the hospital, all the building, engineering and the cleaners, it looks to us like it could be easily sliced off and we certainly don't want that.

In terms of those services that you referred to before, Bastian, if the partnership model as it exists in the north-west, where there's better value for money for the state and that money is able to be redirected into service delivery, well, let's talk about it. We're not 100 per cent averse to it.

Mr DUIGAN - You mentioned before market pressures on various types in the health system, where are those market pressures, what are the real market pressures?

Mr DIGNEY - Ultimately, for a couple of cohorts like the ones I mentioned before, Nick. In allied health, occupational therapy and psychology, there just hasn't been enough of them trained, given the projections from a decade ago on how many of that particular cohort we'd need. That's one.

Psychology is an odd one because it's a very difficult qualification to get so a lot of people don't make it through there.

Ms LOVELL - It's seven years or something.

Mr DIGNEY - The other factor, Nick, is the National Disability Insurance Scheme. The demand for allied health services in that area is unmet and the money that allied health professionals are able to earn by doing assessments for people living with a disability or trying to get an NDIA package, they can earn thousands of dollars a week and they simply are leaving in their droves to go and do that.

CHAIR - I want to take you to our term of reference 5, Staffing and Community Health and Hospital Services, so staffing issues. Do you have any comments on that term of reference?

Mr DIGNEY - As we've outlined in the submission, Ruth, we're working with Health at the moment on a staffing model for the district hospitals which was agreed on by the parties

and we're working through the assessment of that and seeing where it's at. The reality is, as we've outlined, the ability for them to recruit staff. We're already three months into an assessment period of that staffing model and at least half of the hospitals haven't even been able to recruit to the model. How can we assess how good the model is if there's an inability for them to recruit staff to fill the model?

That goes back to those issues I talked about before: this staffing model is only for assessment for 12 months so those additional positions that have been created because of what the model says the numbers are, they're only for a fixed term. No registered nurse is going to leave a permanent job for a fixed-term position at Oatlands or King Island, so they're now banging agency staff into there. We're keen to know how much that's cost them.

Dr SEIDEL - Madam Chair, specifically on the staffing model, that only applies to THS-run facilities or also to the facilities like May Shaw and Nubeena?

Mr DIGNEY - No, only THS. Swansea is run by May Shaw as a private enterprise.

CHAIR - The model that you've worked on -

Mr DIGNEY - District Hits it's called.

CHAIR - What is the underlying service level that's expected to be delivered through that?

Mr DIGNEY - The staffing model comes out of the nurses' agreement. It's basically a workload model for the nursing cohort.

CHAIR - To deliver what workload?

Mr DIGNEY - To deliver whatever nursing is to be required in that particular site. They assess management hours, quality assurance, occupancy, acuity, a range of factors and the equation spits out an FTE number.

CHAIR - We know that many of our little regional hospitals have quite low occupancy rates, which demonstrates a degree of under-utilisation. If historic occupancy rather than capacity is being modelled into that then you could be underdoing it. If the intention is clear to use these hospitals to their full capacity - which you need to have enough staff to do - from your understanding, is the Government's intention to try to maximise utilisation of these facilities?

Mr DIGNEY - Maximise utilisation.

CHAIR - They're planning to staff them to that level but we can't do that because we can't recruit staff because there are one-year contracts.

Mr DIGNEY - Everything that you've said is correct. The staffing model also takes into account the amount of support staff that will be needed - ward aides, hospital aides, health care assistants, cleaners. That was something we got squeezed in at the end which we were thankful for.

CHAIR - Nurses can't operate without support.

Mr DIGNEY - That's right. The utilisation of hospitals, which is something you touched on in that statement, is something that needs to be looked at because there's a real opportunity, if you run it as one system, for those regional hospitals to take the pressure of the acute sides. I come from the north of the state so I always think about my personal experience from Launceston. If Deloraine, Beaconsfield, George Town, Scottsdale hospitals were staffed appropriately they have the capacity to take category 3 medical, category 3 surgery, patients who would otherwise been an inpatient at the LGH.

CHAIR - It's not just numbers, it's skill mix.

Mr DIGNEY - That's right. The other issue is we have this weird thing in the regional hospitals where some of the beds are quarantined for aged care. The THS is getting aged care funding, which is a funding stream, but you have this weird mix where you're delivering residential aged care and acute health in the same space. It's not efficient.

CHAIR - One would argue it's not the best place for aged people to be in either.

Ms LOVELL - No, it's not.

Mr DIGNEY - There's nowhere else for them though unfortunately.

CHAIR - Yes, I accept that.

Mr DIGNEY - The majority of people are simply in there waiting for a placement.

CHAIR - Or a home care package.

Mr DIGNEY - Yes, or a home care package.

Dr SEIDEL - I'm sorry, you're almost out of time. In those outsourced district hospitals, for example, May Shaw, Nubeena and Dover - we've been to Dover and Nubeena - certain KPIs apply, so occupancy rate has to be 85 per cent or it loses funding. It means nurses and support staff just have to make it work because they will have the same recruitment issues to get nurses into those facilities.

Mr DIGNEY - They have even worse recruitment problems, because they're paid on the federal system award. They're not state public servants, so their rates of pay and their terms and conditions are far less than what the state's employees are.

Dr SEIDEL - So it's not a level playing field.

Mr DIGNEY - It's absolutely not a level playing field.

Dr SEIDEL - How much pressure are your members under who work in those facilities?

Mr DIGNEY - They're under significant pressure and they have workload issues every day. They are falling over themselves to deliver the best care they can with the resources that have been provided.

Dr SEIDEL - So, you're talking double shifts and the like.

Mr DIGNEY - Double shifts, extended shifts, we're talking working short, working without an ANUM. All of those things combined are more common than they are not.

Dr SEIDEL - Would it be your preference, based on your experience then, to bring those beds back into a THS-managed environment for consistency, fairness and governance issues, I would imagine?

Mr DIGNEY - Absolutely, yes. If I live in Oatlands and I can go to my local health centre and it's run by the state, why should that be any different if I live in Swansea?

CHAIR - History.

Dr SEIDEL - Politics.

CHAIR - Political history. Do you want to make any closing comments, Lucas?

Mr DIGNEY - There are two things I want to correct in our submission, given how old it is. In the preamble on page 1 we now represent over 9000 union members in Tasmania, as of this morning. On page 8, the third paragraph down is a single line and it says, 'Hospitals which once served a rural community have either closed …', and then it should say, 'or had services significantly reduced'.

CHAIR - Did you want to provide the committee with an updated version of that?

Mr DIGNEY - I will, and I will also provide a copy of those reference documents in terms of the allied health value paper and our recent allied health discussion paper.

CHAIR - Thank you very much for your time, we appreciate you coming in, for your submission and evidence today.

THE WITNESS WITHDREW.

Dr MEG McKEOWN, VICE PRESIDENT, RURAL DOCTORS ASSOCIATION OF TASMANIA, WAS CALLED, MADE THE STATUTORY DECLARATION, AND WAS EXAMINED.

CHAIR - Welcome, Meg, to our Rural Health Inquiry hearings. We appreciate your appearance and the submission that was provided. It was very comprehensive and very helpful. This is a public hearing, it's being broadcast and will be part of the public information that's published on the website, and inform our report at a later time.

If you have anything of a confidential nature you wish to discuss with the committee, you can make that request and the committee will consider that, otherwise it is all public. You are covered by parliamentary privilege while you are before the committee but that may not extend beyond the committee hearing.

Dr McKEOWN - Thank you for the opportunity to present at the inquiry. I also wanted to let you know that I am a Tasmanian. I started out in Zeehan on the west coast in 1974 and completed my secondary schooling in Burnie on the north-west coast in 1992.

CHAIR - The good north-west coast.

Dr McKEOWN - I lived on the family farm in Ridgley during my high school years, and I understand rural and remote Tasmania.

I have come to medicine as a second career, after 12 years as a veterinary surgeon. All of my rural generalist GP specialist training has been in rural, remote and very remote locations, including Antarctica.

Thank you for asking me to present evidence today - evidence that is relevant to rural Tasmanians and their situation of poor health. It should be called the Poor Health Rural Inquiry.

I am currently the medical director of the Moreton Group. We deliver health care to people living in Tasmania without a permanent address. We have 3000 active patients without a permanent address on that service. More recently, we have opened a rural general practice in Ouse, a township of 300 people, located in the Central Highlands, and we now deliver health care to a socioeconomically disadvantaged, ageing, chronically unwell population, with a wider catchment numbering around 1500 people.

I am vice-president for the Rural Doctors Association of Tasmania, known as RDAT, and I am a rural generalist. A rural generalist is a medical practitioner who is trained to meet the specific current and future healthcare needs of Australian rural and remote communities in a sustainable and cost-effective way by providing comprehensive general practice and the required components of other medical speciality care in hospital and community settings as part of a rural healthcare team. The key word for me is 'team' - but the key words for you may be 'cost-effective'.

The major challenge for rural and remote Australia is that health outcomes are poorer than they are for urban populations. Our access as rural Tasmanians to health care is restricted. The health literacy in rural and remote regions is reduced.

To improve health in rural and remote parts of Tasmania, we will need reform, we will need investment, and we will need an adaptive approach to this adaptive problem. We cannot rely on a technical approach.

Just as making safer and safer seat belts will not further reduce your road mortalities, neither will trying harder and harder under our current rural [inaudible] lead to better patient outcomes. You will need to remove the barriers. Fixed thinking about how we have always done things needs to be challenged. New models need to be trialled. Community needs will need to be appraised. There is not going to be one cookie-cutter solution that can be applied to all communities.

What each community has in common is scarce resources, separation from large hospitals, a shortage of health professionals and, on the whole, a population that is more negatively affected by social determinants of health than the city folk.

The Central Highlands local government area ranks 57th out of 574 local government areas in Australia, with a socioeconomic index for area score of only 883. A score of 1 out of 5. They are red on the map. They are on par with the desert areas of the Northern Territory. That map is worth having a look at. What is unique about each community needs to be acknowledged and explored. A plan for the Central Highlands was created last year by the Health Action Team. I do not see it reflected by the local community health service, or the outgoing GP practice for that matter.

We have allowed rural and remote communities to languish in poor health for a long time, and now things are so dire that there is a parliamentary inquiry to try to figure out how to fix it. The fix is going to cost money to ensure the rural people get the care they deserve, which is precisely no less than the care someone living in urban areas of Tasmania receives.

If you want to hear about potential solutions for rural health, consult with the rural health force. I would like to know who you think the Council of Rural Doctors representative for the Tasmanian AMA is. You have had evidence from the AMA. Who do you think the representative for rural doctors in the AMA is in Tasmania?

CHAIR - I don't know. Do you know, Bastian?

Dr McKEOWN - Have a guess.

CHAIR - You?

Dr McKEOWN - It is me. It isn't John Saul and it isn't Helen McArdle. The Council of Rural Doctors' representative for the AMA is me so why did the AMA not send me? Why did they send the president and the vice president to the Rural Health inquiry and not the Council of Rural Doctors' rep? I will tell you why. The AMA Tasmania is not an advocate for rural doctors. That is why RDAT exists.

While the national AMA president, Dr Omar, has written to the president of the Australian College of Rural and Remote Medicine reiterating the AMA's support for the recognition of rural generalist medicine as a specialist field within general practice, the AMA Tasmanian president admitted on radio in August 2020 that she doesn't really know what a

rural generalist is. She thought perhaps it was just a GP who delivers babies, which of course we don't need in Tasmania because GPs don't do that.

Did the Tasmanian AMA happen to mention the federal AMA's integration of general practitioners into rural hospital's position statement released in September? I know they didn't. I do have a copy if you would like it.

CHAIR - Thank you. If you would like to table that.

Dr McKEOWN - The position statement sent a clear message:

> … ensuring that the rural doctors, whether employed by the state or working in private general practice are working together in rural towns in integrated and mutually satisfying arrangements will lead to increased job satisfaction and contribute positively to the retention of the workforce.

The Tasmanian state government needs to stop listening to the Tasmanian AMA about rural issues until the AMA starts listening to the rural doctor contingent. Helen McArdle's written statement that she has submitted said there is an easy solution which would be to provide free transport between hospitals and community services in line with the Cancer Council patient transport. This is a ridiculous statement when a rural generalist multi-disciplinary team model can keep people in their community and out of an overburdened hospital system by delivering primary care in a cost-effective healthcare model.

Helen McArdle was insensitive when she wrote this statement. There were three lives lost in 2012, who she has probably forgotten about, when the cancer transport bus rolled over and killed three patients. In case there are new Tasmanians here today I want you to remember that the transport to treatment minibus carrying nine patients and a driver struck a truck trailer, slammed into a power pole on the Bass Highway at Elizabeth Town and a 65-year-old Devonport woman, a 69-year-old Riana man, were pronounced dead at the scene and an 85-year-old Ulverstone woman died later at the Launceston General Hospital.

Travelling up and down our roads to receive healthcare is dangerous. Bringing people on a bus from rural areas to the city for care is an example of a technical solution for an adaptive problem. This solution offered by the AMA to this very committee would be taking people from their homes and workplaces on a bus to access the city folks' care and it is not appropriate and it is insulting.

Helen McArdle is also wrong when she says there are not enough people for all the services a family as described above would need. What she perhaps meant to say was that our current model does not provide that opportunity. We need to be innovative and support new models of care that provide for the community we are serving. The technical approach would be to bus people. We now need to have an innovative approach.

To quote Ruth Stewart, the National Rural Health Commissioner:

> Innovation - when you approach it as a rural generalist you can enable the delivery of care in your community that is equal to what anybody in Australia can get. It just looks different. We will need forward thinking, legislative change and strong adaptive leadership from all of you. Recognition in

> Tasmania of health professionals who are working in primary care elsewhere in Australia to expand the Tasmanian rural workforce without demanding more doctors is required.

John Saul stated in his evidence:

> But if you have a job for a GP why don't we just support our GPs better? A rural generalist recognises the health professionals in their team as vital. The team becomes more than a sum of the individual parts.

City GPs are not used to this rural generalist model of a team leader with many other health practitioners with them. Having the pharmacist review a patient's medication as part of the rural generalist team is a perfect innovative safety check for the patient and not, as John Saul states, a GP surgery role. The pharmacist can be in the GP surgery so they could be a GP surgery role for the pharmacist that is there.

Once again, the AMA is displaying its lack of understanding of the rural scene. In 2020 John Saul said to me on the phone, 'Can you take over the Tasmanian AMA rural doctor representative role? I have no idea what all these acronyms like ACRAM and RMP even mean. I would be better in the GP rep role'. We swapped positions. Stop listening to people who do not have an understanding and a fix in their thinking about what constitutes a job for a doctor versus a job for another highly qualified health professional.

A change in legislation to enable recognition of paramedic practitioners and physician assistants would be a show of leadership from the state government to the rural Tasmanians. This is an example of an adaptive response in an adaptive space.

Recognition of skills just being skills and upskilling people available to perform those skills would reduce the workload of the currently available health professionals. We already do this from time to time in our health sector. Orderlies in the emergency department of large hospitals will put your plaster cast on. If you get blood taken in the community, it is taken by a lay person, trained only in that skill of blood collection. There is no reason why someone couldn't be a phlebotemist and an admin in a rural practice, for example. Come to Ouse and I will show you how we do it, because that is what we do.

The plasters could be put on by the volunteer drivers or volunteer ambulance officers who can be trained in the specific skill. There are many skills which could be delegated in that way. Upskilling the people around us to provide the services reduces the demand on the health professionals who are in short supply and allowing other fully-qualified, university-trained health professionals to enter primary care space as part of the team, led by the rural generalists will also reduce the burden. The approach is adaptive, innovative, evidence based, safe and cost effective.

Instead of this approach, when I arrived in Ouse I found a big, empty, community health centre with one or two patients seen every day or so for a dressing or an injection which was ordered by someone else. On the first day I was there I cannulated an elderly man with chest pains and there were no IV dressings, there is no plaster sorter to remove plaster because there is no plaster available to be applied. There is no slit lamp to remove foreign bodies from farmers' eyes and there is no bed to administer an infusion in privacy.

Patients are travelling to Hobart for x-ray, gynaecology, dermatology and a whole range of other services. There is a Telehealth set up. I have a seen it used once in the last four weeks for a court case that was televised from New South Wales.

The arrival of Moreton Group has been received overwhelmingly positively by the local residents. We have seen over 350 new patients in four weeks which is one entire town and we have already built our team from one doctor to two doctors, a paramedic practitioner and two admin assistants, one of whom is now able to take blood and soon will become our pharmacy dispenser. However - and this is the disappointing bit - our presence inside the community health centre is somehow seen as a threat by the nurse unit manager.

We have been told that we are horrible, we take up too much space in their otherwise empty facility, we are not to touch the THS equipment. I am actually a THS credentialled VMO GP specialist. I have access to their email and I am committed to working collaboratively with all the healthcare professionals we have in the community. Unfortunately, the old-fashioned structures and the deeply-embedded culture of siloing and fear of change is proving a significant barrier to us doing what we are contracted there, by THS, to do.

Another significant barrier is the personal and financial costs of working in rural health. It is very clear to me why you can't attract doctors to work in the rural and remote sector in Tasmania. I get offers every single day for other work. Come work for us, $2400 a day to $2600 a day. Come for a week, come for two weeks. I have to choose between driving for two and a half hours every day or buying real estate in the community. If I want any personal, social life, this is what I will need to do.

I am not able to only focus on seeing patients, as I am too busy trying to figure out how to do grant applications in order to keep the practice open and I am on the phone, begging for help, trying to fix an outdated and very broken system. These barriers need to be removed if you want a different outcome to the one we are now having. Doing the same thing over and over and expecting a different outcome is the very definition of madness. To remove these barriers will require adaptive leadership, innovation and investment.

Thank you.

CHAIR - Thank you for your frank assessment

Dr McKEOWN - Bleary eyes.

CHAIR - It was still very instructive for the Committee, so I thank you for that. There are a lot of things that you said there and it is a bit hard to know exactly where to start, but I am sure the whole Committee take on board the things you have said to us.

You talked a lot about barriers and removal of barriers and you talked about the need for legislative change. Meg, if you could talk us through the key barriers and whether there is legislative change that will remove that barrier and what that would look like, or other barriers. Perhaps cultural change is one of those.

If you could talk about those and and flesh out those matters a bit more.

Dr McKEOWN - Yes, of course. I was listening to Lucas in the last session talk to the models of funding, and the issues they cause. We have come to Ouse with four days' notice to create a GP practice for a GP who disappeared because they didn't meet the mandate for vaccination. That was empty, and we needed to start, so we started it straight away.

It didn't give us much time to actually negotiate for what we could receive from the state Government. Our negotiations were hampered because in Ouse we're not in the Rural Medical Practitioners agreement anymore. Somehow, we disappeared off the RMP last year at some stage. I can't actually find out -

CHAIR - We being the Moreton Group?

Dr McKEOWN - No, Ouse as a location. It is no longer considered a rural location on the RMP. As a rural medical practitioner, I have no way to actually negotiate for myself in that position. I don't have any cover by legislation. The negotiations happened between my general manager and the state Government.

The state Government seems to think we only need 18 hours of cover by a doctor in Ouse, and 18 hours is all they will fund, based on what we would receive if we were on the RMP. So, we are actually going to be open Monday to Friday. I'm moving to the town and I have to make this work to be able to pay myself, pay the other doctor, pay my paramedic practitioner - who doesn't actually access Medicare benefits - and pay my admin.

Dr SEIDEL - I'm specifically going to follow up on this one now, if you don't mind.

CHAIR - That's fine.

Dr SEIDEL - Meg, you mentioned the RMP agreement. The signatory to that is the department, the minister. The AMA-negotiated that agreement. The last one was done in 2017. How frustrated you are that organisations that are the natural partner for those agreements that affect you as a rural doctor obviously don't take into consideration what rural health actually is all about. Is that an issue for you as an organisation, and for you as a rural doctor?

Dr McKEOWN - Ask the question again?

Dr SEIDEL - It's the AMA that is the signatory to the Rural Practitioner Agreement?

Dr McKEOWN - Yes.

Dr SEIDEL - How come it's the AMA that's doing that, and not the rural doctors?

Dr McKEOWN - It's interesting that you say it's the AMA, because I rang Lara Giddings and I asked her specifically when did Ouse stop being a rural community on the RMP, and she said, 'Ask someone else.'

Dr SEIDEL - Because it's on there now. It's tier three of the 2017 agreement.

Dr McKEOWN - It's not on there anymore. It's removed. You look at the new one. It's gone.

Dr SEIDEL - And that was agreed to by the AMA?

Dr McKEOWN - I don't know. I cannot find out. I've asked you. I rang Lara and asked her. I rang Alison [inaudible] within the department and asked her. She actually doesn't know what the RMP is.

The Rural Doctors Association is also involved in negotiations when it comes to the RMP. We come to the table with the AMA, and Eve Mayfield has been doing that. She also doesn't know when that happened.

CHAIR - I'm not sure what the process is for having it reinstated.

Dr McKEOWN - It might not be helpful to have it reinstated.

CHAIR - It might not be.

Dr McKEOWN - The point that came out of the whole process for me was that the state Government thinks that the largest local government area of Tasmania - it's a vast distance - with the smallest population, only requires 18 hours of GP cover from Ouse.

Ms LOVELL - Meg, you said that under the RMP, that would be the same.

Dr McKEOWN - That was based on what we would be, as a tier three on the RMP, but I don't know how they came up with the 18 hours. That seems very arbitrary. The practice that was there before us was open five days a week. We are booked out now weeks in advance already, so the demand is not 18 hours. If I did 18 hours, people would die. More people would die, I should say, because people are already dying.

Ms LOVELL - Can you explain to us how that works, then. You mentioned all the other things that you need to cover in terms of funding and paying for staffing and things. How do you make that work?

Dr McKEOWN - Our income stream now is a small amount of funding from the state Government for being open for 18 hours, some in-kind support with items within the community health centre - although whenever I touch something from the THS, I get told by the NUM to stop using it; I get told to move from rooms, and there's no collaborative support from her. But there is an agreement with Bruce [inaudible]to have in-kind support by means of some items inside the practice - so, exam beds and a few bits and bobs.

With the Medicare income from billing the patients, we are in a situation where the income is about 30 per cent lower than the rest of the state, on average. They are very poor people. We have agreed to bulk-bill as many people as we can. I have not privately billed anyone yet, except for some WorkCover, but no private billings to a patient as yet. If I do that, I can get a Medicare income of $50 a patient. I am seeing about 20 a day. The income for a rural medical practitioner of my level of experience is more like $1800 a day. My entire income is not even reached by that Medicare income, so I can't pay myself. I haven't been paid. Out of that money, I also need to pay my other staff. It is not financially viable to continue.

Ms LOVELL - How sustainable is that?

Dr McKEOWN - Zero sustainability.

Dr SEIDEL - Why did the Moreton management group actually engage? Is it goodwill just to make it work, because otherwise there would be no doctor whatsoever?

Dr McKEOWN - We were hoping there would be considerable support from the state Government to make it work.

Dr SEIDEL - I would imagine if people in Ouse don't have a doctor, they would have to call an ambulance and they go to the Royal Hobart emergency department, which is already packed.

Dr McKEOWN - Yes.

Dr SEIDEL - It doesn't make sense, does it?

Dr McKEOWN - It does not. They are already having to travel for a whole lot of things I could do for them in Ouse if I was given opportunity and resources to do so. I am quite happy to fill a filling in a tooth. I can do dentistry. I can take x-rays. You sent me to Antarctica and I was quite competent in that space. You brought me back to Tasmania and gave me no resources and then had an inquiry into rural health prices. It makes no sense to me.

It needs proper funding, and we need a correct assessment of what the needs of that community are. Say it is 300 people. You need to spend this amount of time with them. Don't worry about the other 1200 from other regions, just those 300 in Ouse, and we are not going to give you enough funding to make it viable.

Ms LOVELL - Since taking on that practice, have you or the Moreton Group had an opportunity to have this conversation with the minister, the health department, anyone who does control that funding?

Dr McKEOWN - No. It is only very new. We are four weeks in now. That initial discussion is still very fresh, and I don't see anyone scrambling to have it again.

CHAIR - If I was the minister, what you say to me now? Be nice.

Dr McKEOWN - The minister knows this. I have already spoken to him. He came to one of my vaxing clinics for the homeless in Launceston. We had a bit of time with him at the palliative care forum a couple of weeks ago. He knows the situation.

If we are serious about improving rural health, we have to foster the rural generalists. We have to fund the rural generalists' health pathway properly. We have to train the doctors into the positions, but we also need people like me to be able to mentor them and to be able to teach them.

CHAIR - And to be funded to do that.

Dr McKEOWN - I can't teach them if I am all day managing all of the patients. The people I have with me are not funded through Medicare. I have a paramedic practitioner who

works as my physician assistant. She can't bill through Medicare, so all of my earnings are important. If I allow her to see a patient, and I don't see them, they get seen for free.

I either have to see all of my patients and all of her patients, or we find another model where we can fund her, and we make legislative change where we can do that.

CHAIR - What is the legislative change we need for that?

Dr McKEOWN - We need to change the Poisons Act 1971 and its regulations - this formally came before you not long ago - and the Ambulance Service Act 1982, the Mental Health Act 2013, the Public Health Act. All of these.

CHAIR - You agree with that.

Dr McKEOWN - Yes. The Poisons Act would be a great place to start. We were thankfully allowed to have paramedics immunise with us on our program. We would not have been able to immunise every homeless person in Tasmania without the paramedics. We have no health workforce. We managed to multiply the workforce by 10 by just being allowed to employ our paramedics in that role.

It is an IMI injection. When they went to train, the authorised immunisers that were training them said it is very important to realise how serious this IMI injection can be. It can sometimes cause anaphylaxis. However, paramedics have been treating anaphylaxis for their entire career, on their own, on the road, quite competently. Take them out of the ambulance service and they are not allowed to do it. They were allowed to be part of the program, but limited to the COVID-19 vaccination program, under the authorisation of another immuniser.

I can supervise them and my ANIs can supervise them, but they cannot do it independently. When we have a clinic, we have to have either myself or the ANI in charge of the clinic, and the paramedics can be with us; which did limit us a little bit. If I was otherwise engaged and Maddie was away on the north-west, we couldn't run another clinic.

Ms LOVELL - What is an ANI?

Dr McKEOWN - An authorised nurse immuniser.

CHAIR - Have you talked to the minister about the need for legislative reform to at least facilitate this aspect.

Dr McKEOWN - I don't think we have had a forum with the minister about this. I'm happy to. It does need to change, if we want to increase our health workforce. We can either recruit more and more doctors - that doesn't work, there aren't more and more doctors - and no one wants to drive up and down to Ouse 10 times a week.

CHAIR - No one wants to do what you are doing, I wouldn't think.

Dr McKEOWN - No, I don't even want to do it.

CHAIR - Why would any doctor want to do it. You don't spend all those years at university to do that.

Ms LOVELL - You are saying you don't have time to train someone. If you did have time, what are you training them for, what kind of job? You would be turning people off more than anything, if they are watching what you are doing.

Dr McKEOWN - The whole point of the rural generalist model - and it works well in other places; we are way behind in Tasmania -

Mr DUIGAN - In other places, where?

Dr McKEOWN - Queensland is probably where your gold standard RG model came from. Queensland doctors have admission rights and often are the in-charge of the hospitals; it's not so much nurse-based in Queensland. They do have the rural generalists as the in-charge of their little hospital, they will do their specialist practice, their advanced skill practice in that hospital - obstetrics, anaesthetics, surgery - and they will also sit in general practice and see primary health care. They will run the rural emergency departments. All done by GP RGs.

CHAIR - On that, one of the reasons we lost our GPs with obstetrics was insurance.

Dr McKEOWN - Was it?

CHAIR - Apparently, so we were told.

Dr McKEOWN - Who told you that?

CHAIR - Obstetricians, maybe.

Dr McKEOWN - That is interesting, isn't it? What happens when you take the GP obstetrics out of the town? You think, oh well, ladies can travel to the nearest big hospital and have their babies …

CHAIR - You would build a new highway if you were the federal government.

Dr McKEOWN - … but you also lose the GP anaesthetist. If you lose the GP anaesthetist you lose the GP surgeons, so you can't have a proper RG model if you get rid of the GP obstetrics. I have been told, without a shadow of a doubt, we will never ever have GP obstetrics in Tasmania.

CHAIR - Who told you that?

Dr McKEOWN - AMA.

Dr SEIDEL - Can I follow up on this one. There was the state election and not to be political, but the policy was to reintroduce maternity service into rural areas. Mersey, for example, was an idea to consider. It was supported by the RDAT because it was evidence based, strongly opposed by the AMA who doesn't have that level of expertise in this particular area.

Mr DUIGAN - Strongly opposed?

Dr SEIDEL - To reintroducing maternity services into rural areas.

Dr McKEOWN - You have to think about what the AMA is: it is an industry body. It is an industry body protecting their specialists. They don't recognise GPs as a GP specialist. I am a specialist, a GP specialist. They are non-GP specialists, also known by me as a partialist - they only look after one part of the body. Your GP specialists look after everything. They are opposed to GP obstetrics because it threatens their specialist model. They are an industry body. If we have to listen to an industry body about rural options, we should listen to RDAT.

Maybe we shouldn't be listening to industry bodies. Maybe we should be listening to the Australian College of Rural and Remote Medicine. When we think about surgery, talk to the surgical college.

Dr SEIDEL - Point of correction. I looked up the Tasmanian Medical Practitioner Agreement again from 2020, and Ouse is no longer on the list.

Dr McKEOWN - Surprise.

Dr SEIDEL - The way it has been listed, there are special funding arrangements in place and they are outside the Rural Practitioners Agreement. It was signed by the AMA representative.

Dr McKEOWN - Which obviously happened with the previous practitioner that has now left. There is no transparency of what the process was.

Dr SEIDEL - Okay, can we talk about transparency then, because 2017 it was the same doctor/practice in Ouse. In 2020 it is off. It is the same body signing that, the AMA and nobody knows what they actually signed.

Dr McKEOWN - It's more that no one will tell me what actually happened - what the process was, why that happened and whether we should get it reinstated, and have a think about if that has disadvantaged the community or advantaged them. I can't work it out. They won't tell me why it was done.

Dr SEIDEL - For the Ouse community what time frame do you have before you have to pull the trigger and say, 'I can't do this because we are losing - we can't make it work.' You don't make a profit, I would imagine, just will have a surplus; but if you can't even achieve that, what are you going to do next?

Dr McKEOWN - It's a good question. I am hoping to get some other funding streams happening but this is going to be a lot of work for us and it will take away from patient care. There's a Primary Care Rural Innovative Multidisciplinary Models (PRIMM) grant from the Rural Health Commissioner that we will probably qualify for that will help us to prove our model. We will be able to use some of that money to pay the people in our group that are not able to access Medicare billings; but I still have to make more money.

One innovative idea came up when we were brainstorming the other day, that maybe I should leave the practice, and earn $2600 somewhere else and supervise remotely. That would bring in more income than me being in this practice. Me being in this practice is not working.

Dr SEIDEL - You are a highly qualified specialist in rural generalism with more post-nominals than anybody I have seen for a long time. You have made a decision to move into a rural area and to commit to it - buying a house, having a multi-disciplinary team approach - and you are saying that financially it would make more sense to earn a locum rate anywhere else and then just subsidise and do a charity thing.

Dr McKEOWN - Yes. That's where we are at. It needs more funding.

Dr SEIDEL - That's rural Tasmania in 2021.

Dr McKEOWN - Yes, that's correct.

CHAIR - If the governments, federal and state, were serious about this, wouldn't they fund it in such a way that it was at least sustainable?

Dr McKEOWN - They would, if they were serious about this.

CHAIR - Sure. One aspect of that - and this is on page 5 of the submission - 'The consistent message from community general practice is that the MBS rebates for patients are set below the cost of running a general practice'. Would we start there?

Dr McKEOWN - Yes. The MBS rebate was never meant to be payment for the doctor. When it was first created it was meant to be a small rebate to the patient to make affordable health care. I go to the doctor and instead of paying $50, I pay $30 because I get $20 back. It was never meant to be $20 payment to the doctor for the person to go to the doctor.

Now we have had it indexed a little bit, there's $50 rebate. That is not enough money to pay the doctor to see you for 20 minutes. That $50 is meant to be a rebate to the patient to make it a little easier for them to cope with the cost of going to the doctor. It has become the clear message that bulk billing is everyone's right and free health care is everyone's right.

CHAIR - It would be if they paid enough - a high enough -

Dr McKEOWN - It would need to be probably $120, not $50. We either charge the people of the Central Highlands to come to the doctor, in which case some people won't come and they will get sicker; or we have funding from somewhere else.

CHAIR - Have you had discussions with the federal health minister about this matter? Does he understand it?

Dr McKEOWN - We have talked to the Rural Health Commissioner and she is the person that liaises with the federal health minister. He does have a good understanding of what is going on. He knows.

CHAIR - Is he likely to do anything about it?

Dr McKEOWN - No. It would be too expensive. If we did it across the entirety of general practice it would be too expensive. We either have to think about whether we want to fix rural health, or do we want to fix the entirety of health, because it would be very expensive to fix this problem by making everyone get free health care.

CHAIR - If we didn't make it full cost recovery, so you left some smaller gap for patients to pay and, those that can afford to, actually can, then it's not as expensive. Sure, it is more expensive than what's happening now. However, when you balance that against the cost of these people calling an ambulance, turning up in the emergency department and being sicker when they do because they have delayed it, then surely there must be a cost benefit.

Dr McKEOWN - That's a cost to the state government. The federal government doesn't actually care about that. And there's no cost to the patient, to do that.

Dr SEIDEL - To follow up from there, because the agreement as a rural medical practitioner is with the state and yourself, you probably wouldn't mind bulk-billing all of your patients if the RMP agreement would allow a compensation?

Dr McKEOWN - Correct.

Dr SEIDEL - As a practitioner you couldn't care less where the funding comes from.

Dr McKEOWN - I do not care less.

Dr SEIDEL - And you are not asking for million-dollar salaries; you are not a celebrity surgeon who drives an expensive car. You're a rural doctor who wants to make a difference to the community, so it doesn't really matter. Do you believe there is a role for state/Commonwealth partnerships to ensure that doctors can do good work in rural communities?

Dr McKEOWN - Yes, I think it has to be like that because if the federal government made a move to fix all of GP practice to be more affordable for patients across the whole of the country we would go broke. No word of a lie. But if we managed to have some state input and the Medicare together, which we do, but it is not enough from either side to make it viable. Right now, Moreton Group is paying. I am paying for that.

CHAIR - If there was an elevation of support from both sides, you are still going to get the cost shifting. That is part of the problem here, saying we don't care about that, it is not our problem. I will go back to the question. If I was the minister sitting here what would you tell me you need?

Dr McKEOWN - More money.

CHAIR - More money. We always hear we need more money but what do you need more money for?

Dr McKEOWN - To pay the people who work at the practice so that the practice can exist.

CHAIR - What I am hearing you are saying, Meg, is you need the state to put money into GP services to help cover that gap between what Medicare pays and what it costs to see a patient?

Dr McKEOWN - Yes and no, because I don't actually think we should have more and more doctors in these GP practices. I don't think we should have a sixth GP practice. It probably has enough work there for a four GP practice but we don't need to do that. We could do it with one rural generalist coordinating a team and then delivering all the allied health and health services that the community needs. It is not an expensive model, but we need either more income to the practice by billing the patients or we need more funding from other sources to make that viable or we can forget it and they can go into Hobart.

CHAIR - You can put the money into providing that multi-disciplinary practice where the state funds some of those allied health professionals with necessary legislative change to enable them to work across a full scope and perhaps an expanded scope for some.

Dr McKEOWN - Correct. You already know what needs to happen.

CHAIR - Yes, but I need you to tell me because you are on that side of the table and I am on this side.

Dr McKEOWN - If we had a proper collaborative multi-disciplinary team, which is more than the sum of its parts, working in Ouse, delivering the healthcare that is required, because we have worked out what was required. If we had time to do a needs assessment and we had funding from the state government, the federal government and philanthropic if they would like to, which is the Moreton Group, and other grant forces, we would be able to make this happen.

Right now, pretending that we only need 18 hours a week when we need 60 hours per week funding, having legislation that prevents me from utilising the full scope of practice of my practitioners and basically a situation where we can't make enough money unless we bill those patients and then make them not come, I just don't see a way out.

CHAIR - If the model was well-understood, supported and funded, it is a model that would work all around the regional areas of Tasmania, not just Ouse?

Dr McKEOWN - It would. The makeup of your team would change from location to location, depending on needs but the actual model would work anywhere.

Dr SEIDEL - I want to be quite specific there because earlier we have said if you have seen one rural community you have seen one rural community. We know the needs are all very different. So if we have the one model, is there a difference between having the one funding framework which multiple funds according to patient's need and then the composition of the teams that deliver the care, it depends on the context - who is available, who wants to come?

Dr McKEOWN - The first thing that needs to be done is that needs assessment. You can't just march into an indigenous community in the Northern Territory and know how to fix it. It is the same for this. You need to ask the elders what they need. We need to ask the people of Ouse what they need. People ask me, in your medical needs assessment program for people living without a home, how do you work out what they need? I have this amazing thing we do. We ask them and they tell us. We need to ask and we need to find that out and, of course, not every community it the same. I have lived on the west coast, the north-west coast and I have come across the border into the south and that is different.

Dr SEIDEL - In your role as the RDAT vice president, how are you progressing the rural generalist model in training pathways, having the placements in hospitals, ensuring that we can train people in anaesthesiology? We need to make sure that quarantines with specialists don't have those transports. How are we progressing now?

Dr McKEOWN - Yes. It's progressing on a federal level more than a state level. We have a rural generalist pathway committee that I sit on as the ACRRM rep here in Tasmania and I haven't seen it go anywhere. Now we actually have someone in charge of it who is not a rural generalist and has openly been against rural generalism, Lizzi Shires. She is a doctor but is not a rural generalist in charge of the Rural Generalist Pathway so that also needs to be looked at. The Rural Generalist Pathway in Tasmania needs to be ratified and funded and off the ground.

Meanwhile, in ACRRM we have some funding, luckily, to train people on the Rural Generalist Pathway and it's an independent pathway - registrars with ACRRM. If you are a Tasmanian GP registrar you can get funded training through ACRRM but the model in Tasmania is difficult. There's a different employer from the north to the north-west to the south so I have to quit my job in Hobart to apply for a job in the north-west if I work for THS and there's not one employer model.

Every time I move into private practice I lose my other job in public practice and it's difficult. I did that model when I trained in my rural generalist. I had to keep losing my job and hoping that I got the next job. I went to Antarctica and came back and couldn't get back on the program. It's still pretty much like that. RDAT advocates for a one employer model for the rural generalist pathway to be well funded, for rural generalism to be recognised in Tasmania and we support ACRRM's new pathway.

CHAIR - We had better wrap it up. Is there anything you desperately need to say that you haven't said, Meg?

Dr McKEOWN - I don't think so. I'm a lack-of-sleep-deprived mother at the moment.

Ms LOVELL - Thank you so much, Meg.

Dr McKEOWN - No worries.

CHAIR - You are probably most honest when you're like that.

Ms LOVELL - Yes, it's the best way to come in.

Dr SEIDEL - That's exactly right.

Dr McKEOWN - Thank you. That's one way of looking at it.

CHAIR - Thank you very much for your time. If there's anything you think the committee would benefit from having more information or other detail, feel free to forward it on.

Dr McKEOWN - Okay. Thank you.

CHAIR - Thank you very much.

THE WITNESS WITHDREW.

The Committee adjourned at 2.32 p.m.