THE LEGISLATIVE COUNCIL SESSIONAL COMMITTEE GOVERNMENT ADMINISTRATION A SUBCOMMITTEE INQUIRY INTO RURAL HEALTH SERVICES IN TASMANIA MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE ON TUESDAY 17 MAY 2022.

Dr ROSS LAMPLUGH, OCHRE HEALTH, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Ms Forrest) - Welcome, Ross, to this public hearing of the Rural Health Committee Inquiry. We appreciate you accepting an invitation to give evidence. I know you've seen the terms of reference and you've been provided with the information about appearing before a committee. Everything you say is protected by parliamentary privilege while you are before the committee and that may not apply outside the committee. Everything you tell us is on the public record. It is being recorded by *Hansard* and it's also being streamed today, so you are aware of that.

If there's anything you wanted to discuss of a confidential nature, you can make that request to the committee and the committee will consider it.

You probably know most of the members. We are waiting for one of the members, Sarah Lovell, who's been caught up with a range of traffic and other issues on the way - typical Hobart. She will pop in when she's here.

Unless you have any questions, we'll invite you to take the statutory declaration because it is sworn evidence and then ask you to make an opening statement about Ochre Health and the role you play in providing rural health services, particularly in line with our terms of reference. The committee will have questions for you beyond that.

Would you like to introduce yourself?

Sarah has arrived, all good. We are all here.

Dr LAMPLUGH - Thanks heaps for the invitation. It's good to be here. I haven't thought about introducing Ochre so it is just off the cuff. I'm a rural GP by trade, although now I run a business, Ochre Health, and do very little clinical work.

I worked in Bourke in western New South Wales for nearly ten years as a GP anaesthestist and then whilst I was out there, I established Ochre Health with another GP, Hamish Meldrum, who was a GP obstretician out there. We now look after 60 medical centres around Australia but 15 of those are in quite remote communities where we provide all of the entire medical care for the community. We provide the inpatient, outpatient and emergency care for all of the hospitals in those communities. There's a group that has been in Tasmania and another group in New South Wales.

In my opening comments to the committee, I am slightly bewildered by the whole process. In my mind, I think we're asking rural GPs to do a more complicated job with more devastating outcomes in locations that they sometimes don't want to live in, and we're paying them less per hour than being a GP in Sandy Bay. Much, much less per hour than being a dermatologist wherever you'd like to live, and then we scratch our heads and wonder why we've got a rural health crisis. I am genuinely a bit bewildered that we need to have numerous

inquiries and groups and various lobbyists and lobbying groups for GPs all trying to figure out what the problem is. To me the problem is absolutely obvious: we're just not paying appropriately for people to do the job we're asking them to do. If we did, we wouldn't have a rural health crisis.

CHAIR - Ross, we've heard evidence along those lines - about the challenges for rural GPs. Obviously, money is one of them and I might come back to that but we're also hearing things like the lack of back up, the lack of time away from the practice with family or for professional development, and even just having that peer back up. Do you see any way that can be addressed, like through better telehealth or - we'll come back to the money - are there other factors beside the money that you think need to be addressed as well?

Dr LAMPLUGH - There are heaps of factors and that's what Ochre does. We think more broadly about what does a doctor need to encourage them to live in a place like Queenstown or Bourke or Brewarrina or wherever it might be. We try to address all of those needs but that's why this is getting so complex because everyone's trying to figure out what those things are. The reality is that every one of our doctors has different reasons for going to one of those areas.

We can't even design a package and we've been doing this for 20 years, we have private funding and we've been rural GPs. We can't design a package that means that every job we have gets filled like that. If we can't do it, no disrespect, then governments and not-for-profit bodies aren't suddenly going to be able to design a package that will make people go to rural areas.

CHAIR - So, it's more than the money then?

Dr LAMPLUGH - It's much more than the money. If you want to solve the problem in the short-term - if I opened a new café in Hobart and I wanted the best staff in Hobart to come to work for my café, obviously, to drag them across I would have to pay more than whoever was currently paying them. We have to solve the problem in the short-term and keep working on all of those other things because I don't know if it's not sustainable to pay remote GPs what they should get. I don't even know if it's what they should earn. It's enough to encourage them to be there.

For example, during COVID-19, let's say we run 15 communities. We have only missed two days of on-call across 15 communities with all of the challenges of border closures, last-minute refusals of travel applications, doctors getting COVID-19 and various things like that.

CHAIR - That's across New South Wales and Tasmania?

Dr LAMPLUGH - Yes. It would be a handful of shifts in two years we've missed but we've been paying twice as much for locums as we used to pay because at the moment there's a crisis and we've had to respond to that crisis. In the short-term, during COVID-19 we didn't have time to sit down and decide what can we do. Should we offer the doctor a new four-wheel drive and send them on more holidays or do whatever to fill those last-minute gaps? We had to meet the market and it's a simple business rule that if you want people, you've got to meet the market.

I don't want to keep going back to money.

CHAIR - I want to go back to the money. I want to understand from you, Ross, how it works now and the model that it operates under and then how it needs to work to make it attractive and effective, acknowledging that a lot of this is the Commonwealth government not the state government's responsibility.

Talk about the money as well. Don't shy away from it.

Dr LAMPLUGH - I'll talk briefly about the money and then maybe we can get on to all of that other stuff.

On the money side of things, to do a job someone has to feel that:

(1) They're fairly paid and there are two components to that:

(i) They need to feel that they're getting paid a reasonable amount of money for doing what they're doing;

(ii) The other bit that we don't think about enough is that they won't do their job if they think someone else doing a similar job is getting paid four times as much. None of you guys would be doing your job if there was someone sitting in the seat next to you getting paid four times as much for doing the same job because then you feel like it's unfair. You feel like you're being disrespected and it's unfair.

(2) We sometimes hear some of our specialist colleagues say they've done more study. My course through medical school, most people who do medicine would work pretty hard through school. You spend 12 years, probably sacrificing some other stuff at school to get the marks to get to uni. At the end of school, whether you're going to be a GP or a dermatologist, you've done exactly the same thing. You have the same marks and you've probably worked about the same.

You then - in my days because I'm old - did six years of medicine and, again, whether you wanted to be a city GP, a rural GP or a dermatologist, you did the same six years of medicine. You then all did an intern year. We're now 19 years down the track and we've all done the same thing.

Then, the ones who decide that they want to become GPs, they go down a path where they might do another year of residency and a few years of GP training and maybe four years later they're a GP.

If they want to be a dermatologist, and I'll probably get pulled up here because I don't really know, it's probably another seven years, I am guessing, or six years or something like that. If you want to be an urban GP it's actually less training than being a rural GP.

CHAIR - But they're paid the same?

Dr LAMPLUGH - Heck, no. I earned a lot less money as a rural GP per hour.

CHAIR - But you do more training.

Dr LAMPLUGH - You do a little bit more training because often you'll do an extra rural year and you might do some special skills.

But, at the end of the day, we have all done a pretty similar journey to get to where we are going. I think that it frustrates rural GPs sitting there thinking, how come I am earning less per hour than my urban colleagues, living in Sandy Bay or Bondi. Why am I actually earning a third of what my dermatology or radiology mates are earning? Probably less than a third. This is part of the problem and people are shying away. To be fair, the urban GPs are thinking the same questions.

As you know, people are shying away from general practice, but then they are further shying away from rural general practice. You end up trying to get a group of people who have all done exactly the same thing, a small sub set of them, to go to work in a rural area. You say, you go and do the really hard job treating people you know, devastating outcomes when things go wrong. Much more devastating than if I am living in Sandy Bay and one of my patients dies, who I might never see again and I might never see the family. At one stage, out in Bourke, I treated my goddaughter with meningococcus. She presented with no symptoms and I could have easily missed that diagnosis. If she had died, can you imagine turning up to the cricket club on the Saturday, trying to play cricket with her dad, and living with yourself. I mean, the things that keep me awake at night are the couple of rural patients who didn't survive who I have treated, probably in some ways inappropriately in that if they had been in an urban setting, I would have been surrounded by specialists helping me. You ask yourself the questions: Could I have done something different? Could I have done better there? Could they have survived?

Now, that is not something that a dermatologist probably has to tussle with very often. To be fair, it is not something most of my urban GP colleagues have to tussle with.

So, you are asking me to do that job, in that environment, and earn less money per hour than if I was in Bondi, and people are scratching their heads asking, I don't understand why people don't want to go rural. Is it about the housing or the education or the job for the partner or the this or the other? Those things are all relevant. But fundamentally, we have a broken system and until it is fixed, the other things are irrelevant.

CHAIR - Explain to us the current system, the funding models and how that has worked out, and what you think the solution might be.

You have probably told people this a hundred times.

Dr LAMPLUGH - No, I haven't. It is really complex and I don't know the solution. That is one of the reasons why I have never presented to these inquiries, partly because I don't know the solution.

CHAIR - Tell us how it works and what you think are the major problems with it.

Dr LAMPLUGH - The reason why I say that rural GPs earn less per hour is because you are doing a more complicated job. You have fewer quick consultations. In an urban area, you would see more quick consultations in a standard day than you would in a rural area. The way Medicare works is a fundamentally broken system where I am rewarded to see people in six minutes. That is what Medicare is trying to do.

Again, I challenge you to find me another profession that actively works against its incentives to provide on average 13 or 14 minutes care to a patient, when that means that they take home half of the income. Every GP who offers you a 15 minute appointment is sacrificing up to two thirds of their income to actually give you a good experience and to try to treat you well.

Medicare is trying to encourage doctors to spend six minutes with a patient, that is what it does. That is how you make the most money out of Medicare. I am really proud of my colleagues that we haven't fallen into that trap. Some people do, but most people don't.

The reality is that those quick patients who just pop in who just need a script, or need something quickly, you can make some pretty good money out of those patients because you see them quickly and you get paid the same as you would if you spend 20 minutes with them. You don't see as many of those patients in the bush. Patients wait for a long time to see their doctors. They need more care. They present with more problems and you don't see the quick consults.

You are then working in an area where you don't have the same capacity for people to pay privately. If I was seeing patients in Bondi, and maybe I am a bit arrogant, but I think I would have full books and I could charge whatever I liked to every patient I saw. I suspect I could at least double my income that I could earn in Bourke by doing exactly the same work in Bondi and just applying a high private fee to all of the consultations.

CHAIR - Because of the average incomes of the patients in those areas.

Dr LAMPLUGH - That's right. It's also easier to charge someone you don't know. It's very difficult.

I bulkbilled everyone in Bourke. One of the reasons was that I liked to have a beer and play sport and I didn’t want to be chasing bills from the people who I was socialising with. Also, I didn't want them to feel like they had to pay for health care which I fundamentally think people should not have to do. Again, that is what we are pushing.

Medicare is getting to the point - we try to pretend we've got a universal health care system that's free for all. Well, we don't because GPs cannot afford to bulkbill anymore. If you're not going to bulkbill people then it's not a fair system. Rich people are going to get better care than poor people.

Out in the bush to try to do the right thing, as I said, in Bourke I bulkbilled every patient I saw. I never issued one private fee for the ten years I was in Bourke. I saw more complicated patients. I was interrupted regularly during the day because I had patients in hospital where I had to interrupt my clinic to see them if I was on call, and I was on call every second or third day.

If someone presented to the hospital who needed to be seen quickly I would have to possibly cancel the next three or four patients, rebook them, see them after hours or another time or whatever Gaye, my practice manager, managed to do. Then toddle up to see someone at the hospital, earn about the same amount of money as I would have for one consultation in

my surgery and then come back. I've lost three quarters of my income for that hour while I'm at the hospital providing the only care that is available.

There is so much about working as a rural GP but you do earn more. I earned more money overall as a rural GP than I would have if I had worked and billed in the same way in the city but the reason for that is that I was doing two jobs. I was doing anaesthetic lists, I was getting called in overnight, I was on call every second or third day. I was working every second or third weekend. I was getting paid for that by the hospital and I was getting paid for my general practice work by the Commonwealth.

CHAIR - It's not really sustainable though, is it?

Dr LAMPLUGH - It tires you out. There are the exceptions. The guys who win the big kahuna award at the national conferences every year are those guys who have done that for 30 years and have managed to do it but every one of them will tell you that it's affected their families and their family life.

That was another era where people were -

CHAIR - There has been a feminisation of the workforce since then too which has changed things, it appears from the evidence I've read and heard. Is that true?

Not just women but men want to have more time with their families too. You have new people coming into the system - male and female - who don't want to work like that.

Dr LAMPLUGH - The doctors don't want to work like that anymore. They want to spend more time with their family. They want to have more time off. Everyone seems to want to work part time. Hamish, my business partner, said to me at the conference here on the weekend, 'It's amazing. I can barely think of a doctor who has joined Ochre in the last few years who wanted a full-time job.'

Everyone wants more time off.

Doctors, predominantly, used to be men who had a wife at home who looked after the family and sorted everything out for them. That's changed now, so you often have two bread winners working.

Everyone has different views on education. Our kids did the first few years in Bourke and I think it was fantastic for them but other people wouldn't be happy with that. Certainly, once their kids get to secondary school, most doctors tend to send them off to boarding school after that which, again, is expensive.

CHAIR - Ross, can I take you to, say, Smithton, where you run a practice and from what I hear from the locals who are my constituents, it's actually quite stable now. There was a bit of flux when all of that was happening. Can you describe the process there where you look after the GP practice? You also cover the hospital. I understand that's part of the contract.

Can you explain to the committee how that works and what the challenges are as well as the benefits, if there are any?

Dr LAMPLUGH - That's a very good example of where money is not the only problem because the doctors in Smithton are probably not earning any more now under us than they used to when it was the old traditional system. To be frank, the reason that Smithton in particular is stable is because we've removed a lot of the bureaucracy out of the management of the doctors.

I like to talk about my experience because then it's first hand. I got paid late for my hospital work every single month that I was in Bourke. If I was paid 120 times, I was paid late 120 times.

CHAIR - It was New South Wales Health who were paying you?

Dr LAMPLUGH - New South Wales Health, yes. On most of those occasions, I was paid incorrectly. There were computer systems that checked my billing and then paid me. I'll give you two funny examples. One that happened regularly was if I misspelt a patient's name, they'd say, well, that patient wasn't in hospital, and not pay me for it. The other one that I found astounding - which was probably the straw that broke my back - was I treated a patient for about an hour before midnight one night. I think it was before midnight, or 11 p.m., there was a time when the rate went up, and if you're treating someone after that it was a higher rate. Because I'd spent 95 per cent of the time pre the rise in rate, I billed at the lower rate, but the nurses actually processed the patient after the change in time. The computer system said, no, that patient got admitted the next day, you've billed on the wrong day, we can't pay you for that.

It got to the point - quite seriously - that my way of coping was that I never checked my bill; whatever went in the bank, went in the bank. I didn't look when it went in, and I didn't look at how much went in, because I knew that if I kept mucking it up I was going to leave town, because it was driving me insane. I tried to talk to the GM one day, and I asked, 'How often do you get paid late?' He said, 'Well, never.' I said, 'Don't you understand that every time you pay me late, you're disrespecting me and telling me that you're not really that interested, you're devaluing me?'

One of the things we do is we remove some of that bureaucracy about payments, about having to attend meetings that aren't always that useful, about some of the attitudinal stuff. We get in between that. I've seen doctors arguing and leaving town because they've had issues with the hospital. I've seen them leave town because they've had issues with the local council. Another example, we were in Coonamble. Before we went there the council provided a house for the doctor. For a couple of years, the doctor had been complaining about the house and actually left. When we fronted the council and said, 'Look, this house is really not adequate', we were accused a bit of - and when the doctor had been doing it, I think they were just seen as a greedy doctor. We were able to come in and argue with them. I said, 'We don't want a special house for the doctor, we just want a house that one of your staff would live in, because this is patently not -'. Luckily for us, the engineer put his hand up and said, 'Yeah, I said I wouldn't live in that house.'

CHAIR - The same as Queenstown?

Dr LAMPLUGH - Yes. We could come in and have some of those arguments with those other providers, and just let the doctor come do their job.

We also can buy accommodation in a way that others can't. Scottsdale, as an example, where we were having trouble recruiting our second senior doctor into Scottsdale, and accommodation was an issue. In the end we bought a really nice four-bedroom house in Scottsdale with nice views, and suddenly we were able to recruit a second good doctor into Scottsdale.

CHAIR - About managing the hospital, when you've got the responsibility for covering the hospital too, if you could go there?

Dr LAMPLUGH - No worries, yes.

I suppose that comes back to us a little bit as well, that we've got a group of doctors so that we can - I'm not quite sure why, I think the HSNs in the hospital have got a lot to do, and a lot of them will tell you that most of their day is taken up with just trying to fill their roster with doctors. Sometimes doctors can drive you crazy, someone who is earning several hundred thousand dollars a year complaining about money gets under most people's skin, especially if that person is earning a third or a quarter of that.

I have also seen - and we had this situation in one of our towns recently - where we had to have a chat with one of our GMs who was complaining that a doctor who we'd asked to work an extra shift because another doctor hadn't been able to turn up because they had COVID-19, we'd asked this guy to do five days in a row instead of three. The doctor said, 'I am only going to do that at the higher locum rates that I know you pay someone else.'

We often hear this with local doctors, being irritated that they know locums are being paid more than they are. We actually fell into the same error with that doctor for the sake of a couple of days. We had an argument about his pay and luckily, we were able to pull back on that pretty quickly and fix the problem.

Some of that comes from understanding. Don't get me wrong, but when I left Bourke, I look back at some of the correspondence I had written to health services and I probably should have been deregistered. I was so angry, hurt and damaged, and I was obviously so tired, that I was letting things irritate me that shouldn't have, writing stupid letters that did nothing. Probably made me feel better, temporarily, while I was writing the letter, maybe.

Doctors can get quite irritable and quite tired. Part of our role is to manage those relationships and keep an eye on the doctor and make sure they are not getting overtired. We always have more doctors in our towns after we are asked to manage them when they have had pre-us managing them. That in itself often actually reduced the doctor's income, but it makes them happier and less tired and irritable.

CHAIR - Can we talk about the connection with the hospitals in Smithton, in Queenstown, in Scottsdale? Then I will come to you, Mike. Just talk about the hospital arrangements because, that is a state government responsibility.

Dr LAMPLUGH - What happens in Tasmania is that the hospitals - I'm trying to make a long story short. The hospitals or the Tasmanian health service go out to tender when they have a situation that looks like it's failed or is failing, to find a third-party provider who can actually recruit and manage the doctors to keep the hospital running. There have been a few providers doing that work in Tasmania over the years but currently, we are the sole provider

that does that on an outsourced basis. We look after St Helens on the east coast, Smithton, Scottsdale, the west coast and the two islands. We look after all of those sites.

CHAIR - How is the pay arranged for those? I am interested in the money side of that.

Dr LAMPLUGH - What happens there is that effectively we price what it is going to cost us to provide the service. In our tender, we come back to the THS, in this case, and say, well that is what it will cost per year for us to provide that service. They either choose to pay it or they don't choose to pay it or there is another provider who can possibly do it for less. At the end of the day, they contract us, so it works out as a daily rate. We know in each town we have a certain amount of money per day to ensure that we have the doctors we need to run that service.

That arrangement goes right back. I think we were the first private company to ever manage a public hospital medical roster, right back when we were in Bourke in 2002. It happened because Hamish and I had set up our own recruitment business because we couldn't get locums to come to Bourke. We had a bit of a crisis and we don't have time for me to tell you that funny, interesting story. Anyway, we had a crisis and we needed cover and because no one else, including the health service, could find this cover, we found our own cover for the two weeks.

From there, we established our first business, Australia Outback Locums. It was meant to find locums to cover rural doctors. From there we had a couple of doctors apply from New Zealand, which is the point of the story, and they said, 'We would like to come to Australia for an outback adventure.' So, this is an important thing. There are people out there who want to do this work and they don't feel enabled to do it. This couple said they had good jobs in New Zealand, so they asked, 'What are we going to earn?' We said, 'It is all fee-for-service, your Medicare income will depend on how many patients you see. Your hospital income depends, on some days you will get paid almost nothing if you don't get called in by the hospital and other days, if you are there all day, you will earn a lot of money.'

We said it will average out to about a bit under $200 000 a year, or something like that, for your work. And, your Medicare income at the time was probably going to be something similar.

Anyway, we told them that and they said, 'Well, that is fine, but can you guarantee the sum of that income before we move from New Zealand?'

We said, 'We can't, we can't guarantee you that income.'

So, they said, 'Well we have three requirements to move to Australia: one, we want some guarantee of income; two, we don't want to run our practice because we're only coming for a year and we don't want to be employing staff and things; three, we need a childcare spot for our child because we both want to work.'

We lobbied someone in government and managed to get an extra childcare spot. We agreed that we would take on running that practice. Hamish and I were running our own practice in Bourke at the time. We went to the health service, and we said, 'We know that you're paying the doctors - let's say it was - $200 000 a year. All we want you to do is divide it by 365, pay it on a daily basis, and we will run this.' The reason why we wanted to run it

was we were seeing the Brewarrina patients in Bourke without any records. Brewarrina was 100 kilometres away and because there'd been no doctors there for a long time, their patients would come to Bourke. We wouldn't know the patient, wouldn't have records when treating them, so there was a bit of selfishness here in that we wanted Brewarrina sorted out so that our jobs would be easier.

They said we can't divide it by you know, whatever, but it resulted in a tender. The government went to tender, we applied for the tender, and in the process, we lifted the price significantly because we didn't realise that we were going to have an obligation to cover the roster 365. We had to provide all of this governance, different things that were going to cost us money. We ended up tendering for a higher price than the doctors had been receiving. We received that, and the doctors came in, they stayed for five years.

CHAIR - That is how it started, that whole model?

Dr LAMPLUGH - That is how it all started. When they first arrived, we personally met them in Sydney. We both went to Sydney, we put them up in an apartment, we personally took them to get their registration, we handed them a laptop and said - this was 20 years ago when laptops were expensive and a bit new, 'Here's a laptop that you'll need to do your outreach clinics to Weilmoringle and other places. If you stay working with us for one year you can have it for a dollar.' Then we took them out to Brewarrina, made sure their house was nicely set up, nice bunch of flowers and food and toys. We bought an old government vehicle at an auction, gave them a car to drive, gave them a fuel card, we gave them plenty of time off because we had our own recruiting business. We said, 'Just give us some notice and you can have as much time off as you need.' They worked in Brewarrina, and they ended up staying for five years.

For them, it wasn't about the money. They weren't earning any more money through us than they would have been if they'd done that themselves. For them it was about the whole package of how we cared for them. We gave them the ability to come in easily and set up and try before you buy. They knew they could leave town without being embarrassed that they'd left the town because we were going to be there to recruit the next doctors in, and they had plenty of time off. We set up things, like once a month they would come over to Bourke and we'd run an education event, which was really drinks and self-education in Bourke once a month on a Friday night. We ended up with people driving from Cobar 170 kilometres away who weren't working in our practice who had heard about it and were driving over to join us.

CHAIR - Because of professional development and the collegiality.

Dr LAMPLUGH - We tried to give them some professional development support. It is hard - I'm not being critical of the people involved - but in ten years of working in Bourke, doing some really horrible stuff at times, you can imagine the kind of stuff, but in doing that, there was once in ten years I had one of the nurses ask me if I was okay. That is the other problem that a rural doctor doesn't have, is that no one feels that it's their right to look after them, or their responsibility to look after them. There is this funny, isolated individual who runs their own show. Don't get me wrong, a lot of them are pretty arrogant buggers. It'd be hard to ask them if they were okay. That's probably what we do - we're seen to be the care agency.

CHAIR - You ask your doctors, 'Are you okay?'

Dr LAMPLUGH - We try, we don't get it right all the time, but we certainly ask them more than I was asked, that's for sure. We try to if they have treated a - if we hear that there's been a motor accident in the town, we'll try to make sure that we'll ring them up ask, 'Do you need a day off?' We send them a bottle of red for their work, and that kind of simple stuff.

The first two doctors, a husband and wife, who went to Collarenebri in New South Wales, I met them in the Netherlands. We recruited them from there. They came to work for us and similar things happened. (inaudible) was a mad fisherman so I made sure that when he arrived there was a set of fishing gear in his lounge room.

Don't get me wrong, that's really hard - if New South Wales Health had given him a $250 fishing rod someone probably would have lost their job over that.

CHAIR - It probably wouldn't have been in the Estimates' process.

Dr LAMPLUGH - For Hamish and me, it's just our back pocket that we have to worry about so we can spend money and we only have to answer to each other. That makes it easier for us to make decisions and correct problems and things like that. It is easier in some ways for us as a private business to do that.

CHAIR - True.

Mr GAFFNEY - I apologise if I missed some of this. You talked about initially 60 Ochre medical services and 15 remote communities. When did you first set foot in Tasmania?

Dr LAMPLUGH - It's probably a complicated answer. The simple answer is about ten years ago.

Mr GAFFNEY - I am interested to know that you have New South Wales and Tasmania. Why did you see an opportunity to branch into Tasmania, and not Victoria or Queensland? There must have been some signal to you saying, Tasmania is right for our service or what we can offer.

I am interested to know.

Dr LAMPLUGH - That's a very insightful question. You're spot on the money. Each state operates their rural hospitals differently. I will answer in the opposite way. The reason why we haven't made inroads into Queensland, even though individually the services are very similar to New South Wales, is because there's an employee/doctor model there and a very strong attitude by the nurse managers and others that the doctors are their employees and they control what they do. They are not willing to relinquish that sort of control.

In New South Wales the doctors are very much seen as contractors. I was predominantly a local GP who ran my own general practice business and the hospital contracted me in to provide the hospital service so they didn't have great control over me. They were contracting me for specific services and that was probably easier to outsource to a third party.

Tasmania is closer to that New South Wales model where doctors, similar to New South Wales, are paid an on-call fee and then paid for each service they provide - more of a contractor basis. They are actually employees but the attitude down here is more one towards being a contractor. It was easier for them to find someone to outsource that to. That is probably a big part of the answer.

The other part is that my wife grew up in Tasmania and I have an interest in Tasmania so I've spent a lot of time down here.

I had been asked about five years earlier to have a look at one of the services down here that was failing, to give a bit of advice. We had an interest and had our eyes open to opportunities down here.

Mr GAFFNEY - You talked about the remote areas. Is there any intention for Ochre to set up in the cities, Hobart or Launceston?

Dr LAMPLUGH - Yes, we have. Those other 45 sites are all stand-alone medical centres and whilst none of them are in Melbourne or Sydney, there's a cluster. We have one here in Hobart now. We are in the process of building one in Margate. We have a cluster of medical centres in Canberra and another cluster on the Sunshine Coast.

Mr GAFFNEY - With the training of staff, how do you have quality control over what professional development of staff who are in your organisation of Ochre must do? Say, for example, we have a presentation tomorrow by the LGBTIQ+ group about their needs, how does Ochre maintain that it has the right staff and fit for its service?

Dr LAMPLUGH - Obviously, I'm going to put a polish on everything I tell you about Ochre but we have just formally established our practice manager academy within Ochre. We have bought software and established teaching materials so we have a formal process for our practice managers to go through to make sure they've got all the competencies that we think they need to be a practice manager at Ochre. We have always had an interest in teaching, right back from when we were GPs in Bourke. We have the first Australian grade GP registrar who worked out in western New South Wales who came and worked with us in Bourke, and we have interns and registrars, so we have an interest in teaching. That's turned into trying to set up systems to make sure that people are well oriented and well taught. We don't get it right all the time but we try.

Mr GAFFNEY - My last question is that we heard the other day from a lady about Presmed, which is in Osen's Road, that operate in New South Wales. They've got around 60 branches. Do you find within Ochre that there's more flexibility with who might work for you in New South Wales than who might want to come down to Tasmania to work? They know the systems there, so it's more flexible in trying to move some of your staff and doctors around?

Dr LAMPLUGH - Definitely. We definitely have people who will finish in one of our sites, then they want to move for whatever reason, such as moving states, and they will ask us, 'Have you got a job in Tassie?' or, 'Have you got a job in New South Wales?' or something like that. We definitely see some of that. We don't see as much of it in our rural GP VMO cohort as I would like, and I think that's generally because once people finish those jobs, they often go off and do something else. Unfortunately, they don't actually say, 'Well, I've done

five years in Bourke, now I want to do five years in Queenstown'. We don't see as much of that movement, we do see some, but not as much.

Mr GAFFNEY - Okay, thank you.

Mr DUIGAN - I am interested, if we accept that it's all about the money, which I think is a reasonable proposition, how do you make it pay? How does Ochre make it work? Do you need to be providing hospital services, or can you stand up a GP service in isolation? How does it work?

Dr LAMPLUGH - For us, in COVID-19, it's been all about the money, as well as the general problem. However, what's happening as COVID-19 is moving on, we are now starting to backfill those jobs with people earning less money who are now again looking for the other stuff.

When it's a crisis, it's all about the money. I suppose that's what I'm saying. I am sure this is going to hit newspapers in a way that I won't be that happy about, because my personal values, I score very low on money. In fact, when I went to Bourke, the very first night Miranda and I turned up, the nurses and their husbands took us out to dinner and we decided we were taking the job. We hadn't seen the location and I had no idea what money I was going to earn.

What I'm saying is that to fix the problem in the short term, you've got to make it as attractive to go out rurally as you are to go to an urban location, or more so if it's a harder job. The way to fix that is not that difficult given that we spend so much less on a rural patient in Medicare funding than we do on an urban patient. All that someone needs to do is to tip the scale and just keep tipping it. We don't say, 'Gee, it's a bit hard to fill Queenstown next week and we're offering $1500, so we're going to offer $3000 a day.' We say, 'Rightio, we'll put the rate up to $1600, and then $1700, and then $1800, and if we need someone in two days, then we might have to put the rate up to $2500 so that someone who just wants the money' - but we'll only use good doctors, so you've got to be a good doctor. However, there are good doctors out there chasing the dollar who will say, 'I'll do that job for you, and I'll be in Queenstown in 24 hours.'

When it's a crisis, we have to offer the money. When the crisis starts to subside, then you can start to fix the system, and that's when you start to really think about the stuff like housing, and jobs for spouses, and professional and social support, and giving people holidays and making sure they're not burning out, all that kind of stuff happens.

In the short term, you have to keep tipping the scale until you find doctors wanting to go. When there are more doctors wanting to work in Queenstown than Sandy Bay, then you know you're probably paying them too much and you can start to pull the dollars back. Then you can keep pulling the dollars back because by that stage you'll have a workforce that's functional, and people won't need as much money to be encouraged to go there. Our hardest doctor to recruit is always the first doctor in a new medical centre, always.

One of the real credits I'll give the THS is that in both Smithton and Scottsdale they engaged us before the whole system had fallen over. They were two of the first times that has ever happened. Previously, health services have usually waited until there are no doctors left and then they bring us in to fix it and that is difficult.

CHAIR - Is that because of the pressure on the hospital or on the GP practice? Why would the THS get involved in the GP service otherwise?

Dr LAMPLUGH - That is because they knew that the doctors were about to leave both those sites and they would have no doctors in the hospital.

Mr DUIGAN - My overarching question is, how are you able to deliver those services when the previous GP practice fell over because it was no longer viable? Is it because of the scale of your operation that you tip money in when required, or how do you make it work?

Dr LAMPLUGH - Interestingly enough, in both of those cases, the two founding doctors of those practices approached us to say that they had a crisis. They were talking to us, could you guys help us, and they were talking to the THS at the same time and they both still work in our practices in those towns.

In Scottsdale's case, I suppose we have probably been there six to eight years and there are more doctors than they have ever had in Scottsdale. In fact, the first time I rocked into Scottsdale after we took over, I got into trouble by the HSM because she said, 'We need more doctors.' I said, 'We've only been here two weeks, give me a chance.' The last time I walked in, she said, 'I can't fit all the doctors in the meeting room for handover.' It was probably a good problem to have.

What has happened there, Nat Burch is the lead doctor in Scottsdale. Nat is like all of us, getting a bit older. She didn't want to keep doing the same level of on call work that she had been and she definitely didn't want to run the practice and deal with the complexities. So, we have taken away the complexity of running a practice. We employ the staff. We worry about the IT. We do all the HR. We do the recruitment for the doctors. We have also added doctors around there. What has happened with Nat is an even bigger change as Nat actually works now primarily as an educator within our system rather than as a local GP VMO.

Most of those doctors, or a good number of the doctors who have been recruited to Scottsdale, are supervised in some way, shape or form by Natalie. We have been able to because of our size, and also because we think outside the square and we are not confined by the same rules that the health service is and we understand why they are there. I actually worked as a medical administrator for a while. It is not an easy job, but because we don't have to follow those same rules, we have created this job for her, pinching bits of funding from all over the place where she primarily works as an educator and she loves her role. So, she has actually stayed on in Scottsdale much longer that she probably expected.

It is about being flexible. It is about trying to understand the individual needs. It is no disrespect to anyone, but our health service can't do that. It is too big and it's got the people in there who move too often and they are not rural GPs. Hamish and I, probably our most important job in Ochre is educating our non-doctor managers about how doctors think and we try to encourage them to not get cranky if the doctor seems to be greedy and rather think that he/she had a really busy weekend, so just to think a bit differently.

Mr DUIGAN - Scottsdale is an interesting one. You say when you turned up, there was one doctor and now there are more doctors. There is still essentially the same number of people there. The same number of patients there. The same number of MBS swipes.

So, where does the money come from to stand up your much better service?

Dr LAMPLUGH - It comes in two buckets. The MBS money, the Medicare money, it would be costing the Commonwealth a lot more in Scottsdale. This is partly why people don't want to fix the problem. The more doctors we put in the town, the more Medicare funding comes out of the town.

The hospital funding is capped. So, it doesn't matter whether we have two doctors or 20 doctors, they have to share the same amount of funds that we get from the health service after we take our admin costs out of that.

Interestingly enough, although I said that back in the first case they ended up paying us more in Brewarrina than they would have paid the doctors, when I've analysed the cost to a hospital of running a doctor's service, we are a fraction of the price of their full cost once they actually work out what they pay the doctors, the locums, all of the administrative work that goes into it.

I did a case, I think it was in Baradine in New South Wales, where I worked with their finance manager. We'd offered to run the town for $300 000 a year to keep it fully staffed and they said no. It only costs $186 000 a year. I said, 'That's a funny number'. It turns out it was what they had paid the previous doctor in his last year and he had only worked about two thirds of the time and there were a whole heap of other additional on-costs they were funding. When we worked out their real cost we thought it was probably about $430 000 to $440 000 a year so we were going to do it about 30 per cent less than what it was costing them.

What was the response to that?

They closed the health service because they thought it was too expensive so we haven't done that again.

Ms LOVELL - There are a number of witnesses who we have heard from and lots of other evidence that's been given to the committee around multi-disciplinary teams - paramedic practitioners, nurse practitioners; other roles particularly brought into rural practices. Is this something that you make use of? Do you make use of these roles in your practices anywhere, and can you talk about why or why not that might be, if that's the case?

Dr LAMPLUGH - I can't do it quickly but generally we like to have allied health in our medical centres. We measure a heap of our health outcome data every month and have done so since we set up, over 15 years. We know that in our practices which have a broader range of services the patients are healthier. So, wherever we possibly can - the new site that we have built in Liverpool Street, we have built a room just for allied health and then engaged allied health professionals, sometimes on a contract basis, to work from within the medical centre. Sometimes we lease them space outside the medical centre but we try to combine meeting rooms and things so that everyone is talking and working together. That is a really efficient system. Everyone has known that for 40 years: that integrated primary care is the most effective form of medical care there is.

We like to do that. Sometimes it can be difficult to get those people into the sites and because the margins of general practice are getting so narrow, we have seen cases of practices effectively kicking out all of their allied health. If they can get extra doctors they only use

allied health when they haven't got enough doctors. The moment they can recruit more doctors they kick out allied health and fill the space with doctors who generate more money than allied health. That needs to be addressed and there have been ways that people have tried to do this.

I will tell a little story, back in the day in Bourke. My wife is a psychologist so I take a keen interest in allied health. We set up our own allied health team in Bourke 15 years ago. What we did was to combine the funding and, again, we were after something that others weren't. We could go to the TDOCS (tbc), we could go to the hospital, we could go to the jail, we could go to all these different providers and most of them had money for a few hours of OT service or a few hours of physio service. Even the hospital only had the money for a half-time physio. They were never going to recruit a half-time physio to Bourke. We could combine all of that. We then encouraged them to do some private work as well and by doing that we assembled an allied health team in Bourke.

We bought a house. We did it up. It was a nice young persons' house. We bought a Jeep. We filled it up with camping gear. We said you can take this away on weekends and the thing we did the most was we said to all of these people - and they were generally, reasonably newly graduated people - we'll send you to an overseas conference every year in your profession. It's funny, isn't it, because, say, if a physio at the time was earning $80 000 a year, we could have offered $82 000 and it would have made no difference but if you offer $80 000 and an overseas conference, it makes a big difference.

By doing these things, we built a team of ten allied health professionals in Bourke.

CHAIR - You employed them?

Dr LAMPLUGH -We employed all of them.

There was a study done that showed that we had more allied health professionals at that point living in Bourke than there were in western New South Wales put together outside of Bourke. About a third to a half of the money came through the divisions who were giving the money like that for a (inaudible) and we had to tender for that money every year.

To cut a long story short, someone in the division, for whatever reason, decided they could do it better. One year they told us, a month out from the end of the contract - because of course, that's the other problem with our contracts, they don't have a long life - they said to us, 'No, we're going to keep that money in-house and engage them ourselves,' and within six months, nine of them had left. In fact, within three months most of them had left, and we were left with my wife as our clinical psychologist, and I think we retained one other person for a while.

In the process, we worked out we spent a million dollars building that team over two years, because we were subsidising. The problem with that, one of the reasons they took the money back - in defence of the person who made the decision - is we were charging them about $120 for an hour of service, if we were seeing one of their clients. Their argument was, you're only paying the physio $60 an hour, so you guys are making a 50 per cent cut. What they didn't understand, or didn't want to know, was that our allied health, if we engaged them full time, we worked out that on average they were doing 19-20 face to face hours with clients per week. By the time you roster in holidays, and meetings, and writing up notes and people not turning

up and what have you, so just to cover their costs we had to double what we were paying them. That didn't cover any of our other costs, the house, and the Jeep, and all the rest of it.

Again, there's a lack of understanding sometimes, and there's a fear of commercial enterprises sometimes that we are just out to make a heap of money. So the first sniff of a possibility, we tend to find we get brought in to solve the crisis, and then as soon as they think the crisis is over, it goes.

That happened to us in Barham, there were no doctors, we resurrected the service. We had three doctors in Barham. They'd been there for several years, tender came up and they said, 'We'll take this back in-house, thanks very much.' Guess what happened? All the doctors left, very quickly.

Ms LOVELL - One last question. Going back to something you said quite early on, plus you talked about the challenges during COVID-19, and bringing in doctors from other states, and travel restrictions. Now those restrictions have eased up, are you noticing if that trend is improving? Is it stable, is it harder? What's happening in terms of getting doctors into the state now?

Dr LAMPLUGH - It is difficult, it's definitely getting a little bit better, it's not getting better as much as we would have liked. I think locums' attitudes have changed a little bit; they've been much more demanding than they were three years ago. We are finding locums wanting to go to rural areas and telling us they won't do certain things. You scratch your head and say, well, that's part of the job.

Ms LOVELL - They want certain conditions?

Dr LAMPLUGH - Yes, or they're not going to see certain patients, or they're not going to attend the hospital at certain times, and you're just like, well, that's the job. We didn't seem to get much of that previously.

Locums are definitely being a little bit more precious, the rates are still quite a bit higher than they were pre-COVID-19 for a locum, and the other problem we're facing is that doctors are exhausted. We are seeing in our own business the highest rates of leave amongst our doctor group that we've ever seen in 20 years. We've got more doctors taking leave as a proportion per month than we've ever had. People are feeling a bit like I've helped society navigate the crisis, now it's my time to have a rest, and they are even leaving the profession.

Mr GAFFNEY - Earlier you mentioned that you had a couple of situations where you were approached because the THS realised that there were issues with the sustainability of their doctors and keeping them there. How do you find the relationship that you have with the THS? I am not trying to talk out of school, but is it a sound relationship? How do you find working with the THS, and what are you trying to achieve?

Dr LAMPLUGH - Being completely honest, it's terrific, it's really good. We find - those two examples that I gave previously were the first two times I can think of that we've been pulled in before the crisis and really evolved, when it was an emerging crisis rather than an actual crisis. That really helped, so both of those towns were able to fix them quite quickly, because you had those leaders still in place. Quite genuinely, they've been very responsive to things for us, and they're quite good to work with. They are probably a bit more commercial

than some of the others. I probably have to negotiate harder on the contracts down here in Tasmania than I have in other places at times where often it's a matter of you put your price in and it's a 'yes' or 'no'.

It's critical, because when we first started we managed to sort out a lot of sites in New South Wales and we had a fantastic relationship with the then area health service. At one stage, the health service made the decision - we'd probably been there for 10 years or so - to close the obstetric unit in Bourke. Hamish and I were pretty passionately against that view and, a bit naively, we decided we'd go into battle with the people who were funding us. Over a few years, our relationship with that health service deteriorated and it had a real effect on our ability to perform, not being able to have those really good conversations and close relationships.

That's changed so there's now a new group in and we have a fantastic relationship again with that particular health service or the current version of it. That enabled us to do things like, for example, we were about to respond quite quickly to set up a COVID-19 clinic in a small hospital when they thought that Dubbo was going to be overrun and we did a few things with them.

In summary, the relationship with the THS is good and that is critical because we couldn't do our job properly if it wasn't.

Mr GAFFNEY - Do you think it's improving? If you have an issue or a concern, you have a direct link to somebody within the THS who you can voice that to?

Dr LAMPLUGH - Like every organisation, it's all about the people you're dealing with and that's the problem with bureaucracies - people tend to turn over. It depends who you talk to but, generally, the decision-makers we're talking to are responsive and helpful.

CHAIR - I know we've gone well over time.

Dr LAMPLUGH - I'm fine, I'm only driving to Ulverstone. I just won't stop for coffee for so long.

CHAIR - I want to cover two other areas. One is telehealth, but first I want to talk about - and you may not wish to make a comment about this - clearly in places like St Helens, Smithton, Queenstown and Scottsdale there's a hospital attached to your practice, effectively. That was the reach-in response from THS prior to a responsive hard negotiating response. It might have been because the secretary came out of Treasury previously, I'm not sure. We look at the situation in Ouse. The Ouse hospital was closed some years ago - quite a long time ago now - and there have been problems with sustaining a medical practice there. Is there any draw for an organisation like Ochre to go into a community where there isn't the hospital to provide that other source of revenue?

Dr LAMPLUGH - Generally, no. The reason for that is that general practice is becoming less and less viable by the day. I think there's a group of general practice corporate providers who put a paper together recently that showed that their margins three or four years ago were about 8 per cent across a group and they're down to about 3.5 per cent. These are corporate providers with all of the benefits they have to do that.

There was a study done by the college of GPs probably 20 or 30 years ago. Most doctors in Australia - all of our doctors - earn 65 per cent of their fellows. There are doctors earning a lot more than that but ours earn 65 per cent. The college of GPs 30 or 40 years ago did a study and they found most practice owners were taking home 51 per cent of their earnings and they'd be much better off working for someone else. This is 30 years ago and it has become a lot worse.

As you're well aware, medical inflation has gone up in the last six or seven years by about 5 per cent a year and the Medicare schedule has gone up by half a per cent per year. I don't know where people think that money is coming from. Whilst all that's going on, there are state governments or state revenue offices trying to levy payroll tax on general practices. I'll tell you right now, if that happens, you'll see up to half of general practices go broke overnight and close down.

We're getting quite a lot of inquiries from practices wanting to sell at the moment because they're all panicking about the payroll tax issue.

CHAIR - That's a live issue at the moment?

Dr LAMPLUGH - Absolutely, it's a live issue at the moment. There's a practice in Sydney that was charged $2 million or $3 million of back-payroll tax after they were investigated by the New South Wales State Revenue Office.

CHAIR - This is a policy issue of government to apply this, potentially?

Dr LAMPLUGH - I think it's a result of state governments wanting more money and trying to find ways to get it. This is an emerging issue in the whole general practice market. It's seen to be the biggest risk in general practice at the moment if payroll tax comes in. It is pretty simple maths. We pay our doctors nearly $100 million a year. If we have to pay $6 million of payroll tax, we will just close down the business and go home. There's nothing left.

CHAIR - Maybe there needs to be a bit of collaboration between the Commonwealth and the state anyway.

Dr LAMPLUGH - It should be. The answer is very simple. You increase GST and you get rid of payroll tax. It is not hard.

CHAIR - Or a tax review. Just to move off that for a moment, that is a matter we can raise through another process in a couple of weeks.

This does come back to the pay issue.

Dr LAMPLUGH - Going back to roots, the reality is for whatever the reasons are, it is not viable to run a small general practice. You can make a dollar out of it, if you are a local provider running your own practice and probably with your partner providing some free services in the practice to do the accounting or practice managing or whatever. You can make a good living. When we are talking about money, I really want to put it on record. Our average GP probably earns $240 000-$250 000 a year. I am not for one second saying that is not a good wage. What I am saying is, they can earn more than that. You could earn yourself a good

living - I could go to Ouse tomorrow and set up a little practice and earn more than enough than I need to live on.

But as a corporate provider, having to staff that with doctors and staff and all that, there is no way that I could make that break even. You just couldn't do it, not without subsidies.

CHAIR - It becomes very person dependent doesn't it, on someone who is willing to have that lifestyle.

Dr LAMPLUGH - You are looking for someone who wants to move to that town and run their own practice. I talk to people every week. People ring me to ask, can you help me in my town? Every week, I say I am sorry, but we can't, but here are some things you can think about.

Those things will never work. It goes back to what we were saying before, until it is more attractive for a doctor to work in Ouse than it is to work in Sandy Bay.

CHAIR - We've had a lot of evidence provided about rural generalists and this whole lack of understanding around that GPs are actually specialists in their own right. We talked about their rates of pay compared to another specialist who might have done a few more years of training - like in your dermatologist example. However, if the rural generalist program is rolled out more broadly - like they are looking at the Mersey as the hub for rural generalist training - would that make a difference? Because then you would expect this commensurate pay rise for rural generalists.

Dr LAMPLUGH - It can't hurt to have more people trained to do the job, because there is no doubt that one of the things that stops some people going rural is that they think that you have to be a super doctor to go there. That is not true.

CHAIR - Or have an additional set of skills, like anaesthetics or obstetrics.

Dr LAMPLUGH - Yes, you give them some skills so that they feel more confident and you give them the experience in those rural areas so they realise that we are all just the same. We are all just doctors who are doing our best.

There is no doubt that if you want to go and work rural, you have to be a little bit more practical, have more common sense and certainly have to be more resilient because more things are going to go wrong. There are certain personality traits you need to go rural, which is why I completely disagree with the bonded scholarship program that they are giving 17-year-old kids to decide they want to be a rural GP. It is patently ridiculous. There are some personality traits that you need. However, one of the things that stops people is that lack of confidence and skills. That program will help.

Unfortunately, what we have seen in other places is that whilst it can sometimes produce lots of rural generalists, they don't always end up in rural locations. That is a problem. You have to keep pushing people into that funnel and then at least you have the possibility of it working out, I suppose.

CHAIR - Do bonded scholarships still have that threat hanging over them that they will take their provider number if they don't go to a rural area?

Dr LAMPLUGH - You can pay it back and you can do all kinds of things but if you look at the stats there are people who took those scholarships and then left medicine when they were forced to go rural. There were people who committed suicide who were on that program. I am not saying who knows why but there's a very low proportion of people who went on the bonded scholarship program who ended up in rural areas. It's quite common knowledge that a lot of people say they want to to to rural areas to get a medical degree, and why wouldn't you if it was going to help you get into medicine? They probably believe it at the time but the reality is they don't.

CHAIR - One last question from me about telehealth. For remote and rural practices with telehealth, how important is having a good internet connection, good facilities like cameras on the ceiling over the examination bed and things like that?

Dr LAMPLUGH - They are absolutely critical. As we go forward the problem with rural health is that every day that I work as a doctor I'm more likely to get sued than I was yesterday. The reason for that is there is a more litigious society emerging but it's also because medicine is getting more complicated every day. Even in my lifetime - the number of medications I'm expected to know and understand.

When you go back to the good old days when I wish I existed with my little doctor's bag and five pills and a scalpel, I'd still be working clinically now if that was the case. If you're going to ask someone to work in Queenstown, now they must have really good access to help. That's one of the things I always say to the young ones who are hesitant to go out - the phone's your friend. That was in my day, you'd stabilise a patient, you needed to have really good initial emergency management skills but then the next thing I would do is ring someone who knew more than I did. For some reason not everyone is happy to do that, but when you've got cameras over the bed and someone able to look in, someone in the background talking to you -

CHAIR - You can see it live.

Dr LAMPLUGH - To see what you do. That's partly to give you assistance and it's partly to give you confidence. The number of times that Hamish and I were dealing with an emergency in Bourke and we would just ring the other one to say, can you just pop in, I know you're not on call, but can you pop in? Hamish would come in and I would be managing someone with an infarct or whatever it might have been and you'd say, this is the story and this is what I've done. Is there anything you can think of that I have missed? And he would say, no, that sounds fine. Okay. Off you go, back to the pub and I'll keep managing the patient but you manage them much more confidently. That's what some of this telehealth stuff can do. It can give you the confidence that you're not doing anything silly because you don't know what you've forgotten. You know if there's a problem.

There are terrible stories of people forgetting things - simple things that no one picked up.

CHAIR - We have taken a fair bit of your time and unless there's anything pressing remaining?

Thanks, Ross. We really appreciate those insights. It is really helpful. The committee would hope to identify in a report the real challenges, the barriers and potential solutions,

acknowledging that it's not all the state Government's responsibility to fix a lot of this. There is a Commonwealth responsibility too.

Dr LAMPLUGH - No problems. Any time.

CHAIR - Thanks very much. Safe driving too.

THE WITNESS WITHDREW.

THE LEGISLATIVE COUNCIL SESSIONAL COMMITTEE GOVERNMENT ADMINISTRATION A SUBCOMMITTEE INQUIRY INTO RURAL HEALTH SERVICES IN TASMANIA MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE ON TUESDAY 17 MAY 2022.

Dr SHANNON NOTT, VIA WEBEX, RURAL HEALTH DIRECTOR OF MEDICAL SERVICES, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Ms Forrest) - Thank you very much for appearing before us, Shannon. I'm the chair of the committee Ruth Forrest, with Mike Gaffney and Sarah Lovell, and Nick Duigan is our fourth member who will be joining us shortly as he's been held up in a meeting. Our secretary and Hansard are at the back of the room.

We really appreciate you speaking to the committee. You were recommended by other witnesses in terms of your background and experience in the rural health area. We know you work in quite remote areas, and it's been a little hard to be in a position where you could talk to us, so thank you for that. We really appreciate your insight into what you believe the key challenges and opportunities are to enhance the delivery of health care in our rural and remote communities, acknowledging that some remote communities on mainland Australia are potentially harder to get to than some of ours. However, we still have our own challenges here in Tasmania. If you'd like to introduce yourself and talk broadly about your role and the contribution you'd like to make.

Dr NOTT - Thank you very much for having me today. My name is Shannon Nott, I'm here in my capacity as medical adviser for virtual care for New South Wales ministry of Health, but also as the rural health director of medical services for Western NSW Local Health District, a role where I oversee 35 rural and remote health facilities across western New South Wales. I am also an active clinician. I work at the Royal Flying Doctors Service, doing both primary care as well as retrieval.

First and foremost, I'm also here as a rural citizen. I've grown up in rural and remote areas of the country, I have lived there my entire life, my father is a fifth-generation farmer. I have personally experienced the tyranny of distance, the challenges of access to health care, but also the disadvantage that the social determinants bring to rural and remote communities.

Whilst there is a focus on health and hospital facilities and workforce, health outcomes in rural and remote settings cannot be addressed without addressing the underlying social

determinants of health and social disadvantage that are experienced by rural and remote communities Australia wide. This includes things like housing, affordability of fresh fruit and vegetables, the ability to access high quality education and ensuring our children can progress with their education needs throughout their lives, as well as ensuring significant and appropriate job opportunities moving forward to be able to address any issues around socio-economic disadvantage.

Whilst I state that, I don't want to discount the importance of health care workers in rural and remote towns. I note that rural and remote communities Australia wide, in terms of their access to health professionals, receive or experience increasing difficulty in accessing health professionals across the country. No doubt there are challenges in every rural and remote environment Australia wide, including my own in New South Wales, and I'm aware of some of the challenges experienced in Tasmania, and that there are no (inaudible) really targeted and purposeful opportunities to plan, recruit, and--

CHAIR - Just a moment, Shannon, we lost you there for a moment, so if you just go back a little bit.

Dr NOTT - Sure, I was mentioning that Australia wide there are challenges in recruiting and retaining health professionals in rural and remote communities, and that it's been widely recognised that this maldistribution between metropolitan and rural and remote settings has led to a divide in terms of access.

I want to state there is no silver bullet when it comes to addressing this issue. It requires significant planning as well as policies designed to actively recruit and retain health professionals in the bush that will be able to address that, which requires both state level and Commonwealth buy in.

We also recognise that in small rural communities, the notion of rural generalism - specialists, general practitioners with advanced skills to support their local communities -is absolutely required, and a commitment to producing a rural generalist pipeline must be enforced moving forward. This is particularly for every jurisdiction, so that not only can we build a skilled workforce for the future, but we can also grow our own for our respective states, and Tasmania would be no different to New South Wales.

The last point that I wanted to mention is the opportunity of virtual care. I have read a number of submissions presented to this parliamentary inquiry, and I have noted that a number of advocacy groups have identified telehealth or virtual care as an opportunity area for Tasmania to be able to improve some of the access challenges.

We must be mindful that continued efforts to recruit and retain people on the ground need to run in parallel and need to be the focus and priority of any jurisdiction. However, virtual care has significant capability in terms of not only improving access but improving health outcomes for rural and remote communities. If I reflect on a couple of areas in my own region, we've developed a virtual rural generalist service which supports our rural and remote facilities where there is either no local doctor or when the local doctor has put their hand up and said, I need a break. I need fatigue breaks after hours. No longer do doctors want to, or should, work 24/7, 365 days a year which used to be a very common thing in the past, particularly in rural settings.

We've also developed the vCare services where doctors and nurses of frontline clinicians can access 24/7 specialist level advice for emergency presentations. There are a number of other programs across the state, things like telestroke where, if somebody is having an acute stroke, they can access specialist neurologists to support the management of patients across rural and remote settings.

I'll leave it there. I'm sure you have a number of questions. I could talk about a number of different models but I'll leave it there and I'm happy to answer any questions that you may have.

CHAIR - I'd like to start with a couple of questions and other members probably want to come in as well. You talked about the need to address the underlying health determinants and that is an issue in lots of parts of Tasmania. We had a committee look at that some time ago, looking at preventive health broadly, and that was clearly identified there. Still we're having the same discussion many years later.

To start with, I want to go to your point about rural generalism. We have heard from a witness earlier today who's also a doctor who has worked in rural and remote areas. Your point about attracting and retaining and the benefit of having rural generalists who are probably more comfortable operating in those more remote areas. There are a couple of parts to this question, one is the attracting and retaining GPs generally, but particularly attracting and retaining rural generalists in our regional settings. There's an intersection there between the state and the federal government responsibility. How do you see that playing out? That includes the funding of those positions.

Dr NOTT - It's a tricky space and the reality is it requires collaboration between the states and Commonwealth around how we look at funding opportunities because rural generalists, for their community, have a foot in both funding buckets. They support their community from a primary care needs basis, predominantly funded through Medicare but then they also support their hospital which is generally funded through the state. Some of the areas we've had some success in New South Wales look at single employer opportunities where either the state, or through a private/public partnership, fund the doctor where both state and federal money or funding can be put together to service the community.

In my region, when I speak with community members, whilst you explain the intricacies and challenges of the funding buckets and the way that health care is run in rural communities, the reality is that rural people and rural consumers don't care how funding comes about. They care how they can access it and what are their outcomes. We must - people involved with health care and yourselves in parliament - find a way to move forward.

One of the areas that we've been working between state and federal is through a project called collaborative care. This project is funded by the federal government in terms of project support. There is very much real funding put in from the state through our local health district as well as partnership with the Primary Health Network in our region and the Rural Doctors Network, the rural workforce agency for New South Wales. Together, those three bodies that have tried and tested sub-regional approaches to being able to address some of this challenge around rural generalism and the funding component. Of that, the most worked-up model is the four Ts (inaudible) communities and training in Trangie, Trundle, Tullamore and Tottenham, where the district, because of market failure predominantly in the primary care space, has had to step up and run the primary care practices in a comprehensive manner.

CHAIR - Could you give us the four 'Ts again. It got a bit garbled there so the four 'Ts are?

Dr NOTT - Trangie, Tottenham, Tullamore and Trundle.

That's essentially a single employer model where the state is running both the primary care facilities in those small towns. These are towns with populations less than 500 so towns which traditionally, from a traditional business model, for bulkbilling general practices are financially very difficult to maintain, particularly for GPs who may be sole business owners where they have to pay wages, they have to do all their billing and all the licensing and accreditation.

We recognise that doctors in rural environments want a system that allows them to do what they do best, which is treating patients. The four 'Ts model allows us to run the business of running primary care by essentially pooling or bringing together state and federal buckets of money to be able to fund the services for those towns.

Ms LOVELL - Shannon, can I interrupt you there to ask a question on that model? This is something that constantly comes up as one of the challenges with health - particularly with that intersection between primary care and acute care - is that funding model and who is responsible.

Where did that model come from? Was it just that the state said, someone's got to do it so we're just going to do it? Was it lobbied for by particular bodies? Where did that come from?

Dr NOTT - These towns, over a period of time, have had failure of their local general practices because of some of those business reasons that I've referenced. It got to a point about four or five years ago where in speaking with the community, their local GP was waiting to leave. The last GP for those four towns was running their own business. There was a decision made in conjunction with consultation with the community that the districts of the state would step up and start looking at a model that may be translatable or scalable to other locations across our state or the country. With the community, we went through a process of discussion around what does sustainability look like? What does health care in your town look like? Really understanding that and unpicking some of the conversations because in some conversations it was, look, we don't care about getting into discussion around models. We just want a doctor here 24/7.

Then we asked the question, why do you want a doctor here 24/7? It wasn't about having a doctor there 24/7, they wanted to make sure that their elderly had access to scripts on time, that their parents who were in residential aged care could be looked after.

When we started finding and unpicking the actual components that were important for the community we could start looking at a model that was sub-regionally based where doctors worked as a network of practices. Essentially, one team across multiple bases and to have practice management support and LHD support to do what they need to do. We are still going through a process of refining that model and testing it against, in terms of recruitability. We've had some success recruiting doctors into that model. We also want, as part of that collaborative care process, to evaluate it in terms of the quadruple aim, in terms of the value-based health

care. What are our patient experiences? What are the clinician experiences? What outcomes are we driving, and what system level efficiencies?

We don't talk about system level efficiencies. That's not the main driver but it's a consideration when you're thinking about value across health care. We are still going through that process and hope that we will be able to deliver some really good results. There has been a lot of positivity for the community in this space and the community have been very much there as we move forward.

CHAIR - Just on that model, it sounds like you are talking about a network of GPs to provide care to a range of communities that are small, but geographically not thousands of kilometres apart.

Have you or do you intend to look at a model that expands to the use of nurse practitioners or other allied health professionals within that? Because you're talking about meeting community need. What is this community need?

Dr NOTT - When we talk about the model in terms of workforce, we talk about a rural generalist model, not just as in rural generalist doctors but also generalist nurses. If you look at a traditional view of what happens in a country town, the local GP practice will usually employ a practice nurse. The hospital will have hospital nurses, maybe some community nurses. Often the two don't actually cross over, from the nursing perspective, so essentially, they start competing for the workforce. For us, part of this process was actually upskilling our nurses so that they could do community nursing but also practice nursing. Upskilling our administrative staff so that they could work for the hospital but also step in and work for the practice.

For us, it was expanding and making a generalist model out of every person who was supporting this project. Also, looking at how do we implement and integrate other health professions. Nurse practitioners are one. We do not have a nurse practitioner there but there is certainly a willingness to look at good nurse practitioners. One of our challenges across our region is that maldistribution that is associated with doctors is also associated, unfortunately, with nurse practitioners.

Where does telehealth play a role here? Telehealth, in terms of access to sub-specialist care, in terms of the outpatients setting in primary care, but also for the GPs because most of these communities are sole doctor towns, due to their size. We want to be able to give them a break. After hours, these towns are covered by a virtual generalist service. The nursing staff that are on overnight will predominantly contact rural generalists who are trained in their region, understand their region's needs and they will do a virtual assessment of the patient and treat them. The local doctor is still on call, when available, if there is a true emergency that needs another medical set of hands.

The vast majority of presentations to these rural communities are managed after hours and on weekends with virtual medical cover and nursing support as well as paramedic support in the town. That allows our doctors to have a break and we hope that this improves their ability to be retained. Some of the early evaluation of that, the work with the virtual generalist service, the feedback, particularly from VMOs in small towns, doctors visiting their local hospitals, has been that they wouldn't be staying in that hospital if they didn't have that support.

CHAIR - To the uncomfortable discussion about money. Do you want to go to somewhere else first?

Mr GAFFNEY - Just on the nurse practitioner one. Help me out here a little bit.

For nurse practitioners to be involved in Tasmania, to be able to do their full scope of practice, there would have to be some legislative change to some of the bills and acts that the nurses would want to be able to participate or work under.

Are you aware of any movement or passion from the government in New South Wales to address some those legislative barriers that might be holding back some of the nurse practitioners or nurses to do some of that practice?

Dr NOTT - There is a lot of work being done in New South Wales around nursing scope of practice which integrates the nurse practitioner component. You are right to mention that scope of practice of the nurse practitioners are different for individual nurse practitioners, depending on the type of training that they choose to go through, as well as, for lack of a better term, the supervisional medical linkage they have with a doctor or doctors in their local setting.

First and foremost, in rural and remote areas, we need everyone to be able to work to top of scope and that includes our registered nurses and enrolled nurses as well. Looking at ways that we can better train them to work alongside different models of care or multiple different models of care is really important. From a nursing perspective, we need to ensure that nurses have fulfilling careers and can work to top of scope. That means being able to assess people, like some of the remote area nurses do in parts of Queensland, the Kimberley, the Northern Territory, that are backed by policy and guidelines.

You may be aware that we've had our own rural health inquiry in New South Wales, and some of those recommendations were very much ensuring supports for nursing staff. A number of those programs are underway in terms of looking at optimising scope of nurses, and also optimising the workforce support and professional development provided to them in rural contexts.

Mr GAFFNEY - Thank you, and before Ruth goes down the funding one, which she will, one question on that too. We heard here in Tasmania how the longevity of our paramedics is probably only five years or so because of the stressful situations they find themselves in, and a lot of the paramedics are lost to the health service industry because there is no further stepping stone. If there were other courses, like paramedic practitioners et cetera, their skills could be utilised elsewhere.

CHAIR - They are limited to an Ambulance Tasmania employment.

Mr GAFFNEY - Yes, is that an issue that you guys have identified? Or if it has been, how have you been able to keep them within the service industry longer?

Dr NOTT - I think access to paramedics in rural and remote parts of New South Wales and further abroad in Australia has the same challenges that we're talking about with medical and some of the skilled nurses as well, so I don't think we're at all perfect in New South Wales. I'm aware of some of the submissions to your inquiry talk about paramedic practitioners or

paramedic physician assistant practitioners in terms of how they might be able to supplement the medical workforce in rural and remote areas.

Similar to what I was discussing with nurses, in our rural environments we need to look at opportunities for health professionals full-stop to be able to progress their careers and career paths. There is a lot of work, a lot of literature around rural and remote recruitment, retention and workforce, in terms of a framework. There's a program that's publicly available called Making it Happen, which is specifically talking to some areas in which we can recruit and retain rural and remote professional workforce. It provides a framework for remote and rural workforce stability. One of those components - very much in terms of retention - is the relevant professional development career progression. If highly skilled professionals - and this is general, I'm not just talking about health professionals - do not see opportunities to progress their careers, then they will look elsewhere. Unfortunately, if that's not available in a rural and remote area, then that may mean moving to a metropolitan area.

CHAIR - Going to the funding, we were speaking to another doctor who has worked in rural areas previously, and he was describing to us the limitation of the Medicare system in the way it funds clinical appointments. You are really almost forced to have six-minute appointments. In the rural areas patients often delay coming for care and they're more complex and need longer appointments. From your perspective, could you talk about funding, the cost of delivery of service, but also what's needed to attract doctors to regional and rural parts of Australia, Tasmania? Also, with the rural generalist, how much more are they paid, and is that the most appropriate pathway, or should we be looking at the whole problem?

Dr NOTT - I think to start with your final sentence in terms of looking at the rural generalist or looking at the whole problem, I don't think we can isolate state vs federal when looking at rural and remote communities. The reality is that general practice has gone off the nose with a lot of young students going through. We're at an all-time low in terms of medical student interest in general practice as a speciality. I think it's sitting around 15 per cent or a little bit lower across the country. You compare that with the UK which has set very optimistic and high thresholds for primary care where they would like 50 per cent of their total medical grads entering general practice because they recognise that primary care is a significant linchpin of the health system.

There's evidence worldwide looking at where do we need to invest for improvements in health care, and primary care comes out on top all the time. When you talk about funding for doctors in rural and remote environments, that does require us to think about how a business model is working for predominantly rural GPs which is highly reliant on Medicare. The Medicare freeze has not helped the attraction and pay in terms of pay parity for rural doctors against the costs of running a business. Either rural doctors then start charging a gap, which we know results in people delaying care further, or not seeking primary care and ending up in EDs.

We then will have further problems in the hospital sense. Advocacy around how we fund rural environments needs to be looked at. There are avenues for pooling state and federal funding and funding buckets. There are things like the 19(2) exemptions across the country where small rural facilities can both access Medicare for non-admitted patients as well as fund services from a state or other government perspective. The 19(2) exemptions that were most recently under review, a report by Christine Banny (tbc) who has looked at 19(2) and opportunity areas in that space. I think for smaller rural communities, there are opportunities

for us to combine that state and federal funding to be able to ensure continuity and funding of services.

Additionally, when you ask about funding for rural generalists, there is a lot of work being done across the country around recognising rural generalism as a sub-speciality of the field of general practice and that's going through the Medical Board at the moment. With that recognition of rural generalism as a sub-speciality of general practice, there are opportunities for us to pursue awards that recognise the additional training that rural generalists have. Like with some of the components I have previously mentioned, to attract and retain people, whilst money is not the be-all and end-all, it is certainly a factor for people in considering career paths in terms of, will I be able to earn enough to support my family. We have to make sure that there are competitive awards for rural generalists who are working in difficult and often geographically or potentially professionally isolating areas.

CHAIR - With the 19(2) exemptions, I think it was Dennis Lennox who mentioned those in his evidence to us and perhaps others as well. That's obviously under the federal government MBS framework. How widely is that utilised? We have hospitals in our state in a variety of places that provide aged care within their services. Would that be funded through the Commonwealth through a similar exemption? Then you also have patients who turn up after hours for what normally would be a GP service but are seen by the GP who would normally be in the practice - I'm sure you understand what I'm saying.

Dr NOTT - Yes. I'm not completely familiar with the funding systems in Tasmania, but generally, aged care is still funded by the federal government. The 19(2) requires an application at a local facility level to the federal government to be able to be - to exempt. That is a collaboration somewhat between the local facility and the community. There are requirements around consultation of health providers in the community to put that forward to the federal department for application.

There are opportunities for jurisdictions to negotiate what a 19(2) looks like, and I believe there are negotiations underway with different jurisdictions and the federal government around 19(2). In terms of how widespread they are, it seems from the report that was commissioned, that they're highly utilised in Queensland, there's some variability in New South Wales, Victoria, and indeed Tasmania as well, although I am aware that 19(2) has been applied for in a number of your facilities. How it's utilised, there was wide varying ability to bill through 19(2) between the jurisdictions by the realm of, in some circumstances, hundreds of thousands of dollars per facility per annum compared to other places. I wouldn't be able to comment on what Tasmania looks like. I can't recall that off the top of my head, but there would be detail in that document.

CHAIR - As I understand it, if an exemption was sought, that just applies to the general medical services not the aged care or services normally provided by a GP, is that right?

Dr NOTT - It is for non-admitted patients, even emergency department patients who are lower acuity patients. Some of that activity that traditionally would be wholly funded through the state system, you would be able to track Medicare billings through that as well. There are some areas that also look at radiology and pathology, which would also be covered through Medicare in a primary care environment. There are opportunities to look at what that looks like for each jurisdiction.

CHAIR - Some of our hospitals have aged care in them and the staff manage both, like King Island, Queenstown down the west coast, Flinders Island. If a resident in the aged care section of the hospital required a doctor to assess their chest for potential pneumonia, could you apply for that funding from Medicare?

Dr NOTT - Traditionally that should be entirely funded through Medicare. It may be different in Tasmania, but in New South Wales if you have an aged care facility attached to a local hospital or a multipurpose service that we have, the activity in there would entirely be covered through Medicare. There is a caveat to that. If the patient - let's say someone fell - and they got wheeled around to the acute section of the hospital, they're then an emergency patient and under traditional funding arrangements you wouldn't be able to access Medicare for that. There's some subtlety to it, but under a 19(2) if that aged care patient fell, they became an acute patient, moved across into ED and were not admitted then you would be able to bill Medicare for that activity as well.

CHAIR - Sounds like a really complicated system. Going back to the point you made earlier about the single employer model, which would see - as I understand it, and correct me if I'm wrong here, Shannon - there's federal, the state, even primary health networks, but they're funding by the federal government anyway. They put money into a bucket that is then used for the community as a single funding model, which is a bit like - we talked with the people from Buurtzorg who run more allied health, disability services in Western Australia and Queensland. How mature are these models, and is this something that could work in Tasmania?

Dr NOTT - With these models there's a multiple single employer - for lack of a better term, if you use that as an umbrella term - there's a number of single employer models across the country. One of those is the four Ts that I've described to you, where essentially the money gets reinvested back into the community for services moving forward. It allows us to pay the doctors a competitive amount of money. Competitive, not only in terms payment between doctors across the state in New South Wales, but also competitive in relation to some of the locum markets at the moment which have been highly inflated due to COVID-19.

There are other single employer models. I am aware in New South Wales my colleagues to the south of me in Murrumbidgee are trialling a single employer model for registrars, the doctors who are training to become GP specialists. Traditionally when you became a GP registrar, you would go into this funding model through Medicare where you would get a percentage of your billing list. Now, as a young registrar with no patient base, that generally results in a significant loss of income compared to if you had maintained yourself in the hospital environment. Not to mention the loss of additional award structures like sick leave, annual leave and penalty rates and those types of things.

Murrumbidgee has utilised this model to try to increase interest in general practice by maintaining registrars as they trained to become GP specialists, which was not happening in the past.

There are other single employer models where private organisations take the role of the employer. I believe, in Tasmania, Ochre Health have a number of contracts for you. That is under a single employer model or a private model where the state is funding the VMO or hospital-based services where Ochre as an organisation will be able to put into a bucket what they bill through primary care to create attractive and competitive remuneration options for their doctors.

CHAIR - We were talking to Ross earlier today and I did ask him the question about the viability of the model that they oversee, like in King Island, west coast, east coast of Tasmania and Flinders Island. I asked him the questions about where there is a community that doesn't have a rural hospital, is that a financial sustainable model for him or for Ochre? Effectively, he said no. You need to have that intersection between the VMO aspect of the funding and the general practice. In terms of it as a single funded model, yes. It is designed to work where there is the interplay with the state funded rural hospital.

What about those communities that have a doctor but no hospital? They've probably got a pharmacy in town. How can it work there, or can it work there?

Dr NOTT - Based on what exists at the moment, I think that is why we have failure in primary care in some of these communities because this business model, particularly a bulk billing model, recognising that many of these small towns have significant socio-economic disadvantage and the ability for community methods to pay out of pocket is limited.

That is where there needs to be some collaboration between states and the Commonwealth around acknowledging that there are potentially some funding gaps, predominantly in the primary care space. This sits in the realm of if there is no hospital or health service, there is a gap there in terms of primary care services. How do we actually look at funding the gap, because there is a gap at the moment in terms of what Medicare is paying and what the business costs are for private GPs. There are some examples around 3GA programs where the government does fund in a block funded way or an additional way some services. So, RFDSs are block funded for remote communities in terms of providing primary care into those towns. AMSs both get some degree of the block funding but also access Medicare. Looking at that, in terms of what models have worked, both here and overseas, it is an opportunity area in rural and remote health.

CHAIR - I want to ask you about pharmacy services. How important are those to be, not necessarily co-located right in the same facility, but certainly within that community where the other services are? Particularly in small communities where they rely on the sale of non-pharmaceuticals that should make the business profitable at times.

Dr NOTT - Yes. It's very clear, recognising in small rural communities they have an ageing population. You can make assumptions that with an ageing population the burden of chronic disease and (inaudible) disease which people would have increases as well. Obviously, that increases your reliance on medications, so timely access to medication is incredibly important in small rural and remote communities.

The other thing that I will mention, there is an opportunity, referencing telehealth, that medication misadventure in our hospital system worldwide is one of the leading causes of harm in hospitals and health systems. Globally, it's recognised as a priority area for the World Health Organization. We also recognise that clinical pharmacists - hospital-based pharmacists or pharmacists in the hospital - supporting doctors and nurses with medication management and treatment are an effective way of being able to support the system and keep patients safe.

One of the programs we have in our regions are virtual clinical pharmacy services, recognising that they're in small facilities where they may only see two or three patients a day. It's not feasible to have a pharmacist in that facility 24/7; however, with the utilisation of video

conference and infrastructure we can have virtual pharmacists, clinical and hospital-based pharmacists, a team that supports any patient who presents across a wide footprint of rural Australia.

We've done some research on that and the rates, the medication reconciliation, getting medication rates and medications to the right facilities, have risen by 20-fold by implementing that service. Discharge medications, writing accurate lists, the doctors on discharge have risen significantly as well. The best possible medication history, actually making sure that we have accurate knowledge about medications has risen also around 33 times. So, there are ways, and this is a great example of how virtual care is supplementing that face-to-face care in rural regions.

CHAIR - In terms of the virtual pharmacist, obviously, stock of a pharmaceutical product goes out of date. How do you ensure that access to the medications a patient needs in these areas is available and delivered to them when they live in those more isolated areas?

Dr NOTT - That requires strong policy and processes at a local level. Often in smaller facilities, nurses traditionally on night shift are responsible for checking their drug cupboards. That's a process in some facilities where there are administration staff to do that. Also, wherever they're getting their stock from if they have good processes in place with rotating stock. There are drugs that are important in emergency departments that aren't always used so having a good process of rotating drugs is really important. To that question, that requires really strong leadership, locally and across the system, and good processes that support the rotation and timely access to medications.

CHAIR - Thanks for that. We could probably talk to you for ages, Shannon, because there is so much. We appreciate your time and expertise.

Is there anything that you think is a key take-home message that we need to really take on board, aside from fixing the underlying social determinants which is a no-brainer but it seems to be the hardest thing to do? Are there any other key messages you would like to pass on?

Dr NOTT - If you look at that framework for remote (inaudible) for stability and it's through a European website, a collaboration across multiple countries. The website is called Making It Work. That details three areas that I've mentioned before around planning, service modelling to meet needs, recruiting - and we've talked a little bit about recruitment today - and one component of recruitment that we can't forget. When you are recruiting health professionals to rural and remote areas, you are not necessarily only recruiting one person. We need to support thousands in families coming into rural and remote areas. The mining industry has done this pretty well. Where they have had a skilled workforce going in and they have recognised that their spouse may not be able to get a job, they have offered opportunities to upskill or retrain in areas of industry that support moving to a different community.

The retention component requires us to think really carefully about succession planning. There has been a lot of work put in at the national level around rural generalist pipeline and rural generalist training across the system and ensuring that we have robust mechanisms to train junior doctors, and to promote the concept of rural generalism is a must moving forward.

CHAIR - Thank you very much. Thanks for your time. We appreciate the insights and expertise. It has actually consolidated evidence that we have had, which is helpful, so thank you.

Dr NOTT - No problems. Thank you very much for your time.

THE WITNESS WITHDREW.